CF OPERATING PROCEDURE
NO. 160-13

STATE OF FLORIDA
DEPARTMENT OF
CHILDREN AND FAMILIES
TALLAHASSEE, May 1, 2003

Developmental Disabilities

STATEWIDE FORMS USED BY WAIVER SUPPORT COORDINATORS

1. Purpose. This operating procedure describes the process for selection and updating Developmental Disabilities Program (DDP) support coordination forms to be adopted statewide for the routine use by Waiver Support Coordinators. Further, this operating procedure lists the DDP support coordination forms approved for statewide use and their intended purpose.

2. Scope. This operating procedure applies to all Developmental Disabilities offices in each district and region.

3. Definitions. For the purposes of this operating procedure, the following definitions shall be understood to mean:

a. Waiver Support Coordinator means a department-approved, Medicaid-enrolled provider of support coordination services who assists individuals and their families/guardians to identify and choose supports and services based upon outcomes or goals identified by the individual. Each waiver support coordinator must enroll as a provider whether employed by an agency or a solo practitioner and must maintain a caseload not to exceed 36, or as defined by the legislature.

b. Developmental Disabilities Program Support Coordination Forms means forms approved for routine use statewide by Waiver Support Coordinators. Such forms are used by Waiver Support Coordinators to deliver information to the Developmental Disabilities Program in compliance with the Florida Medicaid Coverage and Limitations Handbook.

c. Approved Forms List means the list of Developmental Disabilities Program support coordination forms approved for routine use statewide by Waiver Support Coordinators (see Appendix A to this operating procedure).

4. Uniform Procedure for Use of Developmental Disabilities Program Support Coordination Forms. The Developmental Disabilities Program central office and all districts/regions (in order to assure uniformity of function of Developmental Disabilities Program support coordination forms to be routinely used by Waiver Support Coordinators) will use the following protocol:

a. Developmental Disabilities Program district/region offices will make use of Developmental Disabilities Program support coordination forms and provide appropriate training and technical assistance to all waiver support coordinators on proper use of the forms.

b. Only the Developmental Disabilities Program support coordination forms from the approved forms list will be required of waiver support coordinators on a routine basis.

c. There may be situations that warrant the use of additional DDP forms for a specific purpose for a limited timeframe. This should be limited to individual circumstances and districts/regions must receive approval from the central office prior to implementation.

5. Uniform Procedure for Selection of Developmental Disabilities Program Support Coordination Forms. The Developmental Disabilities Program central office and all districts/regions (in order to select and maintain an approved forms list of support coordination forms to be routinely used by Waiver Support Coordinators) will use the following protocol:

a. The Developmental Disabilities Program central office will be responsible for maintaining the approved forms list of support coordination forms.

b. The Developmental Disabilities Program central office is responsible for any additions to the approved forms list. Developmental Disabilities Program district/region offices will submit to the central office all requests for adding forms to the approved forms list.

c. The Developmental Disabilities Program central office is responsible for any deletion of approved forms from the approved forms list. Developmental Disabilities Program district/region offices will submit to the central office all requests for deleting forms from the approved forms list.

d. Upon receipt of a request for additions or deletions of forms from the approved forms list, the Developmental Disabilities Program central office will forward the request and supporting documents to the district/region offices for review and comment.

e. Upon receipt of the comments from the Developmental Disabilities Program district/region offices, the central office will make a recommendation to the Developmental Disabilities Program Director. Any additions or deletions to the approved forms list must be approved by the Developmental Disabilities Program Director.

f. Once the Developmental Disabilities Program Director approves additions or deletions to the list, the central office will notify the district/region offices of the date of implementation of the change and provide copies of the new approved support coordination forms.

6. Uniform procedure for amending or changing Developmental Disabilities Program Support Coordination Forms. The Developmental Disabilities Program central office and all districts/regions (in order to maintain statewide uniformity of the support coordination forms to be routinely used by Waiver Support Coordinators) will use the following protocol.

a. The Developmental Disabilities Program central office will be responsible for maintaining the approved forms list of DDP support coordination forms.

b. The Developmental Disabilities Program central office is responsible for any changes to the support coordination forms to be routinely used statewide by Waiver Support Coordinators.

c. Developmental Disabilities Program district/region offices will submit to the central office all requests for changes to approved support coordination forms.

d. Upon receipt of a request for changes to forms from the approved forms list, the Developmental Disabilities Program central office will forward the request and supporting documents to the district/region offices for review and comment.

e. Upon review of comments from the Developmental Disabilities Program district/region offices, the central office will make a recommendation to the Developmental Disabilities Program Director. The Developmental Disabilities Program Director must approve any changes to the support coordination forms.

f. Once approved, the new form will be distributed to the Developmental Disabilities Program district/region office for use statewide, supplanting any and all previous versions of that form.

