



Florida Medicaid

DEVELOPMENTAL DISABILITIES INDIVIDUAL BUDGETING MEDICAID WAIVER COVERAGE AND LIMITATIONS HANDBOOK

Agency for Health Care Administration

December 2012
DRAFT



UPDATE LOG
DEVELOPMENTAL DISABILITIES INDIVIDUAL BUDGETING
MEDICAID WAIVER COVERAGE AND LIMITATIONS
HANDBOOK

How to Use the Update Log

Introduction

The current Medicaid provider handbooks are posted on the Medicaid fiscal agent's Web site at www.mymedicaid-florida.com. Select **Public Information for Providers**, then **Provider Support**, and then **Provider Handbooks**. Changes to a handbook are issued as handbook updates. An update can be a change, addition, or correction to policy. An update will be issued as a completely revised handbook.

It is very important that the provider read the updated material in the handbook. It is the provider's responsibility to follow correct policy to obtain Medicaid reimbursement.

Explanation of the Update Log

Providers can use the update log to determine if they have received all the updates to the handbook.

Update describes the change that was made.

Effective Date is the date that the update is effective.

Instructions

When a handbook is updated, the provider will be notified by a notice. The notification instructs the provider to obtain the updated handbook from the Medicaid fiscal agent's Web site at www.mymedicaid-florida.com. Select **Public Information for Providers**, then **Provider Support**, and then **Provider Handbooks**.

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

UPDATE	EFFECTIVE DATE
NEW HANDBOOK	December 2012

DEVELOPMENTAL DISABILITIES INDIVIDUAL BUDGETING MEDICAID WAIVER COVERAGE AND LIMITATIONS HANDBOOK

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INTRODUCTION TO THE HANDBOOK

Overview

Introduction

This chapter introduces the format used for the Florida Medicaid handbooks and tells the reader 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 are eligible to receive them, and the fee schedules.
- Reimbursement Handbooks describe how to complete and file claims for reimbursement from Medicaid.

All Florida Medicaid Handbooks can be accessed via the internet at: www.mymedicaid-florida.com. Select **Public Information for Providers**, then **Provider Support**, and then **Provider Handbooks**.

Legal 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 409, Florida Statutes; and
 - Chapter 59G, Florida Administrative Code.
-

In this Chapter

This chapter contains:

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Purpose

The purpose of the Medicaid handbooks is to educate the Medicaid provider with the 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.

Handbook Use and Format

Provider	The term “provider” is used to describe any entity, facility, person or group who is enrolled to provide services on behalf of the Florida Medicaid program and provides services to Medicaid recipients and bills Medicaid for services.
Provider Staff	Staff employed by the provider agency to carry out some or all duties of a specific service. Provider staff must meet all the requirements outlined in the Developmental Disabilities Individual Budgeting Medicaid Waiver Coverage and Limitation Handbook as specified for that service under the provider qualifications section.
Recipient	The term “recipient” is used to describe an individual who is enrolled in Medicaid.
Provider General Handbook	General information for 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. This general handbook is distributed to all enrolled Medicaid providers and is updated as needed.
Coverage and Limitations Handbook	Each Florida Medicaid coverage and limitations handbook is named for the service it describes. A provider who provides more than one type of service will have more than one coverage and limitations handbook.
Reimbursement Handbook	Each Florida Medicaid reimbursement handbook is named for the claim form that it describes.
Chapter Numbers	The chapter number appears as the first digit before the page number at the bottom of each page in the handbook.
Page Numbers	Pages are numbered consecutively throughout the handbook. Page numbers follow the chapter number at the bottom of each page.
White Space	The "white space" found throughout a handbook enhances readability and allows space for writing notes.

Characteristics of the Handbook

Format

The format styles used in the handbook represent a short and regular way of displaying difficult, technical material.

Information Block

Information blocks replace the traditional paragraph and can consist of one or more paragraphs about a portion of the subject. Blocks are separated by horizontal lines.

Each block is identified or named with a label.

Label

Labels or names 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.

Note

Note is used most frequently to refer the user to important material located elsewhere in the handbook.

Note also refers the user to other documents or policies contained in other handbooks.

Topic Roster

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.

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."

How Changes Are Updated

Florida Medicaid handbooks will be updated as needed. Changes can be:

1. Replacement handbook: major changes will result in the entire handbook being replaced with a new effective date throughout and it will be a clean copy.
 2. Revised handbook: changes will be highlighted in yellow and will be incorporated within the appropriate chapter. These revisions will have an effective date that corresponds to the effective date of the revised handbook.
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Handbook Updates, continued

Effective Date of New Material

The month and year that the new material is effective will appear at the bottom of each page. 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 material will be identified by yellow highlighting. The following information blocks give examples of how new labels, new information blocks, and new or changed material within an information block will be indicated.

New Label and New Information Block

A new label and a new information block will be identified with yellow highlight to the entire section.

New Material in an Existing Information Block or Paragraph

New or changed material within an existing information block or paragraph will be identified by yellow highlighting to the sentence or paragraph affected by the change.

CHAPTER 1

iBUDGET WAIVER

PROVIDER QUALIFICATIONS AND ENROLLMENT

Overview

Introduction

This chapter describes the Developmental Disabilities Individual Budgeting Medicaid Waiver provider qualifications and enrollment specifying the authority regulating waiver services, and the purpose of the program.

Legal Authority

Home and Community-Based Services (HCBS) waiver programs are authorized under section 1915(c) of the Social Security Act and governed by Title 42, Code of Federal Regulations (CFR), Parts 440 and 441.

Sections 393.0662 and 409.906, Florida Statutes (F.S.) and Chapter 59G, Florida Administrative Code (F.A.C.), authorize the application for Florida Medicaid Developmental Disabilities Individual Budgeting Waiver.

The iBudget Waiver program is referenced in Chapter 393, Florida Statutes (F.S.), and Rules 65G-4.0210-.0218.5, F.A.C.

Specific statutory authority for the promulgation of this Handbook into rule is found in sections 393.0662, 408.302, and 409.919, F.S.

The Agency for Health Care Administration (AHCA) has final authority on all policies, procedures, rules, regulations, manuals, and handbooks pertaining to the waiver. The Agency for Persons with Disabilities (APD) is authorized by AHCA to operate and oversee the waiver in accordance with the Interagency Agreement between AHCA and APD regarding the Florida Medicaid Developmental Disabilities Individual Budgeting Waiver.

In This Chapter

This chapter contains:

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Purpose and Description

Purpose

The Developmental Disabilities Individual Budgeting Medicaid Waiver Coverage and Limitations Handbook, hereinafter referred to as the Handbook, is for providers who furnish Developmental Disabilities Individual Budgeting Medicaid Waiver services to individuals enrolled in that waiver. It must be used together with the Florida Medicaid Provider General Handbook, which contains information about the Medicaid program, and the Florida Medicaid Provider Reimbursement Handbook, CMS-1500, which contains procedures for submitting claims for payment.

Description

The iBudget waiver as referenced in Chapter 393, F.S., and Rules 65G-4.0210–.0218.5, F.A.C., is a Medicaid program that provides home and community-based supports and services to eligible persons with developmental disabilities living at home or in a home-like setting. The iBudget waiver program is funded by the federal Centers for Medicare and Medicaid Services (CMS) and matching state dollars.

This waiver reflects use of an individual budgeting approach and enhanced opportunities for self-determination. The purpose of the waiver is to promote and maintain the health of eligible individuals with developmental disabilities; to provide medically necessary supports and services to delay or prevent institutionalization, and to foster the principles of self-determination as a foundation for services and supports. The intent of the waiver is to provide an array of services from which eligible individuals can choose, which allow them to live as independently as possible in their own home or in the community and to achieve productive lives. Eligible individuals can choose between the iBudget waiver or an Intermediate Care Facility for the Developmentally Disabled (ICF/DD).

Enrollment in the waiver enables an individual to have a safe place to live in addition to other medically necessary services and supplies. The waiver embraces the principles of self-determination, which include freedom for the individual to exercise the same rights as all citizens; authority to exercise control over allocated funds needed for one's own support, including the reprioritization of these funds when necessary; responsibility for the wise use of public funds in concert with the enrollee's providers; and self-advocacy to speak and advocate for oneself and others who cannot do so in order to gain independence and ensure that all individuals with a developmental disability are treated equally.

Purpose and Description, continued

Description,
continued

This waiver enhances each individual's opportunity for participant direction by providing greater choice among services within the limits of an individual budget. To facilitate this, similar services are grouped in service families. Individuals will have opportunity to shift funds between services, within a service family and between service families, as long as health and safety needs are maintained, enabling them to respond to changing needs. Prior authorization of service review processes will be tailored to maximize an individual's flexibility while assuring health and safety. Individuals and their families will be supported in exercising greater participant direction by receiving training regarding managing their individual budgets and making informed choices. This training will be provided by waiver support coordinators (WSC), through paid waiver services, and through other means. Individuals and families will also be provided relevant information on the variety of waiver and community supports that are available. iBudget waiver enrollees will have access to a Web site that helps them select waiver services and track waiver service use. This Web site will maximize flexibility while supporting individuals in responsibly managing their individual budgets.

The iBudget waiver program requires using waiver funds as only one of many sources of supporting an individual. Waiver services shall not replace the supports already provided by family, friends and other agencies or programs. The waiver is the payer of last resort. Individuals, families, WSCs, and providers are responsible for seeking non-waiver supports to supplement or replace waiver-paid services. State and federal funds are to be used only when a family or community support is unavailable or while a support is being developed.

The individual, WSC, and service providers shall work together to accommodate the needs of the individual within the individual's waiver services allocation. Individuals will know their service amounts at the outset of the planning process so that cost plans can be based on the individual's priorities

1. The amount of an individual's budget allocation is determined by a formula as specified in APD Rule 65G-4.0212, F.A.C. and depends on the amount of funding for waiver services that is appropriated by the Florida Legislature. Individuals may not have enough funding in their budget allocations to be able to obtain all services through the waiver. They will have to work with their families, circles of support, and WSCs to obtain from other sources those services that their budget allocation is not able to fund.
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Purpose and Description, continued

Description,
continued

2. WSCs are responsible for supporting individuals' self-direction, working creatively to meet their needs, and for monitoring individuals' health and safety. The iBudget waiver system encourages WSCs working with individuals and families to locate and develop natural and community supports. WSCs should work with individuals and families, along with other providers and APD staff, to identify and develop resources, such as help from family, friends, colleagues, churches, businesses, etc., who might be approached directly with requests to support an individual outside of a formal organizational program of assistance. WSCs have a key role in promoting individuals to be competitively employed based on the individual's interests, talents, and abilities.

Providers are responsible for respecting each individual's choices, working with others who support the individual to deliver high-quality services to that individual, and providing necessary information in a timely manner to facilitate each individual's service needs.

Enrollment

Individual Eligibility Requirements for Enrollment into the iBudget Waiver Program

Recipients in the iBudget waiver must meet the eligibility requirements in accordance with Chapter 393, F.S. In addition, the individual must meet the level of care criteria for placement in an ICF/DD and must be eligible for Medicaid under one of a variety of categories described in the Florida Medicaid Provider General Handbook.

Level of Care Requirements for iBudget Waiver Eligibility Requirements

Individuals who are eligible for Medicaid benefits must also meet all of the following conditions to be eligible for enrollment in the waiver:

Applicants must be determined to meet eligibility requirements for waiver services. For applicants who have not yet been determined eligible for services, the determination of waiver eligibility shall be pended until eligibility for services has first been determined. The qualifying definitions for developmental disabilities waivers and the conditions included in that definition are found in section 393.063, F.S.

Eligibility for the waiver is limited to the following qualifying disabilities:

- The individual's intelligence quotient (IQ) is 59 or less; or
- The individual's IQ is 60-69 inclusive and the individual has a secondary handicapping condition that includes:
 - Down Syndrome;
 - Cerebral palsy;

Enrollment, continued

Level of Care Requirements for iBudget Waiver Eligibility Requirements, continued

-
- Spina bifida;
 - Prader-Willi Syndrome;
 - Epilepsy;
 - Autism; or
 - Ambulation, sensory, chronic health, and behavioral problems; or
- The individual's IQ is 60-69 inclusive and the individual has severe functional limitations in at least three major life activities including self-care, learning, mobility, self-direction, understanding and use of language, and capacity for independent living; or
 - The individual is eligible under a primary disability of Down Syndrome, autism, cerebral palsy, spina bifida, or Prader-Willi Syndrome. In addition, the condition must result in substantial functional limitations in three or more major life activities, including self-care, learning, mobility, self-direction, understanding and use of language, and capacity for independent living.

The individual must choose to receive services in the community instead of receiving services in an intermediate care facility for the developmentally disabled, nursing facility, or hospital.

In accordance with 42 CFR 441.301, no waiver services can be provided or billed on dates of service while the individual is an inpatient in a hospital, rehabilitation facility, or long term care facility. The only exception is support coordination services that may be provided while the individual is a patient. These services cannot duplicate the services of a hospital discharge planner or facility social worker and cannot be billed until after the individual is discharged.

Eligibility

Medicaid Eligibility

Individuals who are not already eligible for Medicaid benefits through Supplemental Security Income, (MEDS-AD), or Temporary Assistance to Needy Families at the time of application for the iBudget waiver must apply or have a designated representative apply for Medicaid benefits through the Department of Children and Families. Eligibility can be applied for online at: www.myflorida.com/accessflorida.

Note: Refer to the Florida Medicaid Provider General Handbook for information on verifying individual eligibility for Medicaid State Plan services.

Once Medicaid, waiver eligibility requirements are met, APD shall review the individual's request for home and community-based supports and services and shall determine if:

Eligibility, continued

Medicaid Eligibility, continued

- A waiver vacancy is available;
- Sufficient funding is available to meet the individual's needs; and
- The individual can be safely maintained in the community.

APD maintains the statewide waitlist of applicants awaiting waiver services. Enrollment in the waiver is available only when APD has determined it has sufficient funding to offer an enrollment to an individual.

Conditions Under Which an Individual is Ineligible for the Waiver

When an individual is enrolled in the waiver, that individual remains enrolled in the waiver position allocated unless the individual becomes disenrolled due to one of the following conditions:

- The individual or legal representative chooses to terminate participation in the program;
- The individual moves out of state;
- The individual becomes ineligible for the waiver because of a loss of eligibility for Medicaid benefits and this loss is expected to extend for a lengthy period;
- The individual no longer needs waiver services;
- The individual no longer meets level of care for admission to an ICF/DD;
- The individual no longer resides in a community-based setting but moves to a correctional facility, detention facility, defendant program, or nursing home or resides in a residential facility not defined as a licensed residential setting as specified in this Handbook;
- Is not cooperative with the provision of waiver services as specified in this Handbook, such as refusal to develop a cost plan or support plan, participate in a required Questionnaire for Situational Information assessment, or refusal to annually sign the waiver eligibility worksheet (required to establish a level of care).
- The individual is no longer able to be maintained safely in the community; or
- The individual becomes enrolled in another HCBS waiver.

If an individual is disenrolled from the waiver and becomes eligible for re-enrollment within 365 days, that individual can return to the waiver and resume receiving waiver services.

If waiver eligibility cannot be re-established or if the individual who has chosen to disenroll has exceeded this time period, the individual cannot return to the waiver until a new waiver vacancy and funding is available. In this instance, the individual is added to the waitlist of persons requesting waiver participation. The new effective date is the date eligibility is re-established or the individual requests re-enrollment for waiver participation.

Providers are responsible for notifying the individual's WSC and APD if the provider becomes aware that one of these conditions exists.

Medical Necessity

Medical Necessity

Medical necessity refers to a set of conditions established by AHCA, for determining the need for and appropriateness of Medicaid-funded services for an enrolled recipient. As defined in Rule 59G-1.010(166), F.A.C., as it relates to medical necessity or medically necessary means that, the medical or allied care, goods, or services furnished or ordered as defined as meeting the following conditions:

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

APD shall determine whether a service requested to be provided with waiver funding is medically necessary in accordance with the Medicaid Program medically necessary definition list above. The fact that a physician, advanced registered nurse practitioner, or physician assistant 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 medically necessary or a covered service.

Medical Necessity Determinations

For some services, a medical necessity determination by a qualified professional shall be required to determine that the standards for medical necessity are met and that the requested item meets the service definition, as contained in the approved iBudget waiver and in this Handbook.

If sufficient information is not available to determine that the service or item is medically necessary, a written request from APD for more information will be sent to the WSC and the individual, family, or legal representative. If it is determined that the service is not medically necessary or does not meet other requirements for it to be a paid waiver service, a written denial of the service and notice of due process will be sent from APD to the individual, family, or legal representative and copied to the WSC. An individual receiving Medicaid can appeal decisions made by APD by requesting a hearing, in accordance with federal and state laws and regulations. A request for hearing shall be made to APD, in writing, within 30 days of the individual's receipt of the notice.

A prescription for a service or item does not in itself establish a medical necessity determination.

Medical Necessity, continued

Freedom of Choice

The iBudget waiver is designed around individual choice. Accordingly, individuals served through the waiver can select among enrolled, qualified service providers and can change providers at any time. Within the funds allocated in individuals' budget allocations, individuals are free to change enrolled, qualified providers as desired to meet the goals and objectives set forth in their support plans. Freedom of choice includes individual responsibility for selection of the most cost beneficial residential environment and combination of services and supports to accomplish the recipient's goals.

Requirements

Services and the Hierarchy of Reimbursement

Services shall not be authorized under the waiver if they are available from another source. The WSC determines whether the same type of service offered through the waiver can be accessed through other funding sources, including the Medicaid State Plan, and if so, they shall coordinate the service through the alternate funding source.

Funding sources shall be accessed based on the following in this order:

- Natural and community supports;
- Third Party Payer, such as private insurance;
- Medicare;
- Other Medicaid programs; and
- iBudget waiver, which is the payer of last resort.

For example, the Florida Medicaid Durable Medical Equipment and Medical Supplies services must be accessed before using waiver consumable medical supplies or specialized medical equipment services. Effective, July 1, 2013, WSCs will request incontinence supplies through the Medicaid State Plan pursuant to Rule 59G-13.086, F.A.C., Developmental Disabilities Waiver Disposable Incontinence Medical Supplies Fee Schedule.

If an individual is dually-eligible under Medicare and Medicaid, the WSC must secure services from providers enrolled as Medicare and Medicaid providers so that any services that are covered by Medicare can be billed to Medicare first before billing to Medicaid (For example, Medicaid cannot reimburse a non-Medicaid home health agency for Medicare reimbursable services provided to a dual-eligible individual).

To obtain specific information about Florida Medicaid State Plan coverage, refer to the appropriate Medicaid Coverage and Limitations Handbook for the particular service. Handbooks can be downloaded from the Medicaid fiscal agent's Web site at www.mymedicaid-provider.com. Select **Public Information for Providers**, then **Provider Support**, and then **Provider Handbooks**. The Medicaid Coverage and Limitations handbooks for the particular services are incorporated by reference in the service-specific rules in Chapter 59G-4, F.A.C.

CHAPTER 2 iBUDGET WAIVER DEFINITIONS AND ACRONYMS

Overview

Introduction

This chapter defines terms and acronyms for the Individual Budgeting Medicaid Waiver Program.

In This Chapter

This chapter contains:

TOPIC	PAGE
General Definitions and Acronyms	2-

General Definitions and Acronyms

Agency for Health Care Administration (AHCA)

The single state Medicaid agency responsible for the administration of the iBudget waiver program. This agency has final authority on all policies, procedures, rules, regulations, and handbooks pertaining to the waiver.

Agency for Persons with Disabilities (APD)

The state agency responsible for the day-to-day operation of the iBudget waiver program as described in the AHCA promulgated handbooks.

Agency Provider

Agency Provider - An agency is a business or organization consisting of three or more employees who are issued W-2 forms. The agency or organization must be enrolled to provide a waiver service(s) and is approved by the Regional office of the Agency for Persons with Disabilities to bill at the agency rate based on current quality improvement reviews. The agency rate is used for all services that are directly provided by employees of the provider. All employees must meet the qualifications and requirements specified in the provider's agreement and those specified for enrolled services(s). The provider shall maintain personnel files documenting qualifications of all employees and their background screening results

Allocation, Budget and Contract Control (ABC) System

The system used by the APD that contains key demographic and recipient-related information. This information includes the individual's address, county of residence, program component, legal representative name and address, if applicable, and type of benefits received.

General Definitions and Acronyms, continued

Amount, Duration, Frequency, Intensity, and Scope

Amount, Duration, Frequency Intensity, and Scope are service components as reflected on a recipient's service authorization and are defined as follows:

- **Amount** - The total amount of units or dollar amount for which the service authorization is approved.
 - **Duration** - Length of time a service authorization is approved. Can be found as the beginning and ending dates on the service authorization.
 - **Frequency** - Number of times the service is provided in a given time period. Specific limitations to frequency should not be limited to a specific number per month, unless this has been agreed upon by the individual, waiver support coordinator (WSC), and provider, in advance of service authorization.
 - **Intensity** - The number of units to be provided in a session and can also denote the level (basic, moderate, intensive or 1:1, 1:2, 1:6-10, or standard, moderate, intensive).
 - **Scope** - The service and any limitations to or instructions for activities to be provided.
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Annual Report

A written report by the provider documenting the recipient's progress toward a support plan goal(s) for the year, as required in section 393.0651, F.S.

An annual report must be submitted to the WSC 30 days prior to the support plan effective date. The annual report should incorporate narratives on the recipient's:

- Positive qualities, attributes, capabilities, skills, and talents;
- Progress toward goals;
- Challenges;
- Financial information*;
- Medication information, if applicable to the service being provided;
- Medical status, if applicable to the service being provided; and
- Progress toward future support areas needed that are related to:
 - Health and safety;
 - Financial;
 - Home related (in supported living);
 - Self-care and personal growth; and
 - Community inclusion.

* Financial information only applies to services that have responsibility for oversight of the individual's financial information such as supported living.

Approved Services

Waiver services that are approved by APD or its contracted reviewers as being authorized to purchase using waiver funds for a specific recipient and are identified on the individual's approved cost plan.

Billing Agent An entity that offers claims submission services to providers. Providers can submit claims themselves or choose to have a billing agent. Billing agents must be enrolled as providers in the Medicaid program and have passed the required background screening.

Budget Allocation The waiver funding approved by APD for an individual to expend on medically necessary iBudget waiver services during the dates of service on the approved cost plan in accordance with section 393.0662, F.S.

Budget Allocation Formula The formula used by APD as an element of determining an individual's budget allocation, as required by the Florida Legislature.

Central Record A file, or a series of continuation files based on the Medicaid waiver recipient's records, in paper or electronic format kept by the WSC in which the following documentation must be recorded, stored, and made available for review:

- Individual demographic data including emergency contact information, parental or legal representative contact information, releases of information; and results of assessments, eligibility determination, evaluations, as well as medical and medication information;
- Legal documents such as medical powers of attorney, medical proxies, guardianship or guardian advocacy papers, and court orders; and
- Service delivery information including the current support plan, cost plan or written authorization of services, and implementation plans, as required.

The central record is the property of APD and follows the individual if the individual's WSC changes. It is the responsibility of the WSC to maintain the central record. If the WSC is using an electronic system for record keeping the information must be maintained on a separate drive, which is secured with a password for backup documentation and is available to APD or AHCA upon request. The documents on the disk must be clearly named so that their contents are identifiable and in a format that is usable by APD and AHCA.

Claim Form The CMS-1500 paper claim form. Claim forms must be complete and legible when submitted to the Medicaid fiscal agent for reimbursement for services rendered. Instructions for completing the CMS-1500 claim form are in the Florida Medicaid Provider Reimbursement Handbook, CMS-1500. Alternatively, the provider can also submit claims to the Medicaid fiscal agent electronically by using the software supplied by the Medicaid fiscal agent.

Note: See Chapter 5 of this Handbook for additional billing and reimbursement information.

Community Integrated Settings Local community settings, resources, and locations that facilitate direct personal interaction between persons with and without disabilities.

General Definitions and Acronyms, continued

Community Supports	Resources that are available to all community members, often at little or no cost.
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Cost Beneficial	Economical in terms of the value of the goods or services received in relation to the money spent.
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Cost Plan	The document that lists all approved waiver services for an individual and the maximum cost of each waiver service. The cost plan is maintained in the online APD iBudget waiver system.
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Cost Plan Year	The cost plan year spans the state fiscal year, which begins July 1st and ends June 30th of the following year.
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Daily Attendance Log	A listing of the providers or provider staff by name, who participated in the waiver service delivery, the time period and the days in the month in which each staff person participated in the service.
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Daily Progress Note	A provider's summary of the waiver service delivered with a recipient's progress noted to monitor and document recipient health and safety and address recipient goals(s). Daily progress notes are required for the following services: special medical home care, dietician, private duty nursing, skilled nursing, behavioral analysis, and behavioral assistant. The progress note shall identify, by name, the individual providing the service and the recipient receiving the service, the service time beginning and ending for each progress note, and the date the service was provided.
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Direct Provider Billing	This is the standard billing process for iBudget waiver service providers. All claims for iBudget waiver services must be submitted online or by submitting the CMS-1500 claim form to the Florida Medicaid fiscal agent.
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Direct Service Provider	As defined in section 393.063, F.S., a "direct service provider" means a person age 18 and older who has direct face-to-face contact with an individual or has access to an individual's living areas or to an individual's funds or personal property.
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Florida Medicaid Management Information System (FMMIS)	The information system managed by AHCA that providers use to bill for services rendered under the iBudget waiver.
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General Definitions and Acronyms, continued

Health Insurance Portability and Accountability Act (HIPAA)

As trading partners with Florida Medicaid, all Medicaid providers, including their staff, contracted staff and volunteers, must comply with all applicable state and federal laws and regulations to confidential and protected health information.

Providers who meet the definition of a covered entity according to HIPAA must comply with HIPAA and Health Information Technology for Economic and Clinical Health Act (HITECH) Security and Privacy rules that can be promulgated in the future. In addition, providers must also maintain HIPAA and HITECH compliant Business Associate Agreements with all business associates.

This Handbook contains information regarding changes in procedure codes mandated by HIPAA. The Florida Medicaid provider reimbursement handbooks contain the claims processing requirements for Florida Medicaid, including the changes necessary to comply with HIPAA.

Note: For more information regarding HIPAA privacy in Florida Medicaid see the Florida Medicaid Provider General Handbook.

Note: For more information regarding claims processing changes in Florida Medicaid because of HIPAA, see the Florida Medicaid Provider Reimbursement Handbook, CMS-1500.

Note: For information regarding changes in EDI requirements for Florida Medicaid because of HIPAA, contact the Medicaid fiscal agent EDI help desk at (866) 586-0961.

Home

For the purposes of this handbook, the primary residence occupied by the individual.

iBudget Waiver Program or iBudget Florida

The APD named program through which the Developmental Disabilities Individual Budgeting Home and Community-Based Services Waiver is operated.

iBudget Florida System

The information technology system used in conjunction with APD's ABC system and the FMMIS system by APD staff and WSCs to administer the iBudget waiver.

Implementation Plan

A plan developed by the provider detailing the support plan goal(s) that the service will address, the methods employed to assist the recipient in meeting the support plan goal(s), and the system to be used for data collection and assessing the individual's progress in achieving the support plan goal(s). It is developed and updated with direction from the recipient and includes the name of the recipient receiving services. Refer to service specific documentation requirements, Appendix A.

General Definitions and Acronyms, continued

Individual A person with a developmental disability enrolled in the iBudget waiver.

Individually Determined Goal The goals that a recipient has for their individual life as reflected in the support plan. The recipient's expectations for the services and supports received are defined by these goals, which can also be referred to as personal goals. The supports or services include all resources available to the recipient and not solely those that are provided by the waiver, including natural supports, community supports, and other resources coordinated by the WSC to meet the individual's goals.

Licensed Residential Facility Facilities providing room and board and other services to waiver recipients in accordance with the licensing requirements for the facility type, which include:

- Group homes and foster care facilities licensed in accordance with Chapters 393 and 409, F.S.;
- Comprehensive Transitional Education Programs licensed in accordance with Chapter 393, F.S.;
- Assisted living facilities, and transitional living facilities, licensed in accordance with Chapters 400 and 429, F.S.; and
- Residential habilitation centers, licensed in accordance with Chapter 393, F.S., and any other type of licensed facility not mentioned above, having a capacity of 16 or more persons, if the individual has continuously resided at the facility since August 8, 2001 or prior to this date.

Meaningful Day Activity Choices made by recipients receiving services of how to use their time in order to gain direction, purpose, and quality to their daily life. The individual's choice of meaningful day activities can be based on interests, skills, and talents. Meaningful day activities can involve choices that are not paid for by the waiver, including paid employment, volunteer work, and school. For those services funded by the waiver, the meaningful day activity must directly address identified goals in the recipient's support plan.

Medicaid Provider Agreement The contractual agreement between the provider and AHCA that establishes the provider's eligibility to render services under the Florida Medicaid program and designates responsibilities for the provider.

Medicaid State Plan The Medicaid State Plan is Florida Medicaid's agreement with the Centers for Medicare and Medicaid Services (CMS) that specifies the eligibility categories of low income people and the medical services that Florida Medicaid provides. In Florida, AHCA develops and carries out policies related to the Medicaid program. Florida's State Plan services are required by sections 409.905 and 409.906, F.S.

General Definitions and Acronyms, continued

Medicaid Waiver Services Agreement	The contract between the APD and providers of developmental disabled waiver services. All providers of iBudget waiver services must complete this agreement prior to providing services to recipients enrolled in the iBudget waiver and comply with the terms and conditions of the agreement.
Medical Case Management Team	The health and safety oversight team for an APD Regional Office.
Monitoring	A review, audit, inspection, or investigation of the provider's administrative and programmatic service delivery systems by AHCA, APD, or their authorized agent(s).
Monthly Summary	A written summary by the waiver provider of the month's activities indicating the recipient's progress toward achieving support plan goals for the services billed in that month. The monthly summary is based on applicable daily service logs or daily progress notes all of which must be maintained by the provider. It must include the recipient's name receiving services.
Natural Supports	Support that is provided to recipients by family members, legal representatives, friends, or community resources or agencies without cost or waiver funding. The use of these supports must be fully utilized before seeking funding from the iBudget waiver.
Person-Centered Planning Process	A planning approach based on the recipient's perspective rather than that of a program or resource used to identify the services and supports necessary to meet the recipient's needs. The person-centered planning process shall involve the recipient and significant people in the recipient's life, identifying the goals and outcome considered most important, and the supports necessary to achieve them.
Prescription	An order for the preparation and administrator of a drug or device or instructions written by a physician, a dentist, an ARNP or physician assistant on a prescription pad obtained from an official Medicaid approved prescription pad vendor.

General Definitions and Acronyms, continued

Provider

A person or agency enrolled to provide Home and Community-Based Non-Institutional services as outlined in the Florida Medicaid Provider General Handbook.

Note: The handbooks are available on the Medicaid fiscal agent's Web site at www.mymedicaid-florida.com. Select **Public Information for Providers**, then **Provider Support**, and then **Provider Handbooks**. The Florida Medicaid Provider General Handbook is incorporated by reference in Rule 59G-5.020, F.A.C. The Florida Medicaid Provider Reimbursement Handbook, CMS-1500, is incorporated by reference in Rules 59G-13.001 and 59G-4.001, F.A.C.

Note: Refer to the Florida Medicaid Provider General Handbook for information on verifying provider enrollment, requirements, certifications, provider agreements, terminations, and provider records rights and responsibilities.

Provider File

Documentation maintained by the Medicaid provider regarding the Medicaid recipient in electronic or hard copy formats, or both, as required by APD, which includes the authorization for services, release forms, and service delivery documentation, as specified in this Handbook, that are related to the service and support activities identified in the support plan.

The provider must maintain one copy of the file for at least five years after the last date of service, even when the provider surrenders their agreement or when the recipient chooses another provider.

Quarterly Summary

A written summary by a provider of the activities in that quarter indicating the recipient's progress toward achieving support plan goals for the Medicaid waiver services billed in that quarter. Refer to Appendix A (documentation chart) for a list of services required to submit quarterly summaries.

The quarterly time period begins from the effective date of the support plan. The summary must include the recipient's name receiving the service.

The third quarterly summary is the annual report. A provider can choose to do a monthly summary each month rather than a quarterly summary.

Regional Office

The APD local office responsible for managing a specific geographical region.

Remediation Plan

A plan of proposed corrective actions developed by the provider and agreed upon by APD that address the improvements needed for Medicaid waiver services cited as below standard or non-compliant by APD or its authorized agent.

General Definitions and Acronyms, continued

Service Authorization

An APD document that authorizes the provision of specific waiver services to an individual and includes at a minimum the provider's name and the specific amount, duration, scope, frequency, and intensity of the approved service. The service authorization must be received by a provider before a service can occur. The approved iBudget Waiver Service Authorization format includes a comments section to assist in clarifying the service delivery.

Service Families

Categories that group waiver services related to: Life Skills Development, Environmental and Adaptive Equipment, Personal Supports, Residential Services, Support Coordination, Therapeutic Supports and Wellness, Transportation, and Dental Services. Refer to the chart in Chapter 4 for the specific services grouped in service families.

Service Log

A form used by a provider to document service delivery that contains the name of the individual providing and receiving the service, the time in and out for the period services were provided, and the dates of service provision. The service log should also briefly describe a synopsis of the goal(s) addressed when the service is provided. The service log is maintained either in a paper or electronic format. For Life Skills Development - Level 3, the attendance log with daily time in and time out for each person in attendance shall serve as the service log for that service.

Solo Provider

A solo or independent Medicaid waiver provider who personally renders waiver services directly to individuals and employs less than three individuals to render waiver services.

Support Plan

An individualized plan of supports and services designed to meet the needs of a recipient enrolled in the waiver. The plan should include detailed information regarding the recipient's current needs, current available resources and natural supports, the recipient's goals and the need for the supports and services requested. This document is reviewed, signed, and dated by the recipient or legal representative prior to its implementation. This document is described in section 393.0651, F.S.

CHAPTER 3 iBUDGET WAIVER GENERAL PROVIDER REQUIREMENTS

Overview

In This Chapter

This chapter contains:

TOPIC	PAGE
Compliance and Requirements	3-
Waiver Provider Enrollment	3-

Compliance and Requirements

Compliance with Federal Laws and Regulations

The provider shall comply with the relevant provisions of the following federal laws and regulations:

- Title VI of the Civil Rights Act of 1964, as amended, 42 U.S.C. 2000d et seq., prohibiting discrimination on the basis of race, color, or national origin in programs and activities that receive or benefit from federal financial assistance.
- Section 504 of the Rehabilitation Act of 1973, as amended, 29 U.S.C. s. 794(a), et seq., in regard to employees or applicants for employment.
- The Age Discrimination Act of 1975, as amended, 42 U.S.C. s. et seq., which prohibits discrimination on the basis of age, in programs or activities that receive or benefit from federal financial assistance.
- The Omnibus Budget Reconciliation Act of 1981, Public Law (PL) 97-35, prohibiting discrimination on the basis of sex or religion in programs and activities that receive or benefit from federal financial assistance.
- The Americans with Disabilities Act of 1990, PL 101-336, prohibiting discrimination based on disability in employment, public accommodations, transportation, and state and local government services and telecommunications.
- The Title 42, Code of Federal Regulations (CFR) 431.51, which states that each recipient served by the provider will be provided freedom of choice within the scope of available funding levels. Freedom of choice includes:
 - Opportunities for the recipient to select non-waiver funded supports available to the general community from among those activities or experiences that meet the recipient's needs and preferences;

Compliance and Requirements, continued

Compliance with Federal Laws and Regulations, continued

- Opportunities for the recipient to select providers of Medicaid State Plan services from among those providers enrolled in the Medicaid waiver program, and that also meet the recipient's needs and expectations;
 - Opportunities for the recipient to select providers of waiver services from those eligible to provide waiver services and enrolled in the Medicaid program meeting the recipient's needs and expectations;
 - Opportunities for the recipient to change providers of supports and services;
 - Opportunities for the recipient to work with a provider to identify mutually agreeable times and settings for the provision of supports or services; and
 - The opportunity for the recipient to end participation in the waiver.
 - The Health Insurance and Portability Accountability Act, Title 45 CFR Part 164. This includes provider staff, contracted staff, and volunteers. Providers who meet the definition of a covered entity according to HIPAA must comply with HIPAA privacy requirements. The Florida Medicaid Provider Reimbursement handbooks contain the claims processing requirements for Florida Medicaid, including the changes necessary to comply with HIPAA. Providers who utilize a billing agent are responsible for ensuring the billing agent fully complies with HIPAA regulations and must also obtain a copy of the billing agents' background screening results. This documentation must be maintained by the provider.
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Compliance with State Law and Regulations

- The provider will comply with Chapters 393 and 409, Florida Statutes (F.S.), Chapters 65G and 59G, Florida Administrative Code (F.A.C.), and with all procedures pertaining to the implementation of the waiver, including all rates and fee schedules developed under such laws, rules, and regulations.
 - The provider will uphold the rights and privileges of individuals with developmental disabilities, as specified in Chapter 393.13, F.S., and "The Bill of Rights of Persons Who Are Developmentally Disabled."
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Provider General Requirements

- The provider shall not disclose or use any information concerning a recipient who is receiving services under the waiver without the informed consent of the recipient or the recipient's legal representative, in accordance with Chapter 393.13, F.S., and federal regulations. Consent of the recipient shall be provided in writing by the recipient or legal representative.
-

Compliance and Requirements, continued

**Provider
General
Requirements**,
continued

- If all or part of a provider's business is closed, sold, or transferred, the provider shall maintain and make available to APD and the AHCA all records required to be kept for at least five years from the date of service. If the provider enters into an agreement with a third party to maintain records, they must furnish APD with a copy of such agreement. Any such agreement will require the holder or custodian of the records to comply with the terms set forth in this document for retention and access to said records.
 - The provider shall agree that APD, through AHCA, is responsible for the expenditure of all funds appropriated to APD by the Florida Legislature for individuals receiving services from the iBudget waiver. APD or its authorized agents shall determine the appropriateness or medical necessity of services purchased, in accordance with Rule 59G-1.010 and Chapter 65G, F.A.C. and Chapter 393, F.S., and the amount of APD waiver funds available to purchase services and goods.
 - The provider shall, within the mission and scope of the services offered, safeguard the health, safety, and well-being of all recipients receiving services from the provider and assist recipients in the achievement of personal goals, choice, rights, dignity and respect, security, and satisfaction.
 - The provider shall participate in and support the person-centered planning and implementation process for each recipient. The provider will also use the recommendations from the person-centered planning process to: (1) implement person-centered supports and services; (2) support development of informed choices through education, exposure, and experiences in activities of interest to the person served; (3) enhance service delivery in a manner that supports the achievement of individually determined goals; and (4) make improvements in the provider's service delivery system.
 - The provider shall, with the recipient's or legal representative's permission, participate in the discussion of the recipient's record, the recipient's progress, the extent to which the recipient's needs are being met or any need for modifications to their support plan, implementation plan, or other documents, as applicable. This discussion could involve APD or its authorized representatives, other service providers, the recipient, the legal representative, family, and friends.
 - The provider shall, with the recipient's or legal representative's permission, provide information about the recipient to assist in the development of the support plan, and to attend the support planning meeting when invited by the recipient, family member, or legal representative.
 - Providers and their employees who transport recipients, either as a specific part of their service delivery or as incidental transportation, shall show, at the time of enrollment, proof of a valid Florida driver's license, vehicle registration, and sufficient automobile insurance to use the provider's vehicle or their own vehicle when providing transportation. Subsequent to enrollment, the provider is responsible for keeping this documentation up to date.
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Compliance and Requirements, continued

**Provider
General
Requirements**,
continued

- The provider shall provide and bill only for those services that have been authorized and approved by APD on the recipient's cost plan. These supports and services shall be provided within the amount, frequency, scope, intensity, and duration specified on the recipient's support plan, approved cost plan, and service authorizations. The provider agrees not to bill for services until rendered as authorized.
 - The provider shall immediately notify the AHCA Fiscal Agent using the required form and the APD Regional Office of any change in contact information including e-mail address, mailing address or telephone number. The provider shall also notify AHCA and the APD Regional Office if they plan to close the business or have a change in ownership.
 - All enrolled iBudget waiver providers shall have access to a computer with internet access, which allows for secure transmission to and from APD, and a valid active e-mail address. The computer must be used exclusively by the provider and stored in a secure manner. Waiver support coordination providers must also have internet access through Internet Explorer, emulation software and a State of Florida VPN account to facilitate access to non-public APD networks. All providers must ensure any computer used for business purposes is capable of performing security functions that promote and maintain confidentiality of information. These security functions include password protected logins, virus detection, and secure (encrypted) network communications. Information stored on physical media (e.g., computer hard-drive, USB drive) which is not encrypted should be physically safeguarded to prevent loss or theft. Providers will comply with APD Information Security policies, and State and Federal regulations and laws, in all use of APD computer systems and data. Medicaid providers, including their staff, contracted staff, volunteers and billing agents are required to safeguard the use and disclosure of information pertaining to current and former Medicaid recipients as required by state and federal law and regulations.
 - All providers shall participate in the direct deposit program for Medicaid payments and must have an active savings or checking account.
 - Providers shall agree to abide by the terms and conditions of use of the APD online iBudget waiver system or other electronic system providing such access.
 - The provider must have an approved service authorization prior to providing waiver services. It is the WSC's responsibility to notify the provider when a service authorization has been issued, revised, or cancelled for a recipient served by the provider. Service authorizations will not be back-dated except as approved by the APD Regional Office to ensure payment for emergency services.
-

Compliance and Requirements, continued

Provider General Requirements, continued

- The provider shall successfully complete all APD required training courses, participate in all meetings specific to the type of services provided, and participate in all quarterly provider meetings as scheduled by the APD Regional Office. If advance notice is provided and the Regional Office agrees to accommodate, participation can be via telephone conference call or webinar. Documentation of training shall be maintained by the provider trained and their employer.
 - For services that are billed at the unit, daily, hourly, or quarter-hour rate, the provider must enter documentation on the services provided within 60 calendar days after the end of the month in which the service was provided. Documentation must be entered prior to billing.
 - For services which require assessments, the provider must enter data on the service provided within 60 calendar days after the date on which the service was rendered. Documentation must be entered prior to billing.
 - All waiver enrolled providers will be responsible for implementing applicable changes to service provision based on changes in policy or procedure that are communicated by APD and AHCA.
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Waiver Provider Enrollment

Enrollment

Waiver provider applicants must meet specific qualifications and requirements before becoming eligible to provide waiver services. In addition, provider applicants must have no adverse history with any regulatory agency that causes AHCA or APD to question whether the health, safety, and welfare of a recipient could be jeopardized during the delivery of an approved waiver service. Recipients have the right to choose providers, and enrollment as a waiver provider does not guarantee selection by a recipient.

