



# Florida Medicaid

DEVELOPMENTAL DISABILITIES  
INDIVIDUAL BUDGETING WAIVER SERVICES  
COVERAGE AND LIMITATIONS HANDBOOK

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**Agency for Health Care Administration**

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

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**How to Use the Update Log**

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**Introduction**

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

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**Obtaining the Handbook Update**

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

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**Explanation of the Update Log**

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

**Update** describes the change that was made.

**Effective Date** is the date that the update is effective.

<b>UPDATE</b>	<b>EFFECTIVE DATE</b>
Replacement Handbook	_____

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DEVELOPMENTAL DISABILITIES  
INDIVIDUAL BUDGETING WAIVER SERVICES  
COVERAGE AND LIMITATIONS HANDBOOK  
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## INTRODUCTION TO THE HANDBOOK

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### Overview

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### Introduction

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

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### Background

There are three types of Florida Medicaid handbooks:

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

The current Florida Medicaid provider handbooks are posted on the Medicaid fiscal agent's Web site at [www.mymedicaid-florida.com](http://www.mymedicaid-florida.com). Select Public Information for Providers, then Provider Support, and then Provider Handbooks.

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### Federal and State Authority

The following federal and state laws govern Florida Medicaid:

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

### In This Chapter

This chapter contains:

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

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**Handbook Use**

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**Purpose**

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

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

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**Provider**

Term used to describe any entity, facility, person, or group who is enrolled in the Medicaid program and provides services to Medicaid recipients and bills Medicaid for services.

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**Recipient**

Term used to describe an individual enrolled in Florida Medicaid.

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**Provider  
General  
Handbook**

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

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**Coverage and  
Limitations  
Handbook**

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

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**Reimbursement  
Handbook**

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

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## Characteristics of the Handbook

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

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## Handbook Updates

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### 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 “Effective Date.”

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### Handbook Update Classifications

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

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

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

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### Identifying New Information

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

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### Identifying Deleted Information

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

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### Final Published Handbook

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

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## CHAPTER 1 QUALIFICATIONS AND ENROLLMENT

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### Overview

#### Introduction

This chapter describes Florida Medicaid’s Developmental Disabilities Individual Budgeting (iBudget) Waiver services, the specific authority regulating these services, and provider qualifications and enrollment.

#### Legal Authority

Home and community-based services (HCBS) waivers 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.

Section 409.906, Florida Statutes (F.S.), and Rule 59G-13.070, Florida Administrative Code (F.A.C.), authorize the application for the Florida Medicaid Developmental Disabilities Individual Budgeting Waiver. The iBudget Waiver is referenced in Chapter 393, F.S., and Rule 65G-4.0210, F.A.C.

#### In This Chapter

This chapter contains:

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### Purpose

#### Introduction

The iBudget Waiver 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 both federal and matching state dollars.

This waiver reflects use of an individual budgeting approach and enhanced opportunities for self-determination. The purpose of this waiver is to:

- Promote and maintain the health of eligible individuals with developmental disabilities.
- Provide medically necessary supports and services to delay or prevent institutionalization.
- Foster the principles of self-determination as a foundation for services and supports.

**Purpose**, continued

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**Introduction**,  
continued

Providing an array of services, from which eligible recipients can choose, allows them to live as independently as possible in their own home or in the community and achieve productive lives. Eligible recipients can choose between the iBudget Waiver or an intermediate care facility for individuals with intellectual disabilities (ICF/IID).

The iBudget Waiver enhances each recipient'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. Recipients will have an opportunity to shift funds between services, within a service family, as long as health, safety, and welfare needs are maintained, enabling them to respond to changing needs.

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**Medicaid  
Provider  
Handbooks**

This handbook must be used in conjunction with the Florida Medicaid Provider Reimbursement Handbook, CMS-1500 which contains information about specific procedures for submitting claims for payment, and the Florida Medicaid Provider General Handbook, which describes the Florida Medicaid program.

Note: The Florida Medicaid provider handbooks are available on the Medicaid fiscal agent's Web site at [www.mymedicaid-florida.com](http://www.mymedicaid-florida.com). Select Public Information for Providers, then Provider Support, and then Provider Handbooks. All of the Florida Medicaid provider handbooks are incorporated by reference in Rule Division 59G, F.A.C.

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**Definitions**

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**Agency**

A business or organization enrolled to provide a waiver service(s) that has two or more employees to carry out the enrolled service(s), including the agency owner. An agency or group provider for rate purposes is a provider that employs staff to perform waiver services. For example, a solo or independent provider that hires only subcontractors to perform waiver services is not considered to be an agency or group provider for rate purposes.

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**Agency for  
Health Care  
Administration**

The single state Medicaid agency responsible for the administration of the iBudget Waiver. The Agency for Health Care Administration (AHCA) has final authority on all policies, procedures, rules, regulations, and handbooks pertaining to the waiver.