BY DIRECTION OF THE SECRETARY:

CELESTE PUTNAM
Acting Assistant Secretary for
Programs

Approved Forms List: Forms Required of Waiver Support Coordinators

In order to ensure uniformity and reduce duplication of effort across districts/regions, we are identifying the only forms that should be used by waiver support coordinators. They are as follows:

1. Home and Community-Based Services Waiver Programs Eligibility Work Sheet (CF-DS 3066)
2. Support Plan/Support Plan Update Information Sheet (CF-DS 2051A)
3. Support Plan/Support Plan Update (CF-DS 2051B)
4. Request for Annual Support Plan Extension (CF-DS 2064)
5. Cost Plan (CF-DS 3065)
6. Consent To Obtain or Release Confidential Information (CF-DS 3017)
7. Personal Outcome Measures Outcome Notes (CF-DS 2051C)
8. Prior Service Authorization Request – Form 1 (CF-DS 2065)
9. Prior Service Authorization Request – Request for Reconsideration (CF-DS 2066)
10. Service Authorization (CF-DS 2052)
11. Support Coordination Transfer Checklist of Central Record (CF-DS 3072)
12. Residential Placement Referral (CF-DS 3073)

agency for persons with disabilities
State of Florida

Agency for Persons With Disabilities
Support Plan/ Support Plan Update
Page 1 of _____

Support Plan Development Date:		**Support Plan Effective Date:**		
Support Plan Updates:	First:	**Second:**	**Third:**	**Fourth:**

Name:			**Legal Status:**		
DOB:		SSN:	**Guardians Name:**		
Medicaid #:			**Guardian Type/Area:**		
Residential Address:			**Guardian's Phone:**		
			Guardian's Address:		
Phone: **Home:**		**Work:**			
Home District:			**Residence/ Level of Care Codes**		
District of Residence:			**Foster Care/ Small Group Care Codes**		
Support Plan Written By:				**Intense**	**Moderate**	**Minimal**
Name of Support Coordinator			**Group Home And Residential Habilitation Center:**		
			A	**B**	**C**	D	E
			ICF/DD Level of Care:		

Personal Attributes (interest, talents, attributes, gifts, strengths, preferences, and communication style). How would you describe yourself to others? What things are you good at doing? What type of activities do you most enjoy? Who provided the information?

Future View (personal goals for the future (3-5 years). Things you want different in your life in the next 3-5 years. Where do you eventually see yourself living and working? What will you be doing for fun?

Agency for Persons With Disabilities

Support Plan/ Support Plan Update Page of

Name:	
Support Plan Effective Date:	

Life Area	**Present situation** (in the life areas of home, daily activities/work/school and personal/social). **Include a brief functional description of : (1) capabilities, (2) daily activities, (3) interactions with others, (4) valued roles, (5) community opportunities, (6) supports and services currently being received (both paid and unpaid), (7) issues or concerns (health, challenging behaviors or situations) the person is experiencing, (8) any changes the person wants in their present situation, and (9) important relationships in the person's life. Also include a brief summary of personal goals achieved in the past year and/or the status toward completion. (Add additional pages if needed). This summary will serve as the annual report.**

Agency for Persons With Disabilities

Support Plan/ Support Plan Update Page_ of__

Name:	
Support Plan Effective Date:	

Health Summary: Describe any health concerns and how it impacts on the person. What health concerns do you have? Describe the preventative health services that are needed to stay healthy.
(Attach additional pages and/or reports if needed.)

Who helps you manage your health care?		**Relationship:**		**Phone:**	

Assistive or Adaptive Equipment:		**Yes**		**No**	

Identify glasses, dentures, equipment, etc. What adaptive equipment do you use and what is it used for?

Medications:		Yes, list below		No

Identify all meds: The name and dosage schedule, purpose and any problems/side effects being experienced. Any r problems, e.g., drowsiness, rashes, etc?