Prior to enrollment the provider applicant must comply with the following requirements (forms can be obtained from the APD Regional Office):

- Be determined eligible by the APD Regional Office to enroll as a waiver provider.
- Not be currently suspended as a provider from Medicare or Medicaid in any state.
- Meet provider qualification and responsibility requirements described in Chapter 3 of this Handbook.
- Complete a Medicaid Provider Enrollment application, which can be obtained from the APD Web site www.apd.myflorida.com, through the local APD or from the Medicaid fiscal agent's Web site at www.mymedicaid-florida.com. The application is incorporated by reference in Rule 59G-5.010, F.A.C. This Handbook provides detailed information on each service available through the waiver, including provider qualifications, limitations and required documentation. Applicants should carefully review the description of each service for which they want to become enrolled prior to completing the waiver provider application.

Waiver Provider Enrollment, continued

Enrollment,
continued

- Complete the APD provider supplemental application, which must be obtained from the APD Regional Offices.
- Complete a Level 2 background screening and APD Affidavit of Good Moral Character with results indicating no disqualifying offenses or receive an exemption from disqualification.
- Be assigned a Medicaid provider number.
- Have a current, signed Medicaid Waiver Services Agreement with APD.
- Maintain all certifications necessary to provide services as specified in this Handbook.
- Be age 18 and older.

A provider can be enrolled as an agency or solo provider.

An agency is a business or organization enrolled to provide Medicaid waiver services and has a table of organization with clearly defined position descriptions for all employees.

A provider agency shall maintain a personnel file for each employee documenting that the employee meets the minimum education and experience requirements for the service the employee was hired to provide, has completed all required training as specified in this Handbook, and has satisfied all background screening requirements. The personnel file must be maintained for each employee at least five years after the date of service was billed.

A provider agency shall have policies and procedures in place that include at a minimum:

- How the provider will use a person-centered approach to identify individually determined goals and in promoting choice.
 - A detailed description of how the provider will protect the health, safety, and well-being of the recipients served.
 - How the provider will ensure compliance with background screening and five year rescreening.
 - Hours and days of operation and the notification process to be used if the provider is unable to provide services for a specific time and day scheduled, including arrangement of a qualified backup provider.
 - How the provider will ensure the recipient's medications are administered and handled safely.
 - A description of how the provider will ensure a smooth transition to and from another provider if desired by the recipient or their legal representative.
 - The process that the provider will go through to address recipient complaints and grievances regarding possible service delivery issues.
 - How the provider will ensure recipient confidentiality and the maintaining and storage of records in a secure manner.
-

Waiver Provider Enrollment, continued

Agency Providers,
continued

The iBudget agency rate is used for staff providing services that are billed through the provider agency. All employees of an agency or group provider must meet the qualifications and requirements specified in the provider's agreement and those specified for enrolled service(s). The provider shall maintain personnel files documenting qualifications of all employees, their background screening results, and training records.

Use of Subcontractors

A subcontractor is an individual or business that signs a contract to perform part or all of the obligations of another's contract.

A provider that uses subcontracted staff (reported through an IRS Form 1099) and does not have paid employees (reported through a W-2 Form) will be considered an independent or solo provider.

Solo and Independent Providers

A solo provider, also referred to as an independent provider, must personally render services directly to the recipient and cannot subcontract with or hire other persons to render services to recipients. Exceptions are consumable medical supplies, durable medical equipment, environmental accessibility adaptations, and personal emergency response systems providers.

If the provider is a solo provider and incorporates as a business, the provider is still considered a solo or independent provider for rate purposes unless the provider hires at least two other persons to perform the specific waiver service for which the rate is being established.

If the provider is a solo provider and incorporates, but does not meet other criteria for being an agency provider, the provider is still considered a solo or independent provider for rate purposes.

Waiver Provider Background Screening Requirements

Provider applicants and enrolled providers must comply with the requirements of a Level 2 screening in accordance with section 435.04, F.S. All direct service employees of the provider with access to the recipient or the records of the recipient must also comply with these requirements.

Compliance with background screening requirements can be accomplished, pursuant to section 393.0655, F.S., by submitting the following documents to the provider enrollment staff in the APD Regional Office:

- Completed Live Scan, with payment. Providers using Live Scan must first establish an Originating Agency Case Number (OCA) code for Live Scan participation through the Department of Children and Families.
-

Waiver Provider Enrollment, continued

**Waiver Provider
Background
Screening
Requirements**,
continued

- An Affidavit of Good Moral Character, which must be notarized: This document can be obtained from the APD Web site, www.apdcares.org.
- Local Law Enforcement check: This local check shall be conducted in the jurisdiction which the applicant resides and can be conducted by either the local police or county Sheriff's office.
- Employment References: These checks must cover a minimum two-year period preceding the application. Any gaps in employment must be explained.

Screening is performed at the time of enrollment for provider applicants. Employees of Medicaid Waiver enrolled providers must be screened and results of screening must be obtained prior to the person being hired. Medicaid Waiver providers and employees of Medicaid Waiver providers must also be rescreened every five years. It is the responsibility of the applicant or provider to ensure this request for screening or rescreening is submitted for processing in a timely manner. Rescreening consists of a federal background and name check through the Florida Department of Law Enforcement using the Level 2 standards found in section 435.04, F.S., and either section 393.0655 or 408.809, F.S., and a local criminal check from the county where the employee resides. Providers are responsible for maintaining official documentation of clearance from the Level 2 screening in their administrative records.

If the applicant has had a Level 2 screening within 12 months of the date of application, and can provide a copy of the Level 2 screening documents, the applicant does not need to repeat the screening as long as an employment reference verifies the applicant has not been unemployed for more than 90 consecutive days since the screening occurred. The results of this screening shall be submitted with the Medicaid enrollment application and maintained in the provider's administrative records.

Every employee must attest to meeting the requirements for qualifying for employment and agree to inform the provider immediately if arrested for any of the disqualifying offenses while employed by the provider. This attestation does not replace the need for the Level 2 background screening. Each provider must submit to APD annually a signed affidavit attesting to compliance with a Level 2 background screening, with the exception of support coordination agencies as the background Level 2 screening for individual employees are submitted to APD at the time of application for individual treating provider numbers.

Note: The Medicaid Enrollment Application is available from the Medicaid fiscal agent's Web site at www.mymedicaid-florida.com. Select **Public Information for Providers**, then **Provider Support**, and then **Enrollment** to locate the application. The application is incorporated by reference in Rule 59G-5.010, F.A.C.

Waiver Provider Enrollment, continued

Change in Provider Status

If a provider wishes to expand from solo to agency status, provide additional services, and wishes to expand services geographically, the provider must notify the APD Regional Office serving the geographic area in which expansion is requested. The APD Regional Office must prior approve the expansion. The Regional Office will consider the waiver provider applicant criteria enrollment in this chapter as well as quality assurance and monitoring results, valid complaints and general compliance with waiver provider requirements contained in this Handbook. If a quality assurance monitor review has not been performed, this does not prevent consideration to expand services. All factors should be considered when making a decision relating to proposed service expansions, including any improvements identified at a follow-up quality assurance review, complaints received against a provider or APD Regional Office investigations of provider performance.

Providers shall notify the APD Regional Office and recipients served as soon as they become aware of any change, sale or transfer of ownership. Recipients receiving services shall be given an opportunity to receive services from the new owner, purchaser, or transferee, or to select another provider.

If a provider voluntarily terminates services and later desires to return to the waiver in any capacity, they will be considered a new applicant and shall comply with all the requirements of a new applicant.

Providers shall notify APD in writing prior to any filing for bankruptcy protection or if the financial solvency of the provider becomes unstable. Failure to do shall result in...

Family Members Enrolled as Waiver Providers or Acting as Service Providers

Parents of minor, spouses, guardians, or legal representatives of waiver participants are specifically excluded from payment for any services provided to their child, spouse, or recipient served. Parents or persons related by blood or marriage are considered to be natural supports and as such should be considered for the provision of services without payment.

Under no circumstance can a relative provide support coordination to their family member. Relatives not legally responsible for the care of the recipient cannot be a provider of any direct services to their relative and cannot be hired by or be subcontracted by an enrolled provider to perform any direct service specific to their relative, with the exception of personal supports, respite, or transportation services only. Some direct services may be provided voluntarily as a natural support by a family member in instances such as providing intervention for behavioral needs or assisting with feeding. No other direct services can be performed by a legal guardian or a relative of the recipient, whether that relative is an enrolled provider or employed by or contracted with an enrolled provider. In those limited situations, the relative must meet the same qualifications as the other providers of the same service. Exceptions can only be requested for personal supports services, respite or transportation services. Examples of when an exception might be warranted include the lack of available enrolled Medicaid waiver providers, the inability of providers to meet a specific unique need of the recipient or the recipient's scheduling needs for which no other provider is available. The exception must be thoroughly documented, approved by APD, and a copy of the approval maintained in the client central record.

Waiver Provider Enrollment, continued

**Family Members
Enrolled as
Waiver
Providers or
Acting as
Service
Providers,**
continued

The exception request must document thorough efforts to secure alternative providers who are not relatives of the recipient, including a list of providers who were contacted and the reasons they could not provide the service. Convenience to the recipient, caregiver, or family alone is not adequate justification. The relative must be an enrolled waiver provider, an employee of, or under contract to an enrolled waiver provider. Any services that meet these criteria must be pre-approved in writing by the APD Regional Office prior to services being authorized. WSCs are responsible for submitting draft cost plans meeting these criteria to the region for review prior to processing them through the APD online iBudget waiver system. Parents are not authorized to provide respite services to their own children under the age of 21.

When an exception is granted for a family member to provide services, both the request and written approval from the APD Regional Office shall be maintained by the support coordinator and the service provider.

Incident Reporting

Providers are responsible for reporting incidents to the APD Regional Office as they occur within specified timeframes as noted below. Providers must submit incident reports and follow-up reports on the APD incident reporting form. Incident reports are classified as either critical or reportable.

Providers shall report critical incidents to the APD Regional Office within one hour of becoming aware of the incident. If the incident occurs between the hours of 8:00 p.m. and 8:00 a.m., the incident must be reported no later than 9:00 a.m. the next day. Recipient related critical incidents include:

- Death
- Sexual abuse or misconduct
- Missing
- Circumstance that initiates unfavorable media attention
- Arrest or incarceration
- Hospitalization

The provider shall report incidents classified as reportable within one business day to the APD Regional Office. Reportable incidents include:

- Altercation that results in law enforcement contact
 - Individual injury that requires medical attention in an urgent care center emergency room or physician office setting
 - An incident resulting in the arrest of individual receiving services
 - A missing competent adult
 - Suicide attempt by a recipient
 - Suspected financial exploitation or misuse of a recipient's funds or property
 - Suspected neglect of a recipient's care or treatment
- Other – any event not listed above that jeopardizes a recipient's health, safety, or well-being
-

Waiver Provider Enrollment, continued

Zero Tolerance

- Abuse, neglect, exploitation, or sexual misconduct related to the recipient by a provider of services shall result in the termination of the provider's Medicaid and Waiver Agreements in addition to any other legal sanctions available. The failure of a provider to report any incident of abuse, neglect, exploitation, or sexual misconduct on behalf of the recipient can also result in the termination of the provider's Medicaid and Waiver Agreements. Abuse, neglect, exploitation, or sexual misconduct related to the recipient by an employee of a provider or an employee's failure to report an incident of abuse, neglect, exploitation, or sexual misconduct can be imputed to the provider and can result in termination of the provider's Medicaid and Waiver Agreements;
 - Mandatory Reporting Requirements: Any person who knows, or has reasonable cause to suspect, that a person with a developmental disability is being abused, neglected, or exploited by a relative, caregiver, or household member or, in the case of self-neglect, is required to report such knowledge or suspicion to the Florida Abuse Hotline, which is a nationwide, toll-free telephone number, at 1-800-96-ABUSE (1-800-962-2873), TDD access is gained by dialing 1-800-453-5145. **Failure to report known or suspected cases of abuse, neglect, or exploitation is a criminal offense. In addition, service providers who fail to report known or suspected cases of abuse, neglect, exploitation, or sexual misconduct will be subject to termination of their waiver enrollment status. Criminal and administrative penalties will also be pursued;**
 - The Sexual Misconduct Law: Sexual activity between a direct service provider or employee and a person with a developmental disability (to whom services are being rendered) is not only unethical but can also be a crime, regardless of whether consent was first obtained from the victim. Pursuant to section 393.135, F.S., the term "sexual misconduct" refers to any sexual activity between a covered person (such as a direct service provider) and an individual to whom that covered person renders services, care, or support on behalf of the agency or its providers, or between a covered person and another client who lives in the same home as the individual to whom a covered person is rendering the services, care, or support, regardless of the consent of the client. The crime of sexual misconduct is punishable as a second degree felony;
 - Client-on-Client Sexual Abuse: Known or suspected sexual abuse between two individuals with developmental disabilities must also be reported immediately to the Florida Abuse Hotline at 1-800-96-ABUSE (1-800-962-2873). An investigation will occur in order to determine whether or not the sexual abuse was the result of inadequate supervision or neglect on the part of a service provider or caregiver. The incident must also be reported immediately to the APD Regional Office to ensure the continued health and safety of the individuals involved;
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Waiver Provider Enrollment, continued

Zero Tolerance, continued

- Reporting Abuse, Neglect, Exploitation, or Sexual Misconduct: Direct service providers or staff of a provider who know or suspect that a person with a developmental disability is being abused, neglected, or exploited by a relative, caregiver, or household member; or is the victim of sexual misconduct, should do all of the following immediately:
 - Call the Florida Abuse Hotline, which is a nationwide, toll-free telephone number, at 1-800-96-ABUSE (1-800-962-2873), TDD access is gained by dialing 1-800-453-5145;
 - Notify their supervisor (if employed by an agency);
 - Notify the APD Regional Office;
 - Notify the local law enforcement agency;
 - For situations in which the life of a person with a developmental disability is in immediate danger due to abuse, neglect, or exploitation, direct service providers or staff of a provider should call 911 before calling anyone else.

Provider agencies cannot require their employees to first report such information to them before permitting their employees to call the Florida Abuse Hotline or law enforcement. In fact, 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 section 775.082 or 775.083, F.S.

Provider Notification Requirements

In addition to the requirements listed under the Incident Reporting label in this Handbook, WSCs shall notify the recipient's providers and other appropriate parties when the following issues occur:

- The recipient's continued eligibility for waiver services is in jeopardy due to loss of Medicaid. Any support coordinator that becomes aware of an recipient's loss of Medicaid shall immediately notify the recipient's providers and appropriate APD Regional Office. Any provider that becomes aware of an recipient's loss of Medicaid benefits shall immediately contact the recipient's support coordinator.
- The recipient plans to move out of the region, state, or country.
- The recipient has plans to discontinue receiving services from the provider, waiver, or APD.
- Change in provider contact information including e-mail address, physical address, or phone number.
- Breach of recipient's confidential information. Notification shall include details of circumstances and information that was involved.

Providers will notify the recipient's WSC and other appropriate parties when they become aware of any of the above listed issues.

Waiver Provider Enrollment, continued

General Service Documentation Requirements

Documentation is an electronic or written record that supports the fact that a service has been rendered. When a service is rendered, the provider must document the service, submit billing documentation to the support coordinator and file the documentation before billing. Documentation in accordance with the requirements in Appendix A is required in order to bill and receive payment. A plan of remediation can be required for failure to comply with this Handbook. APD or AHCA can also impose fines or other penalties for infractions that violate the requirements. All documentation must be dated and identify the person rendering the service. Documentation must be signed by the person rendering the service to attest to the accuracy and completeness. Services that are billed on a quarter-hour or hour basis must have from and through date and time documentation.

The specific documentation requirements to bill for each service are contained in the Documentation Matrix. It is the responsibility of each provider to understand and comply with all documentation requirements. Questions about documentation requirements should be directed to the APD Regional Office.

Service Authorization Requirements

The services described in this Handbook represent all of the waiver services that can be approved and purchased by a recipient participating in the iBudget waiver and the only services that can be provided by a service provider. The provider must have an APD approved service authorization for the service rendered. Providers of iBudget waiver services are limited to the amount, frequency, duration, intensity, and scope of the service described on the recipient's service authorization. The service authorizations will be issued by WSCs quarterly. The total units of service are available for the entire quarter and not limited to a monthly amount. In order to allow for increased flexibility, the comments section of the service authorization should be used to describe how the amount, frequency, duration, intensity, and scope of the service are generally intended.

A WSC cannot provide a service authorization at a rate or frequency that is higher than that approved by APD or authorize a service that was not approved by APD. Doing so will result in recoupment from the service provider of service dollars billed without proper authorization. WSCs and service providers must verify that the service authorization is correct according to the authorized amount of services in the APD iBudget system. If corrections are needed the service provider should immediately contact the WSC for resolution.

Waiver Provider Enrollment, continued

**Records
Maintenance and
Storage**

Medicaid requires that the provider retain all business records as defined in 59G-1.010(30) F.A.C., medical-related records as defined in 59G-1.010(154) F.A.C., and medical records as defined in 59G-1.010(160) F.A.C. on all services provided to a Medicaid recipient. Records must be retained for a period of at least five years from the date of service.

All non-electronic files pertaining to a recipient must be physically secured so that only authorized recipients can access them. Recipient records can be scanned and saved into individual computer storage devices, which must be labeled for content and stored securely.

Medicaid providers who create or maintain electronic records pertaining to goods and services paid for by the Medicaid program must develop and implement an electronic records policy to comply with the applicable state and federal laws, rules, and regulations to ensure the validity and security of electronic records. Medicaid providers' electronic records policies should address the technical safeguards required by the Code of Federal Regulations (CFR) Title 45, Part 164.312 where applicable.

Should a provider need to dispose of its business computer, all client information must be removed from the hard drive of the old computer prior to its disposal, using a method that permanently destroys the data. (Simple file deletion is not sufficient.)

**Right to Review
Records**

Authorized state and federal agencies and their authorized representatives may audit or examine a provider's or facility's records. This examination includes all records that the agency finds necessary to determine whether Medicaid payment amounts were or are due. This requirement applies to the provider's records and records for which the provider is the custodian. The provider must give authorized state and federal agencies and their authorized representatives access to all Medicaid patient records and to other information that cannot be separated from Medicaid-related records.

At the time of the request, all records must be provided regardless of the media format on which the original records are retained by the provider.

**Required
Training**

With the implementation of this Handbook, all new providers must complete APD approved provider pre-service basic training prior to receiving their enrollment letter from the APD. Existing agency operators must ensure that employees receive the required pre-service basic training prior to providing services. (See Appendix B for training chart on provider pre-service training requirements. See Appendix C for training chart on service-specific training requirements in addition to the pre-service requirements.)

It is the responsibility of the provider to ensure that training, which carries an expiration date (CPR, First Aid, HIV and AIDS, Infection Control, and HIPAA), is received prior to the expiration date to avoid any lapse in certification.

The provider shall maintain on file for review adequate and complete documentation to verify participation, and the successful completion of by its

employees or subcontractors, all required training courses and certifications. Proof of training will include the title of the training and certificates signed and dated by the trainer. Documentation of training must be maintained by the provider in the staff file for at least five years after the last date of service provided by the provider, employee, and subcontractor.

Providers of consumable medical supplies, durable medical equipment, environmental accessibility adaptations, personal emergency response, physical, occupational, speech and respiratory therapy, skilled, private duty and residential nursing, and dental services are exempt from the pre-service training requirements.

Refer to the Training Matrix in Appendix C for specific training requirements and documentation requirements for each type of service provider.

Protection of a Recipient's Funds and Benefits

Only supported living and residential services providers shall assist with managing a recipient's personal funds and only under limited situations when the recipient needs assistance with money management and natural supports are not available to assist. In these limited situations, the provider shall assist the recipient to maintain a separate checking account or savings account for all personal funds.

If a single trust account is maintained for recipient s residing in licensed residential settings, there must be a separate accounting for each recipient's funds. There must be a monthly reconciliation to the account's total as noted on the bank statement and shall be retained by the provider for review by APD or AHCA. The recipient shall be provided an account. The provider shall not allow any recipient's personal funds be co-mingled with funds of another person, including those of the provider or any of its employees.

The provider shall maintain on file a written consent to manage personal funds, signed by the recipient or the recipient's legal representative. The provider shall maintain on file receipts for single item purchases of \$25.00 or more. Legal representative, if applicable, will be provided with a monthly report of this account and expenditures.

Neither the provider nor its employees nor any family members of the employee or provider can receive any financial benefit as a result of being named the beneficiary of a life insurance policy covering a recipient served by the provider or receive any financial benefit through the will of the recipient at the time of his or her death.

Neither the provider nor its employees nor family members of the employee or provider can benefit financially by borrowing or otherwise using the personal funds of a recipient served by the provider.

Providers who manage any aspect of the recipient's personal funds shall regularly review bank statements and bank balances to ensure Medicaid eligibility is maintained and shall immediately notify the WSC and APD Regional Office when they become aware of an issue that could jeopardize the recipient's Medicaid eligibility.

Neither the provider nor its employees nor family members of the provider shall serve as landlord for recipients served by the provider, nor shall they benefit from the sale of property to a recipient for whom they provide services.

Waiver Provider Enrollment, continued

Protection of a Recipient's Funds and Benefits, continued

Neither the waiver provider nor its employees nor family members of the provider will be named representative payee for Social Security benefit checks with the exception of providers who operate licensed residential facilities and supported living agency providers. A copy of each recipient's annual report to the Social Security Administration must be maintained on file by the provider and available to APD for inspection.

Marketing Practices

When waiver provider markets its services, it shall do so in a professional and ethical manner.

- Neither the provider nor subcontractors nor employees of the provider shall possess or use for the purpose of solicitation lists or other information from any source that identifies recipients receiving waiver services.
 - Neither the provider nor subcontractors nor employees of the provider shall solicit recipients to request services directly or through an agent, through the use of fraud, intimidation, undue influence, or any form of overreaching.
 - Neither the provider, subcontractors, nor employees of the provider shall unduly influence a recipient to request a service, select a service provider, or participate in an activity, regardless of whether the recipient requests, that results in selection of to the provider.
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CHAPTER 4 iBUDGET WAIVER SERVICES COVERAGE AND LIMITATIONS

Overview

Introduction

This chapter describes the services covered under the iBudget waiver. It also describes the requirements for service provision, service limitations, and exclusions. Please refer to the Appendices for all Documentation and Training Requirements.

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Overview, continued

Service Families

Services are organized into service families. This is to help recipients select the service(s) that best meets their needs among similar services.

Group	Service Family	Services and Subservices
1	Life Skills Development	Level 1 (Companion)
		Level 2 (Supported Employment)
		Level 3 (Adult Day Training - ADT)
2	Supplies and Equipment	Consumable Medical Supplies
		Durable Medical Equipment and Supplies
		Environmental Accessibility Adaptations
		Personal Emergency Response Systems (Unit and Services)
3	Personal Supports	Personal Supports
		Respite Care
4	Residential Services	Residential Habilitation (Standard)
		Residential Habilitation (Behavior Focused)
		Residential Habilitation (Intensive Behavior)
		Specialized Medical Home Care
		Supported Living Coaching
5	Support Coordination	Support Coordination-Limited
		Support Coordination-Full
		Support Coordination-Enhanced
6	Wellness and Therapeutic Supports	Behavior Analysis Services
		Behavior Assistant Services
		Dietician Services
		Private Duty Nursing
		Residential Nursing
		Skilled Nursing
		Occupational Therapy
		Physical Therapy
		Respiratory Therapy
		Speech Therapy
Specialized Mental Health Counseling		
7	Transportation	Transportation
8	Dental Services	Adult Dental Services

Overview, continued

Service Families,
continued

A recipient can choose to have more than one service from a service family on the recipient's cost plan during a given period of time (such as the Life Skills Development service family, where a recipient can use Life Skills Development - Level 3 (Adult Day Training - ADT) services on some days and Life Skills Development - Level 2 (Supported Employment) on others. A recipient can choose to receive only one service from the Residential Services service family during a given period of time unless the recipient is transitioning to supported living.

Service Family 1 - Life Skills Development

- Life Skills Development - Level 1 (Companion)
 - Life Skills Development - Level 2 (Supported Employment)
 - Life Skills Development - Level 3 (Adult Day Training - ADT)
-

Life Skills Development - Level 1 (Companion)

Description

Life Skills Development - Level 1 (Companion) services consist of non-medical care, supervision, and socialization activities provided to adults (recipients of age 21 and older). This service must be provided in direct relation to the achievement of the recipient's goals per the recipient's support plan. The service provides access to community-based activities that cannot be provided by natural or other unpaid supports, and should be defined as activities most likely to result in increased ability to access community resources without paid support. Life Skills Development - Level 1 (Companion) services can be scheduled on a regular, long-term basis.

Life Skills Development - Level 1 (Companion) services are not merely diversional in nature, but are related to a specific outcome or goal(s) of the recipient. Activities can be volunteer activities performed by the recipient as a pre-work activity or activities that connect a recipient to the community.

Life Skills Development - Level 1 (Companion), continued

Limitations of Amount, Duration, Frequency, Intensity, and Scope

Level 1 (Companion) services are limited to the amount, scope, frequency, duration, and intensity of the services described on the recipient's support plan and current approved cost plan. The Life Skills Development - Level 1 (Companion) rate shall be based on a maximum of three individuals. Level 1 services are limited to adults only (age 21 and older). A recipient shall receive no more than 64 quarter-hours of this service each day, or a maximum of the equivalent of 16 hours per day of all life skills development services combined. A provider cannot bill beyond these limitations.

This service cannot be provided simultaneously with Life Skills Development - Level 2 (Supported Employment), Life Skills Development - Level 3 (Adult Day Training), personal supports services, or residential habilitation services.

Provider Qualifications

Providers of Life Skills Development - Level 1 (Companion) may be home health or hospice agencies, licensed in accordance with Chapter 400, Part III or IV, F.S. Providers can also be solo or agency providers who are not required to be licensed, certified, or registered.

With the effective date of this rule, providers and employees of agencies shall be age 18 and older, and have at least one year of hands-on supervised experience working in a medical, psychiatric, nursing, or childcare setting or working with recipients who have a developmental disability.

Place of Service

Life Skills Development - Level 1 (Companion) services can be provided in the recipient's own home or family home or while a recipient who lives in their own home, family home, or licensed facility is engaged in a community activity as long as the companion service is not duplicative of what is required by the residential provider licensing requirements. Life Skills Development - Level 1 (Companion) services provided to a recipient living in a licensed group or foster home must be performed in the community, not the licensed living environment. This service cannot be received in the home of the provider, or rendered by a relative or friend of the provider.

Special Considerations

Life Skills Development - Level 1 (Companion) service providers are not reimbursed separately for transportation and travel costs. These costs are integral components of Life Skills Development - Level 1 (Companion) services and are included in the rate.

If the provider plans to transport the recipient in the provider's 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. Subsequent to enrollment, the provider is responsible for keeping this documentation up-to-date.

Life Skills Development - Level 2 (Supported Employment)

Overview

Prior to using an individual's budget allocation to fund waiver services for Life Skills Development – Level 2 (Supported Employment), a person seeking employment supports must first enroll with Vocational Rehabilitation and if the individual is under the age of 22, they must exhaust available resources through the public school system. The waiver will only pay for job development and stabilization in those limited circumstances when DVR documents service denial to the individual. The waiver-funded job development period shall not exceed 2 months without written justification from the provider and approval from the APD Regional Director.

So as to generate additional funding to support an individual's employment goals, supported employment coaches must assist the clients they serve to be aware of and utilize the various work incentives and employment planning tools that are available, and in particular the Plan to Achieve Self- Sufficiency (PASS). So that all coaches are aware of these various incentives and tools, all supported employment coaches must successfully complete APD's pre-service course Introduction to Social Security Work Incentives within one year of the promulgation of this handbook.

Life Skills Development - Level 2 providers will immediately notify the recipient's waiver support coordinators (WSCs) of any changes affecting the recipient's income. The supported employment provider will work with the recipient and the respective WSC to maintain eligibility under the iBudget waiver, as well as health and income benefits through the Social Security Administration and other resources.

To be eligible for payment of supported employment services rendered, the provider must properly complete, maintain, and timely submit, along with the supported employee's billing information, the APD Employment Stability Plan (ESP) form. The ESP form shall be completed and used by the provider as requested by the APD, and shall document the following:

- The development of natural supports in the workplace;
- The reduction of supported employment services rendered (fading of paid supports) as efficiently as possible to provide only the minimal supported employment services necessary for the recipient to maintain competitive employment;
- The recipients employment outcomes, including the attained job or position, benefits received, rate of pay, number of hours worked weekly, and other quality indicators as requested by APD.

Description

Life Skills Development - Level 2 (Supported Employment) services provide training and assistance to support recipients in job development and sustaining paid employment at or above minimum wage unless the recipient is operating a small business. This service can be performed on a full-time or part-time basis and at a level of benefits paid by the employer for the same or similar work performed by trained non-disabled recipients. The provider assists with the acquisition, retention, or improvement of skills related to accessing and

maintaining such employment or developing and operating a small business. With the assistance of the provider, the recipient is assisted in securing employment according to the recipient's desired goals or outcomes. This service is conducted in a variety of settings, to include work sites in which recipients, without disabilities, are employed.

Life Skills Development - Level 2 (Supported Employment) providers will focus on the recipient's needs, as well as provide consultation to the employer on ways to support the recipient in order to sustain paid employment.

There are three models of Life Skills Development - Level 2 (Supported Employment): (1) Individual; (2) Group, and (3) Supported Self-Employment:

The individual model is an approach to obtaining and maintaining competitive employment through the support of a job coach on a one-on-one basis. This can include intensive training when obtaining or starting a new job and systematic follow-along supports for maintaining a job. The individual model can apply to either employment in the general work force or in establishing a business to be operated by the recipient. There are two phases under this model:

Phase 1 is defined as time-limited supports needed to obtain a job and reach stabilization. Billable support activities include:

- Completion of a situational assessment to determine a recipient's employment goals, preferences and skills;
- Job development for a specific recipient, matching the recipient with a job that fits personal expectations; and
- Intensive, systematic on-the-job training and consultation focused on building skills needed to meet employer productivity requirements, learning appropriate behaviors, and acceptance in the social environment of the job setting, and building job-related supports with the employer from those naturally occurring at the work site and other job-related supports.

The number of hours of intervention is intended to diminish over the first few weeks of employment as the supported employee becomes more productive and less dependent on paid supports. Phase 1 ends after demonstration that the supported employee has established job stability. The stabilization period begins when the recipient has achieved satisfactory job performance as judged by the employer, provider, vocational rehabilitation counselor (if applicable), and the recipient; or when the need for paid supports diminishes to fewer than 20 percent of weekly hours of employment. The stabilization period is a minimum of 90 days following the onset of stabilization. If the recipient continues to perform the job satisfactorily the services move into extended, ongoing support services (phase 2).

The provider is expected to provide varying intensities of services to each recipient, beginning with high intensity and fading to achieve stabilization.

Phase 2 is defined as long-term, ongoing supports needed to maintain employment indefinitely. These billable support activities include:

- Ongoing, systematic contacts with recipients to determine the need, intensity, and frequency of supports needed to maintain productivity, social inclusion, and maintain employment;

Life Skills Development - Level 2 (Supported Employment), continued

Description, continued

- Remedial on-the-job training to meet productivity expectations, consultation and refinement of natural supports or other elements important to maintaining employment, and
- Related work supports, such as accessing transportation, and other supports necessary for the recipient to maintain employment, or consultation with family members or other members of the supported employee's support network, including employers and co-workers.

Phase 2 supports assume periodic life changes and personal tensions that will cause job instability. Supports and services are designed to be dynamic and to change in intensity and duration consistent with the needs of each supported employee during periods of job instability and possibly during job loss and re-employment activities. When supports needed to maintain employment for a given recipient become too great in intensity or duration, it will be necessary to move back to Phase 1 services to access a better job match or seek employment alternatives. Moving to Phase 1 supports must include a referral to vocational rehabilitation or the local school system (as applicable) to seek required funding. Medicaid waiver funding shall be used only if these alternative resources are not available.

Group supported employment models are defined as follows:

- Enclave - A group approach to employment where one to eight individuals with disabilities work either as a group or are dispersed individually throughout an integrated work setting with supervision by the employer.
- Mobile Crew - A group approach to employment where a crew, such as lawn maintenance or janitorial, of one to eight individuals with disabilities are in the community in businesses or other community settings with supervision by the provider.
- Entrepreneurial - A group approach to employment where one to eight individuals with disabilities work in a small business created specifically by or for the individuals.

The supported self-employment model of service is defined as working for oneself with direct control over work and services undertaken and can include microenterprise arrangements. Including proprietorships, partnerships, and corporations. Those recipients that select supported self-employment must contribute to the development of a business service product or perform a core function of the business.

Supported self-employment services can be provided to recipients who own their own businesses and need supports and ongoing assistance in the day- to-day running of the business.

Any recipient expressing an interest in supported self-employment will be referred by their WSC to the DVR. The WSC will be responsible for providing the information required to DVR to determine eligibility and vocational goals. Any recipient determined eligible by DVR will generally be provided funding and supports.

Life Skills Development - Level 2 (Supported Employment), continued

Description,
continued

All of the above information contained shall be determined within the ESP initially under the direction of the recipient as part of person-centered planning.

The provider will furnish APD with employment outcome data, including information regarding the recipient's job, benefits, pay, and other quality indicators as part of billing documentation and as otherwise requested.

Limits on the Amount, Frequency, Duration, Intensity, and Scope

A recipient shall receive no more than 64 quarter-hours of this service each day, or a maximum of the equivalent of 16 hours per day of all Life Skills Development services combined. A provider cannot bill beyond these limitations.

Transportation of a recipient to and from a job is not a reimbursable component of Life Skills Development - Level 2 (Supported Employment) services. Recipients needing transportation can receive transportation services when no other community, natural, or generic support is available to provide transportation services. Separate payment for transportation services furnished by the supported employment provider will not be made when rendered as a component of this service.

Note: Refer to the transportation service description in this Handbook for additional information.

Provider Qualifications

Providers of Life Skills Development - Level 2 (Supported Employment) services can be either solo providers or agency providers who are enrolled to provide supported employment.