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**Agency for  
Persons with  
Disabilities**

The Agency for Persons with Disabilities (APD) is responsible for the day-to-day operation of the iBudget Waiver.

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**Definitions**, continued

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**Allocation, Budget, and Contract Control System**

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

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**Amount, Duration, Frequency, Intensity, and Scope**

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 for which a service authorization is approved. Located on the service authorization form as the beginning and ending dates.
  - 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 recipient, the waiver support coordinator (WSC), and the 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.
- 

**Annual Report**

A report of the supports and services received by a recipient throughout the year, a description of progress toward meeting individually determined goals, and any pertinent information about significant events that occurred in the recipient's life during the previous year.

An annual report must be submitted to the WSC 60 days prior to the support plan's effective date to allow time for the WSC to include any pertinent information in the support plan. The third quarterly summary can serve as the annual report. The WSC is responsible for providing this report to the recipient or legal representative.

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**Approved Services**

Waiver services that are approved by APD or its contracted reviewers for a specific recipient and identified on the recipient's approved cost plan.

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**Definitions**, continued

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**Behavior Analysis Services Plan**

The implementation plan for behavior analysis services.

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**Budget Allocation**

The waiver funding approved for a recipient to expend on medically necessary iBudget Waiver services during the dates of service on the approved cost plan.

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**Budget Allocation Formula**

The formula used as an element of determining a recipient's budget allocation, as required by the Florida Legislature.

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**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:

- Recipient 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)
  - Service delivery information (including the original, or a copy of, the waiver eligibility determination, the current support plan, cost plan or written authorization of services, and implementation plans, as required)
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**Community Integrated Settings**

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

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**Community Supports**

Resources available to all community members.

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**Cost Beneficial**

The best value for goods or services received in relation to the money spent.

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**Cost Plan**

The document or electronic record that lists all approved waiver services for a recipient and the maximum cost of each waiver service. Changes to the cost plan can be made throughout the year at the request of the recipient or their legal representative.

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**Definitions**, continued

<b>Cost Plan Year</b>	The cost plan year spans the state fiscal year, which begins July 1 <sup>st</sup> and ends June 30 <sup>th</sup> .
<b>Daily Attendance Log</b>	A list naming the recipients who received a particular waiver service, the time period (e.g., 8:30 a.m. to 2:30 p.m.), and the dates during the month when the service was provided, including the name of the service provider.
<b>Daily Progress Note</b>	A provider's summary of the waiver service delivered on the day that the service was delivered with documenting the a recipient's progress noted; steps taken to monitor and document the recipient's health and safety, and how the provider or intervention addressed the recipient's goal(s). For providers that complete both service logs and daily progress notes, the two can be combined, but must contain all information required for both documents.
<b>Direct Service Provider</b>	A person age 18 years or older who has direct face-to-face contact with a recipient or has access to a recipient's living areas or to a recipient's funds or personal property, as defined in section 393.063, F.S.
<b>Family Home</b>	The primary residence occupied by the recipient and member(s) of the family including parents and siblings, including stepchildren, stepparents, stepsiblings and in-laws.
<b>Home Accessibility Assessment</b>	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.
<b>iBudget Florida System</b>	The information technology system used in conjunction with APD's ABC system and the Florida Medicaid Management Information System to administer the iBudget Waiver.
<b>Implementation Plan</b>	A plan developed by the provider with direction from the recipient and includes the name of the recipient receiving services. The implementation plan details 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 recipient's progress in achieving the support plan goal(s).
<b>Individually Determined Goal</b>	The goals a recipient has for their life as reflected in the support plan.

**Definitions**, continued

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**Legal Representative**

For recipients under the age of 18 years, the legal representative could be the parent(s) or a person appointed by the Florida court to represent the child or anyone designated by the parent(s) of the child to act in the parent(s)' behalf (e.g., due to military absence).

For recipients age 18 years or older, the legal representative could be the recipient, anyone designated by the recipient through a Power of Attorney or Durable Power of Attorney, a medical proxy under Chapter 765, F.S., or anyone appointed by a Florida court as a guardian or guardian advocate under Chapter 393 or Chapter 744, F.S.

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**Licensed Residential Facility**

Facilities providing room and board and other services to waiver recipients.

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**Meaningful Day Activity**

Choices made by recipients regarding how to use their time in order to gain direction, purpose, and quality in their daily lives. The recipient'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.

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**Medicaid Waiver Services Agreement**

The contract between APD and providers of waiver services for individuals with developmental disabilities.

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**Definitions**, continued

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**Medical  
Necessity/  
Medically  
Necessary**

In accordance with Rule 59G-1.010(166), F.A.C., “[T]he medical or allied care, goods, or services furnished or ordered must:

(a) Meet the following conditions:

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

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

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**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).