Current as of:			
Medication Name	Dosage and schedule	Purpose or Diagnosis	Problems/ Side Effects Noted

Note: Pages A, B, and C should be completed by the Support Coordinator Prior to the Support Plan Meeting.

Agency for Persons With Disabilities Support Plan/ Support Plan Update- Page of

Name:	
Support Plan Effective Date:	

Personal Goals for Upcoming Year: What do you want to accomplish this year? What are the most important things you want to see happen in your life?	***Support/Services Needed:** Include all natural, generic, community and paid supports. Identify the type of service and who is responsible. (include only those services needed to accomplish personal goals.)
Other supports/Services Needed: Routine services that are not specifically related to the accomplishment of personal goals but are essential supports/services needed to ensure that the person's health and safety are maintained.	**Who will take the Lead?** Identify the person who will take the lead on scheduling appointments or other type of actions needed.

NOTE: Support coordinator has overall responsibility to coordinate the provision of all supports and services. Support coordinator is identified as responsible in situations in which the coordinator has a definite role/ specific task the coordinator is responsible for completing.

Name:	
Support Plan Effective Date:	

Individual/Guardian Consent: I have participated in the development of the plan and I agree to the contents. I have been informed of my due process rights under Florida Statutes 120 and that I may appeal any portion of this plan. I understand that the purpose of this plan is to identify my or my family's strengths, needs, preferences, and resources to help promote a positive quality of life. I understand that if my needs change, an update to this support plan may be needed. Supports should be identified according to my or my family's needs regardless of the availability of funds. Supports and services needed to meet my needs will be sought from my personal resources, community resources and government resources. When government resources are necessary, they shall be provided based on the availability of general revenue funds.

Individual's Signature:	**Date:**		**Date Copy Sent:**	
	Date Copy Sent to Area:			
Legal Representative's Signature:	**Date:**		**Date Copy Sent:**	
Printed Name and Telephone Number:	**Relationship (parent, guardian advocate, POA)**			

Signature of Support Plan Participants			
Relationship	**Name /Address/Program (if applicable)**	**Date of Signature**	**Date Copy Sent:**

Signature of Support Plan Participants: Enter the relationship, and the name(s)/address/program (if applicable) of the individual(s) who are invited by the person and participated in the development of the support plan, and the date the support plan was signed. Provide the date the support plan was provided/mailed to the participant.

agency for persons with disabilities
State of Florida

AGENCY FOR PERSONS WITH DISABILITIES

Client Information Sheet

Date:		**Name:**	
		SSN:	**County**
		Address:	
Primary Disability:			
Secondary Disability:		**Phone #:**	**Day:** **Evening:**
Referral Date:		**Email:**	
Referred By:		**TDD (Telephone Device for Deaf)**	
Area of Residence:		**DOB:**	**Age:** **Male:** **Female:**
		Legal Status:	
		Guardian Type/ Area:	
Insurance/ Resources: (Please complete)		**Directions to Home:**	
Health Insurance Company:			
Policy #:			
Medicare #:			
Medicaid #:			
Military Benefits:			
Income Amount: **SSI** **SSA:** **Other**			
Other Resources:)			
Background and Personal Information		**Place of Employment**	
Other Names/ Nick Names:		Employer:	
Primary Language In Home:		**Address:**	
Are Interpreter Services Needed?	☐ **Yes** ☐ **No**		
If yes, what kind or language?			
Available Transportation:	**None** **Self** **Bus**	**Phone #:**	Ext.
Taxi **Family** **Walk** **Volunteer**			
Other(Specify):			

Name:	
SSN:	

People to Contact		
Relationship	Name/Address	Phone #/Email
Guardian		
Mother		
Father		
Other Relatives		
Friends		

Programs/ Agencies Involved with Individual/ Family (include health care providers)			
Agency/Program:			
Contact Person:		Phone Number:	
Address:			
Agency/Program:			
Contact Person:		Phone Number:	
Address:			
Agency/Program:			
Contact Person:		Phone Number:	
Address:			
Agency/Program:			
Contact Person:		Phone Number:	
Address:			
Agency/Program:			
Contact Person:		Phone Number:	
Address:			