Employees rendering Life Skills Development - Level 2 (Supported Employment) services shall have a bachelor's degree from an accredited college or university with a major in education; or rehabilitative science or business or related degree. In lieu of a bachelor's degree, a provider rendering this service shall have an associate's degree from an accredited college or university and two years of documented direct experience with recipients with developmental disabilities.

Place of Service

Life Skills Development - Level 2 (Supported Employment) services are provided in the recipient's place of employment in the community or in a setting mutually agreed to by the recipient, the provider, and the employer.

Should the employment location of a recipient change, the provider shall notify the recipient's WSC within five working days.

Life Skills Development - Level 2 (Supported Employment), continued

Special Considerations

Life Skills Development - Level 2 (Supported Employment) services furnished under the waiver are not available through programs funded by the Rehabilitation Act of 1973 or Public Law 94-142. Documentation to this effect shall be maintained in the file of each recipient receiving this service in the form of a written denial of supports from vocational rehabilitation or a note in the progress notes describing the content of a telephone call, the person contacted, and date of the call.

Providers of Life Skills Development - Level 2 (Supported Employment) – group model services will bill for each recipient based on the published stepped rate for the service. The group rate shall be determined based on from two to eight recipients receiving the service.

Providers of Life Skills Development - Level 2 (Supported Employment) – individual model services will bill, based on a one-to-one ratio, the rate established for the service in the published Medicaid rate system.

Payment will not be made for incentives, subsidies, or unrelated vocational training provided to the recipient. The supported employment provider will not bill for supports rendered to the recipient by the employer.

Life Skills Development - Level 3 (Adult Day Training - ADT)

Overview

Life Skills Development - Level 3 (ADT) for adults are training services intended to support the participation of recipients in valued routines of the community, including volunteering, job exploration, accessing community resources, and self-advocacy, in settings that are age and culturally appropriate. Adult day training services can include meaningful day activities and training in the activities of daily living, adaptive, and social skills. The training, activities, and routine established by the ADT shall be meaningful to the recipient and provide an appropriate level of variation and interest.

Description

These services are typically offered five days per week, from six to eight hours per day. A minimum of four hours must include training and program activities.

The service expectation is to achieve individually determined goals and support participation in less restrictive settings.

This training shall be provided in accordance with a formal implementation plan, developed under the direction of the recipient, reflecting goal(s) from the recipient's current support plan.

Life Skills Development - Level 3 (Adult Day Training - ADT), continued

Description, continued

Whenever possible, services should be offered in community integrated settings, but can be offered at a Life Skills Development - Level 3 (ADT) center.

Documentation of services rendered is not considered a billable activity. Life Skills Development - Level 3 (ADT) services can be provided as an adjunct to other services included in the life skills development family on an recipient's support and cost plan. For example, a recipient can receive other life skills development services for part of a day or week and Level 3 (ADT) services at a different time of the day or week. Life Skills Development - Level 3 (ADT) services will only be billable for the prorated share of the day or week that the recipient actually attends that service.

Mobile crews, enclaves, and entrepreneurial models that do not meet the standards for supported employment and are provided in groups of four or more recipients are included as Life Skills Development - Level 3 (ADT) off-site services.

Any recipient, receiving Life Skills Development - Level 3 (ADT), who is performing productive work, either on-site or off-site, must be financially compensated commensurate with members of the general work force doing similar work per wage and hour regulations of the U.S. Department of Labor.

Life Skills Development - Level 3 (ADT) off-site models include services that teach specific job skills and other services directed at meeting specific employment objectives.

- Enclave - A group approach to training where no more than ten individuals with disabilities work either as a group or are dispersed individually throughout an integrated work setting with supervision by the provider.
- Mobile Crew - A group approach to training where a crew (lawn maintenance, janitorial) of individuals with disabilities is in a variety of community businesses or other community settings with supervision by the provider.
- Entrepreneurial - A group approach to training with experienced professionals in assisting the individual with disabilities to set up and work in a small business created especially by or for the individuals. Such models include self-employment and microenterprise. Any profits earned from this model must be used to either pay the individuals per Federal Guidelines or reinvested into the business or both.

At least annually, providers will conduct an orientation informing recipients of supported employment and other competitive employment opportunities in the community.

Life Skills Development - Level 3 (Adult Day Training - ADT), continued

Limits on Amount, Duration, Frequency, Intensity, and Scope

The recipient can choose to attend a Life Skills Development - Level 3 (ADT) program in the frequency that is desired within the budget allocation and as approved on the service authorization. The stepped rate published for Life Skills Development - Level 3 (ADT) is based on one extra hour of staff time to accommodate the variance in recipient schedules for attendance. The provider shall render services at a time mutually agreed to by the recipient and the provider. This will allow a recipient the flexibility to determine when to attend the Life Skills Development - Level 3 (ADT) program for limited hours or only on certain days. Billing can be by the hour for the number of hours attended each day by the recipient, or by the day, defined as between four and six hours. When billing hourly, providers can bill for the first hour of service irrespective of service time provided. Thereafter, providers must use the following billing instructions: Additional time after the initial hour should be rounded up or down. Rounding down should occur for 30 minutes or less and rounding up should occur for 31 minutes or more. No more than eight hours per day or a total of 1,440 hours per year can be provided and billed. No more than 112 hours per week of all Life Skills Development combined can be provided.

This service shall begin for a recipient no earlier than the age of 22 they are no longer in school or when he has graduated from high school, receiving a standard diploma. Recipients wanting to attend ADT prior to the age of 22 without a standard diploma must seek funding through alternative sources outside of the waiver.

Life Skills Development - Level 3 (ADT) services are limited to the amount, duration, frequency, and intensity of the service described on the recipient's support plan and current approved cost plan within the flexibility of the budget. The only services that can be provided at the same time and at the same facility with Life Skills Development - Level 3 (ADT) are behavior analysis, physical therapy, occupational therapy, speech therapy, or skilled nursing, at the request of or convenience of the recipient. Behavior assistant services can be provided as a discrete service in the Life Skills Development - Level 3 (ADT) facility if it does not duplicate services provided by the Life Skills Development - Level 3 (ADT) facility and only as described in a behavior plan.

Provider Qualifications

Providers of Life Skills Development - Level 3 (ADT) services shall be designated by the APD Regional Office as Life Skills Development - Level 3 (ADT) providers. Unless waived in writing by the APD Regional Office, the provider shall meet the following minimum qualifications for staff and staffing ratio:

- The agency manager or director will not have full-time responsibility for providing direct services and will not be included in determining the staffing ratios.
 - The program director will possess at a minimum an Associate's Degree from an accredited college or university and two years, hands on, related experience.
 - Instructors (supervisors) will have one year of direct care-related experience.
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Life Skills Development - Level 3 (Adult Day Training - ADT), continued

Provider Qualifications,
continued

- Related experience will substitute on a year-for-year basis for the required college education.
 - Direct service staff will work under appropriate supervision.
 - The staffing ratio will not exceed ten individuals per direct service staff for adult day training facility-based programs. Supervisory and other management staff can be included in determining the direct care staff ratio. Administrative staff and those not providing direct service to the recipient are not considered direct service staff.
 - Direct service staff must be age 18 and older at the time they are hired.
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Place of Service

Life Skills Development - Level 3 (ADT) services shall be provided in the community whenever possible. Life Skills Development - Level 3 (ADT) services can also be provided in a designated Life Skills Development - Level 3 (ADT) center.

Special Considerations

Life Skills Development - Level 3 (ADT) providers are paid separately for transportation services only when they are enrolled as a transportation provider and transportation is provided between an recipient's place of residence and the training site. Transportation between Life Skills Development - Level 3 (ADT) sites, if the activities provided are a part of Life Skills Development - Level 3 (ADT) services, will be included as a component of the Life Skills Development - Level 3 (ADT) services and included in the rate paid to the provider of the Life Skills Development - Level 3 (ADT) service. Life Skills Development - Level 3 (ADT) staff responsible for transporting individuals must meet the minimum requirements of a transportation provider.

Life Skills Development - Level 3 (ADT) staff is responsible for assisting individuals into and out of facilities when they have been transported in vehicles not owned or operated by the Life Skills Development - Level 3 (ADT) center. Drivers of such vehicles are responsible for ensuring the individual's safe entry into and exit from the vehicle.

Life Skills Development - Level 3 (ADT) services and Life Skills Development - Level 3 (ADT) off-site services will be billed based on the stepped rate for the services.

Life Skills Development - Level 3 (ADT) services shall be billed at the standard rate level for the service. The standard rate is paid when an individual requires minimal assistance, through instructional prompts, cues, and supervision to properly complete the basic personal care areas of eating, bathing, toileting, grooming and personal hygiene.

Life Skills Development - Level 3 (Adult Day Training - ADT), continued

Special Considerations,
continued

Rates based on staffing ratios for ADT services are provided at one of the following levels 1:1; 1:3; 1:5 or 1:6 to 1:10. For any ratio other than 1:10, the following is used to determine the correct ratio assigned to the recipient:

For the purposes of staffing ratios for ADT the following will apply:

1. Indicators of a one staff-to-one individual staffing rate ratio level include:
 - A recipient who is on a behavior services plan that is implemented by the adult day training provider, and who exhibits the characteristics required for behavior residential habilitation or intensive behavior residential habilitation services as outlined in this handbook and as determined by a certified behavior analyst. The need for this level of supervision must be verified in writing by the APD Region Office Local Review Committee chairperson. The recipient is not required to live in a licensed residential facility. The behavior services plan and its effects on the behavior must be reviewed by the local review committee (LRC) on a regular schedule as determined appropriate by the LRC; and
 - The ADT provider must maintain documentation of the LRC review schedule, the LRC review dates and recommendations made, and the changes made related to these recommendations.
 2. Indicators of a one staff-to-three individual staffing rate ratio level include a recipient that:
 - Requires an intense level of personal care support services (to include such areas as specialized eating techniques and positioning needs - as indicated on an APD-approved assessment) or
 - Is on a behavior services plan that is implemented by the ADT provider, and exhibits the characteristics required for behavior residential habilitation services as outlined in the handbook and as determined by a certified behavior analyst (the recipient is not required to live in a licensed residential facility).
 3. Indicators of a one staff-to-five individual staffing rate ratio level include a recipient that:
 - Routinely requires prompts, supervision, and physical assistance, to include lifting and transferring, to complete the basic personal care areas of eating, bathing, toileting, grooming, and personal hygiene as identified in the current abilities section of the APD-approved assessment or
 - Is on a behavior services plan that is implemented by the adult day training provider and requires visual supervision during all waking hours and occasional intervention as determined by a certified behavior analyst. The recipient does not have to live in a licensed residential facility.
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Life Skills Development - Level 3 (Adult Day Training - ADT), continued

Special Considerations, continued

Support provided to groups of nine or ten individuals must be billed as adult day training off-site, regardless of the recipient's wage. If the support is provided in groups of eight or fewer individuals, and the recipients are paid less than minimum wage, the service shall be billed as adult day training off-site. Payment shall not be made for any time period the recipient is absent from the service.

Providers can combine each day's service in a month and bill at the end of the month.

If services terminate before the end of the month, providers shall combine each day's service for the service period and bill at the end of the service period, using the last day of the service period as the date of service.

Service Family 2 – Supplies and Equipment

- Consumable Medical Supplies
 - Durable Medical Equipment and Supplies
 - Environmental Accessibility Adaptations
 - Personal Emergency Response Systems
-

Consumable Medical Supplies

Description

Note: Effective July 1, 2013, WSCs will access incontinence supplies for recipients through the Medicaid State Plan pursuant to Rule 59G-13.086, F.A.C., Developmental Disabilities Waiver Disposable Incontinence Medical Supplies Fee Schedule.

Consumable medical supplies are non-durable supplies and items that enable recipients 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 iBudget waiver must meet all of the following conditions:

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

All items shall meet applicable standards of manufacture, design, and installation.

Consumable Medical Supplies, continued

Description,
continued

This service also includes devices, controls, or appliances specified in the recipient's plan of care which enable recipients to increase their abilities to perform activities of daily living, or to perceive, control, or communicate with the environment in which they live. This service also includes items necessary for life support, ancillary supplies, and equipment for the proper functioning of such items and durable and non-durable medical equipment not available under the Medicaid State Plan. Items reimbursed with waiver funds shall be in addition to any medical equipment and supplies furnished under the Medicaid State Plan and shall exclude those items that are not of direct medical or remedial benefit to the recipient.

**Provider
Qualifications**

Providers of consumable medical supplies include home health or hospice agencies, pharmacies, medical supply companies, and durable medical equipment suppliers and vendors, such as discount stores and department stores. Independent vendors can also provide these services.

Home health agencies and durable medical equipment companies must provide a bond, letter of credit, or other collateral at the time of application, unless the agency has been a Medicaid enrolled provider for at least one year prior to the date it applies to become a waiver provider and has had no sanctions imposed by Medicaid or any regulatory body.

Home health and hospices shall be licensed in accordance with Chapter 400, Parts III and IV, F.S.

Pharmacies shall hold a permit to operate, issued in accordance with Chapter 465, F.S.

Medical supply companies and durable medical equipment suppliers shall hold local occupational licenses or permits, in accordance with Chapter 205, F.S., and shall be currently licensed in accordance with Chapter 400, Part VII, F.S.

Assistive technology suppliers and practitioners shall be certified through the Rehabilitation Engineering and Assistive Technology Society of North America (RESNA).

Retail stores shall hold local occupational licenses or permits, in accordance with Chapter 205, F.S. If a county does not require a permit or license, evidence must be provided and its Federal Employee Identification number made available.

**Limits on the
Amount,
Duration,
Frequency,
Intensity, and
Scope**

Consumable medical supplies cannot duplicate supplies provided by other sources. Refer to the Florida Medicaid Durable Medical Equipment and Medical Supply Services Coverage and Limitations Handbook for additional information on the Medicaid State Plan coverage.

If multiple vendors are enrolled to provide this service, the recipient shall be encouraged to select from among the eligible vendors based on an item's availability, quality, and best price. No more than ten items per day can be purchased (some items have additional limitations as indicated in this handbook).

Consumable Medical Supplies, continued

Limits on the Amount, Duration, Frequency, Intensity, and Scope, continued

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- Diapers, including pull-ups and disposable briefs, for recipients age 21 and older;
 - Wipes, for recipients age 21 and older, if the recipient requires incontinent supplies; and
 - Surgical masks, when prescribed by a physician, ARNP, or physician assistant and are:
 - Worn by a recipient with a compromised immune system as a protection from infectious disease; or
 - Worn by a caregiver who must provide a treatment that requires a strict, sterile procedure in which they are trained to provide care to a recipient who has a compromised immune system and who must be protected at all cost from exposure to any airborne organisms or substances. A physician, ARNP, or physician assistant 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 Durable Medical Equipment and Medical Supplies Program State Plan services, when determined necessary by a licensed dietitian. Recipients that 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 the Medicaid State Plan and prescribed by a physician, ARNP, or physician assistant. This excludes supplies for a recipient who qualifies for food supplements under the Florida Medicaid Durable Medical Equipment and Medical Supplies program or the Medicare program;
 - Dressings not covered by the Medicaid Durable Medical Equipment and Medical Supplies Program State Plan services that are required for a caregiver to change wet to dry dressing over surgical wounds or pressure ulcers, and prescribed by a physician, ARNP, or physician assistant;
 - Hearing aid batteries, cords, and routine maintenance and cleaning prescribed by an audiologist; and
 - Bowel management supplies purchased under the waiver are limited to \$150.00 every three months. These supplies include laxatives, suppositories, and enemas prescribed for bowel management by the recipient's physician, ARNP, or physician assistant.

Items not contained on this list that meet the definition of consumable medical supplies can be approved through exception by APD Regional Office. To request an exception, a physician, ARNP, or physician assistant must prescribe the item. The statement from a physician, ARNP, or physician assistant must delineate how the item is medically necessary, how it is directly related to the recipient's developmental disability, and without which the recipient cannot continue to reside in the community or in the recipient's current placement. Items specifically excluded in this Handbook will not be approved through exception.

Consumable Medical Supplies, continued

Limits on the Amount, Duration, Frequency, Intensity, and Scope, continued

Requests for CMS will be reviewed by the APD Regional Office in consultation with the APD Central Office to determine compliance with the standards for medical necessity set forth in Rule 59G-1.010(166), F.A.C., and to determine whether the requested item fairly meets the service definition. Consumable medical supplies must be directly and specifically related to the recipient'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 excluded from coverage. 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. For example, a physical therapist, occupational therapist, or physician recommending or prescribing items like Tylenol, Ginkgo Biloba, vitamins, gluten-free foods, cotton balls or Q-tips, does not convert that item from general utility items to consumable medical supplies covered under the iBudget waiver. Items covered in this category generally include only those items that are specifically designed for a medical purpose, and are not used by the general public or other general utility uses. It is the general character and not specific use of the item that governs for purposes of coverage under this category.

The waiver does not allow for payment or reimbursement of copayments for consumable medical supplies covered by third party insurance.

Note: The Florida Medicaid Durable Medical Equipment and Medical Supply Services Coverage and Limitations Handbook is available on the Medicaid fiscal agent's Web site at www.mymedicaid-florida.com. Select **Public Information for Providers**, then **Provider Support**, and then **Provider Handbooks**. The handbook is incorporated by reference in Rule 59G-4.070, F.A.C.

Special Considerations

Educational supplies are not consumable medical supplies and are not covered by the waiver. These supplies are expected to be furnished by the local school system or the recipient parent. Recipients or their family members shall not be reimbursed for any supplies they purchase.

Private insurance, Medicare, or the Medicaid State Plan must be billed before billing the Medicaid waiver. Supplies available under the Medicaid State Plan cannot be purchased using waiver funds. Further, waiver funds cannot be used to purchase additional quantities of consumable supplies that are above the Medicaid State Plan limitation amount.

Durable Medical Equipment and Supplies

Description

Durable medical equipment (DME) includes specified, prescriptive equipment required by the recipient. Durable medical equipment generally meets all of the following requirements:

- Can withstand repeated use;
 - Is primarily and customarily used to serve a medical purpose;
 - Is generally not useful to a recipient in the absence of a disability; and
 - Is appropriate for use in the home.
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Provider Qualifications

Providers of DME include home health or hospice agencies, pharmacies, medical supply companies, and durable medical equipment suppliers and vendors, such as discount stores and department stores. In accordance with Rule 59G-4.070, F.A.C., to enroll as a Medicaid provider, a DME and medical supply entity must comply with all the enrollment requirements outlined in the Durable Medical Equipment and Medical Supply Services Coverage and Limitations Handbook.

In accordance with 42 CFR 440.70, providers of DME must be in compliance with all applicable laws relating to qualifications or licensure. In accordance with Chapter 205, F.S., independent vendors, assistive technology suppliers and assistive technology practitioners certified by the Rehabilitation Engineering and Assistive Technology Society of North America (RESNA) can also provide these services.

In accordance with section 409.907, F.S., home health agencies and durable medical equipment companies must provide a bond, letter of credit, or other collateral at the time of application, unless the agency has been a Medicaid-enrolled provider for at least one year prior to the date it applies to become a waiver provider and has had no sanctions imposed by Medicaid or any other regulatory body.

Home health and hospice agencies shall be licensed in accordance with Chapter 400, Part III and IV, F.S.

Pharmacies shall hold a permit to operate issued in accordance with Chapter 465, F.S. Medical supply companies and durable medical equipment suppliers shall hold local occupational licenses or permits, in accordance with Chapter 205, F.S., and be currently licensed in accordance with Chapter 400, part VII, F.S.

Retail stores shall hold local occupational licenses or permits, in accordance with Chapter 205, F.S.

Durable Medical Equipment and Supplies, continued

Limits on the Amount, Duration, Frequency, Intensity, and Scope

All equipment shall have direct medical or remedial benefit to the recipient, shall be related to the recipient's developmental disability, and shall be necessary to prevent the recipient's institutionalization. Assessment and prescription by a licensed physician, ARNP, physician assistant, physical therapist, or occupational therapist is required.

Durable medical equipment and supplies cannot duplicate DME and supplies provided through the Medicaid Durable Medical Equipment and Medical Supplies Program State Plan services or other sources. Equipment and supplies available under the Medicaid State Plan cannot be purchased using waiver funds. Further, waiver funds cannot be used to purchase additional quantities of supplies that are above the Medicaid State Plan limitation amount.

Refer to the Florida Medicaid Durable Medical Equipment and Medical Supply Services Coverage and Limitations Handbook for additional information on Medicaid State Plan coverage.

The following can be provided in accordance with the other requirements and limitations in this Handbook:

- Van adaptations, including 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 exclude 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 recipient with mobility impairments and when the vehicle is the recipient'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 the waiver has funded adaptations to another vehicle during the preceding 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 2½ 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 recipient or family. Payments for repair to adaptations after the warranty expires can be approved by the APD Regional Office. Many automobile manufacturers offer a rebate of up to \$1,000 to recipients purchasing a new vehicle requiring modifications for accessibility. To obtain the rebate the recipient 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.

Durable Medical Equipment and Supplies, continued

Limits on the Amount, Duration, Frequency, Intensity, and Scope, continued

If a recipient or a family purchases a used vehicle with adaptive equipment already installed, the waiver cannot be used to fund the vehicle purchase or any portion of the purchase related to the adaptive equipment already installed.

A rehabilitation engineer or other certified professional can be reimbursed under home accessibility assessment to assess the appropriateness of any van conversion including identification of an appropriate lift system.

- Wheelchair carrier for the back of the car is limited to one carrier for a five-year period.
 - A standard wheelchair, to the extent that it is medically necessary and not covered by the Medicaid Durable Medical Equipment and Medical Supplies Program State Plan services. A physician, ARNP, or physician assistant must prescribe the specific item. The wheelchair covered by this service is a standard (manual) wheelchair and not intended for a recipient who cannot use a standard chair for any length of time without adaptation. Coverage in this category will typically only be provided when the following criteria are met:
 - The recipient has a customized power wheelchair funded through Medicare or Medicaid, which is used as a primary mode of ambulation; or the recipient is ambulatory, but has a documented medical condition that prevents walking for sufficient lengths of time to go about the recipient's daily activities, e.g., cardiac insufficiency or emphysema. This condition must be documented by a physician and include a statement addressing how the recipient is limited in normal daily activities by the condition;
 - The recipient needs a manual wheelchair to facilitate movement within the recipient's own home, and to enable the recipient to be safely transported in an automobile. It must be documented that the vehicle does not have a lift or that the recipient's primary chair, if applicable, cannot be collapsed to fit into a trunk or on a wheelchair carrier;
 - The requested wheelchair is the most cost-beneficial device that meets the needs of the recipient.
 - Payments for repair to wheelchairs after the warranty expires can be approved by the APD Regional Office in consultation with the APD Central Office, if not covered by Medicare or Medicaid.
 - Only one manual wheelchair can be purchased in a five-year period. The waiver will not fund the purchase of both a manual wheelchair and a stroller in a five-year period.
 - Excluded from coverage are wheelchairs requested to facilitate recreational activities, such as beach wheelchairs, sports wheelchairs, or wheelchairs that are not the most cost-beneficial way to meet the needs of the recipient.
 - Waiver services are not used to cover any copayments, with the exception of patient responsibility for Medicare-funded wheelchairs.
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Durable Medical Equipment and Supplies, continued

Limits on the Amount, Duration, Frequency, Intensity, and Scope, continued

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- Strollers, subject to the same criteria and limitations for wheelchairs, as stated above, except reimbursement for a stroller will be limited to \$1,200. Only one stroller or manual wheelchair can be purchased in any five-year period. As a cost-effective alternative the base unit for an adaptive car seat could be covered in lieu of a stand-alone stroller unit. Payments for repair to strollers after the warranty expires can be approved by the APD Regional Office in consultation with the APD Central Office, if not covered by Medicare or Medicaid DME and Medical Supplies Program State Plan services. The APD Regional Office will respond to requests for repairs to strollers within ten working days of receipt of such requests.
 - Portable ramps, when the recipient requires access to more than one non-accessible structure. If more cost effective, a vertical lift or wheelchair lift can be purchased.
 - Patient lift, hydraulic or electric with seat or sling, when the recipient requires the assistance of more than one person to transfer between bed, chair, wheelchair, or commode are limited to adults and limited to one lift every eight years. The cost shall not exceed \$2,000. Payments for repair to lifts after the warranty expires can be approved by the APD Regional Office, if not covered by Medicare or Medicaid Durable Medical Equipment and Medical Supplies Program State Plan services.
 - Patient lifts are available through the Medicaid Durable Medical Equipment and Medical Supplies Program State Plan services. The iBudget waiver will fund ceiling lifts only when the lift systems available through the Medicaid Durable Medical Equipment and Medical Supplies program will not meet the recipient's need. A ceiling lift requires a home accessibility assessment by a rehabilitation engineer or appropriate professional to ensure the structural integrity of the home to support the ceiling lift and track system. When this system is requested, it must be documented that it is the most cost-effective means of meeting the recipient's need and that the specific item selected does not exceed the medically necessary needs of the recipient. Medical necessity is usually limited to necessary access to a recipient bedroom and bath. Only one system will be allowed for any recipient. If after at least five years the recipient moves. It will be determined if the most cost-efficient means to meet the recipient's need is by moving the current system or purchasing a new system if still required by the recipient. A new assessment and determination must be made. The cost shall not exceed \$10,000. Payments for repair to ceiling lifts after the warranty expires can be approved by the APD Regional Office in consultation with the APD Central Office, if not covered by Medicare or Medicaid Durable Medical Equipment and Medical Supplies Program State Plan services.
 - Adaptive car seat, for recipients being transported in the family vehicle and who cannot use the standard restraint system or can no longer fit into a standard child's car seat. The seat must be prescribed by a physical therapist who will determine that the recipient cannot use standard restraint devices or car seats. The physical therapist will identify appropriate equipment for the recipient. Adaptive car seats are limited to one per recipient every three years and the cost shall not exceed \$1,000.
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Durable Medical Equipment and Supplies, continued

Limits on the Amount, Duration, Frequency, Intensity, and Scope, continued

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- Bidet, limited to recipients who are able to transfer onto commodes independently, but whose physical disability limits or prevents thorough cleaning. This item requires a prescription by a physician, ARNP, or physician assistant and an assessment by a physical or occupational therapist to determine that the recipient can use the item independently. The bidet and installation cost shall not exceed \$1,000.
 - Single room air conditioner, when there is a documented medical reason for the recipient's need to maintain a constant external temperature. The documentation necessary for this equipment would be a prescription from a pulmonologist along with a medical statement explaining the medical diagnosis and the reason the air conditioner is necessary. Conditions for which a single room air conditioner can be appropriate include congestive heart failure, severe cardiac disease, COPD (emphysema), or damage or disease of the hypothalamus. Only one single room air conditioner with a maximum of 250 square feet capacity will be approved per recipient for a five-year period. The air conditioning unit cost shall not exceed \$300.
 - Single room air purifier, when there is a documented medical reason for the equipment. The documentation necessary for this equipment would be a prescription from a pulmonologist along with a medical statement explaining the medical diagnosis and the reason the equipment is necessary. Conditions for which a single room air purifier can be appropriate include severe asthma with documented sensitivity to indoor airborne particles, chronic obstructive pulmonary disease, emphysema or pulmonary dysplasia. The air purifier unit cost shall not exceed \$250. Only one air purifier unit will be approved per recipient for a five-year period.
 - Adaptive switches and buttons to operate equipment, communication devices, and environmental controls, such as heat, air conditioning, and lights, for a recipient living alone or who is alone without a caregiver for a major portion of the day. The documentation necessary for this equipment would be an evaluation and prescription by an occupational therapist. Excluded are adaptive switches or buttons to control devices intended for entertainment, employment, or education.
 - Adaptive door openers and locks for recipients living alone or who are alone substantial portions of the day or night and have a need to be able to open, close, or lock doors and cannot do so without special adaptation. These must be prescribed by a physical therapist, occupational therapist, or Rehabilitation Engineering and Assistive Technology Society of North America (RESNA) certified provider.
 - Environmental safety devices limited to door alarms, anti-scald devices, and grab bars for the bathroom. If the items are being installed as part of an environmental accessibility adaptation, they can be billed under the procedure code for the adaptation rather than DME. These must be prescribed by a physical therapist, occupational therapist, or Rehabilitation Engineering and Assistive Technology Society of North America (RESNA) certified provider.
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Durable Medical Equipment and Supplies, continued

Limits on the Amount, Duration, Frequency, Intensity, and Scope, continued

- Adaptive eating devices, including adaptive plates, bowls, cups, drinking glasses, and eating utensils, that are prescribed by a physical therapist, occupational therapist, or RESNA certified provider.
 - Adaptive bathing aids, to facilitate independence, as prescribed by a physical, occupational therapist, or RESNA certified provider.
 - Commercially available picture communication boards and pocket charts, selected and prescribed by a speech therapist.
 - Gait belts for safety during transfers and ambulation, and transfer boards, selected and prescribed by a physical therapist.
 - Egg crate padding for a bed, when medically indicated and prescribed by a physician, ARNP, or physician assistant.
 - Hypoallergenic covers for mattress and pillows, ordered by a physician, who documents necessity based upon severe allergic reaction to airborne irritants.
 - Generators can be covered for an recipient when there is documentation that:
 - The recipient is ventilator-dependent;
 - The recipient requires daily use of oxygen via a concentrator;
 - The recipient requires continuous, 24-hour total parenteral nutrition via an electric pump;
 - The recipient requires continuous, 24-hour infusion of total nutritional formula through a jejunostomy or gastrostomy tube via an electric pump;
 - The recipient requires continuous, 24-hour infusion of medication via an electric pump; or
 - The recipient meets the medical need for a single room air conditioner.
 - The size of the generator is limited to the wattage necessary to provide power to the essential life-sustaining equipment. When a generator is requested, it must be documented that the specific model identified is the most cost-beneficial that meets but does not exceed the recipient's need. One generator per recipient per household can be purchased per ten-year period. Payments for repair to generators after the warranty expires can be approved by the APD Regional Office, if no other funding is available.
 - Bolsters, pillows, or wedges, necessary for positioning, that are prescribed by a physical or occupational therapist.
 - Therapy mat prescribed by a physical therapist when a recipient is involved in a home-therapy program designed by a therapist and carried out by the family or caregiver in the recipient's own or family home.
 - Pulse oximeters can be purchased for recipients with respiratory or cardiac disease, who use supplemental oxygen on a continuous or intermitted basis. This equipment must be prescribed by the recipient's pulmonologist, cardiologist, or primary care physician.
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Durable Medical Equipment and Supplies, continued

Limits on the Amount, Duration, Frequency, Intensity, and Scope, continued

Items not contained on this list that meet the definition of durable medical equipment can be approved through exception by the APD Regional Office in consultation with the APD Central Office. To request an exception, a physician, ARNP, or physician assistant must prescribe the item. The statement from a physician, ARNP, or physician assistant must delineate how the item is medically necessary, how it is directly related to the recipient's developmental disability, without which the recipient cannot continue to reside in the community. The request will be reviewed by the APD Regional Office in consultation with the APD Central Office to determine compliance with the standards for medical necessity set forth in Rule 59G-1.010(166), F.A.C., and to determine whether the requested item fairly meets the service definition. Items specifically excluded in this Handbook will not be approved through exception.

If multiple vendors are enrolled to provide this service, the recipient shall select from among all eligible vendors based on the item's availability, quality, and best price.

A prescription submitted for a piece of equipment, which has general utility or is generally used for physical fitness or personal recreational choice, does not change the character of the equipment for purposes of coverage in this category. For example, a physical therapist, occupational therapist, physician, ARNP, or physician assistant recommending or prescribing a stationary bicycle or hot tub does not convert that item from personal fitness or recreational choice equipment to durable medical equipment covered under the iBudget waiver. Items covered in this category generally include those specifically designed for a medical purpose, and are not used by the general public for physical fitness purposes, recreational purposes, or other general utility uses. It is the general character and not the specific use of the equipment that determines its purpose, for coverage under this category.

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

Excluded Services

Items usually found or used in a physician's office, therapist's office, hospitals, rehabilitation centers, clinics, or treatment centers or items designed for use by a physician or trained medical personnel are not covered. This includes items such as prone or supine standers, gait trainers, activity streamers, vestibular equipment, paraffin machines or baths, and therapy balls.

Also excluded are experimental equipment, weighted vests and other weighted items used for the treatment of autism, facilitated communication, hearing, and vision systems, institutional type equipment, investigational equipment, items used for cosmetic purposes, personal comfort, convenience or general sanitation items, or routine and first aid items.

Durable Medical Equipment and Supplies, continued

Excluded Services, continued

Items for diversional or entertainment purposes are not covered. Items that would normally be available to any child or adult and would ordinarily be provided by families are also excluded. Examples of excluded items are toys, such as crayons, coloring books, other books, and games; electronic devices such as iPods or MP3 players, cell phones, televisions, cameras, film, computers and software; exercise equipment, such as treadmills and exercise bikes; indoor and outdoor play equipment, such as swing sets, slides, bicycles, tricycles (including adaptive types), trampolines, play houses, and merry-go-rounds; and furniture or appliances. Items that are considered family recreational choices are also not covered, including air conditioning for campers, swimming pools, decks, spas, patios, and hot tubs.

In accordance with section 393.13, F.S., totally enclosed cribs and barred enclosures are considered restraints and are not covered under the waiver. Strollers and wheelchairs, when used for restraint, are not covered.

Special Considerations

Recipients and their family members shall not be reimbursed for equipment they purchase. Any durable medical equipment must be determined to be cost-beneficial. Once the most reasonable alternative has been identified and specifications developed, three competitive bids must be obtained for all items \$1,000 and over to determine the most economical option. If three bids cannot be obtained, it must be documented to show what efforts were made to secure the three bids and explain if less than three bids were obtained. For items under \$1,000, only one bid is required as long as it can be demonstrated that the bid is consistent with local market value.

The iBudget waiver shall not provide durable medical equipment that is available for purchase through the Medicaid State Plan DME and Medical Supplies Program State Plan services. The Medicaid State Plan often covers like equipment, but not the specific brand requested. When this occurs, the recipient is limited to the Medicaid State Plan covered device. The lack of coverage for a specific brand name is not a medically necessary justification for a waiver purchase.

All equipment shall have direct medical or remedial benefit to the recipient, shall be related to the recipient's developmental disability and shall be necessary to prevent the recipient's institutionalization. A prescription by a physician, ARNP, physician assistant, or physical or occupational therapist and a statement as to the direct medical or remedial benefit to the recipient is required.

Environmental Accessibility Adaptations

Description

Environmental accessibility adaptations (EAA) are those physical adaptations to the home that are required by the recipient's support plan and are medically necessary to avoid institutional placement of the recipient and enable the recipient 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 recipient's home. Home accessibility assessments can also include pre-inspection of up to three houses a recipient 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.

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 shall hold the required state certificate or registration in that trade category.

Engineers shall 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 shall be licensed in accordance with Chapter 481, F.S., and must have at least one year of experience in environmental adaptation assessment and remodeling or be RESNA certified.

Contractors and electricians shall be licensed in accordance with Chapter 489, F.S.

Plumbers shall be licensed in accordance with Chapter 489 F.S. Certified Environmental Access Consultant (CEAC) certified through the U.S. Rehabilitation Association, Certified Aging in Place Consultant administered through the National Home Builder's Association.

Carpenters and other vendors shall hold local occupational licenses or permits, in accordance with Chapter 205, F.S. Other professionals who can provide environmental accessibility adaptations assessments include providers with experience in the field of environmental accessibility adaptation assessment, with a RESNA certification, and an occupational license.

Environmental Accessibility Adaptations, continued

Limits on the Amount, Duration, Frequency, Intensity, and Scope

Environmental accessibility adaptation services are limited to the amount, duration, and scope of the adaptation project described on the recipient's support plan and current approved cost plan. If multiple vendors are enrolled to provide this service, the recipient shall be encouraged to select from among the eligible vendors based on availability, quality of workmanship, and best price.

Excluded are those adaptations or improvements to the home, which are of general utility and are not of direct medical or remedial benefit to the recipient, such as carpeting, roof repair, central air conditioning, etc.

Environmental accessibility adaptations (EAA) are approved when they are medically necessary. To submit a request, the appropriate professional must complete an assessment documenting how the specific EAA is medically necessary and is a critical health and safety need, how it is directly related to the recipient's developmental disability, how it is directly related to accessibility issues within the home, and how without the identified EAA, the recipient cannot continue to reside in the recipient's current residence. The request will be reviewed by the APD Regional Office to determine whether the standards for medical necessity are met and to determine whether the requested item fairly meets the service definition.

Adaptations specifically excluded in this Handbook will not be approved.

Environmental accessibility adaptations include only adaptations to an existing structure, and must be provided in accordance with applicable state or local building codes. Adaptations that add to the total square footage of the home are excluded from this benefit. No more than five units per day shall be provided and billed and a total limit of \$20,000.00 cannot be exceeded over a five year period.

Place of Service

Environmental accessibility adaptations shall be made only to a recipient's family home or recipient's own home, including rented houses or apartments. Recipients living in foster homes, group homes, assisted living facilities, or homes for special services (any licensed residential facility) are not eligible to receive this service; the responsibility for EAA rests with the facility owner or operator.

Special Considerations

Environmental accessibility adaptations shall be determined "medically necessary" and a critical health and safety need of the recipient must be documented before approval. This determination includes the following considerations:

- There are no less costly or conservative means to meet the recipient's need for accessibility within the home;
 - The environmental accessibility adaptation is individualized, specific, and consistent with the recipient's needs and not in excess of those needs; and,
 - The environmental accessibility adaptation enables the recipient to function with greater independence in the home and without which, the recipient would require institutionalization.
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Environmental Accessibility Adaptations, continued

Special Considerations, continued

Environmental accessibility adaptations that are required to support proper functioning of medical equipment, such as electrical upgrades, are limited to the requirements for the safe operation of the specified equipment

Environmental accessibility adaptations shall be approved for a recipient's own home or family home whether owned or leased, as needed, to make the home accessible to the recipient. Once adaptations are made to a recipient's residence, adaptation to that residence or another residence cannot be made until five years after the last adaptation to the first residence except for extenuating circumstances, such as total loss of residence. The cost of adaptation shall not exceed the value of the residence.

The waiver program does not cover routine repairs to the existing EAA or general repairs to the home or residence.

If a recipient or family builds a home while the recipient is receiving waiver services, major or structural changes will not be covered. Environmental accessibility adaptations covered under these circumstances are the difference in the cost, if any, between a handicapped-accessible bathroom and a standard bathroom. However, the cost difference for each item and adaptation must be documented, with total cost not exceeding \$3,500.