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**Monthly  
Summary**

A written summary by the waiver provider of the services billed during that month, listing the month’s activities, a report of the recipient’s progress toward achieving support plan goals, and the recipient’s name. The monthly summary is based on applicable daily service logs or daily progress notes, all of which must be maintained by the provider. For providers doing monthly summaries, the ninth month of the support plan is the annual report.

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**Definitions**, continued

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<b>Natural Supports</b>	Refers to services or supports that are available from the individual's family members, neighbors, or friends and for which no payment for the service or support is provided. A consideration of the availability of natural supports includes, but is not limited to consideration of the recipient's caregiver(s) age, physical and mental health, travel and work or school schedule, responsibility for other dependents, sleep, and ancillary tasks necessary to the health and well-being of the recipient.
<b>Own Home</b>	A house, apartment, or comparable living space meeting community housing standards, which the recipient chooses, owns or rents, controls, and occupies as a primary place of residence.
<b>Person-Centered Planning</b>	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 involving the recipient and significant people in the recipient's life that they choose to participate in identifying the goals and outcomes considered most important and the supports needed to achieve them.
<b>Plan of Remediation</b>	A plan of proposed corrective actions developed by the provider and agreed to by APD that addresses the improvements needed for Medicaid waiver services cited as below standard or non-compliant by APD or AHCA or their authorized agent.
<b>Prudent Purchase</b>	A purchase 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 as the most reasonable and economical approach necessary to meet that need.
<b>Quarterly Summary</b>	A written summary compiled by the provider of the activities that took place during each quarter, including the recipient's progress toward achieving support plan goals and for the Medicaid waiver services billed during in that quarter.
<b>Regional Office</b>	The APD local office responsible for managing a specific geographical region.
<b>Relative</b>	A family member, not responsible for the care of the recipient. This cannot be the parent of a minor child.

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**Definitions**, continued

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<b>Service Authorization</b>	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 the provider prior to service delivery.
<b>Service Family</b>	Categories that group related waiver services together. These include Life Skills Development, Environmental and Adaptive Equipment, Personal Supports, Residential Services, Support Coordination, Therapeutic Supports and Wellness, Transportation, and Dental Services.
<b>Service Log</b>	A form in paper or electronic format used by a provider to document service delivery that contains the name of the individual providing the service, the recipient receiving the service, the time in and out for the period services were provided, the name of the service, the dates of service provision, summary of services provided, and any follow up needed for the recipient's health and safety.
<b>Solo Provider</b>	A solo or independent provider who personally renders waiver services directly to recipients and does not employ others to render waiver services for which the rate is being paid. If the provider incorporates they are still considered a solo provider for rate purposes, unless they hire employees and meet the definition of agency.
<b>Subcontractor</b>	A subcontractor is an individual or business that signs a contract to perform part or all of the obligations of another's contract.
<b>Support Plan</b>	An individualized plan of supports and services designed to meet the needs of a recipient enrolled in the waiver.

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**Definitions**, continued

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**Zero Tolerance**

- Abuse, neglect, exploitation, or sexual misconduct related to the recipient by a provider of services must 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 recipient 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 recipient. The crime of sexual misconduct is punishable as a second degree felony.
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**Definitions, continued**

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**Zero Tolerance,**  
continued

- Recipient-on-Recipient 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; 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. 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.

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**Qualifications**

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**Agency or Group  
Provider**

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 must maintain personnel files documenting qualifications of all employees and their background screening results. Agencies may have subcontractors, but must retain the required employees to maintain agency status.

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**Architects**

Architects must 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.

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**Qualifications**, continued

**Behavior Analysis**

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

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

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

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**Behavior Assistant**

Behavior assistant providers must be age 18 years or 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.
    - Ninety classroom hours of instruction in applied behavior analysis from non-university, non-college classes or university and college courses. The 90 classroom hours of instruction will count as meeting the requirements of the 20 contact hours.
-

**Qualifications**, continued

**Behavior Assistant,**  
continued

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- Twenty contact hours of instruction in a curriculum meeting the requirements specified by the APD state 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. For initial certification, role play, videotaped feedback, or instructional videos demonstrating the skills being taught, must be included.
    - As proof of instruction, the provider must have either a certificate of completion or a college or university transcript and a course content description, verifying the applicant successfully completed the required instruction.
  - Certification by the Behavior Analyst Certification Board (BACB) as a Registered Behavior Technician™ (RBT™) may substitute for the requirements above.
  - Training in an APD approved emergency procedure curriculum consistent with Rule 65G-8.002, F.A.C., where providers work with recipients with significant behavioral challenges.

In-service training may be acquired through supervision and other training offered through instruction in applied behavior analysis or a related topic provided by the regional behavior analyst or other BACB approved CE provider. Supervision may qualify on an hour-for-hour basis on a single randomly selected audited case, up to 75 percent (six hours) of the required training requirements (eight hours). Some continuing education events may be sponsored by the regional offices and offered for free under the BACB certificate that designates APD's behavioral services unit as an approved continuing education provider.