Additional Information:		Area	
		Contact Person:	
		Phone Number:	
Name/Title of Person Completing This Form:		Support Coordinator:	
Name:		Name:	
Title:		Phone Number:	

agency for persons with disabilities
State of Florida

Agency for Persons with Disabilities

Consent to Obtain or Release Confidential Information

Individuals Name:		Date of Birth

☐ **Permission for Obtaining Record Information**. I hereby give my permission and consent to the Agency for Persons with Disabilities or its representative to obtain the specified protected health information on the above named consumer from agencies, individuals and institutions identified below OR

☐ **I hereby request the specified protected health information on the above named consumer be sent to me OR**

☐ **Permission for Release of Information**. I hereby give my permission for the Agency for Persons with Disabilities or its representative to discuss matters related to my services or goals or to release protected health information to the following person, agency or institution.

The information requested below will be used/disclosed for the following purposes:

	Medical Reports		Social Service Reports
	Academic Records and Plans		Speech and Hearing Reports
	Habilitation Plans/Support Plans		Physical Therapy Reports
	Psychological Reports		Occupational Therapy Reports
	Other (Please specify):		

Name, address, or fax # of individual or agency from whom information is to be obtained:

Name, address, or fax # of individuals or agencies to whom information is to be provided:

1. **I understand that information may only be re-released with my approval except as required by law. However, I understand that if the receiver of the information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be re-disclosed and no longer protected by these regulations.**
2. **I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain services or my eligibility for benefits. I may inspect or copy any information used/disclosed under this authorization.**
3. **I understand that I may revoke this authorization in writing at any time by contacting my support coordinator, except when the requested information has already been sent, based on this authorization.**
4. **I certify that I understand the above statements either personally or through my legal representative.**
5. **I also understand that this form is valid for no longer than 90 calendar days unless otherwise indicated. I understand that I may specify that it be for a shorter period of time.**

Expiration date: _____

Signature of Client or Legal Representative | **Printed Name/Relationship to client** | **Date**

If this authorization has been signed by a personal representative (above) on behalf of an individual, his/her authority to act on behalf of the individual must be set forth here:

agency for persons with disabilities State of Florida	Developmental Disabilities Program **Residential Placement Referral**					
Support Coordinator:						
Agency:						
Address:						
Telephone Numbers	**Home:**		**Office:**		**Pager/ Mobile:**	
Consumer:						
Date of Referral:						
District/ Region:						

	Checklist for Referral Packet
	Completed Residential Placement Referral form.
	Copy ICG
	Current Support Plan and the Support Planning Information.
	Additional documents as follows:
	Psychological Evaluations
	Psychiatric Evaluations
	Critical Medical Reports
	Skills Assessments
	Behavioral Assessments
	Other (Specify)

1. Consumer:		Age:		DOB:	

2.. Legally Competent Adult:		Yes		No	
If no, guardian's name and relationship					

3. Reason for Current Referral (brief History, description of current situation and presenting problems:

4. Level of Mental Retardation if applicable:

	Mild		Severe		Moderate		Profound

5. Important Medical issues (describe, if any, i.e., seizure disorder, heart problems, diabetes, hypertension, etc.):

Ambulation status:		Height:	
Allergies:		Weight:	
Special Diet:			
Vision:		Hearing:	

6. Physical Handicaps (describe, if any):

7. Behavioral Issues (Describe, if any, i.e., non-compliance, verbal aggression, physical aggression, etc. Identify any significant behaviors which could pose a risk to other residents in a group setting.):

8. Previous Residential Placement History if available, provide facility names, dates of placements, and reason(s) for withdrawal):

9. ICG Completed:

Score:		**Functional**		**Behavior**		**Physical**		**Overall**

For **behavioral** scores of 3,4, or 5:

Behavioral Assessment Completed:		Yes		No	
If no, what is the status:					
If yes, attach assessment.					
Reviewed by Local Review Committee:		Yes		No	
LRC Recommendations:					

For **Physical** scores of 3,4, or 5:					
Nursing Assessment Completed:		**Yes**		**No**	
If no, what is the status:					
If yes, attach assessment.					
10. Medicaid Wavier Status:	**Check all that apply.**				
	On MW cap		**Ineligible for Medwaiver cap**	**Date:**	
	Referred for crisis funding				
	Eligible for Medwavier funding				