A recipient's rental property is limited to minor adaptations as defined below. Prior to any adaptation to a rental property, a determination should be made as to what, if anything, the landlord will cover. The landlord, prior to service, shall approve all proposed environmental accessibility adaptations in writing. The written agreement between the recipient or family and the landlord must specify any requirements for restoration of the property to its original condition if the occupants move and must indicate that APD and waiver funding are not obligated for any restoration costs. Waiver funds cannot be placed in escrow to undo any accessibility adaptations when the recipient moves out. Recipients or families requesting EAA are expected to apply for all other assistance that can be available to assist in meeting the recipient's needs. This includes local housing authorities, county, local, and community funding, etc.

Environmental accessibility adaptations shall be separated into two categories. Minor adaptations shall be defined as those EAA costing under \$3,500 for all adaptations in the home. Major adaptations shall include those adaptations to a home when the total cost is \$3,500 and over. Total EAA cannot exceed \$20,000 during a five-year period. Major environmental accessibility adaptations require the assessment of a rehabilitation engineer or other professional qualified to make a home accessibility assessment. This home accessibility assessment shall include evaluation of the current home and describe the most cost-beneficial manner to permit accessibility of the home for the recipient on the waiver.

The evaluation must demonstrate that the environmental accessibility adaptation recommended is a "prudent purchase." A prudent purchase is a purchase made based on a combination of quality and cost, where quality is measured by the ability to meet the recipient's accessibility need and cost is measured by being the most reasonable and economical approach necessary to meet that need. Each environmental accessibility adaptation must be the most reasonable alternative based on the results of the review of all options, including a change in the use of rooms within the home or alternative housing.

Environmental Accessibility Adaptations, continued

Special Considerations, continued

Environmental accessibility adaptations must be cost-beneficial. Once the most reasonable alternative has been identified and specifications have been developed, three competitive bids must be obtained for all EAA to a home costing \$3,500 and over to determine the most economical option.

If three bids cannot be obtained the WSC must document in the support coordination notes what efforts were made to secure the three bids and explain why fewer were obtained. For EAA costing between \$1,000 and \$3,499 at least two competitive bids must be obtained. If two bids cannot be obtained, it must be documented in the support coordination notes to show what efforts were made to secure the two bids and explain why only one was obtained. For EAA costing under \$1,000 only one bid is required, as long as it can be demonstrated in the bid that the bid is consistent with local market value for like environmental adaptations. Environmental accessibility adaptations do not include those adaptations or improvements to the home that are of general utility, are considered to be standard housing obligations of the owner or tenant, are considered to be experimental, or are not of direct medical or remedial benefit to the recipient on the waiver. Routine maintenance of the adaptations and general repair and maintenance to the home is the responsibility of the owner or landlord and not a covered waiver service.

Examples of items not covered include replacement of carpeting and other floor coverings unless removed to achieve the installation of the adaptation; roof repair; driveways; decks; patios; fences; swimming pools; spas or hot tubs; sheds; sidewalks (unless this is the person's only means of access into the home); central heating and air conditioning; raised garage doors; storage (e.g., cabinets, shelving, closets); standard home fixtures (e.g., sinks, commodes, tub, stove, refrigerator, microwave, dishwasher, clothes washer and dryer, wall, window and door coverings, etc.); furnishings (e.g., furniture, appliances, bedding); and other non-custom items that can routinely be found in a home. Also, specifically excluded are any adaptations that will add square footage to the home.

Personal Emergency Response Systems

Description

A personal emergency response system is an electronic communication system that enables a recipient to secure help in the event of an emergency. The recipient can 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 recipient's location.

Limits on the Amount, Duration, Frequency, Intensity, and Scope

A personal emergency response system is limited to those recipients who live alone or who are alone for significant parts of the day and have no regular caregiver for extended periods of time, and otherwise require extensive routine supervision. Recipients living in licensed residential facilities are not eligible to receive this service. 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 line but does include the cost of the monthly service fee.

Personal Emergency Response Systems, continued

Provider Qualifications

EAA providers shall be licensed electrical contractors, alarm system contractors, etc.; contract agencies for Community Care for the Elderly (CCE) must be authorized by Chapter 430, F.S., Community Care for Disabled Adults (CCDA) programs must be authorized by Chapter 410, F.S., or hospitals. Freestanding equipment can also be purchased from independent vendors, such as discount or home improvement stores, but these vendors cannot provide monitoring.

Electrical or alarm system contractors shall be licensed in accordance with Chapter 489, Part II, F.S.

Hospitals shall be licensed in accordance with Chapter 395, F.S.

Independent vendors shall hold local occupational licenses or permits, in accordance with Chapter 205, F.S.

Place of Service

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

Special Considerations

A personal emergency response system is available only for at-risk recipients who require a limited degree of supervision but live alone or are alone for periods of time without a caregiver. The need for a personal emergency response system must be addressed in the recipient's support plan.

Service Family 3 – Personal Supports Services

- Personal Supports
 - Respite
-

Personal Supports

Description

Personal supports services provide assistance and training to the recipient in activities of daily living, such as in the areas of eating, bathing, dressing, personal hygiene, and preparation of meals. When specified in the support plan, this service can also include housekeeping chores, such as bed making, dusting, and vacuuming, and assistance to do laundry, shopping, and cooking, which are incidental to the care furnished, or which are essential to the health and welfare of the recipient rather than the recipient's family.

Personal Supports, continued

Description,
continued

This service can also provide respite services to a recipient age 21 and older living in their family home. The provider, to the extent properly qualified and licensed, assists in maintaining an recipient's own home and property as a clean, sanitary and safe environment. These services can include heavy household chores to make the home safer, such as washing floors, windows and walls; tacking down loose rugs and tiles; or moving heavy items or furniture. Services also include non-medical care, supervision, and socialization. This service can provide access to community-based activities that cannot be provided by natural or unpaid community supports and are likely to result in an increased ability to access community resources without paid support. This service is provided in support of a goal in the support plan and is not purely diversional in nature.

Assistance is provided on a one-on-one basis to recipients who live in their family homes unless they are engaged in a community-based activity. Community-based activities can be provided to recipients living in their family home or in their own homes in groups not to exceed three.

**Limits on the
Amount,
Duration,
Frequency,
Intensity, and
Scope**

Personal supports are limited to adults only (age 21 and older). Personal supports can be provided to recipients age 18 years and older who are in a supported living situation or living in their own home.

The recipient's support plan shall specifically explain the duties that a personal supports provider will perform for the recipient.

Personal supports services cannot be provided during the time a recipient is attending an adult day training program.

Services can be billed by the hour or by the day. If it is more cost effective to bill the daily rate as opposed to the hour, the recipient has the option to adjust the cost plan to use the most cost-effective unit for service provision. In order to meet their needs, a recipient can negotiate a rate to maximize their iBudget waiver allocation.

Providers of recipients in supported living arrangements who receive both personal supports and supported living coaching must coordinate their activities to avoid duplication. The personal supports services are separate and are not a replacement for the services performed by a supported living provider. Personal supports provided in supported living must follow plans and strategies developed by the supported living provider as detailed in the support plan, the circle of support, or both. Personal supports are designated to encourage community integration and participation in the recipient's home. Personal supports in supported living are also designated to teach the recipient about home-related responsibilities.

Personal supports providers are not reimbursed separately for transportation and travel costs. These costs are integral components of the personal supports service and are included in the basic rate.

Personal Supports, continued

Limits on the Amount, Duration, Frequency, Intensity, and Scope, continued

Personal supports services are billed by the quarter-hour up to 96 quarter-hours or by the day if the recipient is receiving more than eight hours per day.

For recipients under the age of 21, refer to the Florida Medicaid Home Health Services Coverage and Limitations Handbook for additional information on Medicaid State Plan coverage. The handbook is available on the Medicaid fiscal agent's Web site at www.mymedicaid-florida.com. Select **Public Information for Providers**, then **Provider Support**, and then **Provider Handbooks**.

Provider Qualifications

Providers of personal supports can be home health or hospice agencies, licensed in accordance with Chapter 400, Part III or IV, F.S. Providers can also be solo and unless the provider is a nurse, are not required to be licensed, certified, or registered if they bill for and are reimbursed only for services personally rendered.

With the effective date of this Handbook, new solo providers and employees of agencies shall be age 18 and older, and have at least one year of hands-on supervised experience working in a medical, psychiatric, nursing, or childcare setting or working with recipients who have a developmental disability or 30 semester hours, 45 quarter-hours, or 720 classroom hours of college or vocational school.

An agency using more than one employee to provide services and billing for their services, shall be registered as a homemaker, sitter, or companion provider in accordance with section 400.509, F.S.

Place of Service

Personal supports shall be provided in the recipient's own home or family home or while the recipient who lives in one of those settings is engaged in a community activity. Personal supports can also be provided at the recipient's place of employment. No service can be provided or received in the provider's home, the home of a relative or friend of the provider, a hospital, an Intermediate Care Facility for the Developmentally Disabled (ICF/DD), or other institutional environment.

Neither the personal supports services provider nor the provider's immediate family shall be the recipient's landlord or have any interest in the ownership of the recipient's housing unit, as stated in Rule 65G-5.004, FAC. A provider is defined as a solo provider or a corporation, including all board members and any paid employees and staff of the provider agency, its subsidiaries, or subcontractors. If renting, the name of the recipient receiving personal supports services must appear on the lease either singularly, with a roommate, or a guarantor.

Personal supports services rendered by a provider or an employee of a provider who is living in a recipient's home must be billed at the live-in rate for the service.

Personal Supports, continued

Place of Service,
continued

When the personal supports provider lives in the recipient's home, the worker will share equally in the room and board for the home. The equal share determination shall be made prior to any stipend calculation for the recipient. The recipient has the option to negotiate with the personal supports provider for a share of the household expenses during the time that the personal supports provider shares the living arrangement when it is not the primary residence.

Personal supports services that are provided on an hourly basis, instead of a live-in basis, shall be billed by the quarter-hour in accordance with the rate for personal supports services. The recipient can opt to receive personal supports services at a daily rate.

If the recipient owns the home, the waiver support coordinators (WSC) or the APD Regional Office staff must assist the recipient in negotiating the provider's share of expenses and then negotiate offsetting the fee by the amount the provider owes the recipient for rent and other expenses. The provider's share of expenses is the housing and expenses shared between the recipient and the provider in a supported living arrangement. These expenses include sharing the telephone, cable, internet, rent, utilities, lawn care, etc.

In supported living situations, an agreement must be entered into between the provider and the recipient that outlines the financial obligations of the provider and the recipient. The supported living coach will develop an attachment to the recipient's financial profile outlining the average "share of expenses" between the in home support staff, the recipient, and any other occupant of the home.

Special Considerations

Recipients living in foster or group homes are not eligible to receive personal supports, except:

- During an overnight visit with family or friends away from the foster or group home to facilitate the visit.
 - When a group home resident recovering from surgery or a major illness does not require the care of a nurse, and the group home operator is unable to provide the personal attention required to insure the recipient's personal care needs are being met. Under these circumstances, it would be considered reasonable to provide this service to a group home resident only on a time-limited basis. Once the recipient has recovered, the service must be discontinued. The use of personal supports in this situation must be requested by the WSC and approved by the APD Regional Office with a copy of the approval maintained in the WSC file and the provider file.
 - When an recipient living in a licensed group home is employed and needs personal supports services at the employment site.
 - Personal supports can be provided in a group home when the primary caregiver is unable to perform their usual and customary natural supports. This service is generally used due to a brief planned or emergency absence or when the primary caregiver is available but temporarily physically unable to supervise the recipient for a brief period of time.
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Personal Supports, continued

Special Considerations, continued

Reimbursement for nursing oversight of services provided by home health agencies and nurse registries, as required by 42 CFR 484.36 and Rule 59A-8 F.A.C., is not a separate reimbursable service. The cost must be included in the personal supports service.

Personal supports providers are not reimbursed separately for transportation and travel cost. These costs are included in the rate.

Respite Care

Description

Respite care is a service that provides supportive care and supervision to recipients under the age of 21 when the primary caregiver is unable to perform the duties of a caregiver. This service is generally used due to a brief planned or emergency absence, or when the primary caregiver is available, but temporarily physically unable to care for or supervise the recipient for a brief period of time. Respite care is not intended to be used as after school care or supplement personal care assistance when daily limits for personal care assistance is exceeded.

Respite care for recipients age 21 and older is available as a part of the Personal Supports service family.

Limits on the Amount, Duration, Frequency, Intensity, and Scope

Respite care service providers are not reimbursed separately for transportation and travel cost as these costs are integral components of the service and are included in the basic rate.

Respite care services are limited to the amount, duration, intensity, frequency and scope of the service described on the recipient's support plan and current-approved cost plan.

Respite services are only available to recipients under the age of 21 and who live in the family home.

Billing is at the quarter-hour with a maximum of 39 units per day, or by the day, whichever is most cost effective. The day rate is billed for ten hours of service or more.

Provider Qualifications

With the effective date of this Handbook, new solo providers and employees of agencies hired after this date shall be age 18 and older and have at least one year of supervised direct care experience working in a medical, psychiatric, nursing or childcare setting or working with recipients who have a developmental disability or 30 semester hours, 45 quarter-hours, or 720 classroom hours of college or vocational school.

Respite Care, continued

Provider Qualifications, continued

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

Providers 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. An agency using more than one employee to provide services and billing for their services, shall be registered as a homemaker, sitter, or companion provider in accordance with section 400.509, F.S.

Nurses who render respite care services as solo providers shall be licensed in accordance with Chapter 464, F.S.

Place of Service

Respite can be provided in the recipient's family home, while involved with activities in the community, in a licensed group home, foster home, or assisted living facility (ALF).

Special Considerations

Recipients living in licensed group homes or who are in supported or independent living are not eligible to receive respite care services.

Providers of respite services must use a stepped quarter-hour rate for the service or the daily rate if respite services are provided for ten or more hours a day or 40 quarter-hours. The provider must bill for only those hours of direct contact with the recipient (s).

Relatives who live outside the recipient's home and are enrolled as Medicaid waiver providers can provide respite care services and be reimbursed for the services under specific circumstances. The relative must meet the same qualifications as other providers of the same service. With regard to relatives providing this service, safeguards must be taken to ensure that the payment is made to the relative as a provider, only in return for specific services rendered, and there is adequate justification as to why the relative is the provider of care. An example of a valid justification can be a general lack of enrolled providers due to the rural setting. Approval for use of a relative to provide respite services must be granted by the APD Regional Office. Documentation of APD's approval must be maintained in both the provider's and WSC's files.

Most recipients 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 recipient has a complex medical condition. If a nurse provides this service, a prescription from a physician, ARNP, or physician assistant will be necessary.

A relative is defined as someone other than a legally responsible family member, required to provide care for the recipient, such as a parent of a minor child.

Service Family 4 – Residential Services

- Residential Habilitation (Standard)
 - Residential Habilitation (Behavior Focused)
 - Residential Habilitation (Intensive Behavior)
 - Specialized Medical Home Care
 - Supported Living Coaching
-

Residential Habilitation

Description

Residential habilitation services provide supervision and specific training activities that assist the recipient to acquire, maintain, or improve skills related to activities of daily living. The 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 recipient to reside in the community. This training is provided in accordance with a formal implementation plan, developed by the provider with direction from the recipient and reflects the recipient's goals from the current support plan.

Recipients with challenging behaviors can require more intense levels of residential habilitation services described as behavior focus residential habilitation or intensive behavioral residential habilitation. The necessity for these services is determined by APD based on specific individual behavioral characteristics that impact the immediate safety, health, progress, and quality of life for the recipient, and the determination that less intensive services have not been sufficient to alter these behaviors. The need for increased levels of residential habilitation, behavior focus residential or intensive behavioral residential habilitation must be verified and approved by the APD Regional Office in consultation with the APD Central Office.

Payments to providers of residential habilitation services are not made for the recipient's room and board, the cost of facility maintenance, upkeep, and improvement, other than such costs for modifications or adaptations to a facility required to ensure the health and safety of residents, or to meet the requirement of the applicable life safety code. Payment for residential habilitation does not include payments made, directly or indirectly, to members of the recipient's immediate family. Payments will not be made for the routine care and supervision of a recipient that would be expected to be provided by a family or group home provider, or for activities or supervision for which payment is made by a source other than Medicaid.

Residential Habilitation, continued

Description,
continued

There are five agency provider types approved to perform this service. They are:

- Certified behavior analysts (CBA) licensed in accordance with Chapter 393, F.S.
- Assisted living facilities (ALFs), licensed in accordance with Chapter 400, F.S.
- Licensed group homes in accordance with Chapter 393, F.S.
- Transitional living facilities, licensed in accordance with Chapters 393 and Chapter 400, F.S. 5.
- Licensed foster homes, licensed in accordance with Chapter 393, F.S.

For assisted living facilities (ALF) which provide medication administration, a staff member who is licensed to administer medications must be available to administer medications in accordance with a health care's provider order or prescription label in accordance with Chapter 429 F.S.

Agencies can hire direct care providers who are age 18 and older and must have one year supervised experience working in a medical, psychiatric, nursing, or child care setting or working with recipients with developmental disabilities or 30 semester hours, 45 quarter-hours, or 720 classroom hours of college or vocational school.

There are three different rate components for Residential Habilitation Services. They are:

- Day
- Live-in
- Month

Residential habilitation services are provided in APD licensed facilities. Limitations, provider qualifications, and other information are provided in this chapter for each type of residential habilitation listed below:

- Standard residential habilitation
 - Behavior focus residential habilitation
 - Intensive behavior residential habilitation
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Residential Habilitation, continued

Limits on the Amount, Frequency, Duration, Intensity, and Scope

A recipient cannot receive residential habilitation services and supported living coaching services at the same time, except when the recipient lives in a licensed residential facility and has a personal goal or outcome for supported living on a support plan. In this case, the recipient can receive both services for a maximum of 90 days prior to their move to the supported living setting.

The APD Regional Office can approve residential habilitation. live-in services for recipients who reside in a licensed foster or group home with no more than three recipients living in the home. Residential habilitation live-in services can be billed for when the recipient is present up to 365 days per year or 366 days per leap year.

A provider or an employee of a provider is not required to “live in” the licensed home for the live-in rate to be applied for the service. The live-in daily rate provides up to 24 hours of supports.

Residential habilitation provided in a licensed home must bill at the monthly rate if the recipient resides in the home for a minimum of 24 days in the month. Providers must bill at the daily rate for recipients who are in the home fewer than 24 days for the month. Billing however cannot be submitted until after the month is completed. If billing by the month, providers shall not bill on a date the recipient was not present. Providers shall use the last date the recipient was present as the date of service.

Residential Habilitation, continued

Provider Qualifications

After the effective date of this rule, new providers and agency staff hired after this date who provide direct care residential habilitation services in a licensed residential facility must have one year supervised experience working in a medical, psychiatric, nursing, or child care setting or working with recipients with developmental disabilities or 30 semester hours, 45 quarter-hours or 720 classroom hours of college or vocational school and must be age 18 and older.

Place of Service

This service is provided primarily in a licensed residential facility as defined in Chapter 2 of this Handbook. However, some activities associated with daily living that generally take place in the community such as grocery shopping, banking, or working on social and adaptive skills are included in the scope of this service.

Residential Habilitation (Standard)

Special Considerations

Residential habilitation providers are paid separately for transportation services if they are currently enrolled as an iBudget waiver transportation provider, only when transportation is provided between an recipient's place of residence and another waiver service. Incidental transportation or transportation provided as a component of residential habilitation services is included in the residential habilitation rate paid to the provider. Residential habilitation providers are not reimbursed separately for time spent documenting services as these costs are integral components of the services and are included in the basic rate.

Residential habilitation training services shall not take the place of a recipient's job or another meaningful day service, but must be scheduled around such events. For example, if a recipient works a Monday through Friday, 9:00 a.m. – 4:00 p.m. schedule, residential habilitation training services must be scheduled in the evening hours and on weekends.

Providers shall maintain a minimum level of staffing consistent with the minimum direct care staff hours per recipient per 24-hour day table identified in the following. Staffing ratios shall be established by the provider using the available total minimum direct care staff hours per recipient per 24-hour day consistent with the support and training needs of recipients receiving residential habilitation services for functional, behavioral, or physical needs. The provider will meet the minimum staffing levels on a per day basis for each home providing residential habilitation or shall provide the required staffing over a 7-day period for each home to accommodate for recipient absences from the home and to establish optimal coverage on weekends. Providers of residential habilitation services and their employees shall provide sufficient staffing and staff ratios while delivering these services to meet recipient needs and provide appropriate levels of training and supervision for recipients of the service.

Residential Habilitation (Standard), continued**Special Considerations**, continued

Staffing hours (ratios) are a performance measurement for the provider and are not related to any specific recipient's residential habilitation needs. Minimum staff ratios apply solely to the provider's performance requirements for recipients based on the authorized residential habilitation level of residents being served.

Direct Care Staff Hours per Person per 24-Hour Day		
Level of Disability	Hours per Day	Hours per Week
Basic Level	2	14
Minimal Level	4	28
Moderate Level	6	42
Extensive 1 Level	8	56
Extensive 2 Level	11	77

Hours counted must be provided by Residential Habilitation staff or by other staff who are providing direct care or direct time spent on client training, intervention, or supervision. Provider compliance with staffing levels for residential habilitation services substantiates Medicaid billing requirements only; other provisions of this Handbook remain fully applicable to all providers.

To determine minimum required staffing for each level of support for residential habilitation services, the minimum direct care staff hours per person per 24-hour day authorized for recipients receiving residential habilitation services are multiplied by the number of recipients receiving the service at that level in the home setting. All available staff hours per level are totaled to obtain a daily minimum total number of staff hours. The resulting total is then divided by eight hours of staff work time to produce a full-time equivalent (FTE) level per day. The number of all available staff hours is multiplied by seven to establish a weekly minimum total. For example: The calculation below is for six recipients receiving the service and living in the same home, all authorized at the moderate level of supports. The minimum number of direct care staff hours per person per 24-hour day for the moderate level is six hours. The calculation is as follows:

Six recipients x six direct care staff hours per person per 24-hour day = 36 available direct care staff hours per day, or 252 available direct care staff hours per week. 36 direct care staff hours per day divided by an 8-hour staff working day = 4.5 FTEs per day for minimum residential habilitation direct care staffing purposes.

An example of the application of 4.5 staff FTEs at the moderate level as calculated above: The 4.5 FTEs generated using the calculation above can be used to establish a staffing pattern for standard or behavior focused residential habilitation providers and their employees of 1.5 staff per 8-hour shift over a 24-hour period. If recipients are engaged in the receipt of other services during a period of time during the day, the residential habilitation provider can modify the staffing pattern to maximize staff during the time that recipients are in the home and receiving the service, and to optimize coverage on the weekends and holidays.

Residential Habilitation (Behavioral Focused)

Limits on the Amount, Duration, Frequency, Intensity, and Scope

In order for the provider to receive a residential habilitation with a behavioral focus rate for a recipient, the provider must meet the specified staff qualifications for the service, and the recipient must exhibit the characteristics listed below. This level of service shall be approved for a recipient only when it has been determined through use of the APD-approved instrument by the APD area behavior analyst or designee, and the support planning process that a recipient requires residential habilitation services with a behavioral focus.

At least annually thereafter, the APD area behavior analyst or designee will re-evaluate the recipient through use of the APD-approved instrument to confirm that the recipient continues to meet service eligibility criteria.

The need for residential habilitation with a behavior focus and the rate for the service shall be identified on the recipient's support and cost plan and on the authorization for service submitted to the provider by the recipient's WSC. The provider must document evidence of the recipient's continued need as well as evidence that the services are assisting in meeting the recipient's needs so that transition to less-restrictive services as appropriate remain possible.

Residential habilitation services with a behavior focus are appropriate for recipients exhibiting at least one of the following behavioral issues, within the past six months, as documented and appropriately referenced in their central record:

- Exhibits self-inflicted, detectable, external, or internal damage requiring medical attention or the behavior is expected to increase in frequency, duration, or intensity resulting in self-inflicted, external, or internal damage requiring medical attention. These types of behaviors include head banging, hand biting, and regurgitation.
 - Exhibits external or internal damage to other persons that requires medical attention or the behavior is expected to increase in frequency, duration, or intensity resulting in external or internal damage to other persons that requires medical attention. These types of behaviors include hitting others, biting others, and throwing dangerous objects at others.
 - Arrest and confinement by law enforcement personnel.
 - Causes major property damage or destruction in excess of \$500 for any one intentional incident.
 - Displays a life-threatening situation. These types of behaviors include excessive eating or drinking, vomiting, ruminating, eating non-nutritive substances, refusing to eat, swallowing excessive amounts of air, and severe insomnia.
 - Behavior has led to the use of restraint or emergency medications within six months.
-

Residential Habilitation (Behavioral Focus), continued

Provider Qualifications

A provider who is a board certified behavior analyst or a board certified assistant behavior analyst, or a Florida certified behavior analyst with a bachelor's degree, or a person licensed under Chapter 490 or Chapter 491, F.S. must provide on-site oversight for residential services with a minimum of 30 minutes of on-site oversight each week for each recipient.

Direct care staff providing residential habilitation services in a licensed residential facility must:

- Be age 18 and older.
- Have one year of supervised experience working in a medical, psychiatric, nursing, or child care setting or working with persons who have a developmental disability.
- Receive training in an APD –approved emergency procedure curriculum consistent with 65G-8.002, F.A.C., where providers will be working with recipients with significant behavioral challenges.

No fewer than 75 percent of the provider's direct service staff working with the recipient (s) for whom the behavior focus residential habilitation rate applies shall have completed at least 20 contact hours of face-to-face instruction. The 20 hours of training can be obtained by completing an in-service training program offered privately or through a college or university. Proof of training must be maintained in the provider's file for review and verification in the following content areas:

- Introduction to applied behavior analysis – basics and functions of behavior;
 - Providing positive consequences, planned ignoring, and stop-redirect-reinforce techniques; and
 - Data collection, recording, and documentation.
-

Place of Service

Residential facilities licensed pursuant to Chapter 393.067.F.S.

Special Considerations

Providers of residential habilitation and behavior focus residential habilitation in a licensed facility shall bill for services only when the recipient is present, using the monthly or daily rate authorized based on the published rate for the service.

Behavior focused residential habilitation is intended to be a temporary placement and, as such, once the person's challenging behaviors can be shown to respond to effective treatment, the recipient should be transitioned to the next lower effective level of treatment service. The conditions under which an recipient can be ready for transitioning should be considered on a person-by-person basis. The conditions for transition from behavior focused residential habilitation serves as guidelines under which the treatment team must recommend a less structured, more open environment, including levels of involvement from direct care staff, staff supervisors, and professional care providers. The goal of behavior focused residential habilitation service is to prepare the recipient for full or partial reintegration into the community, with established behavioral repertoires, such as developing a healthy lifestyle, filled with engaging and productive activities.

Residential Habilitation (Behavioral Focus), continued

Special Considerations,
continued

Conditions to be considered for recipient transition to alternate levels of residential habilitation include:

- The behavioral excesses that made treatment necessary occur at reduced rates and with reduced severity.
- The behaviors do not typically occur as a function of new environmental conditions.
- The behaviors intended to replace the problem behavior now occur more often in the presence of the environmental conditions that previously evoked behavioral excesses.
- Level of supervision has been reduced or the recipient functions with less supervision or supervision is the same as that which is likely to be provided in the residential setting to which the recipient is most likely to move, and those settings in which the recipient is likely to have access.
- The provider has determined an effective means of managing the person’s behavior to offer recommendations for transition to new levels of staff and the physical environment requirements needed to maintain or to continue the recipient’s improvement.

When any of the conditions identified above apply, the recipient should be considered for transition to the next lower effective level of treatment service. However, treatment would continue with the focus shifting to ensuring that the gains made are maintained or continued.

Providers of behavior focus residential habilitation services shall provide a level of service consistent with the minimum direct care staff hours per person per day identified in the following table. Staffing ratios shall be established by the provider using the available total minimum direct care staff hours per person per 24 -hour day Table, consistent with the support and training needs of individuals receiving residential habilitation services for functional, behavioral or physical needs. The provider will provide the minimum hours needed per day basis for each recipient, or shall provide the required staffing over a 7-day period for each home to accommodate for absences from the home and to establish optimal coverage on weekends. Providers of residential habilitation services and their employees shall provide sufficient staff ratios while delivering these services to meet more than one recipient’s needs and provide appropriate levels of training and supervision for recipients of the service.

Residential Habilitation Staff Hours per Recipient per Day		
Level of Recipient Disability	Hours per Day	Hours per Week
Basic Level	2	14
Minimal Level	4	28
Moderate Level	6	42
Extensive 1 Level	8	56
Extensive 2 Level	11	77

Residential Habilitation (Behavioral Focus), continued

Special Considerations,
continued

Residential Habilitation service hours counted must be provided by the action of client training, intervention, or supervision. Provider compliance with direct care staffing levels for residential habilitation services substantiates Medicaid billing requirements only; other provisions of this Handbook remain fully applicable to all providers.

To determine minimum required staffing for each level of support for residential habilitation services, the minimum direct care staff hours per person per 24-hour day authorized for recipients receiving residential habilitation services are multiplied by the number of recipients receiving the service at that level in the home setting. All available staff hours per level are totaled to obtain a daily minimum total number of staff hours. The resulting total is then divided by eight hours of staff work time to produce a full-time equivalent (FTE) level per day. The number of all available staff hours is multiplied by seven to establish a weekly minimum total. For example: The calculation below is for six recipients receiving the service and living in the same home, all authorized at the moderate level of supports. The minimum number of direct care staff hours per person per 24-hour day for the moderate level is six hours. The calculation is as follows:

Six recipients × six direct care staff hours per person per 24-hour day = 36 available direct care staff hours per day, or 252 available direct care staff hours per week. 36 direct care staff hours per day divided by an 8-hour staff working day = 4.5 FTEs per day for minimum residential habilitation direct care staffing purposes.

Example of the application of 4.5 staff FTEs at the moderate level as calculated above: The 4.5 FTEs generated using the calculation above can be used to establish a staffing pattern for standard or behavior focus residential habilitation providers and their employees of 1.5 staff per 8-hour shift over a 24-hour period. If recipients are engaged in the receipt of other services during a period of time during the day, the residential habilitation provider can modify the staffing pattern to maximize staff during the time that recipients are in the home and receiving the service, and to optimize coverage on the weekends and holidays.

The service provides for comprehensive monitoring of staff skills and their implementation of required procedures. Monitoring for competence must occur at least once per month for 50 percent of direct service staff that have completed the training described above. Staff must be recertified in the training requirements yearly. The provider also has a system that demonstrates and measures continuing staff competencies on the use of procedures that are included in each recipient's behavior analysis services plan.

Residential Habilitation (Intensive Behavior)

Limits on the Amount, Duration, Frequency, Intensity, and Scope

Intensive behavior (IB) residential habilitation is for recipients who present issues with behavior that are exceptional in intensity, duration, and frequency, that meet one or more of the following conditions and whose needs cannot be met in a behavior focus or standard residential habilitation setting.

Within the past six months the recipient:

- Engaged in behavior that caused injury requiring emergency room or other inpatient care from a physician or other health care professional to self or others.
- Engaged in a behavior that creates a life-threatening situation. Examples of these types of behavior are excessive eating or drinking, vomiting, ruminating, eating non-nutritive substances, refusing to eat, swallowing excessive amounts of air, and severe insomnia.
- Set a fire (arson) in or about a residence or other facility in an unauthorized receptacle or other inappropriate location.
- Attempted suicide.
- Intentionally caused damage to property in excess of \$1,000 in value for one incident.
- Engaged in behavior that was unable to be controlled via less restrictive means and necessitated the use of restraints, mechanically, manually or by commitment to a crisis stabilization unit, three or more times in a month or six times across the applicable six-month period.
- Engaged in behavior that resulted in the recipient's arrest and confinement.
- Required visual supervision during all waking hours and intervention as determined by a certified behavior analyst or licensed behavior analysis professional to prevent behaviors previously described above that were likely, given past behavior in similar situations, without such supervision.
- Engaged in sexual behavior with any person who did not consent or is considered unable to consent to such behavior, or engaged in public displays of sexual behavior (e.g., masturbation, exposure, voyeurism, etc.)

If the supervision and environment is such that the recipient lacks opportunity for engaging in the serious behaviors, the behavior analyst providing oversight must determine that the behavior would be likely to occur at least every six months if the recipient is without the supervision or environment provided and document in the recipient's records.

Intensive behavioral residential habilitation shall provide to the recipient aggressive, consistent implementation of a program of specialized and generic training, treatment, health services and related services that is directed toward: (1) the acquisition of the behaviors necessary for the recipient to function with as much self-determination and independence as possible; and (2) the reduction or replacement of high risk, problems with behavior. Treatment within intensive behavioral residential habilitation also includes medical oversight by psychiatric and nursing services when recipients served have specific concerns related to routine use of psychotropic medications or emergency medications for the management of behavior, mood, or thought process.

Residential Habilitation (Intensive Behavior), continued

Limits on the Amount, Duration, Frequency, Intensity, and Scope, continued

Recipient support plan goals should relate to the assessment, management, and replacement of problems with behavior. As treatment progresses and is effective, recipient goals should also include generalization and maintenance of new behavior and behavior reductions in settings that are increasingly similar to less intensive treatment settings, but within which continued treatment and maintenance services are included.

The recipient's problems with behavior and any related medical conditions must be the central focus of treatment plans. This means that recipient behavior change targets included in the treatment plan must be linked to the initial problem statement. For example, if a problem with behavior was described as self-injury that occurs when the person individual is in the presence of aversive stimuli of a specific nature, then the targets for change would include alternatives to self-injury that would be controlled by the same stimuli. In addition, the individual's assessment might identify socially-skilled behavior deficits in social skills that make self-injury more likely. These deficits might include communication, social skills and basic self-care skills necessary to independently function in other settings where they will serve to replace or reduce the occurrence of problem behaviors.

Recipients in intensive residential habilitation programs must be taught to function more independently with continuous training, supervision, and support by the staff. Over time, with effective intervention, a noticeable reduction in the severity of a recipient's behavior should occur. However, even though there can be substantial improvement in behavior, the provider's goal is to ensure that gains made are maintained in settings other than the treatment setting alone and services should remain comprehensive and continuous, so that the recipient can effectively transition to less intensive services.

Intensive behavior residential habilitation for a recipient must be approved and authorized by The Agency for Persons with Disabilities (APD). Authorization for this service shall be approved for a recipient only when it has been determined through use of the APD-approved assessment by the APD area behavioral analyst or designee that the individual characteristics have been met for intensive behavior residential habilitation. At least annually thereafter, the area behavioral analyst or designee will re-evaluate the recipient through use of the APD-approved assessment to confirm that the recipient continues to meet service eligibility criteria.

The review process for service approval shall include evaluation of the level of need of the recipient and the effectiveness of services being provided. Authorized rates for this service are standardized but may vary for an individual based upon their or her individual's IB matrix score and specific service needs. Evaluation and authorization shall occur prior to service delivery, for new services, within 30 days for existing services and at least annually thereafter. The provider must meet provider qualifications for this level of service. The following individual characteristics and service characteristics defined below must be met in order to receive an intense behavioral residential habilitation rate. APD service authorization shall be based on established need and re-evaluated at least annually while the recipient is receiving the services. The provider must document evidence of continued need, as well as evidence that the service is assisting the recipient in meeting the recipient's needs so that transition to a lower level or less intense services can be possible.

Residential Habilitation (Intensive Behavior), continued

Limits on the Amount, Duration, Frequency, Intensity, and Scope, continued

Behavior assistant services shall not be provided as an additional billable service in conjunction with intensive behavioral residential habilitation.

Minimum staffing requirements for intensive behavior residential habilitation services shall be determined at the time the rate for the service is established, but no less than the ratio established for behavior focus extensive 2.

Providers of residential habilitation services and their employees shall provide sufficient staffing ratios while delivering these services to meet more than one recipient's needs in the same home, provide appropriate levels of training and supervision for recipients receiving the service, and to ensure that procedures can be implemented consistent with the requirements found within their emergency procedure curriculum.

Provider Qualifications

Providers of intensive behavioral residential habilitation services shall meet the behavioral focus provider and staff qualifications identified above, and in addition shall ensure:

- All adjunct services (behavioral, psychiatric, counseling, nursing) are included in the service or separately billed to recipient private insurance policies or sources of reimbursement other than the Medicaid waiver program or APD;
 - All direct care service needs are met without an addition to the approved rate;
 - The program or clinical services director meets the qualifications of a level 1 behavior analyst, including a doctorate level board certified behavior analyst or a master's level board certified behavior analyst, or a practitioner licensed under Chapters 490 and 491, F.S. The Program or Clinical Services Director must be in place at the time of designation of the organization as an intensive behavioral residential habilitation program;
 - Staff responsible for providing behavior analysis services will meet at a minimum the requirements for a Florida certified behavior analyst or board certified assistant behavior analyst under Chapter 393, F.S. or a practitioner licensed under Chapters 490 and 491, F.S.;
 - The ratio of behavior analyst-to-individual is no more than one full-time analyst-to-20 individuals;
 - All direct service staff will complete at least 20 contact hours of face-to-face competency-based instruction with performance-based validation, and comply with staff monitoring and the re-certification system as described above for behavioral focused residential habilitation; and
 - All direct service staff will receive training in an Agency-approved emergency procedure curriculum consistent with Rule 65G-8.002, F.A.C., where staff will be working with recipients with significant behavioral challenges.
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Place of Service

APD residential facilities licensed pursuant to Chapter 393.067, F.S.

Residential Habilitation (Intensive Behavior), continued

Special Considerations

Intensive behavior residential habilitation services must also include the arrangement of contingencies designed to improve or maintain performance of activities of daily living. This would occur when a recipient, e.g., does not bathe regularly and this results in the recipient being socially isolated. The objective in this case would typically be to establish acceptable bathing routines in the absence of highly engineered contingencies. In these cases, incidental training is provided. For example, a recipient is provided instruction while getting dressed in order to assist the recipient in learning to select appropriate clothing for a specific job site. In this way, training on basic skills is provided as one component of active treatment.

Individual behavioral service plans for recipients receiving intensive behavioral residential habilitation will include a written fading plan to decrease services or the level of service as improved behavior and when applicable, a medical condition improves. Environmental changes or adjustments that are made as the person's behavior and medical condition improves shall be tracked, measured, and graphed for the recipient's records.

The goal of an intensive behavior residential habilitation service is to prepare the recipient for full or partial reintegration into the community, with established behavioral repertoires, such as developing a healthy lifestyle, filled with engaging and productive activities.