All behavior assistant services provided must be authorized in a behavior assistant plan contained within the behavioral analysis service plan developed by the supervising behavior analyst or provider licensed under Chapter 490 or Chapter 491, F.S., reviewed and approved by the regional behavior analyst or designee.

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**Carpenters**

Carpenters and other vendors must hold local occupational licenses or permits, in accordance with Chapter 205, F.S.

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**Consumable Medical Supplies**

Home health agencies and durable medical equipment (DME) 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.

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

Independent vendors can also provide these services.

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**Qualifications**, continued

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**Contractors and Electricians**

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

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**Dental**

Providers of adult dental services must 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.

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**Dietitian Services**

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

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**Durable Medical Equipment**

In accordance with 42 CFR Part 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.

Medical supply companies and durable medical equipment suppliers must 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.

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**Engineers**

Engineers must be licensed in accordance with Chapter 471, F.S., and have one year of experience in environmental adaptation assessment and remodeling or be RESNA certified.

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**Environmental Accessibility Adaptations**

Any enrolled environmental accessibility adaptations (EAA) provider who provides construction work must present a qualified business number, as required in section 489.119, F.S. In accordance with section 489.113, F.S., subcontractors of a qualified business must hold the required state certificate or registration in that trade category.

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**Home Health and Hospice**

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

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**Hospitals**

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

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**Qualifications**, continued

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**Independent Vendors**

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

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**Licensed Residential Facility**

A licensed residential facility must be in accordance with the licensing requirements for the facility type, which include:

- Group homes and foster care facilities licensed in accordance with Chapter 393 and Chapter 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 Chapter 400 and Chapter 429, F.S.
  - Residential habilitation centers licensed in accordance with Chapter 393, F.S.
  - Any other type of licensed facility not mentioned above, having a capacity of 16 or more persons, if the recipient has continuously resided at the facility prior to or since August 8, 2001.
- 

**Life Skills Development-Level 1 (Companion)**

Providers and employees of agencies must be age 18 years or older, have a high school diploma or general education diploma (GED), 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 have 30 semester hours, 45 quarter-hours, or 720 classroom hours of college or vocational school.

Providers hired after January 1, 2015 must meet the qualifications outlined in this handbook.

Providers that transport recipients in the provider's private vehicle must, at the time of enrollment, show proof of a valid:

- Driver's license.
  - Vehicle registration.
  - Automobile insurance.
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**Qualifications**, continued

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**Life Skills  
Development-  
Level 2  
(Supported  
Employment)**

Providers of supported employment services must have a bachelor's degree from an accredited college or university with either:

- A bachelor's degree from an accredited college or university with a major in education, rehabilitative science, business or a related degree.
- An associate's degree from an accredited college or university.
- The equivalent of two years of college and two years of documented direct experience with recipients with developmental disabilities.
- One year of college and three years of documented direct experience with recipients with developmental disabilities.

Providers hired after January 1, 2015 must meet the qualifications outlined in this handbook.

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

The provider must 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 must 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 a high school or GED and one year of direct, care-related experience.
- 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 10 recipients per direct service staff for ADT 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 years or older at the time they are hired.

Providers hired after January 1, 2015 must meet the qualifications outlined in this handbook.

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**Qualifications**, continued

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**Occupational Therapy**

Providers of occupational therapy and assessment services must 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.

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**Personal Emergency Response System**

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

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**Personal Supports**

Providers and employees of agencies must be age 18 years or older, have a high school diploma or GED, 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 have 30 semester hours, 45 quarter-hours, or 720 classroom hours of college or vocational school.

Providers hired after January 1, 2015 must meet the qualifications outlined in this handbook.

Solo providers must have a high school diploma or a GED and at least one year of hands-on supervised experience working in a medical, psychiatric, nursing or child care setting or working with recipients who have an intellectual disability or have 30 semester hours, 45 quarter hours, or 720 classroom hours of college or vocational school.

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**Pharmacy**

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

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**Qualifications**, continued

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**Physical Therapy**

Providers of physical therapy and assessment services must 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. Assessments can only be performed by a licensed physical therapist. A licensed physical therapist assistant is not qualified to perform physical therapy assessments.

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

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**Plumbers**

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

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**Private Duty Nursing**

Providers of private duty nursing services must be nurses registered or licensed in accordance with Chapter 464, F.S., and within the scope of Florida's Nurse Practice Act for recipients who require ongoing nursing intervention in their own home or family home. 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.

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**Required Training**

All providers and their direct service staff must comply with training requirements as noted in the appendices of this handbook.

It is the responsibility of the provider to ensure that all direct service employees complete the appropriate training in a timely fashion and any training, which carries an expiration date is successfully completed prior to that expiration date.

