**Verification of Available Services**

**Client Name:** Click or tap here to enter text. **iConnect ID#:** Click or tap here to enter text.

**WSC Name:** Click or tap here to enter text.

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

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| **Section A. Natural Supports**  *Complete this section A. for all clients with natural supports. If the client does not have natural supports, skip to section B.* |
| **Statement of Parent, Legal Representative, or Other Caregiver’s Health Limitations**   1. Describe any health issue, disability, or other concern that the parent, legal representative, or other caregiver has that limits his or her ability to provide services or supports to the client requested through the iBudget Waiver. This may also include responsibilities for providing care to other dependents.  |  | | --- | |  |  1. Supporting documentation must be attached in iConnect that the WSC relied upon to make this factual statement. Any physical, medical, or mental limitation to care must be corroborated by an appropriate health care practitioner. Is supporting documentation attached in APD iConnect? Choose an item.   **Parent, Legal Representative, or Other Caregiver’s Work or School Schedule**   1. Does the parent, legal representative, or other caregiver’s work or school schedule limit his or her ability to provide services and supports to the client requested through the iBudget Waiver? Describe below.  |  | | --- | |  |  1. Documentation from the parent, legal representative, or other caregiver’s employer or school that was relied upon to make this statement must be attached in APD iConnect. Is employer documentation attached in iConnect? Choose an item. |
| **Section B. Services available through other government programs**  *Complete this section B. for all clients.* |
| **1. Managed Care Plan**  *If the client is not enrolled in a Managed Care Plan, skip to B.2.*   1. Name of Managed Care Plan: Click or tap here to enter text. 2. Description of services received through the Managed Care Health Plan: Click or tap here to enter text.   **2. Statewide Dental Managed Care Plan**  *If dental services are not requested through iBudget, skip to B.3*.   1. Why are the dental services not requested through the statewide dental managed care plan? Click or tap here to enter text. 2. If services were denied by the dental managed care plan, documentation must be attached in APD iConnect. Is dental denial documentation attached in iConnect? Yes  No   **3. Home Health and Therapy Services – Client Under 21**  *Complete this B.3. for all clients under the age of 21. If the client is 21 and over, skip to B.4.*   1. Describe Home Health services (including Personal Care and Nursing) that the client is receiving through Medicaid: Click or tap here to enter text. 2. If the client is not receiving Home Health or Therapy services, specify the status of accessing these services: Click or tap here to enter text.   **4. Therapy Services – Client Age 20 and Older**  *Complete this B.4. for clients age 20 and over. For clients under age 20, skip to B.5.*   1. Specify the frequency of Therapy services that the client is receiving from Medicaid.   Physical Therapy: Click or tap here to enter text.  Occupational Therapy: Click or tap here to enter text.  Respiratory Therapy: Click or tap here to enter text.  Speech Therapy: Click or tap here to enter text.  **5. Applied Behavioral Analysis (ABA) Services**  *Complete this B.5. for clients under the age of 21 who have service needs related to maladaptive behaviors. Skip to B.6. for clients 21 and over or clients who do not have maladaptive behaviors.*   1. Specify any behavioral services the client is receiving through Medicaid: Click or tap here to enter text. 2. If the client is not receiving behavioral services through Medicaid, specify the status: Click or tap here to enter text.   **6. Equipment and Supplies**  *Complete this B.6. for any client requesting consumable medical supplies or durable medical equipment from the iBudget Waiver. Skip to B.7. if no equipment or supplies are requested.*   1. Describe equipment and supplies that are received, including quantity if applicable through Medicaid: Click or tap here to enter text. 2. If the client requires equipment and supplies, specify the status of the WSC assisting the client to receive these services through Medicaid: Click or tap here to enter text.   **7. Medicare**  *Complete this B.7. for clients who have Medicare. Skip to B.8. if the client does not have Medicare.*   1. Is the client enrolled on a Medicare Special Needs Plan (D-SNP)? Choose an item. 2. Specify the amounts of each service received through Medicare.   Physical Therapy Click or tap here to enter text.  Occupational Therapy Click or tap here to enter text.  Speech Therapy Click or tap here to enter text.   1. List any other services, not including prescription drugs, that Medicare is providing. Click or tap here to enter text.   **8. Educational and Vocational Services**  *Complete this B.8. for clients who receive educational and/or vocational services. Skip to B.9. if the client does not receive educational and vocational services.*   1. Describe educational and vocational services being received. Include a schedule for when educational and vocational services are delivered. This includes primary, intermediate, secondary, postsecondary, and adult education programs. Click or tap here to enter text.   **9. Mental Health Services**  *If the client does not have a mental health diagnosis skip to B.10.*   1. If the client has a mental health diagnosis, describe the services received at this time. Click or tap here to enter text. 2. If no services have been received, describe the reason. Click or tap here to enter text.   **10. Other Government Resources (local, state, or federal)**   1. Identify any other government resource(s) the client is receiving. Click or tap here to enter text. |
| **Section C. Community Supports and Resources**  *Complete this section C. for all clients.* |
| 1. Identify community supports that the client is receiving and describe what the WSC has done to secure such resources for the client in the last year. Identify the specific agencies or organizations contacted, the dates contacted, and the outcomes.  |  | | --- | | Click or tap here to enter text. | |
| **Section D. Private Health Insurance**  *Complete this section D. for all clients who have private health insurance. For clients who do not have private health insurance, skip this section.* |
| 1. Name the insurance carrier(s) and describe the services and supports the client receives through private insurance.  |  | | --- | | Click or tap here to enter text. |  1. Describe services and supports requested and denied through private insurance.  |  | | --- | | Click or tap here to enter text. |  1. Is the documentation that the WSC relied upon to make the statement in D.2. attached in iConnect? Choose an item.   If no, explain why.   |  | | --- | | Click or tap here to enter text. | |

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

**WSC Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**WSC Signature (electronic is acceptable): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:** Click or tap here to enter text.