Intensive behavior residential habilitation is intended to be a temporary placement and as such once the recipient's challenging behaviors can be shown to respond to effective treatment, the recipient should be transitioned to the next lower effective level of treatment service. The conditions under which a recipient can be ready for transitioning should be considered on a person-by-person basis. The conditions for a recipient's transition from intensive behavior residential habilitation serve as guidelines under which the treatment team must recommend a less structured, more open environment, including levels of involvement from direct care staff, staff supervisors, and professional care providers. The goal of intensive behavior residential habilitation service is to prepare the recipient for full or partial reintegration into the community, with established behavioral repertoires, such as developing a healthy lifestyle, filled with engaging and productive activities.

Conditions to be considered for transition include:

- The behavioral excesses that made treatment necessary occur at reduced rates and with reduced severity. The behaviors do not typically occur as a function of new environmental conditions.
 - The behaviors intended to replace the problem behavior now occur more often in the presence of the environmental conditions that previously evoked the behavior excesses.
 - Level of supervision has been reduced or the recipient functions with less supervision, or supervision is the same as that which is likely to be provided in the residential setting to which the recipient is most likely to move, and those settings in which the recipient is likely to have access.
 - The provider has determined an effective means of managing the person's behavior to offer recommendations for transition to new levels of staff and the physical environment requirements needed to maintain or to continue the recipient's improvement.
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Residential Habilitation (Intensive Behavior), continued

Special Considerations,
continued

When the conditions identified above are met, the recipient should be transitioned to a lower level of intensive residential habilitation and no longer require intensive residential habilitation treatment. However, treatment would continue with the focus shifting to ensuring that the recipient gains made maintain or continue to improve in settings that have more variability in the prevailing contingencies and afford greater access to unplanned, everyday encounters with untrained people.

Special Medical Home Care

Description

Special medical home care services are provided in APD licensed foster or group homes serving recipients with complex medical conditions, requiring an intensive level of nursing care. This can include recipients who are ventilator dependent, require tracheostomy care, or have a need for deep suctioning to maintain optimal health. This does not include recipients whose only need is for gastrostomy tube feedings, medications, or insulin injections without other intensive needs. The service can be provided for a period of up to 24 hours per day nursing services and medical supervision for all the recipients residing in the home. The group home must have APD Central Office authorization and maintain appropriate and sufficient staffing at all times to meet the intensive needs of all recipients residing in the home. The rate for special medical home care is considered to be an inclusive rate.

Limits on the Amount, Duration, Frequency, Intensity, and Scope

Only those recipients with complex medical conditions, requiring an intense level of nursing care, and who reside in licensed homes with the designation of special medical home care are eligible for this service. Rates for this service must be approved and authorized through the APD Central Office. Authorization for each recipient in the home requires review by the APD Central Office nursing staff. Authorized rates for service can vary based on the specific service needs of the recipient. Service authorization shall occur prior to service delivery and at least every six months by the APD Central Office nursing staff while the recipient is receiving the service. The APD can establish a level of nursing staff based on recipient support needs at the time of the review required to authorize the service and rate.

Provider Qualifications

Providers of special medical home care shall employ registered nurses, licensed practical nurses, and certified nurse assistants licensed or certified in accordance with Chapter 464, F.S. Certified nurse assistants must work under the supervision of a registered nurse or licensed practical nurse.

Group homes shall be licensed in accordance with Chapter 393, F.S. Nurses and certified nurse assistants must perform services within the scope of their license or certification.

Supported Living Coaching

Place of Service

Special medical home care services shall be provided at an APD licensed foster or group home that has been approved by the APD Central Office to provide this level of care.

Description

Supported living coaching services provide training and assistance, in a variety of activities, to recipients who live in their own homes or apartments. These services are provided by a qualified supported living coach to a recipient residing in a living setting meeting the requirements set forth in Rule 65G-5.004, F.A.C., and can 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 recipients to reside on their own.

In order to identify the types of training, assistance, and intensity of support needed for the recipient, the provider shall complete a Functional Community Assessment. This document is designed to assist the provider in becoming familiar with the recipient and the recipient's capacities and needs. This assessment addresses all aspects of daily life including relationships, medical and health concerns, personal care needs, household and money management, community mobility, and community interests. The supported living provider is responsible for completing the Functional Community Assessment prior to the recipient's move into a supported living arrangement or within 45 days of service implementation for a recipient already in a supported living arrangement. The Functional Community Assessment, which is updated at least annually, is available in the Guide to Supported Living available on the APD Web site at www.apd.myflorida.com/customers/supported-living/living-guide/index.htm.

Supported Living Coaching, continued

Description,
continued

To ensure that the recipient's housing selection meets housing standards, the supported living provider must complete an initial Housing Survey for each person. The supported living coach must complete the Housing Survey prior to the lease being signed. The Housing Survey is available in the Guide to Supported Living available on the APD Web site at: www.apd.myflorida.com/customers/supported-living/living-guide/index.htm. Upon final on-site inspection of the home by the supported living provider and the WSC, the WSC's approval of the housing survey is required. The housing survey is also reviewed quarterly as part of the quarterly home visit and made available for review by the WSC as part of the quarterly home visit. These updates shall include a review of the recipient's overall health, safety, and well-being.

For each recipient served, the supported living provider shall complete a Financial Profile available in the Guide to Supported Living available on the APD Web site at: www.apd.myflorida.com/customers/supported-living/living-guide/index.htm. The profile is an analysis of the household costs and revenue sources associated with maintaining a balanced monthly budget for the recipient. In addition to substantiating the need for a monthly subsidy or initial start-up costs, the profile will serve as a source of information for determining strategies for assisting the recipient in money management. The supported living provider is to assist the recipient in completing the financial profile and submitting it to the WSC no more than ten days following the selection of housing by the recipient. If the financial profile indicates a need for a one time or recurring subsidy, the profile must be submitted to and approved by the APD Regional Office before the recipient signs a lease.

Providers of supported living services shall comply with requirements found in the Medicaid Waiver Services Agreement, Chapter 65G-5, F.A.C., and those specified in this Handbook.

**Limits on the
Amount,
Duration,
Frequency,
Intensity, and
Scope**

Supported living coaching services are limited to the amount, intensity, frequency, duration, and scope of the services described on the recipient's support plan.

The provider shall render supported living coaching services at the time and place mutually agreed to by the recipient and provider. The provider shall have an on-call system in place that allows recipients access to services for emergency assistance 24 hours per day, 7 days per week. The provider must specify a backup person to provide services in the event that the provider is unavailable. The specified backup provider must be a certified, enrolled Medicaid provider and certified as a supported living coaching provider, pursuant to Chapter 65G-5, F.A.C. Telephone access to the provider or the backup provider shall be available, without toll charges to the recipient. Services provided and documented by the backup provider must be billed by the backup.

Supported living coaching services are limited to adults (age 18 and older).

Supported Living Coaching, continued

Limits on the Amount, Duration, Frequency, Intensity, and Scope

Supported living coaching encourages maximum physical integration into the community. The homes of individuals receiving supported living coaching services shall meet requirements set forth in Rule 65G-5.004, F.A.C.

Recipients who live in family homes, foster homes or group homes are not eligible for these services unless recipients have an identified goal to move into their own homes or apartments. Within 90 days before moving, supported living coaching services can be made available to recipients who are in the process of looking for a residence, even though they will reside in a family, foster, or group home during the search process and can be receiving residential habilitation services. Supported living coaching services cannot be authorized or reimbursed for a recipient who chooses a home that does not meet acceptable housing standards as outlined in the APD Housing survey. Supported living coaching services are provided on a one-to-one basis. The provider will bill for supported living coaching services in accordance with the APD rate structure. If services are provided with two or more individuals present, the amount billed must be prorated based on the number of recipients receiving the service if there are two or more recipients receiving the service at the same time.

Provider Qualifications

Providers of supported living coaching services can be solo providers or employees of agencies.

Solo providers or employees of providers must be age 18 and older and shall have an associate's degree from an accredited college or university and two years of direct supervised experience working with recipients with developmental disabilities.

Place of Service

Supported living coaching services are provided in the recipient's home, apartment, or in the community. In order to be considered a supported living arrangement, the home must be available for lease by anyone in the community and cannot be co-located on the same property as the recipient's family home.

Neither the provider nor the provider's immediate family shall be the recipient's landlord or have any interest in the ownership of the housing unit. , as stated in Rule 65G-5.004, FAC. A provider is defined as a solo provider or a corporation including all board members and any paid employees and staff of the provider agency, its subsidiaries or subcontractors. If renting, the name of the recipient receiving services must appear on the lease either singularly, with a roommate, or a guarantor.

Special Considerations

Providers of supported living coaching services must participate in iBudget waiver monitoring reviews conducted by the APD or its authorized representatives.

When a recipient receives personal supports, life skills development services, or both, in addition to supported living coaching, the providers must work together to avoid duplication of activities with coordination by the WSC.

Supported living coaching services are separate and should not be duplicative of services performed by the personal supports provider.

Supported Living Coaching, continued

Special Considerations, continued

If the supported living coach is providing one or more additional services to the recipient, documentation must clearly reflect the service being provided and billed for at a given time.

Supported living coaching services are not to be provided concurrently with residential habilitation services, except for the 90 days prior to the recipient moving into the supported living setting.

Supported living provider agencies choosing to serve as representative payees for recipients they serve can do so upon review and approval of the recipient's circumstance by the APD Regional Office. Supported living providers must review, with the recipient and the legal representative, if applicable, alternative payee options and obtain informed consent.

Service Family 5 – Support Coordination

- Limited
 - Full
 - Enhanced
-

Support Coordination

Description

Support coordination is the service of advocating for the recipient and identifying, developing, coordinating, and accessing supports and services on the recipient's behalf, regardless of funding source. Support coordination can also involve assisting the recipient or family to access supports and services on their own. Such supports and services can be provided through a variety of funding sources, including the iBudget waiver program, Medicaid State Plan services, third party payers, and natural supports. They also include generic resources through other state, federal, and local government and community programs and supports, available to all residents; to support people where they live and work to find meaningful relationships and community membership.

The iBudget waiver program is structured to strongly encourage the use of Medicaid waiver funds to supplement and not replace the supports already provided by family, friends, neighbors, vocational and educational programs, and the community. Waiver services are only one element of the supports for a recipient; in fact, the waiver is to be the payer of last resort. Recipients, families, waiver support coordinators (WSC), and providers are responsible for seeking non-waiver supports to augment and even replace waiver-paid services.

Support Coordination, continued

Description,
continued

The iBudget Florida program is structured to strongly encourage the use of waiver funds to supplement and not replace the supports already provided by family; friends; neighbors, other vocational and educational programs; and the community. Waiver services are only one element of the supports for an individual; in fact, the waiver is to be the payer of last resort. Individuals, families, WSC, and providers are responsible for finding non-waiver supports to augment and even replace waiver-paid services.

In an individual budgeting system like iBudget Florida, the individual, the WSC, and the service providers work together to accommodate the needs of the individual within the individual's waiver budget allocation. With individual budgeting, the individual learns what the budget is prospectively, at the outset of the planning process. By knowing the amount of resources the state will provide, the individual, his or her family, and his or her WSC can plan based on their priorities.

WSCs shall use a person-centered approach to identify an recipient's goals and plan and implement supports and services to achieve them. Examples of sources of information about the recipient and the recipient's unique goals, needs, and preferences include conversations with the recipient and those who know the recipient best, information obtained from the APD-approved assessment, and service providers. Information about the APD-approved assessment is available on the APD Web site at: www.apd.myflorida.com/

The amount of an individual's budget allocation will depend in large part on the amount of funding for waiver services that is appropriated by the Florida Legislature. Individuals cannot have enough funding in their budget allocations to be able to obtain all services through the waiver. They can have to work with their families, friends, and WSCs to obtain from other sources those services that their budget allocation is not able to fund. WSCs are responsible for supporting individuals' self-direction, working creatively to meet their needs, and being vigilant about monitoring individuals' health and safety. The iBudget Florida system places a special emphasis on WSCs' working with individuals and families to locate and develop natural and community supports. This will require exploration to go beyond the generic resources available from established non-profits. Instead, WSCs will need to work with individuals and families to identify and develop resources, such as the help of family friends, colleagues, churches, businesses, etc., who might be approached directly with requests to support an individual outside of a formal organizational program of assistance.

All levels of WSC shall help the individual monitor and manage the individual's budget allocation.

WSCs promote the health, safety, and well-being of individuals. They also promote the dignity and privacy of and respect for each individual, including when sharing personal information and decisions.

Three levels of WSC are available through the iBudget waiver: limited, full, and enhanced. If recipients are eligible for more than one level of WSC, they can choose the level that best meets their needs.

WSCs employed by an agency must have their own individual treating provider numbers.

Support Coordination, continued

Qualifications

Providers of support coordination can be either solo or agency providers. All WSCs, including solo providers or WSCs employed by an agency, shall be determined eligible by the APD Regional Office and individually enrolled in the Medicaid program as individual treating providers.

When the WSC submits a complete application including a Level 2 background clearance and an APD pre-service training verification, the APD Regional Office will determine the applicant eligible to conduct face-to-face visits or to have contact with a recipient. For agency employees, billing can be completed using the agency Medicaid number with supervision of the applicant and sign-off of work by an agency supervisor who is a certified WSC.

The requirements for solo providers and support coordination supervisors employed by an agency are:

- A bachelor's degree from an accredited college or university;
- Three years of paid, supervised experience in developmental disabilities, special education, mental health, counseling, guidance, social work, or health and rehabilitative services. A master's degree in a related field can substitute for one year of the required experience.

The experience requirements for WSCs employed by agencies are:

- A bachelor's degree from an accredited college or university;
- Two years of paid, supervised experience in developmental disabilities, special education, mental health, counseling, guidance, social work, or health and rehabilitative services. A master's degree in a related field can substitute for one year of the required experience.

The WSC cannot perform any support coordination activities (such as face-to-face visits, unsupervised contact with a recipient, review of the recipient's central records, or receiving confidential information) until the WSC has received Level 2 background screening results that indicate no disqualifiers.

**Dual
Employment**

Basic to the service of support coordination is the requirement that the WSC is available and accessible to the recipients receiving services on a 24-hour-per-day, 7-day-per-week basis for full or enhanced support coordination or for true emergencies only in the case of limited support coordination. This means that support coordination must take precedence over any other form of the provider's employment or business holdings.

Support Coordination, continued

**Dual
Employment**,
continued

For WSC applicants who are employed at the time of application as a Medicaid waiver provider and who intend to remain in their current employment, the Medicaid waiver application must include a plan for dual employment. The plan should address the type of employment held at the time of the application, the number of hours worked on a weekly basis, description of how the WSC will be contacted by recipients served during hours employed at the other job, and how conflicting priorities, emergencies, and meetings will be handled. The plan shall also address long-range plans for reducing or terminating employment should the WSC begin serving a full caseload.

The APD Regional Office shall approve the applicant's plan for dual employment as part of the enrollment process. If it is determined that the applicant cannot be available to meet the needs of recipients served, the application will be denied.

If a WSC is employed by a support coordination agency and is dually employed, it will be the responsibility of the agency manager or support coordination supervisor to provide oversight for their employees related to their plan for addressing dual employment.

If the APD Regional Office determines that the dually-employed WSC is not available or accessible to recipients served or cannot carry out other duties and responsibilities required of a WSC, the WSC must either terminate other employment or be terminated as a waiver provider.

Should an enrolled waiver support coordination provider, agency manager or supervisor, who is dual employed, choose to expand the caseload size, an update to the dual employment plan shall be submitted to the APD Regional Office that specifically addresses the manner in which contact will be maintain and competing priorities addressed. As a part of quality assurance and improvement, the APD Regional Office can request an update to the plan at any time to address any deficiencies or need for improvement based on trends, complaints received, or billing issues.

If an enrolled WSC is seeking dual employment while already performing support coordination responsibilities, the WSC must submit a plan for dual employment to the APD Regional Office for review and approval.

Under no circumstances can WSCs dual employment include the provision of services to recipients other than a case management or support coordination function.

**Selection of and
Access to
Support
Coordinators by
Recipients**

Unless an exception is granted by the APD , the WSC does not have the option as an iBudget waiver provider, to decline to serve recipients who choose services if the recipients are within the geographic boundaries approved by APD and the WSC has the capacity to serve them. Exceptions made by the APD Regional Office must be approved in writing by the APD Central Office. The WSC must also be available to recipients who want to interview WSCs for service choice of provider at a location that is convenient to the recipient.

Support Coordination, continued

Selection of and Access to Support Coordinators by Recipients, continued

The WSC must be available to meet the recipient's needs and to perform the duties and responsibilities required by this Handbook. The WSC must have an on-call system in place that allows recipients to contact the WSC 24 hours per day, 7 days per week. While there is an expectation that emergency calls will be returned immediately, for non-emergency calls, the provider must respond by the end of the next consecutive calendar day or weekday, depending upon the level of support coordination chosen. The WSCs on-call system must be approved by the APD Regional Office as a part of the application process. Each WSC is required to identify a backup WSC to provide ongoing services during absences of the primary WSC. This backup provider must be a certified and enrolled WSC. The name and contact information for the backup person must be clearly communicated to recipients served and to the APD Regional Office.

Access to the WSC or backup WSC shall be available to recipients on their caseload without telephone toll charges.

The provider and all its employees who supervise staff, train staff, or conduct support coordination activities shall not influence the recipient's choice of supports and service providers.

Prohibited Activities

The provider, its board members, and its employees or subcontractors shall be legally and financially independent from and free-standing of persons or organizations providing waiver services within the state of Florida, other than support coordination and related administrative activities to recipients who receive services from APD.

The provider, its employees or subcontractors shall not:

- Provide any waiver service other than support coordination be a subsidiary of, or function under the direct or indirect control of, persons or organizations providing waiver services within the state of Florida, other than support coordination and related administrative activities to recipients who receive services from APD.
 - At the time of certification and at any time thereafter, provide waiver services within the state of Florida other than support coordination, or work for a company that provides waiver services or related administrative activities to recipients who receive services from APD.
 - Be the legal representative, apply to be the legal representative, or be affiliated with an organization or person who is the legal representative or of an recipient served by the provider.
 - Be the legal representative or representative payee for any benefits received by a recipient served by the provider.
-

Support Coordination, continued

Prohibited Activities, continued

- Render support coordination services to a recipient who is a family member of the provider or any employee of the provider or who subcontracts with the provider, unless the recipient receives services in an APD region where the family member is not certified to provide support coordination.
 - Secure paid services on behalf of an recipient from a service provider who is a family member of the provider or any employee of the provider.
 - Assume control of an recipient's finances or assume possession of an recipient's checkbook, investments, or cash.
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Support Coordination Caseload Size

Standard Caseload Size

The caseload size for WSCs is established by the Florida Legislature at 43 full-time recipients per support coordinator. A recipient who receives limited WSC is considered a half-time individual on the caseload. WSCs who provide limited WSC can have a caseload greater than 43 recipients, not to exceed the equivalent of 43 full-time recipients.

Supervisors of support coordination within an agency shall limit their caseload to fewer than the equivalent of 43 full-time recipients and must ensure that all WSCs employed by the agency receive adequate supervision to ensure the support coordination needs of the recipient are met.

Vacancies and Leaves of Absence

Within five days of a vacancy occurring or leave of absence granted to a WSC employed by a support coordination agency, the support coordination agency must notify the APD Regional Office in writing, including a list of recipients affected. If a vacancy is due to the termination or resignation of a WSC or a written request by a WSC for leave based on the intent of the Family and Medical Leave Act, agency caseloads can temporarily exceed the maximum 43 full-time recipients for a maximum period of 60 consecutive calendar days from the date the vacancy occurred. Failure of the support coordination provider to notify the APD Regional Office of the vacancy within the required timeframes will result in recoupment of funds received by the provider.

If a support coordination agency cannot fill a reported vacant position within the time period allotted, the APD Regional Office must be notified prior to the 60th consecutive calendar day. Upon receipt of this notification, the APD Regional Office will provide a 14 consecutive calendar day notice to the affected recipients and the agency of the need to select a different support coordination provider. This notification will allow sufficient time for the recipient to choose an available provider from within or outside the current agency and the provider to complete the necessary paperwork or take other necessary action on behalf of the recipient.

Vacancies resulting in caseloads exceeding the maximum of 43 full-time recipients for more than the above-stated number of days can subject the provider to recoupment of funds and can result in the recipients served to transition to another enrolled provider.

Support Coordination, continued

**Support
Coordination
Caseload Size,**
continued

Penalties and Processes for WSC Temporarily Exceeding Caseload Limits

All WSC caseload transfers will be accomplished by the APD Regional Office working with the provider to identify those recipients affected by the vacancy allowing the temporary WSC to exceed the maximum caseload of the equivalent of 43 full-time recipients.

**Expansion of
Services**

Expansion of services includes increasing the number of recipients served by a WSC solo or agency provider, as well as a WSC solo provider changing status to an agency provider. To expand services, a WSC provider must have no alerts, no verified legally sufficient complaints within the past 12 months, no documentation cites indicating recoupment that have not been sufficiently resolved, have attained a satisfactory overall score on their last quality assurance monitoring conducted by the APD, AHCA or their authorized representative, and be approved by the APD Regional Office to expand services. The APD Regional Office can review a sample of files prior to granting the expansion request.

**Support
Coordination
Quality
Assurance**

Owners, of support coordination agencies shall have a comprehensive internal quality assurance management plan to actively monitor and supervise treating WSCs employed by that agency. This plan should include a systematic method of inspecting and reviewing all required documentation and activities. The agency, owner shall provide ongoing technical assistance and training to its employees in order to ensure that they are fulfilling all requirements as effectively and professionally as possible. This includes processing of all documentation related to support and cost planning, issuing service authorizations to providers in a timely manner, actively monitoring any contracted services, meeting required submission deadlines, or any other activities required by this Handbook.

If there is a pattern of deficiencies or problems within a support coordination agency or solo WSC that continues to occur, the APD Regional Office can request and recommend the agency status or solo WSC be terminated. At that time, any WSCs that are determined to be fulfilling their requirements under the waiver can be enrolled as solo providers or can transfer to another support coordination agency. In addition, any WSCs that have failed to fulfill waiver requirements satisfactorily can be subject to adverse actions outlined in their Medicaid provider agreement and this Handbook.

**WSC Access
to Agency
Electronic
Systems**

The WSC provider is responsible for the cost of the electronic access to the APD's intranet site, as well as entering, updating, and ensuring the accuracy of all demographic and client-related information pertinent to the recipient in the ABC and iBudget waiver systems. This information includes recipient address, county of residence, program component, legal representative name and address, if applicable, and type of benefits received. Failure of the WSC to enter, update, and ensure the accuracy of information within five calendar days of becoming aware of a change, could result in recoupment of waiver funds paid to the provider.

Support Coordination, continued

Access to Agency Electronic Systems, continued

The WSC is also responsible for the cost to access any APD or ACHA required management, claim submission information, or data collection systems.

Transition of Recipients between Support Coordinators

Changes in support coordination provider shall occur at the beginning of a month unless otherwise approved by the APD Regional Office.

If while serving an recipient, the recipient chooses another support coordination or provider, the current provider shall render quality services for the recipient until the end of the month, when the transfer to the new WSC takes place, unless otherwise instructed by the APD Regional Office. Additionally, the current provider shall assist the recipient in making a smooth transition to the new provider.

Central Record

The provider shall maintain each recipient's central record in accordance with Chapter 393, F.S. and APD procedures. The central records shall be the property of APD and must be relinquished to APD immediately upon request. APD retains the right to review, retrieve, or take possession of a recipient's record at any time.

When a new WSC is selected by the recipient, the WSC agency is downsized, or the support coordination service is terminated, either voluntarily or involuntarily, the WSC shall ensure that all appropriate central record information is transferred to the new provider or to the APD Regional Office, as directed, within one week of the effective date of the action. Once notified, any activity necessary for the maintenance of the central record must be completed by the WSC who has possession of the record.

Notwithstanding the section above, the previous provider is responsible for maintaining a copy of the recipient's file for any services paid for five years after the latest date of service.

Billing Requirements

For reimbursement purposes, the WSC provider must meet certain basic billing requirements. These include:

- Support coordination notes that document the support coordination services rendered. These notes must be specific to the recipient. Notes must clearly demonstrate and accurately reflect the support coordination services being rendered to the recipient and verify that support coordination services are being received and rendered as specified in the support plan. Services must meet all requirements specified herein.
 - A valid service authorization from APD.
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Support Coordination, continued

Contact Requirements and Allowable Activities for Billing

Recipient Contact Requirements

The requirements by WSC level are:

- Full support coordination: at a minimum, two billable contacts with, or activities on behalf of, a recipient each month in order to bill Medicaid.
- Limited support coordination: at a minimum, one billable contact with, or activity on behalf of, a recipient each month in order to bill Medicaid.
- Enhanced support coordination: at least four billable contacts monthly with, or on behalf of, the recipient in order to bill Medicaid.

The WSC requirements for recipient face-to-face visits based on specific location are:

- For recipients in supported living, the WSC must conduct monthly face-to-face visits with a face-to-face visit being in the recipient's home at least once every three months. This face-to-face visit will include a supported living quarterly review. The WSC will also conduct at least one other billable activity on behalf of the recipient each month. Recipients receiving supported living services must receive at least full support coordination.
 - For recipients living in an assisted living facility (ALF), WSCs must conduct monthly face-to-face visits, with every other month face-to-face contact at the facility. Recipients residing in ALF's must receive full support coordination.
 - For recipients residing in a licensed residential facility, WSCs must conduct monthly face-to-face visits with a face-to-face visit being with the recipient in the recipient's place of residence every three months. Recipients residing in APD licensed residential facilities must receive full support coordination.
 - For recipients living in the family home, the face-to-face contact with the recipient in the residence is required every six months for full support coordination and once a year for limited support coordination. The recipient's family cannot waive the required visit in the home. For full support coordination, the provider must conduct a face-to-face visit every three months and have at least one other billable activity. For limited support coordination, the provider must conduct two face-to-face visits annually and at least one billable contact per month. The need for more frequent face-to-face visits can be determined by the recipient, family or primary caregiver. The WSCs shall document this preference in the recipient's support plan; however, if this results in a number of contacts beyond the minimum for limited, the recipient will need to move to full support coordination.
 - For recipients residing in their own home and considered to be in an independent living situation, the WSC must conduct face-to-face visits every three months in a variety of settings, with a face-to-face visit in the recipient's place of residence at least every six months.
 - For recipients receiving enhanced support coordination, the reason for this level of support coordination must be specified in the support plan. The recipient will receive two face-to-face visits monthly and at least two additional billable activities during the same month.
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Support Coordination, continued

Contact Requirements and Allowable Activities for Billing, continued

- For recipients receiving enhanced support coordination for transition purposes, the recipient will receive weekly face-to-face contact visits for the first month after transition to community-based services with one other billable contact. After that month, the visits will be two visits monthly along with at least two other billable contacts monthly. This service delivery format will continue as long as enhanced support coordination is needed, but at a minimum of three months following transition.

The purpose of the face-to-face visit with the recipient is to discuss progress, changes, or both, to the recipient's goals, status of any resolved issues and satisfaction with current supports received. Each visit should be viewed as an opportunity to give or receive meaningful information that can be used to more effectively assist the recipient with achieving goals. Face-to-face contacts shall relate to or accomplish one or more of the following:

- Assist the recipient to reach individually determined needs and goals on the support plan, including gathering information to identify the recipient's desired outcomes.
- Monitor the health and well-being of the recipient.
- Obtain, develop, and maintain resources needed or requested by the recipient to include natural supports, generic community supports, and other types of resources.
- Increase the recipient's involvement in the community as the recipient desires..
- Promote advocacy or informed choice for the recipient.
- Follow up and resolved concerns or conflicts.

Allowable Activities for Billing

WSCs must conduct at least one other contact or activity on behalf of the recipient they serve each month. These contacts or activities are not merely incidental, but are planned and shall relate to or accomplish those items listed above. These contacts can be with the recipient or with persons important in the recipient's life, including family members, legal representatives, service providers, community members, etc., and can be via telephone, letter writing, or e-mail transmission. Any contact or activity on behalf of the recipient must be documented in the support coordination progress notes. The contacts must be individualized and related to services and benefits specific to the recipient receiving services. Administrative activities such as typing letters, filing, mailing, or leaving messages shall not qualify as contacts or activities. In addition, activities including telephone calls to schedule meetings, setting up face-to-face visits, or scheduling meetings with the recipient's employer, family, providers, do not qualify as contacts.

Support Coordination, continued

General Support and Service Requirements

At least once annually, on behalf of the recipient, the WSC will:

- Conduct a pre-support plan meeting or telephone interview to assist the recipient in identifying personal goals, needs, and supports prior to the development of the support plan.
 - Complete the support plan meeting at a time and place selected by the recipient. Once completed, the plan must contain signatures of the recipient, legal representative, and others the recipient invited to participate in the support plan meeting. At a minimum, it shall involve a person-centered planning process that considers all supports that can be available to a recipient, whether waiver-funded or funded by other sources. or provided on an informal, direct volunteer basis.
 - Complete the cost plan in sufficient time so it will be effective on July 1 of each year.
 - Work cooperatively with other service providers and the APD Regional Offices to ensure that the APD's online iBudget waiver system has accurately generated service authorizations.
 - Complete the waiver eligibility worksheet regarding eligibility for Medicaid and Medicaid Home and Community-Based Waiver Services and ensure that Medicaid eligibility is maintained by providing all necessary assistance to the individual to maintain Medicaid benefits. as a part of the support plan. The WSC must obtain the signature of the recipient or legal representative on the worksheet during the support plan meeting to ensure the recipient has opted to receive home and community services.
 - Complete an annual report of the supports and service received throughout the year, description of progress toward meeting individually determined goals and any pertinent information about significant events that have happened in the life of the recipient for the previous year.
 - Provide information to recipients currently in, ADT, sheltered workshops, or segregated work environments to apprise them of the options available for work activities, volunteer activities and training. The WSC shall request a benefits planning query (BPQY) from the Social Security Administration for each recipient, indicating an interest in options, for the purpose of monitoring income and assets, to determine impact upon Medicaid eligibility. The BPQY will be discussed with the recipient, family, or both, or legal representative and will be placed in the recipient's central record. This documentation can be in the form of a case note.
 - For recipients in a supported living arrangement or licensed residential facility who are taking two or more medications for seizure management or psychiatric issues, the WSC will document in the support coordination notes, attempts and efforts to ensure a review is completed annually by a licensed psychiatrist, neurologist, or an advance registered nurse practitioner or physician assistant, who acts pursuant to a protocol with the psychiatrist or neurologist.
 - On an ongoing basis, the WSC will conduct the following activities and document efforts in the support coordination progress notes:
 - Review documentation of all the recipient's providers service delivery, including service logs and claims information to verify that only services received have been billed.
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Support Coordination, continued

General Support and Service Requirements, continued

- Assist with managing APD budget allocations to ensure that recipients have sufficient funds to meet their Medicaid services needs throughout the year. As part of this task, the WSC shall assure that purchased supports and services do not exceed the annual limits of the current approved services authorizations and budget allocation. If the WSC becomes aware that the service limits have been exceeded, or if the WSC feels the recipient's budget allocation can be depleted before the end of the year, the WSC shall immediately notify the APD Regional Office.
 - Monitor service provision to ensure the recipient's health and safety.
 - On an as-needed basis:
 - Make changes to the recipient's support plan and as needed to the cost plan through the online iBudget waiver system, along with required documentation. If the change negatively affects a provider, the support coordinator shall notify the provider within 24 hours via telephone or e-mail and process the change in the iBudget waiver system within five calendar days of becoming aware of the change to give the provider as much notice as possible.
 - Update the support plan.
 - Provide notice to the individual regarding APD determinations that can impact on service delivery.
 - Notify other providers and the APD Regional Office when it is determined that a recipient becomes ineligible for Medicaid. The WSC will work with providers and the APD Regional Office to plan for alternative funding sources.
 - Provide a printed or scanned copy of the full iBudget waiver cost plan to the individual, guardian, or both, within ten working days following the effective date. This should occur for the initial iBudget waiver cost plan and for the annual cost plan for each new fiscal year. The printed cost plan should include the first page showing the annual budget allocated amount, reserve, and flexible amounts. In addition, the pages showing the allocation per month for each service should be printed. The cost plan must be provided via secure e-mail, U.S. certified mail or hand-delivered during a face-to-face meeting if that meeting is within the 10-day timeframe identified above.
 - When changes are made to the support plan with an APD approved cost plan throughout the year, the WSC must provide a copy of all changes made to the recipient, guardian, or both, via secure e-mail, U.S. mail or hand-delivered. The WSC must document in the case notes the date and method by which the support and cost plan was provided to the recipient or guardian.
 - A copy of the support and cost plan signature page must be filed in the recipient's central record.
 - Address and resolve issues identified by meeting with the recipient and pertinent providers.
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Recipients Newly Enrolled on a Waiver

When a recipient is newly enrolled to receive waiver services, the WSC shall provide a copy of the notice of privacy practices required by HIPAA regulations to the recipient or legal representative upon initial contact with the recipient and at any time there is a significant change that necessitates the protection of a recipient's personal health information.

Support Coordination, continued

Recipients Newly Enrolled on a Waiver, continued

For new waiver recipients, the WSC will provide the recipient with information about the concepts of the iBudget waiver program, basic budget management, and information on services available. Once the recipient's budget allocation, support plan, and budget have been established, the WSC will use information from the recipient, the APD-approved assessment, available on the APD Web site at www.apd.myflorida.com, and other available assessments as a basis for working with the recipient to develop the recipient's initial support and cost plan.

The WSC must complete and submit the support plan and cost plan through the APD online iBudget waiver system, along with any required supporting documentation, within 30 consecutive days of the recipient's selection of the WSC. Copies of the support plan will be given to the recipient within ten consecutive calendar days of the date of the recipient's signature on the plan.

If a recipient is in a crisis situation, the support and cost plan shall be submitted through the online iBudget waiver system within 30 consecutive calendar days. Updates to the plan shall be submitted as soon as additional information becomes available.

Recipients Who Have Been Receiving Waiver Services

For recipients who have been receiving waiver services, the WSC is responsible for assisting the APD Regional Office staff in scheduling and completing the APD-approved assessment. When requests for assistance in scheduling the assessment or requests for access to central records are received from the APD Regional Office, the WSC will comply within five consecutive calendar days.

The WSC shall work with the recipient to develop a cost plan in order to implement the support plan, on at least an annual basis. Typically, this cost plan will have an effective date of July 1 of each year and will address the subsequent 12-month period.

If access to the APD online iBudget waiver system is available, the recipient or legal representative can develop all or part of the support and cost plan based on the decisions of the recipient and submit it for the WSC to amend or complete, if necessary, and review. Alternatively, the WSC shall develop the plans based on the choices and preferences of the recipient and submit it through the online iBudget waiver system ensuring all required documentation for service review is included.

WSC Activities Required for Recipients Enrolled on a Waiver

The WSC shall work with the recipient to revise their support and cost plan as necessary using the process described in previous paragraphs. The updated plan should be submitted to the APD Regional Office within five consecutive calendar days from the date the WSC receives supporting documentation required for the specific request. A description of these changes should be noted in the WSC case notes for the recipient's central record. If the change is related to a crisis or significant change in circumstances, then the assessment and support plan should be updated.

Support Coordination, continued

**WSC Activities
Required for
Recipients
Enrolled on a
Waiver**, continued

To ensure that the recipient or legal representative, if applicable, is aware of and agrees to a support and cost plan developed or revised by a WSC, the WSC shall obtain verbal, electronic, or written approval of the plan changes from the recipient or legal representative prior to submitting to review through the online APD iBudget waiver system. The WSC shall record any verbal approvals in a case notes. In addition, the WSC must certify that the individual and/or his or legal representative have approved the change verbally, or in writing, by completing the corresponding check box in the online iBudget waiver system. This box should only be checked when the above activities have occurred. If verbal approval is obtained, the WSC will document in the case notes, the person giving approval and the date the approval was given.

An approved support and cost plan shall be provided to the recipient or legal representative at any time it is requested, but at a minimum, within ten consecutive calendar days of the effective date of the new support plan.

The WSC shall provide any documentation requested by the APD Regional Office to determine whether requested changes to cost plans are approvable. The APD Regional Office will respond within ten business days of their receipt of the updated plan and complete documentation. If necessary, within three consecutive calendar days of receiving a notice of the APD Regional Office's decision, the WSC shall submit a cost plan conforming to the decision.

For emergency requests involving situations that cannot be addressed by revising the recipient's support and cost plan on a temporary basis, the WSC shall notify the APD Regional Office of the emergency situation. The WSC shall provide to the APD Regional Office the updated support and cost plan and any supporting documentation within three consecutive calendar days of becoming aware of the emergency.

Support Coordination, continued

Responsibilities for Recipients in Supported Living Arrangements

For recipients who wish to move from a family home, group home, or other setting into a supported living arrangement, supported living coaching services can be approved for a period not to exceed 90 days to assist the recipient in finding a home. It is the responsibility of the WSC to review activities occurring during this time period to ensure that the supported living goal can be achieved within this timeframe. The 90-day timeframe is intended to be a one-time approval. If the WSC determines that the recipient will be unable to move As a result, if it is evident that the goal will not be achieved before the 90-day timeframe expires the WSC should provide other options to the recipient regarding a different service that could be pursued.. service should be reviewed to determine whether a more appropriate service should be requested.

Prior to a recipient's move to the recipient's own home, it is the WSC's responsibility to visit the proposed home to ensure health and safety standards are met and that the home meets acceptable standards as outlined in the APD Housing survey The WSC, along with the recipient and supported living provider, will review the APD health and safety checklist, APD financial profile, and the supported living provider's implementation plan to ensure a smooth transition to the recipient's new home. For recipients in supported living, the WSC shall coordinate and monitor services provided by the supported living provider and personal supports provider, if applicable, to ensure each is assisting the recipient in achieving individually determined goals and to avoid or eliminate duplication of services. The WSC will ensure that the goals, roles, and responsibilities of each provider are clearly delineated in the support plan and that authorized services are being rendered in accordance with the recipient's wishes.