The provider must maintain on file for review, adequate and complete documentation to verify participation, and the successful completion of, by its direct service employees or subcontractors, all required training courses and certifications. Proof of training, both required and in-service, is defined in the iBudget Training Requirements for iBudget Waiver providers, found in the appendices.

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, or and subcontractor. Further, a copy of the employee's completed training documentation will be provided to the employee upon request.

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**Qualifications**, continued

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**Residential Habilitation**

Residential habilitation services must be licensed residential facilities as defined in this handbook.

Providers of behavior focus and intensive behavior residential habilitation must be designated by the APD region office. Agencies must hire direct care providers who are age 18 years and older, must have one year supervised experience working in a medical, psychiatric, nursing, or child care setting, or experience working with recipients with developmental disabilities, or have 30 semester hours, 45 quarter-hours, or 720 classroom hours of college or vocational school.

Providers hired after January 1, 2015 must meet the qualifications outlined in this handbook.

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**Residential Nursing**

Providers of residential nursing services must be nurses registered or licensed in accordance with Chapter 464, F.S., and within the scope of the Nurse Practitioner Act. Nurses can provide these services as independent vendors or as employees of licensed residential facilities.

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**Respiratory Therapy**

Providers of respiratory therapy and assessment services must 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.

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**Respite Care**

Solo providers and employees of agencies must be age 18 years or older, have a high school diploma or GED, 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 have 30 semester hours, 45 quarter-hours, or 720 classroom hours of college or vocational school.

Providers hired after January 1, 2015 must meet the qualifications outlined in this handbook.

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.

An agency using more than one employee to provide services and billing for their services, must 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 must be licensed in accordance with Chapter 464, F.S.

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**Qualifications**, continued

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**Retail Stores**

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

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**Skilled Nursing**

Providers of skilled nursing services must be nurses registered or licensed in accordance with Chapter 464, F.S., and within the scope of the Nurse Practitioner Act.

Nurses can provide this service as solo vendors, 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.

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**Special Medical Home Care**

Group homes must be licensed in accordance with Chapter 393, F.S.

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

Providers of special medical home care must 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.

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**Specialized Mental Health Counseling**

Providers of specialized mental health services must be:

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

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

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**Qualifications**, continued

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**Speech Therapy**

Providers of speech therapy and assessment services must be speech-language pathologists or 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 year of post-degree 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 in accordance with Chapter 468, Part I, F.S.

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**Subcontractors**

Subcontractors are required to meet the same qualifications as the contractor for each type of service provision.

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**Support Coordinator**

Agency employed solo providers and support coordination supervisors requirements include:

- 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.

Agency employed WSC requirements include:

- 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.
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**Qualifications**, continued

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**Supported Living Coach**

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

Solo providers or employees of provider agencies must be 18 years of age and must have a bachelor's degree from an accredited college or university with a major in education, rehabilitative science, business or a related degree. In lieu of a bachelor's degree, a provider rendering this service must have an associate's degree or two years of college and two years of documented direct supervised experience with recipients with developmental disabilities, or one year of college and three years of documented direct supervised experience with recipients with developmental disabilities.

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**Transportation**

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.

All providers must comply with the following:

- Reporting requirements of Chapter 427, F.S., in order to provide and be reimbursed for transportation under the iBudget Waiver. Proof of vehicle inspection completed by an Automotive Service Excellence (ASE) certified mechanic, certified by the National Institute of Automotive Service Excellence. The vehicle inspection must be completed annually thereafter and provided to the regional office for inclusion in the provider's files. If the provider has a contract with the CTC, the provider must follow the vehicle inspection guidelines outlined in their contract with the CTC.
- A valid Florida driver's license and proof of current and valid automobile and liability insurance as required in Rule 41.2006, F.A.C.

Family members or friends or who are not considered "for hire" provider must have a valid driver's license and a current automobile and liability insurance.

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## Enrollment

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### Introduction

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.

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

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### Enrollment

Prior to enrollment, the provider applicant must comply with the following requirements:

- Be determined eligible by the APD regional office to enroll as a waiver provider
  - Not be currently suspended or terminated as a provider from Medicare or Medicaid in any state
  - Meet provider qualification and requirements described in this handbook
  - Complete a Medicaid Provider Enrollment application (which can be accessed from the Medicaid fiscal agent's Web site at [www.mymedicaid-florida.com](http://www.mymedicaid-florida.com))
  - Carefully review the description of each service for which the applicant wants to become enrolled prior to completing the waiver provider application
  - Complete the APD provider 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
  - Be age 18 years or older
-

**Enrollment**, continued

**Waiver Provider  
Background  
Screening  
Requirements**

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Provider applicants and enrolled providers must comply with the requirements of a Level II screening in accordance with section 435.04, F.S., and 409.907, F.S. All Medicaid Provider Applicants must retain their fingerprints in the secure web-based system, known as the “Care Provider Background Screening Clearinghouse” or “clearinghouse.”