11. Adaptive Skills Assessment (Check appropriate column):			
	Independent	**Requires Assistance**	**Dependant**
Basic Skills			
Eating			
Toileting			
Personal Hygiene			
Dressing			
Receptive Communication			
Expressive Communication			
Ability to Evacuate			

Comments:

12. Consumer/ Family requests placement in		
	Local County only: (specify county)	
	Within region	
	Anywhere in state	

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State of Florida

Attachment A
CENTRAL RECORD TRANSFER FORM

Consumer's (Legal) Name: _____

SS#_____D.O.B._____

(New) Address: _____

_____
(city) (state) (zip)

Reason For Transfer:_____

Comments: _____

Transferred Record From: Area or Agency_____

Name of person transferring record:_____

==========

Area to Receive Record for Transfer: _____

Transfer to: (Name & Address) _____

_____

_____

Transferred Record Received By: Area or Agency:_____

Name of person Receiving record:_____

X_____
Signature Date

PLEASE SEND SIGNED COPY OF THIS FORM TO:

NAME : _____

AREA : _____

ADDRESS: _____

To be completed for waiver participants:

Please check as completed:			
	Current Support Plan.		Current Information Sheet.
	Current Medicaid Eligibility Worksheet.		Current Case Notes.
	Current Cost Plan.		ABC updated.
	All documents filed in central record.		Current ICG.

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State of Florida

CASE CLOSURE

Consumer's (Legal) Name: _____

SS#_____D.O.B._____

Address: _____

_____
(city) (state) (zip)

Death: Date _____ Death Review Required**:** ☐ **Yes** ☐ **No**

Place of Death (i.e., GH, family home, hospital, other) _____

Loss of Contact: List efforts made to locate the individual and dates

_____

_____

_____

_____

Services No Longer Needed or Not Appropriate: List Reason(s)

_____

_____

Moved Out of State: (new address, if known)

_____

_____
(city) (state) (zip)

Other: _____

Verified By: Area Office Staff or Unit Supervisor:_____
(printed name)

X_____ _____ **ABC Updated** _____
Signature Date (initial)

Send Central Record to: Closed Files ☐ **Archives** ☐

agency for persons with disabilities
State of Florida

Agency for Persons with Disabilities
Request for Annual Support Plan Extension

TO:						
FROM:						
DATE:						
Area/ Region:						
Customer Name:						
Current annual Support Plan Date:						
Extension Requested for:		30 days		60 days		90 days, or
	Other (Specify):					
Justification for Extension:						
APD Authorizing Signature:				**Date:**		

agency for persons with disabilities
State of Florida

Agency for Persons with Disabilities
Outcome Notes

Name:		**Interviewer:**	
SSN:		**Dates:**	
District:			

Place a yes (Y) or no (N) in the appropriate column for the presence or absence of each outcome or individualized support.	OUTCOME	INDIVIDUAL SUPPORT	List in the appropriate space any reason why an outcome or individual support was not present
1. Personal Goal (Working Toward)			Outcome
			Support
2. Choose Live (Options)			Outcome
			Support
3. Choose Work (Options)			Outcome
			Support
4. Intimate Relationships (Satisfaction)			Outcome
			Support
5. Satisfied Services (Expectations)			Outcome
			Support

6. Satisfied Personal Life (Satisfaction)			Outcome
			Support
7. Daily Routine (Options)			Outcome
			Support
8. Privacy (Satisfaction)			Outcome
			Support
9. Personal Information - Share			Outcome
			Support
10. Use Environments (Maximum Use)			Outcome
			Support
11. Integrated Environments (W/O Disabilities)			Outcome
			Support
12. Participate in Community (Satisfaction)			Outcome
			Support

13. Interact in Community (Satisfaction)			Outcome
			Support
14. Social Roles (Satisfaction)			Outcome
			Support
15. Friends (Satisfaction)			Outcome
			Support
16. Respected			Outcome
			Support
17. Choose Services (Options)			Outcome
			Support
18. Personal Goals			Outcome
			Support
19. Natural Supports (Satisfaction)			Outcome
			Support

20. Safe			Outcome
			Support
21. Exercise Rights			Outcome
			Support
22. Treated Fairly			Outcome
			Support
23. Best Health (Person Defines)			Outcome
			Support
24. Abuse and Rights (Free Distress)			Outcome
			Support
25. Continuity and Security			Outcome
			Support
Other Comments:			