Additionally, for recipients in supported living, it is the WSC's responsibility to schedule a quarterly meeting and attend the meeting with the recipient in the recipient's home. Unless specifically declined by the recipient, the supported living provider and personal supports provider should also be invited. During this meeting the following activities will occur:

- The WSC will review the recipient's progress toward achieving support plan goals and determine if services are being provided in a satisfactory manner, consistent with the recipient's wishes.
 - The WSC will review the APD health and safety checklist and the APD housing survey and determine if there is a need for follow-up with unresolved issues or if changes are needed.
 - For recipients who are receiving assistance with financial management from the supported living provider, the WSC will review the bank statements, checkbook, and other public benefits, such as Social Security benefits and health care coverage to determine waiver eligibility at the time of the quarterly meeting.
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Support Coordination, continued

Responsibilities for Recipients in Supported Living Arrangements, continued

- For recipients receiving an APD supported living subsidy, the WSC will review the financial profile to verify that it accurately reflects all sources of income and monthly expenses of the recipient.
- The WSC will document the results of this meeting in the support coordination case notes.
- If there is an issue that cannot be resolved during the meeting, it will be referred within three consecutive calendar days to the APD Regional Office for review.

Responsibilities for Recipients in Their Own Home, Not Receiving Supported Living Coaching Services

For recipients who wish to move to their own home but who do not receive or do not need supported living coaching services, it is the WSC's responsibility to coordinate and monitor services provided by the personal supports provider, if applicable, to ensure that each provider is assisting the recipient in achieving support plan goals and to avoid or eliminate duplication of services. The WSC will ensure that the goals, roles, and responsibilities of each provider are clearly delineated and that authorized services are being rendered in accordance with the recipient's support plan.

It is the WSC's responsibility to visit the recipient's home to ensure health and safety standards are met and that the home meets acceptable standards as outlined in the APD Housing survey. The WSC, along with the recipient and the personal supports provider, if applicable, will review the health and safety checklist and financial profile on a quarterly basis. The WSC will document this activity in the support coordination case notes.

For recipients receiving a supported living subsidy from APD, the WSC will review the financial profile on a quarterly basis, to verify that it accurately reflects all sources of income and monthly expenses of the recipient. The WSC will document this activity in the support coordination case notes.

Criteria for Required Support Coordination Levels

iBudget waiver recipients will be required to receive the following levels of support coordination:

- Full:
 - All recipients age 21 and older during the first three months after their transition to the iBudget waiver;
 - Recipients in the foster care system, up to three months after their transfer out of the foster care system;
 - Recipients in supported living, residential placement, and residing in an ALF.
- Enhanced:
 - Recipients transitioning from a public or private intermediate care facility for the developmentally disabled, a nursing facility, or the Florida Mentally Retarded Defendant Program (MRDP), during the three months prior to their anticipated date of transfer and the three months after the actual date of transfer;
 - Recipients who are crisis enrollees, up to six months after their enrollment in the waiver.

Support Coordination, continued

Criteria for Required Support Coordination Levels, continued

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- If the recipient is age 21 and older and is not required to receive a specific level of support coordination, the recipient can choose:
 - Limited support coordination – this can be selected only after the recipient received services through the iBudget waiver system for at least three months and they, or their designated representative, have completed the approved training on the APD iBudget waiver system;
 - Full support coordination;
 - Enhanced support coordination.
 - For recipients under the age of 21, who are not required to receive a specific level of support coordination, they can choose:
 - Limited support coordination during the first six months after enrolling in the iBudget waiver program;
 - Full support coordination;
 - Enhanced support coordination.
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Full Support Coordination

Full support coordination provides significant support to an recipient to ensure the recipient’s health, safety, and well-being. The WSC can share tasks with the recipient and the recipient’s family, or other support persons as they desire, but ultimately the WSC shall be responsible for performing all tasks required to locate, select, and coordinate services and supports, whether paid with waiver funds or through other resources. The following are provided as duties for full support coordination in addition to the other tasks generally described herein:

- Be on-call to the recipient 24 hours per day, 7 days per week; provide basic information to recipients about the waiver and iBudget system and referrals to the APD Regional Office where more detailed training is available;
 - Assist the recipient with identifying, interviewing, selecting, and coordinating service providers;
 - Through conversations with the recipient, and those who know and support the recipient, and through reviews of service providers’ documentation, and monitoring the recipient’s involvement in and satisfaction with services to determine if the activities meet the recipient’s expectations;
 - Attend medical appointments, recipient education plan meetings, social security meetings, and similar appointments at the recipient’s request.
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Limited Support Coordination

Limited support coordination services are services that are intended to be less intense than full support coordination. Limited support coordination services are billed at a reduced rate and have reduced contact requirements. Limited support coordinators are not on-call 24 hours per day, 7 days per week. Limited support coordination occurs during times and dates prearranged by the recipient and the WSC. In the event that the recipient experiences emergencies that require a more intensive level of support coordination, a change to full support coordination should be initiated through the online iBudget Florida system using funding presently in the individual’s budget allocation.

Support Coordination, continued

Limited Support Coordination, continued

In addition to the general requirements provided elsewhere in this section, the WSC providing limited support coordination shall:

- Provide basic information to the recipient about the APD iBudget waiver system and the waiver system, and make referrals to the APD Regional Office where the recipient can get more detailed training.
 - Provide information and referrals on locating, selecting, and coordinating waiver providers, Medicaid State Plan, community, natural, and other supports. The individual, his or her family, and other persons supporting the individual shall themselves locate, select, and coordinate the supports and services, notifying the WSC of their decisions.
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Eligibility

Adults receiving limited support coordination can request to return to full support coordination due to an increased need for assistance, but must remain in full support coordination for a minimum of three months. After this return to full support coordination services. The additional funding required for a move to full support coordination must come from the individual's current budget allocation.

Enhanced Support Coordination

Enhanced support coordination services consist of activities that assist the recipient in transitioning from a nursing facility or intermediate care facilities for the developmentally disabled (ICF/DD), to the community or for assisting recipients who have a circumstance that necessitates a more intensive level of support coordination. Examples for this enhanced level of support coordination include recipients who are enrolling in the waiver through crisis, or recipients who are experiencing mental health issues. When a transition is involved, enhanced support coordination is intended to be time-limited for three months prior to a discharge from the above-named facilities and three months after the move occurs or for a total of no more than six months for situations that are related to a change in the recipient's situation as described above. As the person's iBudget Florida allocation allows, the recipient can select to receive enhanced support coordination for a longer period of time as appropriate.

If an recipient is moving from an institutional placement into the community, the WSC providing enhanced support coordination shall work directly with the recipient, institutional staff, and the selected waiver providers prior to the move to ensure a smooth transition to community services, including those funded through the waiver and other services and supports necessary to ensure the health and safety of the recipient. The WSC will coordinate their activities with the facility's discharge planning process.

The WSC shall develop an initial support plan for the recipient. The plan shall consider information from the provider's summary of the recipient's development, behavioral, social, health, and nutritional status and a discharge plan designed to assist the recipient in adjusting to their new living environment.

Support Coordination, continued

Enhanced Support Coordination, continued

WSCs can bill at the enhanced support coordination level for the three months prior to a recipient's move, but only after the recipient has been discharged from the facility, providing all activities required for a move have been completed. The WSC shall pay particular attention to the ongoing evaluation of the proposed support system to ensure a smooth transition, including oversight and coordination with all service providers to ensure services are being delivered consistent with the recipient's needs.

The WSC shall have, at a minimum, weekly face-to-face contact with the recipient for the first 30 days following discharge into the community. The WSC providing enhanced support coordination is on-call 24 hours per day, 7 days per week for the recipient.

The WSC shall update the recipient's support plan at the end of 30 consecutive calendar days to identify progress made with the transition to community services and possible changes needed in supports and services, and follow-up on unresolved issues.

If the transition is delayed or does not occur, the WSC cannot bill the waiver for WSC services.

Place of Service

Support coordination can be provided in the recipient's home or anywhere in the community. In order to develop relationships with the recipient and those important to the recipient, the WSC is encouraged to interact with and observe the recipient in a variety of settings and at different times of the day, different days of the week.

Special Considerations

When a recipient is hospitalized, their community Medicaid stays in place and the WSC can bill if billable contacts are made, as long as the billing is not on a date of service when the recipient is an inpatient. The WSC's involvement should complement, but not duplicate that of the hospital discharge planner or facility case manager or social worker. The WSC should make sure that available supports through Medicaid or Medicare are accessed prior to waiver services.

When a recipient is in a nursing home or other extended care facility, the person's Medicaid will change to ICP Medicaid at the end of the month following admission. After that time, The WSC should maintain contact with the facility's discharge planner and be ready to assist with transition back to community based services upon the recipient's discharge from the long-term care facility. The WSC's involvement should complement, but not duplicate, that of the facility discharge planner and the WSC should make sure that available supports are accessed through Medicaid and Medicare. If the person individual does not return to the community, the WSC cannot bill for activities while the individual was an inpatient in a hospital or nursing facility.

The WSC shall not request or authorize services, units, or rates not consistent with this Handbook and fee schedules.

Service Family 6 – Wellness and Therapeutic Supports

- Behavior Analysis Services
 - Behavior Assistant Services
 - Dietician Services
 - Nursing
 - Private Duty Nursing
 - Residential Nursing
 - Skilled Nursing
 - Occupational Therapy
 - Physical Therapy
 - Respiratory Therapy
 - Speech Therapy
 - Specialized Mental Health Counseling
-

Behavior Analysis Services

Description

Behavior analysis services are provided to assist recipients to learn new or increase existing functionally equivalent replacement skills for identified challenging behaviors or to learn other behaviors that are directly related to existing challenging behaviors. In the absence of challenging behavior, Behavioral Services under the Medicaid Waiver are not reimbursed. Behavior analysis services include the use of behavior programming and behavioral programs. Behavior analysis includes the design, implementation, and evaluation of systematic environmental modifications to understand a recipient's behavior and strives to positively change the recipient's behavior in socially significant ways. Behavior analysis uses direct observation and measurement of a recipient's behavior and environment.

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

Behavioral services for the recipient must include procedures to insure generalization and maintenance of positive behaviors. The services are designed to facilitate ongoing changes in the recipient's environment, the interactional styles of caregivers and the contingencies for the recipient's behavior provided by other people in order to make lasting improvements in the recipient's behavior. Training for parents, caregivers, and staff is integral to the implementation of a behavior analysis services plan and to the monitoring of its effectiveness.

Behavior Analysis Services, continued

Description, continued

Services should be initiated with a plan to fade services to an optimal level. As caregivers show increasing competence in delivering the implementation plan and the individual is showing improvement in the targeted behaviors, The plan should set forth target behavior criteria to be achieved by the recipient that lead to a specified reduction in level of service. In those cases where no progress has been demonstrated by the recipient for an extended period of time, services can be faded or discontinued upon review by the APD regional behavior analyst local review committee chairperson, or other options, such as selection of another behavior analysis provider can be considered.

Delivery of behavioral services is a complex process that includes assessing, planning, and training directly with the recipient and at times, with others supporting the recipient when the recipient is both present and not present.

Direct Services

Examples of direct services provided to the recipient include analog functional analysis, evaluating new procedures, observation of the recipient in the natural environment for descriptive functional assessment, and direct training with the recipient.

Other examples of direct services provided to caregivers, staff, or other providers while the recipient is present include observation of caregivers, staff, or other providers with feedback about their interactions with the recipient and training or modeling procedures to be implemented by them.

Services can also include training provided to caregivers, staff, or other providers when the recipient is not present, since they will ultimately be primarily responsible for behavior plan implementation.

Indirect Services

In all instances the progress notes shall thoroughly document the activities, observation, data collection, analysis, and planning.

In addition, indirect activities that occur when the recipient 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 an recipient's behavior plan to the APD local review committee, and attending meetings relevant to the recipient's treatment. Providers can only bill for indirect services up to a maximum of 25% 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.

Limits on the Amount, Duration, Frequency, Intensity, and Scope

A recipient shall receive no more than 16 units of behavior analysis service per day. A unit is defined as a 15-minute time period or portion thereof. 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 recipients with Disabilities Education Act (IDEA).

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.

Behavior Analysis Services, continued

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 (e.g., 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 experience (e.g., 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 evidence 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.

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.

Place of Service

These services can be provided in the recipient's place of residence, during life skills development services, or anywhere in the community. In all cases, behavior analysis services must be provided in the setting(s) relevant to the behavior problems being addressed.

Special Considerations

The practice of behavior analysis and assessment is described more fully in Chapter 65G-4.009, F.A.C., which is available online at www.flrules.org. Behavior analysis support plans that include behaviors identified in Rule 65G-4.010, F.A.C., require submission to the Local Review Committee chairperson for review within five working days of implementation by certified behavior analysts or persons licensed pursuant to Chapter 490 or 491, F.S., meeting provider qualifications.

Behavior Assistant Services (BAS)

Description

The primary purpose of the behavior assistant services (BAS) is to provide support in implementing the behavior analysis services plan created by the waiver behavior analyst or provider licensed under Chapter 490 or 491, F.S. The assistant must maintain a copy of the plan. This includes assisting the certified behavior analyst in assessing the recipient, assisting in implementing new procedures in the presence of the behavior analyst, acting as a model for correct implementation for the recipient or the caregivers, or coaching caregivers to implement the behavior program. Unlike other services, the behavior assistant provider's focus is more on working with the caregivers to provide them with the skills to execute the procedures as detailed in the behavior analysis services plan, rather than the provision of intervention directly with the recipient.

In the initial stages of treatment, the behavior assistant services provider can provide direct intervention with the recipient to help bring the identified behavior under control within a short period of time. However, thereafter, any direct intervention performed by the behavior assistant provider must be performed in the presence of caregivers and used as a training vehicle or a method of evaluating a caregiver's maintenance of skills needed for behavior program implementation.

Behavior assistant services are to be time limited. Once paid or unpaid supports gain skills and abilities to assist the recipient to function more independently and in less challenging ways, the behavior assistant services should be faded out and discontinued. This time period for use of this service is limited to 6 months; however, depending on varied complexities of the behavior, effectiveness of treatment and procedures implemented, exceptions may be granted by the Regional Office Operations Manager or designee in consultation with Regional Behavior Analyst.

All Behavior Assistant Services provided must be authorized in a Behavior Assistant plan contained within the Behavior Analysis Services Plan developed by a supervising behavior analyst or provider licensed under chapter 490 or 491, F.S., reviewed and approved by the Area Behavior Analyst or designee. The Behavior Analysis Services Plan should include methods for evaluating competency of caregivers in behavior plan implementation, and a time-based fading plan in which there is an incremental reduction in service by the behavior assistant as well as the supervising behavior analyst, as the long-term caregivers become competent in the procedures and assume more of the responsibilities for implementing the plan. The Behavior Analysis Services Plan must be designed, implemented or monitored and approved in accordance with 65G-4.009 and 65G-4.010, F.A.C. 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 Behavior Analyst.

In addition to training and systematically transferring the implementation of procedures to the caregivers, behavior assistant services include monitoring of caregivers implementing the behavior plan, data collection, copying of forms, documents and maintenance of materials for data collection and implementation of procedures, as well as communicating with the supervising behavioral services provider, in order to assist the Behavior Analyst or provider licensed under Chapter 490 or 491, F.S.

Behavior Assistant Services (BAS), continued

Description,
continued

In all instances of behavior assistant services, the progress notes shall thoroughly document the recipient's activities, observations, data collection, and planning.

Behavior assistant services are designed for recipients receiving behavior analysis under one or more of the following conditions:

- Health and safety needs that are a direct result of the recipient's challenging behaviors that pose a documented risk to the recipient or the community and can result in a loss of current living environment and 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 requiring time limited supports to demonstrate their efficacy.
- For a time limited period during transitional residential changes, such as movement from intensive behavior residential habilitation to behavior focused residential habilitation, or other significant life changes where challenging behaviors are likely to increase and new caregivers need to be trained to ensure a successful move.

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 the recipients with Disabilities Education Act (IDEA).

**Limits on the
Amount,
Duration,
Frequency,
Intensity, and
Scope**

Behavior assistant services are provided for up to 6 months and limited to a maximum of 32 quarter-hours per day. Individuals requiring over 24 quarter hours per day must have monthly reviews by the Local Review Committee. Behavior assistants must receive and maintain documentation of supervision by the supervising licensed behavior analyst licensed provider for at least one hour per month, or more, as deemed appropriate by the by the local review committee LRC chairperson or Regional Office APD behavior analyst. Supervision should include observation of the Behavior Assistant working with the individual, their caregivers, or other providers. The Behavior Assistant must maintain documentation signed by the Behavior Analyst providing supervision. Supervision should include observation of the behavior assistant working with the recipient, caregivers, or other providers.

Behavior Assistant Services (BAS), continued

Provider Qualifications

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

- Two years of experience providing direct services to recipients with developmental disabilities, or
 - At least 120 hours of direct services to recipients with complex behavior problems, as defined in Rule 65G-4.010(2), F.A.C., or
 - 90 classroom hours of instruction in applied behavior analysis from non-university, non-college classes or university and college courses; and
- 20 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 (face-to-face or via 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.
- At least eight hours of supplemental training in general behavior analysis skills for annual recertification, 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 shall be accompanied by authentication documentation that the degree is equivalent to the educational requirements for the position.

Place of Service

These services can be provided in the recipient's place of residence setting(s) relevant to the behavior problems being addressed, but typically with the primary caregivers present.

Special Considerations

The services of a behavior assistant must be approved by the Local Review Committee Chairperson, 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 Rules 65G-4.009 and 65G-4.010, F.A.C. Recipients requiring over 24 quarter-hours per day must have monthly reviews by the an APD committee or the APD regional office behavior analyst.

Dietitian Services

Description

Dietitian services are those services prescribed by a physician, ARNP, or physician assistant that are necessary to maintain or improve the overall physical health of a recipient. The services include annually assessing the nutritional status and needs of an recipient; recommending an appropriate dietary regimen, nutritional support and nutrient intake; and providing counseling and education to the recipient, family, direct service staff, and food service staff. The services can also include the development and oversight of nutritional care systems that promote a recipient's optimal health.

Limitations

A recipient shall receive no more than 12 units of these services per day. A unit is defined as a 15-minute time period or portion thereof.

Provider Qualifications

Providers of dietitian services shall be dietitians or nutritionists licensed in accordance with Chapter 468, Part X, F.S.

Place of Service

This service can be provided in the provider's office, in the home, or anywhere in the community.

Special Considerations

Dietitian services require an annual order or prescription from a physician, ARNP, or physician assistant and shall be limited only to recipients who require specialized oversight of their nutritional status in order to prevent deterioration of general health that could result in an institutional placement. The order or prescription must identify the specific condition for which the recipient is prescribed the service.

Recipients requiring nutritional supplements must have a dietitian's assessment documenting such need that is updated at least annually. Nutritional supplements are available through the Medicaid Durable Medical Equipment and Medical Supplies Program State Plan services, under specific circumstances. For additional information on the Medicaid State Plan coverage requirements, refer to the Florida Medicaid Durable Medical Equipment and Medical Supply Services Coverage and Limitations Handbook.

Note: The Florida Medicaid Durable Medical Equipment and Medical Supply Services Coverage and Limitations Handbook is available on the Medicaid fiscal agent's Web site at www.mymedicaid-florida.com. Select **Public Information for Providers**, then **Provider Support**, and then **Provider Handbooks**. The handbook is incorporated by reference in Rule 59G-4.070, F.A.C.

Private Duty Nursing

Description

Private duty nursing services are prescribed by a physician, ARNP, or physician assistant 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. and within the scope of Florida's Nurse Practice Act for recipients who require ongoing nursing intervention for a duration over four continuous hours per day in their own home or family home.

A nursing assessment must be performed to determine the need for the service or to evaluate the recipient for care plan development. Reimbursement for a nursing assessment is considered as two hours of service at the registered nurse rate. Only registered nurses can perform an assessment. Nursing assessments should be updated annually and as needed if there is a significant change in the recipient's health status.

Limits on the Amount, Duration, Frequency, Intensity, and Scope

Private duty nursing services are available under the Medicaid State Plan to recipients under the age of 21. Licensed nursing is available to children and adults when determined medically necessary by the Medicaid State Plan Program

To be eligible for this service, a recipient must require active nursing interventions on a continuous basis. This service is provided on a one-to-one basis to eligible recipients. If the service is provided with two or more recipients present, the amount of time billed must be prorated between the numbers of recipients receiving the service. Nursing services available under the Medicaid State Plan cannot be purchased using waiver funds.

A recipient shall receive no more than 96 units of this service per day. A unit is defined as a 15-minute time period or portion thereof.

Note: Refer to the Florida Medicaid Home Health Services Coverage and Limitations Handbook for additional information on Medicaid State Plan coverage. The handbook is available on the Medicaid fiscal agent's Web site at www.mymedicaid-florida.com. Select **Public Information for Providers**, then **Provider Support**, and then **Provider Handbooks**. The handbook is incorporated by reference in Rule 59G-4.130, F.A.C.

Provider Qualifications

Providers of private duty nursing services shall be nurses registered or licensed in accordance with Chapter 464, F.S.

Nurses can provide this service as employees of licensed home health, hospice agencies, or nurse registries licensed in accordance with Chapter 400, Part III or IV, F.S. They can also be enrolled as independent vendors providing services under their own name and license.

Place of Service

Private duty nursing services shall be provided in the recipient's own home or family home.

Private Duty Nursing, continued

Special Considerations

Private duty nursing services shall not be used for ongoing medical services and oversight in a licensed residential facility.

Residential Nursing Services

Description

Residential nursing services are services prescribed by a physician, ARNP, or physician assistant and consist of recipient continuous nursing care provided by registered or licensed practical nurses, in accordance with Chapter 464, F.S., and within the scope of Florida's Nurse Practice Act, for recipients who require ongoing nursing intervention for a duration of over four continuous hours in a licensed residential facility, group, or foster home.

A nursing assessment must be performed to determine the need for the service or to evaluate the recipient for care plan development. Reimbursement for a nursing assessment is considered two hours of service at the registered nurse rate. Only registered nurses who are enrolled waiver providers can perform an assessment. Nursing assessments should be updated annually and as needed, if there is a significant change in the recipient's health status.

Limits on the Amount, Duration, Frequency, Intensity, and Scope

Nursing services available under the Medicaid State Plan can not be purchased using waiver funds.

A recipient shall receive no more than 96 units of this service per day. A unit is defined as a 15-minute time period or portion thereof.

Note: Refer to the Florida Home Health Services Coverage and Limitations Handbook for additional information on Medicaid State Plan coverage. The handbook is available on the Medicaid fiscal agent's Web site at www.mymedicaid-florida.com. Select **Public Information for Providers**, then **Provider Support**, and then **Provider Handbooks**. The handbook is incorporated by reference in Rule 59G-4.130, F.A.C.

Special Considerations

The rate for residential nursing must be billed according to the licensure of the nurse that provides the service whether it is a licensed practical nurse or registered nurse. Payment for licensed practical nurse services billed at the registered nurse rate is considered to be an overpayment.

Residential Nursing Services, continued

Provider Qualifications

Providers of residential nursing services shall be nurses registered or licensed in accordance with Chapter 464, F.S. Nurses can provide these services as independent vendors or as employees of licensed residential facilities. Residential nursing shall not be used for ongoing medical oversight in a licensed group or foster home considered to be the recipient's place of residence. The provision of residential nursing in a licensed group or foster home due to the ongoing medical needs of the recipient will be addressed as a reduced residential habilitation rate to reflect economies of scale.

This is applicable to residential nursing provided by waiver providers and private duty nursing for recipients under the age of 21 provided by the Medicaid State Plan in a licensed facility.

Place of Service

Residential nursing services must be provided at a licensed group or foster home considered to be the recipient's place of a residence.

Skilled Nursing

Description

Skilled nursing is a service prescribed by a physician, ARNP, or physician assistant and consists of part-time or intermittent nursing care visits provided by registered or licensed practical nurses within the scope of Florida's Nurse Practice Act, in accordance with Chapter 464, F.S., for recipients who require a skilled nursing visit for a duration of four hours per day and under.

A nursing assessment must be performed to determine the need for the service, or to evaluate the recipient for care plan development. Reimbursement for a nursing assessment is considered two hours of service at the registered nurse rate. Only registered nurses who are enrolled waiver providers can perform an assessment. Nursing assessments should be updated annually and as needed if there is a significant change in the recipient's health status.

Limits on the Amount, Frequency, Duration, Intensity, and Scope

Skilled nursing services are available under the Medicaid State Plan to recipients under the age of 21 with a private duty nursing. Licensed nursing is available to children and adults when determined medically-necessary by the Medicaid State Plan Program.

Nursing services available to recipients over the age of 21 under the Medicaid State Plan cannot be purchased using waiver funds

Skilled Nursing, continued

Limits on the Amount, Frequency, Duration, Intensity, and Scope, continued

The recipient shall receive no more than four visits per day for combination of a licensed practical nurses or registered nurse. This service can be provided concurrently (at the same time and date) with another service being furnished by another provider. Skilled nursing services do not include time spent completing the Outcome and Assessment Information Set (OASIS) assessment.

Note: Refer to the Florida Medicaid Home Health Services Coverage and Limitations Handbook for additional information on Medicaid State Plan coverage. The handbook is available on the Medicaid fiscal agent's Web site at www.mymedicaid-florida.com. Select **Public Information for Providers**, then **Provider Support**, and then **Provider Handbooks**. The handbook is incorporated by reference in Rule 59G-4.130, F.A.C.

Provider Qualifications

Providers of skilled nursing services shall be nurses registered or licensed in accordance with Chapter 464, F.S.

Nurses can provide this service as solo vendors or as employees of home health, hospice agencies, or nurse registries licensed in accordance with Chapter 400, Part III or IV, F.S. They can also be enrolled as independent vendors providing services under their own name and license.

Home health agencies must also be enrolled in the Medicaid home health program and meet federal conditions of participation in accordance with 42 CFR Part 484.

Place of Service

Skilled nursing services shall be provided at the recipient's place of residence and other waiver service sites, such as an adult day training program.

Special Considerations

Skilled nursing services shall not be used for the ongoing medical oversight and monitoring of direct care staff or caregivers in a licensed residential facility or in the recipient's own home or family home.

Occupational Therapy

Description

Occupational therapy is a service prescribed by a physician, ARNP or physician assistant that is necessary to produce specific functional outcomes in self-help, adaptive, and sensory motor skill areas, and assist the recipient to control and maneuver within the environment. The service includes an occupational therapy assessment. In addition, occupational therapists shall train direct care staff and caregivers, if applicable, to ensure they are carrying out therapy goals correctly. This activity must be performed with the recipient present.

Occupational therapy is a one-to-one service with a recipient.

Occupational Therapy, continued

Limits on the Amount, Frequency, Duration, Intensity, and Scope

Occupational therapy and assessment services are available through the Medicaid Therapy Services Program State Plan services to recipients under the age of 21. Services for these recipients cannot be purchased under the waiver.

Refer to the Florida Medicaid Therapy Services Coverage and Limitations Handbook for additional information on Medicaid State Plan coverage.

Recipients who receive this service through a school health program can still be eligible for additional Medicaid State Plan occupational therapy services.

A recipient shall receive no more than four quarter-hours per day (for acute needs) or two quarter-hours per day, two or three times per week for chronic or maintenance needs. A unit is defined as a 15-minute time period or portion thereof. Effective April 1, 2012, occupational therapy assessments are limited to two times per year.

Note: The Florida Medicaid Therapy Services Coverage and Limitations Handbook is available on the Medicaid fiscal agent's Web site at www.mymedicaid-florida.com. Select **Public Information for Providers**, then **Provider Support**, and then **Provider Handbooks**. The handbook is incorporated by reference in Rule 59G-4.320, F.A.C.

Provider Qualifications

Providers of occupational therapy and assessment services shall be licensed as occupational therapists, occupational therapy aides, or occupational therapy assistants, in accordance with Chapter 468, Part III, F.S. These providers can also provide and bill for the services of a licensed occupational therapy assistant. The licensed occupational therapy assistant is not qualified to perform occupational therapy assessments. Assessments can only be performed by a licensed occupational therapist.

Occupational therapists, aides, and assistants can provide services as independent vendors or an employee of an agency.

Occupational therapy aides and assistants must be supervised by an occupational therapist in accordance with the requirements of their professional licenses.

Place of Service

These services can be provided in the therapist's office, in the recipient's residence, or anywhere in the community

Physical Therapy

Description

Physical therapy is a service prescribed by a physician, ARNP or physician assistant that is necessary to produce specific functional outcomes in ambulation, muscle control, and postural development and to prevent or reduce further physical disability.

The service can also include a physical therapy assessment. In addition, physical therapists must train direct care staff and caregivers, if applicable, to ensure they are carrying out therapy goals correctly. This activity must be performed with the recipient present.

Physical therapy is a one-to-one service with a recipient.

Limits on the Amount, Duration, Frequency, Intensity, and Scope

Physical therapy and assessment services are available through the Medicaid Therapy Services Program State Plan services to recipients under the age of 21. Services for these recipients cannot be purchased under the waiver.

Recipients who receive this service through a school health program are still eligible for medically-necessary services funded by the Medicaid Therapy Services Program State Plan coverage. When additional therapy is necessary, families must seek Medicaid Therapy Program State Plan services. Refer to the Florida Medicaid Therapy Services Coverage and Limitations Handbook for additional information on Medicaid State Plan coverage.

Adults can receive up to \$1,500 annually in outpatient services under the Medicaid Hospital Program State Plan service, including physical therapy. If the recipient is able to use a hospital outpatient facility for physical therapy and the setting is appropriate to meet the recipient's needs, it can be possible to receive limited services funded by the Medicaid Hospital Program State Plan services.

The waiver should only be used to fund physical therapy services for adults either when the outpatient dollar limits are reached and maximum benefit has not been achieved or when physical therapy must be provided in a location other than a hospital outpatient facility.

A recipient shall receive no more than four quarter-hours per day for acute needs or two quarter-hours per day, two or three times per week for chronic or maintenance needs. A unit is defined as a 15-minute time period or portion thereof. Physical therapy assessments are limited to two per year.

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 www.mymedicaid-florida.com. Select **Public Information for Providers**, then **Provider Support**, and then **Provider Handbooks**. The Florida Medicaid Therapy Services Coverage and Limitations Handbook is incorporated by reference in Rule 59G-4.320, F.A.C., and the Florida Medicaid Hospital Services Handbook is incorporated by reference in Rule 59G-4.160, F.A.C.

Physical Therapy, continued

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. Physical therapists can provide this service as independent vendors or as an employee of an agency. They can also employ and bill for the services of a licensed physical therapist assistant. The licensed physical therapist assistant is not qualified to perform physical therapy assessments. Assessments can only be performed by a licensed physical therapist.

Physical therapist assistants must be supervised by a physical therapist in accordance with the requirements of their professional licenses.

Place of Service

This service can be provided in the therapist's office, recipient's residence, or anywhere in the community.

Respiratory Therapy

Description

Respiratory therapy is a service prescribed by a physician, ARNP, or physician assistant and relates to impairment of respiratory function and other deficiencies of the recipient's 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. Respiratory therapists provide training, while the recipient is present, to direct care staff or caregivers, if applicable, to ensure that adequate and consistent care is provided. Respiratory therapy services can also include a respiratory assessment.

Respiratory therapy is a one-to-one service with a recipient.

Limits on the Amount, Frequency, Duration, Intensity, and Scope

Respiratory therapy and assessment services are available through the Medicaid Therapy Services Program State Plan services for recipients under the age of 21. Services for these recipients cannot be purchased under the waiver. Recipients receiving this service through a school health program are still eligible for medically-necessary services funded by the Medicaid State Plan. When additional therapy is necessary, families must seek the Medicaid State Plan services for funding. The Medicaid Durable Medical Equipment (DME) and Medical Supplies Program State Plan services covers respiratory equipment and supplies for adults and children. The waiver cannot reimburse for respiratory supplies and equipment. A recipient shall receive no more than four units of this service per day and no more than 1,464 quarter-hours per year. A unit is defined as a 15-minute time period or portion thereof. Two assessments per year are allowed. Respiratory assessments are limited to two assessments per year.

Respiratory Therapy, continued

Limits on the Amount, Frequency, Duration, Intensity, and Scope, continued

Note: Refer to the Florida Medicaid Therapy Services Coverage and Limitations Handbook and the Florida Medicaid Durable Medical Equipment and Medical Supply Services Coverage and Limitations Handbook for additional information on Medicaid State Plan coverage. The handbooks are available on the Medicaid fiscal agent's Web site at www.mymedicaid-florida.com. Select **Public Information for Providers**, then **Provider Support**, and then **Provider Handbooks**. The Florida Medicaid Therapy Services Coverage and Limitations Handbook is incorporated by reference in Rule 59G-4.320, F.A.C., and the Florida Medicaid Durable Medical Equipment and Medical Supply Services Coverage and Limitations Handbook is incorporated by reference in Rule 59G-4.070, F.A.C.

Provider Qualifications

Providers of respiratory therapy and assessment services shall be respiratory therapists licensed in accordance with Chapter 468, Part V, F.S. Respiratory therapists can be either independent vendors or an employee of an agency.

Place of Service

Respiratory therapy is provided in the recipient's place of residence.

Speech Therapy

Description

Speech therapy is a service prescribed by a physician, ARNP, or physician assistant and is necessary to produce specific functional outcomes in the communication skills of a recipient with a speech, hearing, or language disability, or service necessary to remediate swallowing disorders and oral motor functions. The service can also include a speech therapy assessment, which does not require a prescription. In addition, this service can include training of direct care staff and caregivers, if applicable, to ensure therapy goals are being carried out correctly. If the service includes training of staff, the recipient receiving services must be present.

Speech therapy is a one-to-one service with a recipient.

Limits on the Amount, Frequency, Duration, Intensity, and Scope

Speech therapy and assessment services are available through the Medicaid Therapy Services Program State Plan services for recipients under the age of 21. Services for these recipients cannot be purchased under the waiver. Recipients receiving this service through a school health program are still eligible for medically-necessary services funded by Medicaid State Plan coverage. When additional therapy is necessary, families must seek Medicaid State Plan services coverage.

Assessments for augmentative communication devices are covered by the Medicaid Therapy Services Program State Plan services for all Medicaid enrolled recipients.

Speech Therapy, continued

Limits on the Amount, Frequency, Duration, Intensity, and Scope, continued

A recipient shall receive no more than four quarter-hours of this service per day for acute needs or two quarter-hours per day, two or three times per week for chronic or maintenance needs. A unit is defined as a 15-minute time period or portion thereof. The speech therapy assessments are limited to two per year, if needed, to address progress or treatment needs.

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 can perform services within the scope of their licenses.

Speech-language pathologists can provide this service as an independent vendor or as an employee of an agency. Speech-language pathologists can 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, can also provide this service. Speech-language assistants must be supervised by a speech-language pathologist in accordance with the requirements of their professional license, per Chapter 468, Part I, F.S.

Place of Service

This service can be provided in the therapist's office, in the recipient's place of residence, or anywhere in the community.

Specialized Mental Health Counseling

Description

Specialized mental health services for persons with developmental disabilities are services provided to maximize the reduction of an recipient'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 recipients 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 recipient's support plan, mental health interventions designed to help the recipient 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.

Specialized Mental Health Counseling, continued

Limits on the Amount, Duration, Frequency, Intensity, and Scope

This service supplements mental health services available under the Medicaid Community Behavioral Health Program State Plan services. Mental health services are available to recipients with diagnosed mental illnesses who can benefit from and participate in therapeutic services provided under the Medicaid Community Behavioral Health Program. Refer to the Florida Medicaid Community Behavioral Health Coverage and Limitations Handbook for additional information on Medicaid State Plan coverage.

This service excludes hippotherapy, equine therapy, horseback riding therapy, music therapy, and recreation therapy.

This service is provided one to two times weekly for one hour per session.

Note: The Florida Medicaid Community Behavioral Health Coverage and Limitations Handbook is available on the Medicaid fiscal agent's Web site at www.mymedicaid-florida.com. Select **Public Information for Providers**, then **Provider Support**, and then **Provider Handbooks**. The handbook is incorporated by reference in Rule 59G-4.050, F.A.C.

Provider Qualifications

Providers of specialized mental health services shall 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 shall have two years of experience working with recipients dually diagnosed with mental illness and developmental disabilities.

Place of Service

These services can be provided in the provider's office, the recipient's place of residence, or anywhere in the community.

Special Considerations

For purposes of this service, "family" is defined as the persons who live with or provide care to a recipient served on the waiver, and can include a parent, spouse, children, relative, foster family, or in-laws. "Family" does not include recipients who are employed to care for the recipient.

Community mental health centers are not eligible to enroll to provide this service. If they are able to meet the needs of a recipient, their services should be billed to the Medicaid Community Behavioral Health program for that recipient.

Service Family 7 – Transportation Services

- Transportation
-

Transportation Services

Description

Transportation services are the provision of rides to and from the recipient's home and community-based waiver services, enabling the recipient to receive the supports and services identified on both the support plan and approved cost plan, when such services cannot be accessed through natural (i.e., unpaid) supports.

Transportation services funded through the iBudget waiver shall be used only for recipients who have no other means to get to a service identified on the support plan and approved cost plan. Family members, neighbors, or friends who are already transporting the recipient, or who are capable of transporting the recipient at no cost to the waiver, shall be encouraged to continue their support of the recipient. Recipients who are capable of using the fixed route public transit system to access services on their support plan shall be encouraged to use that method of transportation. Transportation services should be negotiated at the most cost effective rate from a provider that meets or exceeds the transportation disadvantaged system safety standards.

This service is not available for transporting a recipient to school through 12th grade or age 22 while the recipient is still eligible to receive a free and public education. Transportation to and from school is the responsibility of the public school system. For other transportation needs not identified on the recipient's support plan and approved cost plan, the recipient should be directed to the local community transportation coordinator or, if available, the local fixed route fixed schedule public transit (bus system).

Vehicles shall not carry more passengers than the vehicle's registered seating capacity. Driver and driver's assistant(s) are considered passengers.

Fifteen passenger vehicles that are not lift-equipped shall not carry more than ten passengers at any given time, and shall follow the National Highway Transportation Safety Board guidelines for loading such vehicles.

Boarding assistance shall be provided as necessary or as requested by the recipient 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. Recipients 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 recipient, recipient's legal representative, or recipient's representative. Drivers and drivers' assistants shall not provide any assistance that is unsafe for the driver, the driver's assistant, or the recipient.

Transportation Services, continued

Description,
continued

In accordance with section 316.613, F.S., children age 5 and younger must be transported in a federally-approved child restraint device. 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. 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. For children from birth through age 3, such a restraint device must be a separate carrier or a vehicle manufacturer's integrated child seat. For children ages 4 through 8, 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, can 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 with passenger-side air bags turned on, children under the age of 12 and any recipient who weighs less than 100 pounds must be transported in the back seat. In vehicles that also have side-impact air bags, recipient who weighs less than 100 pounds must be transported as close to the middle of the back seat 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 recipients.

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 recipient 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.