All direct service employees of the provider with access to the recipient or the records of the recipient must also comply with the requirements in section 435.04, F.S., and 393.0655, F.S. All direct service providers must also:

- Have an Affidavit of Good Moral Character which must be notarized (the most current version of this is document can be obtained from the APD Web site, [www.apdcares.org](http://www.apdcares.org)).
- Have a local law enforcement check (this local check must be conducted in the jurisdiction which the applicant resides and can be conducted by either the local police or county Sheriff’s office).
- Employment reference checks must be performed.

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. Providers are responsible for maintaining official documentation of clearance from the Level II screening in their administrative records.

An employee who has undergone a fingerprint-based criminal history check by a specified agency before the clearinghouse is operational is not required to be checked again solely for the purpose of entry in the clearinghouse. Every employee who is or will become subject to fingerprint-based criminal history checks to be eligible to be licensed, have their license renewed, or meet screening or rescreening requirements by a specified agency once the specified agency participates in the clearinghouse will be required to submit their fingerprints and retain the fingerprints for reporting the results of searching against state incoming arrest fingerprint submissions.

To ensure that the information in the clearinghouse is current, the fingerprints of an employee required to be screened and included in the clearinghouse must be:

- Retained by the Department of Law Enforcement pursuant to section 943.05(2)(g) and (h) and (3), and the Department of Law Enforcement must report the results of searching those fingerprints against state incoming arrest fingerprint submissions to the AHCA for inclusion in the clearinghouse.
  - Resubmitted for a Federal Bureau of Investigation national criminal history check every 5 years until such time as the fingerprints are retained by the Federal Bureau of Investigation.
  - Subject to retention on a 5-year renewal basis with fees collected at the time of initial submission or resubmission of fingerprints.
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**Enrollment**, continued

**Change in  
Waiver Provider  
Status**

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If a waiver provider wishes to expand from solo to agency enrollment status, provide additional services, or 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 approve prior to the expansion.

Providers must notify the APD regional office and recipients as soon as they become aware of any change, sale, or transfer of ownership. Recipients receiving services must 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 must comply with all the requirements of a new applicant.

Before the APD regional office approves a provider for expansion, the regional office must determine that the provider meets the specific service requirements stipulated in this handbook. If a provider does not have a history of a quality improvement organization (QIO) review, this does not prevent consideration for expansion. Factors such as demand for service specific providers within a geographic area may be considered. With the promulgation of this rule, before the APD regional office approves a provider for expansion, the APD regional office must determine that the provider meets the respective handbook requirements for expansion to occur. The APD regional office must ensure that the provider has:

- An 85% or higher on their last QIO report.
- No identified alerts (i.e., background screening, medication administration, and validation, etc.).
- No outstanding billing discrepancies or plan of remediation.
- No adverse performance history in their home region.
- No open investigations or referrals to AHCA and DCF APD staff must check with the provider's home regional office to see if there is a history of complaints filed and logged on the remediation tracker, any open investigations or referrals to AHCA's Medicaid Program Integrity (MPI) or the Attorney General's Medicaid Fraud Control Unit (MFCU), or the Department of Children & Families (DCF).

The APD regional office has thirty calendar days to review and determine if a provider is in good standing to permit the expansion. The APD regional office must submit any intended denial for expansion to the Deputy Director for Operations or designee for approval and copy the Bureau of Quality Management.

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**Enrollment**, continued

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**Family Members**

Parents of minors, spouses, guardians, or legal representatives of waiver recipients are excluded from payment for any services under this waiver unless the recipient is enrolled in the Consumer Directed Care Plus program authorized under the 1915(j) state plan amendment. Parents or persons related by blood or marriage are considered to be natural supports and as such should be considered as providers of services without compensation.

Relatives not legally responsible for the care of a recipient cannot be a provider of any direct or indirect services and cannot be hired by or be subcontracted by an enrolled provider to perform any direct service to their relative, with the exception of personal supports, respite or transportation services. In those limited situations, the relative must meet the same qualification as other providers of the same waiver service. Reasons for using a relative not legally responsible for the care of the recipient must be documented and include the lack of available providers or the ability to meet specific scheduling needs of a recipient that other providers cannot meet. Convenience to the recipient, care or family alone is not adequate justification.

Family members can be a provider or can work for a provider but cannot provide direct services to their family member. Family members can be employed by providers, but cannot be paid for providing services to their relative.

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**Provider Agency Requirement**

A provider agency must maintain a personnel file for each employee, documenting that the employee meets the minimum education and experience requirements for the service the employee or direct care staff 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 or direct care staff at least five years after the date of service was billed.

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**Transportation**

The public transportation provider must be an enrolled Medicaid waiver provider.

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 Chapters 14-90, F.A.C.

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**Enrollment**, continued

**Transportation**,  
continued

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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 - ADT providers, which regularly provide services to recipients, can enroll as transportation providers to transport the recipients to and from the agencies' programs.

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).

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**CHAPTER 2**  
**COVERED, LIMITED, AND EXCLUDED SERVICES**

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**Overview**

**Introduction**

This chapter describes information about coverage, limitations, and exclusions. It also describes who can provide and receive services and any applicable service requirements.

**In This Chapter**

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## General Information

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### Medical Necessity

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

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### Medical Necessity Determinations

A medical necessity determination by a qualified professional (such as a registered nurse, board-certified behavior analyst, qualified developmental disabilities professional, or physician) must be obtained at least annually and periodically upon request to determine that the level of service requested continues to meet the level of the recipient's need, as well as being consistent with the service definition 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, the Agency for Persons with Disabilities (APD) will send a written request for more information to the waiver support coordinator (WSC) and the recipient, 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, APD will send a written denial of the service and notice of due process to the recipient, the family, or the legal representative and copy the WSC. The recipient can appeal decisions made by APD by requesting a hearing, accordance with 42 C.F.R. 431.200. A request for hearing must be made to APD, orally or in writing, within 30 days of the recipient's receipt of the denial, reduction, or termination of services. If the hearing request is received within the time frame stated above, then services will continue pending the outcome of the hearing. A prescription, as defined in Rule 59G-1.010, F.A.C., for a service or item does not in itself establish a "medical necessity" determination.

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### Funds and Allocation

The recipient, WSC, and service providers work together to accommodate the needs of the recipient within the recipient's waiver services allocation. Service amounts are determined at the onset of the planning process in order for cost plans to be based on the recipient's priorities.

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### Protection of Recipient Benefits

Only supported living and residential services providers 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 must assist the recipient to maintain a separate checking account or savings account for all personal funds.

Except as provided in this section for single trust accounts, the provider must 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. If a single account is maintained for recipients residing in licensed residential settings, there must be a separate accounting for each recipient's funds. There must be a monthly reconciliation with the account and the total on the bank statement, and this must be retained by the provider for review by APD or AHCA. The legal representative must be provided a copy of the reconciliation statement each month.

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**General Information**, continued

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**Protection of Recipient Benefits**, continued

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

Neither the provider, its employees, or 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, its employees, or 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 must regularly review bank statements and bank balances to ensure Medicaid eligibility is maintained and must 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, its employees, or family members of the provider serve as the landlord for recipients served by the provider, nor can they benefit from the sale of property to a recipient to whom they provide services.

Neither the waiver provider, its employees, or 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. The provider must keep on file, and available for APD inspection, a copy of each recipient's annual report to the Social Security Administration.

Supported living coaches may only be the representative payee under the following circumstances:

- There are no other available persons to serve as the representative payee
  - The individual entered supported living and representative payee arrangement prior to the promulgation of this handbook
  - Authorization is granted by the APD regional office for arrangements made after the promulgation of this handbook
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**General Information**, continued

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**Marketing Practices**

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

- Neither the provider nor subcontractors nor employees of the provider 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 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 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.
- 

**Freedom of Choice**

The iBudget Waiver is designed around individual choice. Recipients served through the waiver can select among enrolled, qualified providers and can change providers at any time within the funds allocated in their individual budget allocations. 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 and objectives set forth in their support plans, while ensuring the level of services provided is appropriate to address the recipient's needs.

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**Training**

Recipients and their families will be supported in exercising greater participant direction by receiving training on managing their individual budgets and making informed choices.

This training will be provided by WSCs through paid waiver services, and through other means. Recipients and families will also be provided relevant information on the variety of waiver and community supports that are available.

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**Support Plan Requirements**

The plan is based on the preference, interests, talents, attributes and needs of a recipient. The recipient or legal representative must be consulted in the development of the plan and must receive a copy of the plan and any revisions made to the plan. Each plan must include the least restrictive and most cost-beneficial environment for accomplishment of the objectives for individual progress and a specification of all services authorized. This also includes identification of natural and community supports as well as paid services. The plan must include provisions for the most appropriate level of care for the recipient. The ultimate goal of each plan must include provision for the most appropriate level of care for the recipient. The ultimate goal for each plan must be to enable the recipient to live a dignified life into the least restrictive setting, appropriate to the recipient's needs. This document is reviewed, signed, and dated by the recipient and legal representative prior to its implementation.

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**General Information**, continued

**Service Families**

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

<b>Group</b>	<b>Service Family</b>	<b>Services and Subservices</b>
1	Life Skills Development	Level 1 - Companion
		Level 2 - Supported Employment
		Level 3 - Adult Day Training
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
		Dietitian 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



**General Information**, continued

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**Who Can Receive**

Individuals 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 intermediate care facility for individuals with intellectual disabilities (ICF/IID) and must be eligible for Medicaid under one of the program codes described in the Florida Medicaid Provider General Handbook.