Recipients served through the iBudget waiver are also eligible to obtain bus passes in lieu of other transportation services described herein. Bus passes can be purchased only from public transit authorities that operate the community's fixed-route, fixed-scheduled public bus system. The public transit authority must be an enrolled Medicaid waiver provider. Bus passes will be purchased in monthly and weekly units only. No more than three monthly bus passes or 15 weekly passes per quarter are allowed. Transportation providers issuing bus passes will bill for monthly and weekly units only. Recipients can use a combination of bus passes and paratransit trips to go to their waiver services if they have adequate funds in their allocated budget. Bus passes are used as a means for the recipient to use in getting to and from another specific iBudget waiver service, to access their community supports and generic services and as a means to exercise their freedom to participate in full integration in their community. Goals should be indicated in the recipient's support plan, which relate to community activities in which the recipient will be utilizing through their bus pass and transportation must be an approved service on the recipient's cost plan. A provider cannot charge the recipient any more than what it charges the general public for the bus pass purchased through the iBudget waiver.

Transportation Services, continued

Limits on the Frequency, Duration, Intensity, and Scope

Providers of Life Skills Development - Level 3 (ADT), personal supports, residential habilitation, respite care, specialized mental health services, support coordination, and supported living coaching cannot bill separately for transportation that is an integral part of the provision of their primary service with the following exceptions:

- If the provider of one of these indicated services is enrolled as a transportation provider;
- If the recipient is being transported between the recipient's place of residence and the site of a distinct waiver service; or
- If the recipient is being transported between two waiver service sites and the service at each site is delivered by a different provider.

Transportation between service sites operated by the same provider or transportation that is an integral part of the service being received by the recipient is included in the rate paid to the providers of the appropriate types of waiver services and shall not be billed separately.

Transportation services are available through the Medicaid Non-Emergency Transportation Program State Plan services to transport recipients to Medicaid-eligible medical appointments and services. iBudget waiver funds shall not be used when the recipient's trip is for a Medicaid State Plan service.

When a transportation provider is paid by the Medicaid State Plan to transport a Medicaid recipient to an eligible service, the recipient will be charged a copayment, which the recipient is responsible for. iBudget waiver funds cannot be used to pay any copayment for Medicaid funded transportation services.

When the recipient uses an iBudget waiver provider for transportation to a service listed on the support plan and current approved cost plan and the provider is paid with waiver funds, the provider shall not charge the recipient a copayment.

Providers can bill for their service by the mile, by the one-way trip, or by the month. Regardless of how services are billed, all providers, except limited service providers, which include family members, friends, or neighbors, must, during the rate-setting process, define the charges for their services in terms of cost per vehicle mile. Providers must ensure group trips, ride sharing, and multi-loading to the greatest extent possible. If more than one recipient is being transported, the mileage charge will be shared among the number of waiver recipients transported. When a provider is reimbursed by the trip, a recipient shall receive no more than two one-way trips per day. Only providers that want to bill for actual expenses incurred can bill by the month. Limited transportation providers (e.g., family members, friends, or neighbors) will be reimbursed at the state mileage rate.

Transportation Services, continued

Provider Qualifications

All providers must comply with reporting requirements of Chapter 427, F.S., in order to provide and be reimbursed for transportation under the iBudget waiver. Transportation providers can be community transportation coordinators (CTC) for the transportation disadvantaged; limited transportation providers; public transit authorities that run the community's fixed-route, fixed-schedule public bus system; group homes and other residential facilities in which the recipients being transported reside; adult day training programs to which the recipients are being transported; and other public, private for-profit, and private not-for-profit transportation entities. The manner in which each of these types of providers can be used is specified in Chapter 427, F.S., and described in the following. All providers must have a valid Florida driver's license.

Pursuant to Chapter 427, Part I, F.S., transportation services shall be purchased from CTC utilizing the public, private for-profit, or private not-for-profit transportation operators within each county's coordinated transportation system.

In limited situations, relatives, friends, and neighbors can provide transportation when it has been documented by the WSC and approved by the APD Regional Office that there are no providers available to provide transportation due to the geographic area or the specific needs of the recipient. In these situations, relatives, friends, and neighbors are not considered as "for hire" entities and are reimbursed at the state mileage rate. The APD Regional Office is not required to contact or obtain authorization from the CTC in these situations. The CTC has no responsibility for overseeing service delivery of such providers. The APD Regional Office is responsible for this oversight.

Public Transit Authorities that operate the community's fixed-route, fixed-schedule public bus system can enroll as providers in the iBudget waiver to facilitate the purchase of monthly or other frequency bus passes for participants. If natural supports are unavailable, this transportation option is to be used for recipients who can use the fixed-route, fixed-schedule public bus system to go to some or all of their waiver services. Bus passes are to be purchased for recipients who can utilize the bus system to go to their waiver service sites whenever the cost of the trips to be taken during the month, if taken by Paratransit, would exceed the cost of the monthly bus pass. Public transit authorities are required to adhere to minimum safety standards set forth in Chapter 14-90, F.A.C.

The APD Regional Office is not required to contact or obtain authorization from the CTC in order to use the services of the fixed-route fixed-schedule bus system. The CTC has no responsibility for overseeing service delivery of such providers. Group homes or other residential facilities in which recipients live can enroll as transportation providers to transport the recipients to and from their waiver services. Life Skills Development - Level 3 (Adult Day Training) providers that recipients regularly attend can enroll as transportation providers to transport the recipients to and from the agencies' programs. In order to use group homes, residential facilities, or Life Skills Development - Level 3 (ADT) agencies as transportation providers, the APD Regional Office must obtain written authorization from the CTC.

Transportation Services, continued

Provider Qualifications, continued

The authorization APD receives from the CTC will result in a written agreement that sets forth the roles and responsibilities of the CTC, the group home, residential facility, or life skills development agency and the APD region for complying with vehicle and passenger safety standards, adhering to, monitoring, and overseeing service delivery and any necessary reporting to ensure compliance with Chapter 427, F.S.

Transportation providers that are not part of the CTC system (e.g., taxi companies and private for-profit and not-for-profit transportation companies) can be paid with waiver funds to transport recipients to and from waiver services if the CTC determines it is unable to provide or arrange the required transportation.

The CTC has no responsibility for monitoring adherence to driver, vehicle, and passenger safety standards or overseeing service delivery of such providers. The provider and APD Regional Office are responsible for complying with reporting requirements of Chapter 427, F.S., through the APD director's designee on the Commission for the Transportation Disadvantaged.

If the APD Regional Office wishes to utilize a transportation provider that is not a part of the coordinated transportation system, the APD Regional Office must contact the CTC in the recipient's county of residence and follow their procedures for use of alternative providers, as required by the Florida Commission for the Transportation Disadvantaged. This authorization will be issued to the APD Regional Office. These providers must meet the driver, vehicle, and passenger safety standards of overseeing service delivery of such providers. The provider and region are responsible for complying with reporting requirements of Chapter 427, F.S., through the APD director's designee on the Commission for the Transportation Disadvantaged.

Place of Service

Transportation is provided anywhere in the community.

Special Considerations

When a recipient must have an escort to provide assistance, the transportation provider can be paid for transporting both the recipient and the escort, unless it is the policy of the transportation provider to allow an escort to ride free of charge. Some county coordinated transportation systems do not charge for an escort to ride with a recipient with a disability.

When paid vendors are also family members, controls must be in place to ensure that the payment is made to the relative only in return for specific services rendered; and there is adequate justification, approved by the APD Regional Office, as to why the relative is the paid vendor of the service, rather than a natural support. Documentation must be maintained in the WSC's file for the recipient as well as in the provider's file.

Service Family 8 – Dental Services

- **Adult Dental Services**
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Dental Services

Description

Adult dental services cover dental treatments and procedures that are not otherwise covered by the Medicaid Dental Services Program State Plan services.

Adult dental services include diagnostic, preventive, and restorative treatment; extractions; endodontic, periodontal, and surgical procedures. The services strive to prevent or remedy dental problems that, if left untreated, could compromise a recipient's health, by increasing the risk of infection or disease, or reducing food options, resulting in restrictive nutritional intake.

Emergency dental procedures to alleviate pain and or infection and full and partial dentures are covered by Medicaid State Plan dental services.

Limits on the Amount, Duration, Frequency, Intensity, and Scope

Adult dental services are limited to recipients age 21 and older. Adult dental services will not duplicate dental services provided to adults by the Medicaid dental services covered by the Medicaid State Plan. The Medicaid Dental Services also provide dental services for recipients under the age of 21.

Adult cleanings are limited to two per year.

There is no limit in the number of emergency episodes per year or the number of teeth that can be extracted per emergency episode under Medicaid State Plan services. Refer to the Florida Medicaid Dental Services Coverage and Limitations Handbook for additional information regarding Medicaid State Plan coverage.

A recipient shall receive no more than ten units of this service per day.

Note: The Florida Medicaid Dental Services Coverage and Limitations Handbook is available on the Medicaid fiscal agent's Web site at www.mymedicaid-florida.com. Select **Public Information for Providers**, then **Provider Support**, and then **Provider Handbooks**. The handbook is incorporated by reference in Rule 59G-4.060.

Provider Qualifications

Providers of adult dental services shall be dentists licensed in accordance with Chapter 466, F.S.

Unlicensed dental interns and dental students of university-based dental programs can provide services under the general supervision of a licensed dentist, but cannot act as a treating provider or bill the Medicaid waiver for covered services.

Place of Service

Adult dental services shall be provided in the provider's office or other setting, determined appropriate by the provider.

Dental Services, continued

**Special
Considerations**

Adult dental services are to be authorized only to prevent or remedy problems that could lead to a deterioration of the recipient's health, thus placing the recipient at risk of an institutional placement. Second opinions by waiver enrolled dentists are covered by this service when extensive dental work is planned or there is a question about medical necessity.

Providers of adult dental services are paid by date of service. The provider will submit an invoice listing each procedure and negotiated cost. All procedures or treatments rendered on one day shall be totaled into one bill for payment on the date of service.

CHAPTER 5 iBUDGET WAIVER REIMBURSEMENT INFORMATION

Overview

Introduction

This chapter provides and describes reimbursement information regarding the iBudget waiver program.

In This Chapter

This chapter contains:

TOPIC	PAGE
Reimbursement Information and Procedure Codes	5-
Procedure Code Modifiers and Definition of Modifiers	5-

Reimbursement Information and Procedure Codes

Medicaid reimburses enrolled providers who bill for home and community-based waiver services using procedure codes based on the Healthcare Common Procedure Coding System (HCPCS) codes, Level I and Level II. Level I procedure codes are a systematic listing and coding of procedures and services performed by providers. Each procedure or service is identified by a five digit numeric code. The codes are part of the standard code set described in the Physician's Current Procedure Terminology (CPT) book. Please refer to the CPT book for complete descriptions of the standard codes. CPT codes and descriptions are copyrighted by the American Medical Association. All rights reserved. Level II procedure codes are national codes used to describe medical services and supplies. They are distinguished from Level I codes by beginning with a single letter (A through V) followed by four numeric digits. The codes are part of the standard code set described in HCPCS Level II Expert code book. Please refer to the HCPCS Level II Expert code book for complete descriptions of the standard codes. The HCPCS Level II Expert code book is copyright by Ingenix, Inc. All rights reserved. There are specific procedure codes and maximum units of service that Medicaid reimburses for iBudget waiver..

Overview, continued

**Billing
Procedures**

Each provider is required to submit all claims (paper or electronic) for waiver services directly to Medicaid's fiscal agent. Billing for services that use a quarter-hour unit must be billed according to the following schedule:

- Services provided for 1-15 minutes are billed for one quarter-hour.
- Services provided for 16-30 minutes are billed as two quarter-hours.
- Services provided for 31-45 minutes are billed as three quarter-hours.
- Services provided for 46-60 minutes are billed as four quarter-hours.

When billing for services by the quarter-hour the provider should total at the end of each billing period actual time spent with the recipient and round the total to the nearest quarter-hour as described above. Rounding for the specific service provided should occur only once at the time of billing. Specific billing instructions and procedures for submitting claims can be found in the Florida Medicaid Provider Reimbursement Handbook, CMS-1500. The Medicaid fiscal agent provides billing training for providers of waiver services. The Medicaid fiscal agent can be contacted at 800-289-7799 to request this training.

Note: The Florida Medicaid provider handbooks are available on the Medicaid fiscal agent's Web site at www.mymedicaid-florida.com. Select **Public Information for Providers**, then **Provider Support**, and then **Provider Handbooks**. The Florida Medicaid Provider Reimbursement Handbook, CMS-1500, is incorporated by reference in Rule 59G-4.001, F.A.C.

**iBudget Waiver
Service Rate**

All rates are determined based on the availability of appropriated funding from the Florida Legislature. The provider and the recipient can negotiate for a lower rate. When the handbook states a recipient cannot be provided or receive more than a specified amount of services, this also means the provider cannot bill for more than the specified limitation.

Overview, continued

**Provider
Responsibility**

When presenting a claim for payment under the Medicaid program, a provider has a duty to supervise the provision of, and be responsible for, goods and services claimed to have been provided, to supervise and be responsible for preparation and submission of the claim, and to present a claim that is true and accurate and that is for goods and services that:

- Have actually been provided to the recipient by the provider prior to submitting the claim;
- When required by federal or state law, the provider rendering the service is actively licensed or certified to provide the service;
- Are iBudget waiver-covered goods or services that are medically necessary;
- Are of a quality comparable to those provided to the general public by the provider's peers;
- Have not been billed in whole or in part to a recipient or a recipient's responsible party;
- Are provided in accordance with applicable provisions of all Medicaid rules, regulations, handbooks, and policies and in accordance with federal, state and local law; and
- Are documented by records made at the time the goods or services were provided. .

**Administrative
Sanctions**

AHCA shall impose sanctions on providers in accordance with Section 409.913 F.S. and Rule 59G-9.070, F.A.C. Sanctions include the following:

- Suspension from participation in the Medicaid Program;
- Termination from participation in the Medicaid Program;
- Imposition of fines;
- Imposition of liens against provider assets;
- Prepayment reviews of claims;
- Comprehensive follow-up reviews; and
- Corrective-action plans

Overpayment

Overpayment includes any amount that is not authorized to be paid by the Medicaid program whether paid as a result of inaccurate or improper cost reporting, improper claims, unacceptable practices, fraud, abuse, or mistake.

Withholding of Payment

Pursuant to Section 409.913(25)(a), F.S., AHCA may withhold Medicaid payments, in whole or in part, to a provider upon receipt of reliable evidence that the circumstances giving rise to the need for a withholding of payments involve fraud, willful misrepresentation, or abuse under the Medicaid program, or a crime was committed while providing goods or services to Medicaid recipients, pending completion of legal proceedings.

Pursuant to section 409.913(27), when AHCA has made a probable cause determination and alleged that an overpayment to a Medicaid provider has occurred, AHCA, after notice to the provider, may:

- Withhold, and continue to withhold during the pendency of an administrative hearing pursuant to Chapter 120, F.S., any reimbursement payments until such time as the overpayment is recovered, unless within 30 days after receiving notice thereof the provider:
 - Makes repayment in full; or
 - Establishes a repayment plan that is satisfactory to the Agency for Health Care Administration
 - Withhold, and continue to withhold during the pendency of an administrative hearing pursuant to Chapter 120, F.S. reimbursement payments if the terms of a repayment plan are not adhered to by the provider.
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Violation Definition

Each day that an ongoing violation continues, such as refusing to provide Medicaid-related records or refusing access to records, is considered to be a separate violation.

Each instance of the following actions is considered to be a separate violation:

- Improper billing of a Medicaid recipient;
- Providing a Medicaid recipient goods or services that are inappropriate or of inferior quality as determined by competent peer judgment;
- Knowingly submitting a false or erroneous Medicaid provider enrollment application or request for prior authorization for Medicaid services; or
- Filing a false or erroneous Medicaid claim leading to an overpayment.

Overview, continued

Examples of Sanctionable Violations

AHCA may seek any remedy provided by law when:

- The provider's license has not been renewed, or has been revoked, suspended, or terminated, for cause, by the licensing agency of any state.
- The provider has failed to make available or refused access to Medicaid-related records to an auditor, investigator, or other authorized employee or agency of AHCA, a contractor of AHCA, an authorized employee of APD the Attorney General, a state attorney, or the federal government.
- The provider has not provided or has failed to make available such Medicaid-related records as AHCA, its contractor, or APD has found necessary to determine whether Medicaid payments are or were due and the amounts thereof.
- The provider has failed to maintain records made at the time of service, or prior to service if prior authorization is required.
- The provider is not in compliance with provisions of the:
 - Medicaid provider publications that have been incorporated by reference as rules in the Florida Administrative Code;
 - State or federal laws, rules, and regulations;
 - Medicaid provider agreement between AHCA and the provider; or
 - Certifications found on claim forms or on transmittal forms for electronically submitted claims that are submitted by the provider or authorized representative, as such provisions apply to the Medicaid program.
- The provider has provided goods or services to a recipient that are inappropriate, unnecessary, excessive, or harmful to the recipient, or of inferior quality.
- A provider or an authorized representative of the provider has submitted or caused to be submitted false or erroneous Medicaid claims that have resulted in overpayments to a provider or that exceed those to which the provider was entitled under the Medicaid program.
- The provider, or an authorized representative of the provider, has submitted or caused to be submitted a Medicaid provider enrollment application that contains false or incorrect information.
- The provider or an authorized representative of the provider has collected from or billed a recipient or a recipient's responsible party improperly for amounts that should not have been so collected or billed by reason of the provider's billing the Medicaid program for the same service.
- The provider is found liable for negligent practice resulting in death or injury to the provider's patient.
- The provider has failed to comply with the notice and reporting requirements of section 409.907, F.S.
- AHCA has received information of patient abuse or neglect or of any act prohibited by section 409.920, F.S.
- The provider has failed to comply with an agreed-upon repayment schedule.

Incomplete or Missing Records

Incomplete records are records that lack documentation that all requirements or conditions for service provision have been met. Medicaid may recover payment for services or goods when the provider has incomplete records or does not provide the records.

Self-Audits

A provider has an obligation to ensure that claims submitted to the Medicaid program are true and accurate. Section 409.913, F.S., obligates AHCA to impose a sanction on providers when AHCA has discovered certain specified violations of Medicaid laws, including the laws governing the provider's profession. These sanctions are imposed in accordance with Rule 59G-9.070, F.A.C., Administrative Sanctions of Providers, Entities and Persons. However, section 409.913, F.S., also authorizes AHCA to institute amnesty programs wherein Medicaid providers may repay an overpayment without the imposition of sanctions. For example, providers have the opportunity to conduct a self-audit as defined in Rule 59G-9.070, F.A.C.

If, as a result of a self-audit, a provider determines that a claim was paid by the Medicaid program in error, the provider shall have the opportunity to repay the overpayment to AHCA without resulting in the imposition of sanctions under Rule 59G-9.070, F.A.C.

Limitation

Providers cannot bill for services when a recipient is not in attendance, except as noted in the description section of that service. A provider shall not render a claim or bill for more than one service to the same recipient at the same time and date unless authorized to do so by APD. Services authorized to bill concurrently with another service include behavior analysis, behavior assistant, private duty nursing, skilled nursing, and residential nursing. Personal supports and life skills development - level 2 (supported employment) can also be billed concurrently. Life skills development - level 3 (adult day training - ADT) can also be billed at the daily rate concurrently with therapy services provided during the day if the recipient receives at least four hours of the ADT service.

With the exception of support coordination, waiver services cannot be billed while a recipient is in the hospital or nursing facility. Residential habilitation and special medical home care can be billed the date of admission and the date of discharge from the hospital or nursing facility if the service is provided on those days. Services cannot be billed with a date of service when the recipient is inpatient in any institutional setting.

**Procedure Code
Modifiers and
Definition of
Modifiers**

For certain types of services, a two-digit modifier must be entered on the claim form. Modifiers more fully describe the procedure performed so that accurate payment can be determined.

APPENDIX A

BILLING AND DOCUMENTATION REQUIREMENTS

DOCUMENTATION REQUIREMENTS

The following documentation shall be maintained by providers. Documentation shall be provided to the waiver support coordinator (WSC) a copy retained in the provider's files located in the provider's office or facility. All providers must keep information on file, including Medicaid application, background screening results for all staff as applicable, reference checks, education, training and experience, applicable licensure, and registration or certification as applicable.

Billing and Reimbursement Requirements	
Adult Dental Services	<ul style="list-style-type: none"> • Copy of claim(s) submitted for payment including invoice for services. • All treatment records.
Life Skills Development	<p>Life Skills Development - Level 1 (Companion)</p> <ul style="list-style-type: none"> • Copy of claim(s) submitted for payment. • Service log. <p>Life Skills Development - Level 2 (Supported Employment)</p> <ul style="list-style-type: none"> • Copy of claim(s) submitted for payment. • Service log. • Recipient's implementation plan and supporting data. The implementation plan will be developed, at a minimum, within 30 days of the initiation of the new service, or within 30 calendar days of the support plan effective date for continuation of services and annually thereafter. A copy of the implementation plan, signed by the recipient, shall be furnished to the recipient, legal representative and to the WSC at the end of this 30-day period. The progress toward achieving the goal(s) identified on the implementation plan shall be documented in notes or quarterly summaries, as specified in each service. • Quarterly summary of each quarter of the support plan year. • Documentation, in the form of a letter from the Division of Vocational Rehabilitation (VR) services or a case note detailing contact with a named VR representative, the date, summary of conversation, etc., indicating a lack of available VR funding for supported employment. • Employment stability plan, also known as the Individualized plan for employment (IPE) must be completed at the time of first claim submission and annually thereafter at the time of support plan update, and at any time updates and changes are made before they are implemented; and must include. • Documentation that supported self-employment services are not available from VR can be in the form of one of the following: <ul style="list-style-type: none"> - A letter from VR - Documentation detailing contact with a named VR representative to include the date and summary of conversation - Claims for services are to be made upon completion of each individual benchmark. • Copy of claim(s) submitted for payment. • A copy of daily attendance log.

DOCUMENTATION REQUIREMENTS

The following documentation shall be maintained by providers. Documentation shall be provided to the WSC a copy retained in the provider's files located in the provider's office or facility. All providers must keep information on file including Medicaid application, background screening results for all staff as applicable, reference checks, education, training and experience, applicable licensure, registration or certification as applicable.

Billing and Reimbursement Requirements	
<p>Life Skills Development, continued</p>	<p>Life Skills Development - Level 3 (Adult Day Training - ADT)</p> <ul style="list-style-type: none"> • Quarterly summary of each quarter of the support plan year. The third quarterly summary also serves as the annual report and must include a summary of the previous three quarters. • Staffing documentation such as staffing schedules, payroll records indicating identified support staff and hours worked, and any other supplemental support staffing schedules that document required staffing ratios. • If the provider plans to transport recipients in the provider's private vehicle, at the time of enrollment, the provider must be able to show proof of a valid: (1) driver's license, (2) car registration, and, (3) insurance. Subsequent to enrollment, the provider is responsible for keeping this documentation up-to-date. An implementation plan will be developed, at a minimum, within 30 days of the initiation of the new service, or within 30 calendar days of the support plan effective date for continuation of services and annually thereafter. A copy of the implementation plan, signed by the recipient, shall be furnished to the recipient, legal representative and to the WSC at the end of this 30-day period. The progress toward achieving the goal(s) identified on the implementation plan shall be documented in notes or quarterly summaries, as specified in each service.
<p>Personal Supports</p>	<ul style="list-style-type: none"> • Copy of claim(s) submitted for payment. • Copy of service log. • For services billed at the daily rate, staffing documentation such as in-staffing schedules, payroll records indicating identified staff and hours worked, and other supplemental in-home support staffing schedules that document required staffing ratios. • If the provider plans to transport the recipient in the provider's 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. Subsequent to enrollment, the provider is responsible for keeping this documentation up-to-date at all times without any lapse in coverage, licensure or registration and must provide proof of such documentation upon request.
<p>Respite - Recipients Under the Age of 21 in Family Home Only</p>	<ul style="list-style-type: none"> • Copy of claim submitted for payment. • Service log.

DOCUMENTATION REQUIREMENTS

The following documentation shall be maintained by providers. Documentation shall be provided to the WSC a copy retained in the provider's files located in the provider's office or facility. All providers must keep information on file including Medicaid application, background screening results for all staff as applicable, reference checks, education, training and experience, applicable licensure, registration or certification as applicable.

Billing and Reimbursement Requirements	
Residential Habilitation (Standard)	<ul style="list-style-type: none"> • Copy of claim(s) submitted for payment. • Daily attendance log. • An implementation plan will be developed, at a minimum, within 30 days of the initiation of the new service, or within 30 calendar days of the support plan effective date for continuation of services and annually thereafter. A copy of the implementation plan, signed by the recipient, shall be furnished to the recipient, legal representative and to the WSC at the end of this 30-day period. The progress toward achieving the goal(s) identified on the implementation plan shall be documented in notes or quarterly summaries, as specified in each service. • Quarterly summary of each quarter of the support plan year. The third quarterly summary also serves as the annual report and must include a summary of the previous three quarters. • Staffing documentation such as direct care staffing schedules, payroll records indicating identified direct care support staff and hours worked and any other supplemental support staffing schedules that document staffing ratios and direct contact hours worked. <p>If the provider plans to transport recipients in the provider's 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. Subsequent to enrollment, the provider is responsible for keeping this documentation up-to-date.</p>
Residential Habilitation (Behavior Focused)	<ul style="list-style-type: none"> • Copy of claim(s) submitted for payment. • Daily attendance log. • A copy of the individual implementation plan to be developed within 30 days of the initiation of a new service or within 30 days of the support plan effective date for continuation of services and annually thereafter. • Quarterly summary of each quarter of the support plan year. The third quarterly summary also serves as the annual report and must include a summary of the previous three quarters local review committee (LRC) review dates and recommendations made specific to the plan and review schedules for the plan as indicated in Rule 65G-4.009, F.A.C. • Staffing documentation such as direct care staffing schedules, payroll records indicating identified direct care support staff and hours worked and any other supplemental support staffing schedules that document staffing ratios and direct contact hours worked. • If the provider plans to transport recipients in the provider's 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. Subsequent to enrollment, the provider is responsible for keeping this documentation up-to-date.

DOCUMENTATION REQUIREMENTS

The following documentation shall be maintained by providers. Documentation shall be provided to the WSC a copy retained in the provider's files located in the provider's office or facility. All providers must keep information on file including Medicaid application, background screening results for all staff as applicable, reference checks, education, training and experience, applicable licensure, registration or certification as applicable.

Billing and Reimbursement Requirements	
Residential Habilitation (Intensive Behavior)	<ul style="list-style-type: none"> • Copy of claim(s) submitted for payment. • Daily attendance log. • A copy of the individual implementation plan to be developed within 30 days of the initiation of a new service or within 30 days of the support plan effective date for continuation of services and annually thereafter. • Quarterly summary of each quarter of the support plan year. The third quarterly summary also serves as the annual report and must include a summary of the previous three quarters. • APD LRC review dates and recommendations made specific to the plan and review schedules for the plan as indicated in Rule 65G-4.009, F.A.C. • Staffing documentation such as direct care staffing schedules, payroll records indicating identified direct care support staff and hours worked and any other supplemental support staffing schedules that document staffing ratios and direct contact hours worked. • If the provider plans to transport recipients in the provider's 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. Subsequent to enrollment, the provider is responsible for keeping this documentation up-to-date.
Specialized Medical Home Care	<ul style="list-style-type: none"> • Copy of claim(s) submitted for payment. • Nursing Care Plan and revisions. • Nursing Assessment (must be completed at the time of the first claim submission and annually thereafter). • Daily progress notes on days service was rendered, for the period being reviewed. Notes should be directly related to the recipient's plan of care and treatment. • Prescription for service. • List of duties to be performed by the nurse.
Supported Living Coaching	<ul style="list-style-type: none"> • Copy of claim(s) submitted for payment. • Daily progress note, which includes documentation of activities, supports, and contacts with the recipient, other providers, and agencies with dates and times, and a summary of support provided during the contact, any follow-up needed and progress toward achievement of support plan goals. These progress notes shall be placed in the recipient's record prior to claim submission. • Individual implementation plan, or in the case of transition, a transition plan, must be completed within 30 days of the initiation of the new service, or within 30 calendar days of the support plan effective date for continuation of services and annually thereafter. A copy of the implementation plan, signed by the recipient, shall be furnished to the recipient, legal representative and to the WSC at the end of this 30-day period.

DOCUMENTATION REQUIREMENTS

The following documentation shall be maintained by providers. Documentation shall be provided to the WSC a copy retained in the provider's files located in the provider's office or facility. All providers must keep information on file including Medicaid application, background screening results for all staff as applicable, reference checks, education, training and experience, applicable licensure, registration or certification as applicable.

Billing and Reimbursement Requirements	
Supported Living Coaching	<ul style="list-style-type: none"> • Quarterly summary of each quarter in the support plan year. The third quarterly summary also serves as the annual report and must include a summary of the previous quarters. • In addition to the minimum required components of the individual implementation plan described in the definitions section of this Handbook, the individual implementation plan for supported living coaching service must also contain the following: <ul style="list-style-type: none"> - The frequency of the supported living service - How home, health, and community safety needs will be addressed and the supports needed to meet these needs to include a personal emergency disaster plan, which must be updated annually and anytime the recipient moves to a different residence. - The method for accessing the provider 24 hours per day, 7 days per week for emergency assistance - A description of how natural and generic supports will be used to assist in supporting the recipient. - A financial profile that includes strategies for assisting the recipient in money management when requested by the recipient or legal representative and to evaluate the need for a supported living subsidy. The financial profile is critical in determining whether or not the housing selected by the recipient is within the recipient's financial means and will identify the need for monthly subsidy, which must be approved by the APD Regional Office. Up-to-date information regarding the demographic, health, medical and emergency information, and a complete copy of the current support plan. If the support plan has not been provided by the WSC, there should be documented attempts to obtain a copy. • If the provider plans to transport the recipient in the provider's 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. Subsequent to enrollment, the provider is responsible for keeping this documentation up-to-date.
Consumable Medical Supplies	<ul style="list-style-type: none"> • Copy of claim(s) submitted for payment. • Copy of service log, listing supplies purchased. • Original prescription for the supply (if prescribed).
Durable Medical Equipment and Supplies	<p>Prior to the provider submitting the claim for payment, the recipient's WSC must document that the equipment was received and it works according to the manufacturer's description, either by conducting a site visit or obtaining verbal verification from the recipient or family.</p> <ul style="list-style-type: none"> • Copy of pre-approved claim(s) form submitted for payment. • Original prescription for the medical equipment, if prescribed by a physician, ARNP or physician assistant. • Service log listing equipment provided and documenting WSC verification that equipment was received and works, per manufacturer's description, prior to submission of claim for payment.

DOCUMENTATION REQUIREMENTS

The following documentation shall be maintained by providers. Documentation shall be provided to the WSC a copy retained in the provider's files located in the provider's office or facility. All providers must keep information on file including Medicaid application, background screening results for all staff as applicable, reference checks, education, training and experience, applicable licensure, registration or certification as applicable.

Billing and Reimbursement Requirements	
Environmental Accessibility Adaptations	<p>Prior to the provider submitting the claim for payment, the recipient's WSC must document that the services were completed in accordance with the contract or agreement, either by conducting a site visit or by obtaining written verification from the recipient or family. Environmental accessibility adaptations can be billed across two cost plans if the work is completed in phases. For each phase of work, the WSC must obtain the written verification from the recipient or family or conduct a site visit.</p> <ul style="list-style-type: none"> • Copy of claims submitted for payment. • Copy of service log; including documentation of WSC's verification that services were completed in accordance with the contract or agreement prior to submission of claim for payment. • Original prescription for adaptations and medical equipment.
Personal Emergency Response Systems (Unit and Services)	<ul style="list-style-type: none"> • Copy of claims(s) submitted for payment. • Service log or invoice, detailing services provided.
Support Coordination-Limited, Full, and Enhanced	<p>Providers of support coordination services must participate in monitoring review conducted by the Agency for Persons with Disabilities (APD), The Agency for Health Care Administration (AHCA), or an authorized representative of the State. Support coordination providers are expected to meet the needs of recipients receiving services, regardless of the number of contacts it takes to meet those needs. WSCs should not assume that meeting the basic billing requirements will necessarily result in a successful monitoring review and approval to continue services.</p> <p>For monitoring purposes, the provider must have on file the following, for the period reviewed or for the period billed:</p> <ul style="list-style-type: none"> • Documentation in the support coordination case notes of activities and contacts that assisted the WSC in meeting individually determined goals and outcomes provided opportunities to full participate in community life and addressed the recipient and family concerns. The notes should clearly and adequately detail services provided in sufficient detail. • A copy of all of the recipient's support plans filed in the recipient's central record. • Documentation, in the central record, that the basic billing requirements were met for the months in which the provider was reimbursed for services. • Documentation in the central records that a face-to-face visit with the recipient was conducted in their place of residence as required by this Handbook. • Current and correct demographic information for the recipient including current health and medical information and emergency contact information.

DOCUMENTATION REQUIREMENTS

The following documentation shall be maintained by providers. Documentation shall be provided to the WSC a copy retained in the provider's files located in the provider's office or facility. All providers must keep information on file including provider application, background screening results for all staff as applicable, reference checks, education, training and experience, applicable licensure, registration or certification as applicable.

Billing and Reimbursement Requirements	
Transportation	<ul style="list-style-type: none"> • Copy of claim(s) submitted for payment. • Trip logs.
Behavior Analysis Services	<p>Documentation of services must comply with Rule 65G-4.009, F.A.C. Reimbursement* and monitoring documentation to be maintained by the provider includes:</p> <ul style="list-style-type: none"> • Copy of claim(s) submitted for payment. • Daily progress notes for dates of service billed. • Graphic display of acquisition and reduction target behaviors • Behavior analysis support plan (BASP) within 90 days of first billed date of service. • Evidence that the provider has submitted the BASP to the LRC as required by Chapter 65G-4, F.A.C., within five days of implementation. • Quarterly summary for each quarter in which services were provided. The third quarterly summary also serves as the annual report and must include a summary of the previous quarters. • Copy of assessment report.
Behavior Assistant Services	<ul style="list-style-type: none"> • Copy of claim(s) submitted for payment. • Copy of current behavior analysis service plan (BASP). • Daily progress notes for dates of service billed. • Monthly evidence of required supervision by behavior analyst. • Copy of that data is provided to behavior analyst at least monthly. • Quarterly summary for each quarter in which services were provided. The third quarterly summary also serves as the annual report and must include a summary of the previous quarters.
Dietician Services	<ul style="list-style-type: none"> • Copy of claim(s) submitted for payment. • Daily progress notes for days service was rendered and billed. • Monthly nutritional status report. • Dietician assessment. • Individual dietary management plan. • Quarterly summary for each quarter in which services were provided. The third quarterly summary also serves as the annual report, and must include a summary of the previous quarters. Original prescription for the service, and annually thereafter.
Occupational Therapy	<ul style="list-style-type: none"> • Copy of claim(s) submitted for payment. • Daily progress notes for days service was rendered and billed. • Monthly summary note. This does not substitute for daily progress notes. • Assessment report (if requesting reimbursement for assessment). • Quarterly summary for each quarter in which services were provided. The third quarterly summary also serves as the annual report and must include a summary of the previous quarters. Original prescription for the service, and every six months thereafter.

DOCUMENTATION REQUIREMENTS

The following documentation shall be maintained by providers. Documentation shall be provided to the WSC a copy retained in the provider’s files located in the provider’s office or facility. All providers must keep information on file including Medicaid application, background screening results for all staff as applicable, reference checks, education, training and experience, applicable licensure, registration or certification as applicable.

Billing and Reimbursement Requirements	
Physical Therapy	<ul style="list-style-type: none"> • Copy of claim(s) submitted for payment. • Daily progress notes for days service was rendered and billed. • Monthly summary note. This does not substitute for daily progress notes. • Assessment report (if requesting reimbursement for assessment). • Quarterly summary for each quarter in which services were provided. The third quarterly summary also serves as the annual report and must include a summary of the previous quarters. Original prescription for the service and every six months thereafter.
Private Duty Nursing	<ul style="list-style-type: none"> • Copy of claim(s) submitted for payment. • Copy of the nursing care plan with annual updates. • Daily progress notes for days service was rendered and billed. • Individual nursing assessment and annually thereafter. • Monthly summary, which includes details regarding health status, medication, treatments, medical appointments, and other relevant information. • Original prescription for the service and annually thereafter. • List of duties to be performed by the nurse. <p>Nurses delivering this service as independent providers must provide proof of meeting the educational requirements specified in Chapter 464.008(1), F.S., for licensure as a registered professional nurse or a licensed practical nurse, whichever is applicable.</p> <p>Nursing assessments and care plans should be updated annually or if there is a significant change in the recipient’s health status. They are required at the time of first claim submission and annually thereafter</p>
Residential Nursing	<ul style="list-style-type: none"> • Copy of claim(s) submitted for payment. • Copy of the nursing care plan with annual updates. • Daily progress notes for days service was rendered and billed. • Individual nursing assessment and annually thereafter. • Monthly summary, which includes details regarding health status, medication, treatments, medical appointments, and other relevant information. • Original prescription for the service and annually thereafter. • List of duties to be performed by the nurse. <p>Nurses delivering this service as independent providers must provide proof of meeting the educational requirements specified in section 464.008(1), F.S. for licensure of a registered professional nurse or a practical nurse, whichever is applicable.</p>

DOCUMENTATION REQUIREMENTS

The following documentation shall be maintained by providers. Documentation shall be provided to the WSC a copy retained in the provider's files located in the provider's office or facility. All providers must keep information on file including provider application, background screening results for all staff as applicable, reference checks, education, training and experience, applicable licensure, registration or certification as applicable.

Billing and Reimbursement Requirements	
Residential Nursing , continued	Nursing assessments and care plans should be updated annually or if there is a significant change in the recipient's health status. They are required at the time of first claim submission and annually thereafter.
Respiratory Therapy	<ul style="list-style-type: none"> • Copy of claim(s) submitted for payment. • Daily progress notes for days service was rendered and billed. • Quarterly summary for each quarter in which services were provided. The third quarterly summary also serves as the annual report and must include a summary of the previous quarters. • Original prescription for service and every six months thereafter. • Assessment report, if a claim is submitted for an assessment.
Skilled Nursing	<ul style="list-style-type: none"> • Copy of claim(s) submitted for payment. • Nursing care plan with annual updates. • Daily progress note for dates of service rendered. • Individual nursing assessment (must be completed at time of first claim submission and annually thereafter). • Original prescription for service and annually thereafter. Monthly summary, which includes details regarding health status, medication, treatments, medical appointments, and other relevant information. • List of duties to be performed by the nurse. <p>Nurses delivering this service as independent providers must provide proof of meeting the educational requirements specified in Chapter 464.008(1), F.S., for licensure as a registered professional nurse or a licensed practical nurse, whichever is applicable.</p> <p>Nursing assessments and care plans should be updated annually or if there is a significant change in the recipient's health status. They are required at the time of first claim submission and annually thereafter.</p>
Speech Therapy	<ul style="list-style-type: none"> • Copy of claim(s) submitted for payment. • Daily progress note for dates of service rendered. • Quarterly summary for each quarter in which services were provided. The third quarterly summary also serves as the annual report and must include a summary of the previous quarters. • Original prescription for the service and every six months thereafter. • Assessment report, if a claim is submitted for an assessment.
Specialized Mental Health Counseling	<ul style="list-style-type: none"> • Copy of claim(s) submitted for payment. • Daily progress note for dates of service rendered. • Monthly summary note. • Assessment and treatment plan, even if preliminary, or plan for further action, must be completed at time of first claim submission and a final treatment plan at the subsequent claim submission.

APPENDIX B

APD TRAINING REQUIREMENTS FOR IBUDGET WAIVER PROVIDERS

APD provider training requirements are broken into three categories: Required Basic, Required Pre-Service Certification, and Required In-Service (also known as Continuing Education in certain professions). A chart follows this section and provides additional details on course titles, course descriptions, timeframes for successfully completing courses, trainer qualifications, documentation of successful completions, and the frequencies in which courses need to be completed.

Required Basic Training

Except for exemptions noted below, the following basic training courses are required to be successfully completed by all direct care staff of all providers:

- Core Competencies
- Health Information Portability and Accountability Act (HIPAA)
- Zero Tolerance
- AIDS, HIV, and Infection Control
- CPR
- First Aid

Two additional trainings must be completed by direct care under certain circumstances:

- Medication Administration and Validation
- Reactive Strategies and Validation

The first additional training involves providers who will be administering or assisting to administer any medication. This training is entitled “Medication Administration Training” and includes a successful validation component. The second involves serving a recipient with a behavior plan containing reactive strategies or if staff is expected to implement approved reactive strategies. This training is entitled “Reactive Strategies Training” and also includes a successful validation component.

The final Required Basic Training course is required to be successfully completed by all independent waiver providers, as well as all management and administrative staff of all agency waiver providers:

- Developmental Disabilities Individual Budgeting Medicaid Waiver Coverage and Limitation Handbook Training.

Staff of the following types of providers are **exempt** from completing any training in this Handbook unless training and continuing education credits are related to their licensure in order to maintain current active status as referenced in Florida Statutes and Florida Administrative Rules:

- Adult Dental
- Consumable Medical Supplies
- Durable Medical Equipment
- Environmental Accessibility Adaptations
- Personal Emergency Response Systems

Direct care staff who hold professional certificates for the following services are only required to complete the required training entitled Core Competencies, Zero Tolerance, and HIPAA:

- Dietician
- Occupational Therapy
- Physical Therapy
- Private Duty Nursing
- Residential Nursing Services

- Respiratory Therapy
- Skilled Nursing
- Specialized Mental Health Counseling
- Speech Therapy

Required Pre-Service Certification Training

Required Pre-Service Certification Training Providers of the following types of services, must also successfully complete pre-service certification in addition to the basic training courses:

- Family & Guardian Training
- Life Skills II (Supported Employment Coaching)
- Support Coordination
- Supported Living Coaching

So as to generate additional funding to support an individual's employment goals, supported employment coaches must assist the clients they serve to be aware of and utilize the various work incentives and employment planning tools that are available, and in particular the Plan to Achieve Self-Sufficiency (PASS). So that all coaches are aware of these various incentives and tools, all supported employment coaches must successfully complete APD's pre-service course Introduction to Social Security Work Incentives within one year of the promulgation of this handbook.

In-Service Training (and Continuing Education)

Providers of the following types of services, must also successfully complete In-Service Trainings or Continuing Education courses in order to maintain current active status as referenced in Florida Statutes or Florida Administrative Rules. A chart is provided in Appendix C that provides details as to which providers must complete in-service hours and which must completing continuing education hours. These include:

- | | |
|---|---|
| • Adult Dental | • Private Duty Nursing |
| • Behavior Analysis Services | • Residential Habilitation (Behavior Focused) |
| • Behavior Assistant Services | • Residential Habilitation (Intensive Behavior) |
| • Dietician Services | • Residential Nursing |
| • Life Skills Development I (Companion) | • Respiratory Therapy |
| • Life Skills Development II (Supported Employment) | • Skilled Nursing |
| • Life Skills Development III (Adult Day Training) | • Specialized Medical Home Care |
| • Occupational Therapy | • Specialized Mental Health Counseling |
| • Personal Supports | • Speech Therapy |
| • Physical Therapy | • Support Coordination |
| | • Supported Living Coaching |

Providers are not limited to taking training courses only from The Agency for Persons with Disabilities (APD) and should take advantage of conferences and professional presentations whenever possible. To determine whether or not a course would count toward required in-service training, it is recommended to get written approval from APD staff.

Repeating the same course every year will not meet this requirement.

Certificates of Completion

Documentation of successful completion of required provider basic training is defined differently for classroom training (face-to-face), web-based training, and validation training.

Classroom Training

A certificate of successful completion of classroom training is the only acceptable documentation for meeting the required provider basic training. Providers who do not successfully complete all course requirements will not be issued a certificate of successful completion. A certificate of successful completion means the provider has attended all required sessions, completed all applicable assignments, and successfully completed and passed any required course tests.

The only acceptable proof of APD standardized classroom training will be the standardized course certificate developed by the APD. For courses provided by trainers certified by the American Red Cross, American Heart Association, and the American Safety and Health Institute, the standard certificates developed by those organizations are the only acceptable proof of successful completion.

Elements that must be included on the certificate are as follows:

- Participant's name
- Title of the course (as titled in the handbook)
- The term "successfully completed" (which denotes attendance of all sessions, completion of all homework and passing all tests) for APD certificates and completed for all non-APD certificates
- Location where training occurred (address and city)
- Date training occurred
- Name of the trainer and signature
- Evidence that the trainer has appropriate credentials (e.g., a trainer certified by APD, Red Cross, etc.)

Certificates for in-service classroom training must include, in addition to the information above, the number of hours the training lasted.

All classroom trainers must maintain the following training records for a minimum of seven years:

- Daily sign-in sheet (for each day of class) that must include the following:
 - Attendees name printed and originally signed
 - Title of the training (which matches title on the certificate and in the handbook)
 - Date of the training
 - Printed name of the trainer(s) with original signatures
 - Location where the training occurred (address and city)
 - Original test(s) for each attendee with score noted
 - Copy of certificates of persons who successfully completed the course

Web-Based Training

Proof of provider web-based training will include a printed certificate or transcript with the following elements:

- Participant's name
- Title of the course (if not titled as in the handbook written confirmation of the course content can be required)
- Date or period over which training course was completed and notation that course was successfully complete
- Name of entity providing training (for example state college, technical institute, American Health and Safety Institute, etc.)

For in-service web-based training certificates, the number of hours the training represents must also be included on the certificate or in an attachment from the organization that provided the training.

Validation Training

For medication administration validation the certificate must include all requirements listed in Chapter 65G-7, F.A.C., which at the time of this promulgation include the following:

- The name and address of the provider being validated and, if an employee, the name of the agency
- The date of assessment and validation
- A description of the medication routes and procedures that the provider is authorized to supervise or administer
- Any limitations on the applicant's validation to administer medication, such as limitations on validated routes of medication administration
- The printed name and original signature of the validating nurse or physician as it appears on their professional license
- The validating nurse or physician's license number and license expiration date

For reactive strategy validation the certificate must include all requirements listed in Chapter 65G-8, F.A.C., which at the time of this promulgation include the following:

- the name of the curriculum
- the name of the trainer
- the date(s) of training
- the date of certificate expiration

If Chapter 65G-8, F.A.C., certificate requirements change, they will take precedence over this Handbook.

The provider or provider agency shall maintain on file, a copy of all certificates of direct care staff and trainers documenting successful completion of all required training, continuing education, and annual in-service requirements. The provider is responsible for any additional documentation as noted in F.A.C. rules.

Please see Appendix D for the iBudget Waiver Provider Training Matrix.

In situations where providers have new training requirements in this Handbook, which were not included in previous handbooks, you will have one year from the date of this Handbook's effective date to take the newly required courses.

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Required Basic Courses	Course Description	Time-frame	Trainer Qualification	Documentation	Frequency
Core Competencies	<p>Modules entitled as follows and developed by the APD State Office Training Unit:</p> <ul style="list-style-type: none"> • Defining Developmental Disabilities • Roles and Responsibilities of Direct Care Professionals • Maintaining Health, Safety and Wellbeing of APD Customers • Individual Choices, Rights and Responsibilities • Basic Training in Person-Centered Planning and Service Delivery 	Within 30 days of providing services	Classroom trainers must be certified in writing by APD and web-based courses must be approved in writing by the APD Central Office Training Unit.	See Documentation Requirements on Page B-3.	Once, refresher courses recommended when course content substantially changes
Health Information Portability and Accountability Act (HIPAA)	Regulations related to Public Law 104-191	Within 30 days of providing services	No trainers. Web-based only and must be approved in writing by the APD Central Office Training Unit.	See Documentation Requirements on Page B-3.	Annually
Zero Tolerance	<p>Modules entitled as follows and developed by the APD State Office Training Unit:</p> <ul style="list-style-type: none"> • Defining and Recognizing Abuse, Neglect and Exploitation • DCF Hotline Abuse Reporting Requirements and Procedures • APD Incident Reporting Requirements and Procedures • Prevention and Safety Planning 	Prior to providing services	Classroom trainers must be certified in writing by APD and web-based courses must be approved in writing by the APD Central Office Training Unit.	See Documentation Requirements on Page B-3.	At initial employment and every three years thereafter

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<p>AIDS, HIV, and Infection Control</p>	<p>Courses endorsed by the American Red Cross, Florida Department of Health, or American Safety and Health Institute that meet the requirements of section 381.0035, F.S. Use of HIV/AIDS 101 (available from any Florida Health Department) is also acceptable.</p>	<p>Within 30 days of providing services</p>	<p>Certified in writing by the American Red Cross, Florida Department of Health, or the American Safety and Health Institute. A copy of the trainer's certification must be maintained on file by the provider.</p>	<p>See Documentation Requirements on Page B-3. The certificates must also note whether certification is time limited and if so, for what period (one year, two years, etc.) If the certification is not time limited, this should also be noted.</p>	<p>Once, but retraining should be completed if violations exist or course content changes substantially.</p>
<p>CPR</p>	<p>Courses endorsed by the American Red Cross, American Heart Association, or American Safety and Health Institute live classroom training only. Online courses do not meet this requirement.</p>	<p>Within 30 days of providing services</p>	<p>Certified in writing by the American Red Cross, American Heart Association, or American Safety and Health Institute.</p>	<p>See Documentation Requirements on Page B-3. For courses with time limited certification, it must be clearly noted on the face of all certificates awarded. These certificates must also note whether certification is time limited and if so, for what period (one year, two years, etc.). If the certification is not time limited, this should also be noted.</p>	<p>Provider staff must possess a valid certificate.</p>
<p>First Aid</p>	<p>Courses endorsed by the American Red Cross or the American Safety and Health Institute live classroom training only. Online courses do not meet this requirement.</p>	<p>Within 30 days of providing services</p>	<p>Certified in writing by the American Red Cross or the American Safety and Health Institute.</p>	<p>See Documentation Requirements on Page B-3. For courses with time limited certification, it must be clearly noted on the face of all certificates awarded. These certificates must also note whether certification is time limited and if so, for what period (one year, two years, etc.) If the certification is not time limited, this should also be noted.</p>	<p>Provider staff must possess a valid certificate</p>

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<p>Developmental Disabilities Individual Budgeting Medicaid Waiver Coverage and Limitations Handbook</p>	<p>Modules entitled as follows and developed by APD's state office training unit:</p> <ul style="list-style-type: none"> • Provider Qualifications and Requirements for each waiver service • Medicaid Waiver Services Agreement and its Attachments • Reimbursement Information 	<p>Prior to providing services</p>	<p>Classroom trainers must be certified in writing by APD and web-based courses must be approved in writing by the APD Central Office Training Unit.</p>	<p>See Documentation Requirements on Page B-3.</p>	<p>Once, additional training on new or changed regulation as rule changes occur</p>
<p>Medication Administration Training and Certification pursuant to Chapter 65G-7, F.A.C. (both training and validation must be successfully completed by any provider and provider staff who assist with or administer medication.)</p>	<p>Pursuant to Chapter 65G-7, F.A.C.</p>	<p>Prior to the provider or provider staff administering or assisting with medication</p>	<p>Classroom trainers must be certified in writing by APD and web-based courses must be approved in writing by the APD Central Office. Validation must be face-to-face as specified in Chapter 65G-7, F.A.C.</p>	<p>See Documentation Requirements on Page B-3.</p>	<p>As defined by Chapter 65G-7, F.A.C.</p>
<p>Reactive Strategies Training and Validation (both training and successful validation must be completed by any provider staff who work with a recipient who has a behavior plan containing reactive strategies or is expected to implement approved reactive strategies.) Training by the provider should be related to the provider policy for implementing Chapter 65G-8, F.A.C.</p>	<p>Pursuant to Chapter 65G-8, F.A.C.</p>	<p>Within 30 days of providing services to a recipient who has a behavior plan containing reactive strategies or when the staff is expected to implement approved reactive strategies</p>	<p>Classroom trainers must be certified consistent with the requirements set forth in the curricula approved by the APD State Office. Validation must be face-to-face and consistent with Chapter 65G-8, F.A.C.</p>	<p>See Documentation Requirements on Page B-3.</p>	<p>As defined by Chapter 65G-8, F.A.C.</p>

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Supported Employment Pre-Service	<ul style="list-style-type: none"> • Best Practice of Supported Employment • Introduction to Social Security Work Incentives 	Prior to providing services	Classroom = Certified by the APD State Office Web-based = approved by APD	See Documentation Requirements on Page B-3	Once, but retraining can be required if violations exist or course content changes substantially.
Self-Employment Pre-Service	<ul style="list-style-type: none"> • Must be a Certified Business Technical Assistant and Consultant (CBTAC). 	Prior to providing services	Certified by Vocational Rehabilitation	See Documentation requirements on Page B-3	Once, but retraining can be required if violations exist or course content changes substantially
Support Coordination Pre-Service	<ul style="list-style-type: none"> • Statewide Pre-Service Certification • Area Specific Pre-service Certification • Use of personal outcomes to establish a person-centered approach to service delivery – two-day course 	Prior to providing services	Certified by the APD State Office	See Documentation Requirements on Page B-3	Once, but retraining can be required if violations exist or course content changes substantially.
Supported Living Pre-Service	<ul style="list-style-type: none"> • Defining and Exploring Supported Living • Understanding Coaching Services and Requirements • Planning Supports • Documenting Progress • Supporting Success • Enhancing Quality 	Prior to providing services	Certified by the APD State Office	See Documentation Requirements on Page B-3	Once, but retraining can be required if violations exist or course content changes substantially.

PLEASE SEE APPENDIX D FOR THE IBUDGET WAIVER PROVIDER TRAINING MATRIX

APPENDIX C

SERVICE SPECIFIC TRAINING REQUIREMENTS

Service	Specific Training Requirements
<p>Adult Dental</p>	<p><i>Required Basic Training</i> Providers of this service and their staff must comply with required training and continuing education credits related to their certification or licensure as a dental professional in order to maintain current active status as referenced in Florida Statutes and Florida Administrative Rules.</p> <p><i>Continuing Education</i> Providers of adult dental services must comply with required training and continuing education credits related to their licensure in order to maintain current active status as a dental professional referenced in Florida Statutes and Florida Administrative Rules.</p>
<p>Behavior Analysis Services</p>	<p><i>Required Basic Training</i> Providers of this service must complete all relevant basic training courses noted in Appendix B within 30 days of employment. Depending upon the individuals being served, medication administration, reactive strategies, or both, may also need to be completed prior to service provision. All new employees must successfully complete all relevant training noted here and in Appendix B before working alone with recipients.</p> <p><i>Continuing Education</i> Behavior analysis providers must also comply with required training and continuing education credits related to their certification as behavior analysts or licensed under Chapter 490 or 491, F.S., in order to maintain current active status as referenced in Florida Statutes and Florida Administrative Rules.</p>
<p>Behavior Assistant Services</p>	<p><i>Required Basic Training</i> Providers of this service must complete all relevant basic training courses noted in Appendix B within 30 days of employment. Depending upon the individuals being served, medication administration, reactive strategies, or both, may also need to be completed prior to service provision. All new employees must successfully complete all relevant training noted here and in Appendix B before working alone with recipients.</p> <p><i>Continuing Education</i> Behavior assistant providers must comply with required training and continuing education credits related to their certification as a behavior assistant in order to maintain current active status as referenced in Florida Statutes and Florida Administrative Rules.</p>

<p>Consumable Medical Supplies</p>	<p><i>Required Basic Training</i> Providers of this service and their staff must comply with required training and continuing education credits related to their certification or licensure in order to maintain current active status as referenced in Florida Statutes and Florida Administrative Rules.</p>
<p>Dietician Services</p>	<p><i>Required Basic Training</i> Providers of this service must successfully complete only Core Competencies, Zero Tolerance, and HIPAA as noted in Appendix B within 30 days of employment.</p> <p><i>Continuing Education</i> Dietician providers must comply with required training and continuing education credits related to their licensure in order to maintain current active status as a dietician referenced in Florida Statutes and Florida Administrative Rules.</p>
<p>Durable Medical Equipment and Supplies</p>	<p><i>Required Basic Training</i> Providers of this service and their staff must comply with required training and continuing education credits related to their certification or licensure in order to maintain current active status as referenced in Florida Statutes and Florida Administrative Rules.</p>
<p>Environmental Accessibility Adaptation</p>	<p><i>Required Basic Training</i> Providers of environmental accessibility adaptation services and their staff must comply with required training and continuing education credits related to their certification or licensure in order to maintain current active status as referenced in Florida Statutes and Florida Administrative Rules.</p>
<p>Life Skills Development 1, 2, 3</p>	<p><u>Life Skills Development - Level 1 (Companion)</u></p> <p><i>Required Basic Training</i> Providers of this service must complete all relevant basic training courses noted in Appendix B within 30 days of employment. Depending upon the individuals being served, medication administration, reactive strategies, or both, may also need to be completed prior to service provision. All new employees must successfully complete all relevant training noted here and in Appendix B before working alone with recipients.</p> <p><i>Annual In-Service Training Requirement</i> Four hours of annual in-service training must be completed and be related to the specific needs of at least one recipient being currently served. Specific needs can include health needs, community resources, or person-centered planning. Retaking basic APD training courses will not be counted toward this requirement. Documentation of completion for in-service is defined in Appendix B.</p>

<p>Life Skills Development 1, 2, 3, continued</p>	<p><u>Life Skills Development - Level 2 (Supported Employment)</u></p> <p><i>Required Basic Training</i></p> <p>Providers of this service must complete all relevant basic training courses noted in Appendix B within 30 days of employment. Depending upon the individuals being served, medication administration, reactive strategies, or both, may also need to be completed prior to service provision. All new employees must successfully complete all relevant training noted here and in Appendix B before working alone.</p> <p><i>Required Pre-Service Certification Training</i></p> <p>This is one of four types of providers who must successfully complete pre-service certification courses in addition to the basic training courses. Course content and timeframes for completion are also noted in Appendix B.</p> <p>Additionally, if a Life Skills Development - Level 2 (Supported Employment) provider is seeking to support recipients who are self-employed, the provider must be certified as a Certified Business Technical Assistance and Consultation (CBTAC) by the Florida Department of Education, Division of Vocational Rehabilitation prior to providing those services.</p> <p><i>Annual In-Service Training Requirement</i></p> <p>Eight hours of annual in-service training related to employment must be completed by persons providing Life Skills Development - Level 2 (Supported Employment). Retaking basic APD training courses will not be counted toward this requirement. Documentation of completion for in-service hours is defined in Appendix B.</p> <p><u>Life Skills Development - Level 3 (Adult Day Training)</u></p> <p><i>Required Basic Training</i></p> <p>Providers of this service must complete all relevant basic training courses noted in Appendix B within 30 days of employment. Depending upon the individuals being served, medication administration, reactive strategies, or both, may also need to be completed prior to service provision. All new employees must successfully complete all relevant training noted here and in Appendix B before working alone with recipients.</p> <p>In those facilities that perform medication administration or use (or can use) reactive strategies, a minimum of a least one staff member or 50 percent of all staff at the facility (whichever is greater), must have been trained on Reactive Strategies and Medication Administration.</p> <p><i>Annual In-Service Training</i></p> <p>Eight hours of annual in-service training must be completed and be related to the implementation of individually tailored services. Individually tailored services can include exploring ways to integrate person-centered planning in service delivery, integrating recipients with disabilities into their community and integrating recipients with disabilities into employment or volunteerism within an integrated environment. Retaking basic APD training courses will not be counted toward this requirement. Documentation of completion for in-service training is defined in Appendix B.</p>
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<p>Occupational Therapy</p>	<p><i>Required Basic Training</i> Providers of this service must complete only Core Competencies, Zero Tolerance, and HIPAA as noted in Appendix B within 30 days of employment. The new employee or provider must successfully complete all relevant training noted here and in Appendix B before working without another trained employee present.</p> <p><i>Continuing Education</i> Occupational Therapy providers must comply with required training and continuing education credits related to their licensure in order to maintain current active status as an occupational therapist referenced in Florida Statutes and Florida Administrative Rules.</p>
<p>Personal Emergency Response System</p>	<p><i>Required Basic Training</i> Providers of this service and their staff must comply with required training and continuing education credits related to their certification or licensure in order to maintain current active status as referenced in Florida Statutes and Florida Administrative Rules.</p>
<p>Personal Supports</p>	<p><i>Required Basic Training</i> Providers of this service must complete all relevant basic training courses noted in Appendix B within 30 days of employment. Depending upon the individuals being served, medication administration, reactive strategies, or both, may also need to be completed prior to service provision. All new employees must successfully complete all relevant training noted here and in Appendix B before working alone with recipients.</p> <p><i>Annual In-Service Training Requirement</i> Four hours of annual in-service training must be completed and be related to the specific needs of at least one recipient being currently served. Specific needs can include health needs, community resources or person-centered planning. Retaking basic APD training courses will not be counted toward this requirement. Documentation of completion for in-service training is defined in Appendix B.</p>
<p>Physical Therapy</p>	<p><i>Required Basic Training</i> Providers of this service must complete only Core Competencies, Zero Tolerance, and HIPAA as noted in Appendix B within 30 days of employment. The new employee or provider must successfully complete all relevant training noted here and in Appendix B before working without another trained employee present.</p> <p><i>Continuing Education</i> Physical therapy providers must comply with required training and continuing education credits related to their licensure in order to maintain current active status as a physical therapist referenced in Florida Statutes and Florida Administrative Rules.</p>

<p>Private Duty Nursing</p>	<p><i>Required Basic Training</i> Providers of this service must complete only Core Competencies, Zero Tolerance, and HIPAA as noted in Appendix B within 30 days of employment. The new employee or provider must successfully complete all relevant training noted here and in Appendix B before working without another trained employee present.</p> <p><i>Continuing Education</i> Private duty nurse providers must comply with required training and continuing education credits related to their licensure in order to maintain current active status as a licensed practical nurse or registered nurse as referenced in Florida Statutes and Florida Administrative Rules.</p>
<p>Residential Habilitation (Live-in)</p>	<p><i>Required Basic Training</i> Providers of this service must complete all relevant basic training courses noted in Appendix B within 30 days of employment. Depending upon the individuals being served, medication administration, reactive strategies, or both may also need to be completed prior to service provision. All new employees must successfully complete all relevant training noted here and in Appendix B before working alone with recipients.</p>
<p>Residential Habilitation (Behavior Focused)</p>	<p><i>Required Basic Training</i> Providers of this service must complete all relevant basic training courses noted in Appendix B within 30 days of employment. Depending upon the individuals being served, medication administration, reactive strategies, or both may also need to be completed prior to service provision. All new employees must successfully complete all relevant training noted here and in Appendix B before working alone with recipients.</p> <p><i>Annual In-Service Training Requirement</i> Eight hours of annual in-service training related to behavior modification must be completed. Documentation of completion for in-service hours is defined at the beginning of this Appendix. Retaking basic APD training courses will not be counted toward this requirement.</p>
<p>Residential Habilitation (Intensive Behavior)</p>	<p><i>Required Basic Training</i> Providers of this service must complete all relevant basic training courses noted in Appendix B within 30 days of employment. Depending upon the individuals being served, medication administration, reactive strategies, or both, may also need to be completed prior to service provision. All new employees must successfully complete all relevant training noted here and in Appendix B before working alone with recipients.</p> <p><i>Annual In-Service Training Requirement</i> Eight hours of annual in-service training related to behavior modification must be completed. Documentation of completion for in-service hours is defined in Appendix B. Retaking basic APD training courses will not be counted toward this requirement.</p>

<p>Residential Habilitation (Standard)</p>	<p><i>Required Basic Training</i> Providers of this service must complete all relevant basic training courses noted in Appendix B within 30 days of employment. Depending upon the individuals being served, medication administration, reactive strategies, or both, may also need to be completed prior to service provision. All new employees must successfully complete all relevant training noted here and in Appendix B before working alone with recipients.</p>
<p>Residential Nursing</p>	<p><i>Required Basic Training</i> Providers of this service must complete only Core Competencies, Zero Tolerance, and HIPAA as noted in Appendix B within 30 days of employment. The new employee or provider must successfully complete all relevant training noted here and in Appendix B before working without another trained employee present.</p> <p><i>Continuing Education</i> Residential nursing providers must comply with required training and continuing education credits related to their licensure in order to maintain current active status as a licensed practical nurse or registered nurse referenced in Florida Statutes and Florida Administrative Rules.</p>
<p>Respiratory Therapy</p>	<p><i>Required Basic Training</i> Providers of this service must complete only Core Competencies, Zero Tolerance, and HIPAA as noted in Appendix B within 30 days of employment. The new employee or provider must successfully complete all relevant training noted here and in Appendix B before working without another trained employee present.</p> <p><i>Continuing Education</i> Respiratory therapy providers must comply with required training and continuing education credits related to their licensure in order to maintain current active status as a respiratory therapist referenced in Florida Statutes and Florida Administrative Rules.</p>
<p>Respite- children in family home only</p>	<p><i>Required Basic Training</i> Providers of this service must complete all relevant basic training courses noted in Appendix B within 30 days of employment. Depending upon the individuals being served, medication administration, reactive strategies, or both, may also need to be completed prior to service provision. All new employees must successfully complete all relevant training noted here and in Appendix B before working alone with recipients.</p>

<p>Skilled Nursing</p>	<p><i>Required Basic Training</i> Providers of this service must complete only Core Competencies, Zero Tolerance, and HIPAA as noted in Appendix B within 30 days of employment. The new employee or provider must successfully complete all relevant training noted here and in Appendix B before working without another trained employee present.</p> <p><i>Continuing Education</i> Skilled nursing providers must comply with required training and continuing education credits related to their licensure in order to maintain current active status as a licensed practical nurse or registered nurse referenced in Florida Statutes and Florida Administrative Rules.</p>
<p>Specialized Medical Home Care</p>	<p><i>Required Basic Training</i> Providers of this service must complete all relevant basic training courses noted in Appendix B within 30 days of employment unless certified as registered nurse or licensed practical nurse. Depending upon the individuals being served, medication administration, reactive strategies, or both, may also need to be completed prior to service provision. All new employees must successfully complete all relevant training noted here and in Appendix B before working alone with recipients.</p> <p><i>Continuing Education</i> Specialized medical home care providers must comply with continuing education credits related to their certification or licensure as a licensed practical nurse or registered nurse in order to maintain current active status as referenced in Florida Statutes and Florida Administrative Rules.</p>
<p>Specialized Mental Health Counseling</p>	<p><i>Required Basic Training</i> Providers of this service must complete only Core Competencies, Zero Tolerance, and HIPAA as noted in Appendix B within 30 days of employment. The new employee or provider must successfully complete all relevant training noted here and in Appendix B before working without another trained employee present.</p> <p><i>Continuing Education</i> Specialized mental health counseling providers must comply with required training and continuing education credits related to their licensure as a psychiatrist, psychologist, clinical social worker or marriage and family counselor as referenced in Florida Statutes and Florida Administrative Rules.</p>

<p>Speech Therapy</p>	<p>Required Basic Training Providers of this service must complete only Core Competencies, Zero Tolerance and HIPAA as noted in Appendix B within 30 days of employment. The new employee or provider must successfully complete all relevant training noted here and in Appendix B before working without another trained employee present.</p> <p>Continuing Education Speech therapy providers must comply with required training and continuing education credits related to their licensure in order to maintain current active status as a speech therapist referenced in Florida Statutes and Florida Administrative Rules.</p>
<p>Support Coordination— Limited, Full or Enhanced</p>	<p>Required Basic Training Providers of this service must complete all relevant basic training courses noted in Appendix B within 30 days of employment. All new employees must successfully complete all relevant training noted here and in Appendix B before working alone with recipients.</p> <p>Required Pre-Service Certification Training Support coordination providers must complete the course entitled “Support Coordination Pre-Service,” prior to beginning to serve any recipients.</p> <p>Within six months of successfully completing the pre-service training, each new support coordinator must assume a minimum caseload of recipients. If a support coordinator discontinues providing support coordination services for more than one year and wants to return as a provider of support coordination, the pre-service training must be completed again.</p> <p>At the discretion of the APD Area Office based on unsatisfactory monitoring results, any support coordinator can be required to retake any portion of the pre-service certification course or any other required basic training.</p> <p>Annual In-Service Training Requirements All waiver support coordinators, as well as supervisors, directors, and managers of agencies shall attend a minimum of 24 hours of job-related in-service training annually.</p> <p>At least six hours of the annual in-service training shall relate to the purpose of APD waivers and the necessity for waiver support coordinators to assist recipients they support by using a person-centered approach to services, work and community life. In addition, at least four will focus on employment-related services or benefits planning and management, as well as, opportunities such as customized employment options, information and referral to vocational rehabilitation services, public school transition planning processes, and asset development.</p>

<p>Support Coordination— Limited, Full or Enhanced, continued</p>	<p>All support coordinators shall successfully complete APD’s course entitled “Introduction to Social Security Work Incentives” within one year of receiving their certificate of enrollment as a support coordination provider. Waiver support coordinators who are certified and enrolled at the time this Handbook becomes effective must complete this required training within one year of the handbook’s effective date.</p> <p>Internal management meetings conducted by support coordination agencies for their staff shall not apply toward the continuing education annual requirement. For support coordination agency employees and supervisors, one half of the in-service requirement must be provided by trainers who are not employed by a support coordination agency. Up to 12 hours per year for attendance at support coordination meetings conducted by the Area Offices can count toward the annual 24 hour in-service requirement.</p> <p>Documentation of completion for in-service hours is defined in Appendix B. Retaking basic APD training courses will not be counted toward this requirement.</p>
<p>Supported Living Coaching</p>	<p>Required Basic Training Providers of this service must complete all relevant basic training courses noted in Appendix B within 30 days of employment. Depending upon the individuals being served, medication administration, reactive strategies, or both, may also need to be completed prior to service provision. All new employees must successfully complete all relevant training noted here and in Appendix B before working alone with recipients.</p> <p>Required Pre-Service Certification Training Supported living coaching providers must complete the APD course entitled “Supported Living Pre-Service,” prior to beginning to serve any recipients. Documentation of the successful completion of service specific training requirements is defined in Appendix B.</p> <p>Annual In-Service Training Requirements Supported living coaching providers must complete eight hours of annual in-service. Such trainings should be related to affordable housing options, asset development, money management, specific health needs of recipients they are currently serving, accessing governmental benefits other than those Medicaid waiver (such as food stamps, legal services, etc.), or employment-related topics. Documentation of completion for in-service hours is defined in Appendix B. Retaking basic APD training courses will not be counted toward this requirement.</p>
<p>Transportation</p>	<p>Required Basic Training Providers of this service (drivers) must complete all relevant basic training courses noted in Appendix B within 30 days of employment. Depending upon the individuals being served, medication administration, reactive strategies, or both, may also need to be completed prior to service provision. All new employees must successfully complete all relevant training noted here and in Appendix B before working alone with recipients.</p>

APPENDIX D

iBUDGET WAIVER PROVIDER TRAINING MATRIX

Developmental Disabilities Individual Budgeting Medicaid Waiver Coverage and Limitations Handbook

	REQUIRED BASIC COURSES								ADDITIONAL			
Course	Core Competencies	HIPAA	Zero Tolerance	Medication Adm.*	Reactive Strat.**	AIDS-HIV-Inf. Cont.	CPR	First Aid	iBudget Waiver Coverage and Limitations Handbook - (Required of all indep. Providers and all administrative staff of Provider Agencies)	Required Pre-Service Certification Training	Annual Required In-Service Training= RIT (Continuing Education = CE)	
Adult Dental										EXEMPT		
Behavior Analysis Services	X	X	X			X	X	X		X		CE
Behavior Assistant Services	X	X	X			X	X	X		X		CE
Consumable Medical Supplies										EXEMPT		
Dietician	X	X	X							X		CE
Durable Medical Equipment										EXEMPT		
Environmental Accessibility Adaptations										EXEMPT		
Life Skills Development - Level 1 (Companion)	X	X	X			X	X	X		X		RIT 4 hrs./yr.
Life Skills Development - Level 2 (Supported Employment)	X	X	X			X	X	X		X	X	RIT 8 hrs./yr.

Course	REQUIRED BASIC COURSES								ADDITIONAL		
	Core Competencies	HIPAA	Zero Tolerance	Medication Adm.*	Reactive Strat.**	AIDS-HIV-Inf. Cont.	CPR	First Aid	iBudget Waiver Coverage and Limitations Handbook - (Required of all indep. Providers and all administrative staff of Provider Agencies)	Required Pre-Service Certification Training	Annual Required In-Service Training= RIT (Continuing Education = CE)
Life Skills Development - Level 3 (Adult Day Training - ADT)	X	X	X			X	X	X			
Occupational Therapy	X	X	X						X		
Personal Emergency Response									EXEMPT		
Personal Supports	X	X	X			X	X	X	X		
Physical Therapy	X	X	X						X		
Private Duty Nursing	X	X	X						X		
Residential Habilitation (Live-in)	X	X	X			X	X	X	X		
Residential Habilitation - Behavior Focus	X	X	X			X	X	X	X		RIT 8 hrs./yr.
Residential Habilitation - Intensive Behavior	X	X	X			X	X	X	X		RIT 8 hrs./yr.
Residential Habilitation - Standard	X	X	X			X	X	X	X		

Developmental Disabilities Individual Budgeting Medicaid Waiver Coverage and Limitations Handbook

Course	REQUIRED BASIC COURSES								iBudget Waiver Coverage and Limitations Handbook - (Required of all indep. Providers and all administrative staff of Provider Agencies)	ADDITIONAL	
	Core Competencies	HIPAA	Zero Tolerance	Medication Adm.*	Reactive Strat.**	AIDS-HIV-Inf. Cont.	CPR	First Aid		Required Pre-Service Certification Training	Annual Required In-Service Training= RIT (Continuing Education = CE)
Residential Nursing	X	X	X						X	Residential Nursing	X
Respiratory Therapy	X	X	X						X	Respiratory Therapy	X
Respite	X	X	X			X	X	X	X	Respite	X
Skilled Nursing	X	X	X						X	Skilled Nursing	X
Special Medical Home Care	X	X	X						X	Special Medical Home Care	X
Specialized Mental Health Counseling	X	X	X						X	Specialized Mental Health Counseling	X
Speech Therapy	X	X	X						X	Speech Therapy	X
Support Coordination	X	X	X			X	X	X	X	X	RIT 24 hrs./yr.
Supported Living Coaching	X	X	X			X	X	X	X	X	RIT 8 hrs./yr.
Transportation	X	X	X			X	X	X	X		

X	denotes course requirements for direct care staff by provider type
EXEMPT	denotes exemptions from APD training requirements by provider type
X	denotes the course that must be taken only by individual providers and administrative staff of agency providers - not direct care staff
*	denotes that both training and validation must be successfully completed by any provider and provider staff who assists with or administers medication
**	denotes that both training and validation must be successfully completed by any provider and provider staff who work with a recipient who has a behavior plan containing reactive strategies or is expected to implement approved reactive strategies

APPENDIX E
REGIONAL OFFICES FOR THE
AGENCY FOR PERSONS WITH DISABILITIES

**REGIONAL OFFICES FOR
THE AGENCY FOR PERSONS WITH DISABILITIES**

Region and Telephone Number	Counties in the Area
Northwest Region Tallahassee Office (850) 487-1992 Pensacola Office (850) 595-8351	Bay, Calhoun, Escambia, Gadsden, Gulf, Holmes, Jackson, Jefferson, Leon, Liberty, Okaloosa, Santa Rosa, Wakulla, Walton, and Washington
Northeast Region Jacksonville Office (904) 992-2440 Gainesville Office (352) 955-5793 Daytona Office (386) 947-4026	Alachua, Baker, Bradford, Clay, Columbia, Dixie, Duval, Flagler, Gilchrist, Hamilton, Lafayette, Levy, Madison, Nassau, Putnam, St. Johns, Suwannee, Taylor, Union, and Volusia
Central Region Orlando Office (407) 245-0440 Wildwood Office (352) 330-2749 Lakeland Office (863) 413-3360 Ft. Pierce Office (772) 468-4080	Brevard, Citrus, Hardee, Hernando, Highlands, Indian River, Lake, Marion, Martin, Okeechobee, Orange, Osceola, Polk, Seminole, St. Lucie, and Sumter
Suncoast Region Tampa (813) 233-4300 Ft. Myers (239) 338-1572	Charlotte, Collier, DeSoto, Glades, Hendry, Hillsborough, Lee, Manatee, Pasco, Pinellas, and Sarasota
Southeast Region West Palm Beach (561) 837-5564 Broward (954) 467-4218	Broward and Palm Beach
Southern Region (305) 349-1478	Dade and Monroe

Visit the APD Web site for current contact information www.apd.myflorida.com.

Visit the AHCA Web site at www.ahca.myflorida.com for the AHCA Area Offices contact information. The AHCA Area Offices contact information is also in Appendix A of the Florida Medicaid Provider General Handbook.