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**Medicaid Eligibility**

Individuals who are not already eligible for Medicaid benefits through Supplemental Security Income (SSI), Medicaid for Adult Disabled (MEDS-AD), or Temporary Assistance to Needy Families (TANF) 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 (DCF). Individuals can apply for eligibility online at [www.myflorida.com/accessflorida](http://www.myflorida.com/accessflorida).

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**APD Eligibility**

APD maintains the statewide waitlist of individuals waiting for waiver services. Enrollment in the iBudget Waiver is available only when APD has determined it has sufficient funding appropriated to offer an enrollment to an individual, when a review of the individual's diagnosis and related characteristics indicate that the ICF/IID level of criteria has been met, and when a determination of Medicaid eligibility has been made.

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**Conditions Under Which a Recipient is Ineligible for the Waiver**

When a recipient is enrolled in the iBudget Waiver, that recipient remains enrolled in the waiver position allocated unless the recipient becomes disenrolled due to one of the following conditions:

- The recipient or legal representative chooses to terminate participation in the waiver.
  - The recipient moves out-of-state.
  - The recipient loses eligibility for Medicaid benefits and this loss is expected to extend for a lengthy period.
  - The recipient no longer needs waiver services.
  - The recipient no longer meets level of care for admission to an ICF/IID.
  - The recipient 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).
  - The recipient is no longer able to be maintained safely in the community.
  - The recipient becomes enrolled in another home and community-based services (HCBS) Waiver.
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**General Information**, continued

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**Conditions Under Which a Recipient is Ineligible for the Waiver**, continued

If a recipient 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 occurs and funding is available. In this instance, the individual is added to the waitlist of individuals 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 recipient's WSC and APD if the provider becomes aware that one of these conditions exists.

If a recipient, family member, or legal representative refuses to cooperate with the provision of waiver services as specified in this handbook (such as refusing to develop a cost plan or support plan, participation in a required Questionnaire for Situational Information Assessment or other approved agency needs assessment tool, or refuses to annually sign the waiver eligibility worksheet, required to establish a level of care, they may be removed from the waiver, as the waiver requires these specific documents for continued waiver eligibility).

Recipients are exempted from this provision if they do not have the ability to give informed consent and do not have a guardian or legal representative.

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**Required Policies and Procedures**

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

- Procedures for using a person-centered approach to identify individually determined goals and promoting choice.
  - A detailed description of how the provider will protect the health, safety, and well-being of the recipients served.
  - Procedures for ensuring 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 (such as arrangements for a qualified back-up provider).
  - Procedures for ensuring 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 for addressing recipient complaints and grievances regarding possible service delivery issues.
  - Procedures for ensuring recipient confidentiality and maintaining and storing records in a secure manner.
  - Policies and procedures which detail the methods for management and accounting of any personal funds, of any and all recipients in the care of, or receiving services from, the provider.
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**General Information**, continued

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**General Provider Requirements**

- The provider must, 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 must, 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.
  - The provider must immediately notify the APD regional office, of any change in contact information including e-mail address, mailing address or telephone number. The provider must also notify the APD regional office if they plan to close their business or have a change in ownership.
  - All enrolled iBudget Waiver providers must 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. 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.
  - Providers must agree to abide by the terms and conditions of use of the APD online iBudget Waiver system or other electronic system providing such access when made available by APD.
  - The computer hard drives used by waiver providers must implement Full Disk Encryption software. For other types of electronic data storage devices that store confidential iBudget Waiver recipient data, such data must be encrypted using a minimum of a 128-bit encryption algorithm.
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**Person-Centered Planning Requirements**

The provider must participate in and support the person-centered planning and implementation for each recipient. The provider will also use the recommendations from the person-centered planning 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.

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**General Information**, continued

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**Documentation Requirements**

Documentation is an electronic or written record confirming that a service has been rendered. When a service is rendered, the provider must document and file the service at the time the services are rendered, and submit billing documentation to the support coordinator before billing.

Documentation in accordance with the requirements in Appendix A, Billing and Documentation Requirements is required in order to bill and receive payment. A plan of remediation may be required for failure to comply with the requirements listed in this handbook. Fines or other penalties can be imposed 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. If using an electronic signature the name of the person providing the service should be typed on all documentation related to billing.

Services that are billed on a quarter-hour or hour basis must have “from” and “through” time and date documented.

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.

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**Central Record**

The central record is the property of APD and follows the recipient if the recipient’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 it must be secured with a password maintained on a separate drive or disk, which is for backup documentation and is available to APD or AHCA upon request. The documents on the disk must be clearly named so that the contents are identifiable and in a format that is usable by APD and AHCA.

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**General Information**, continued

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**Incident Reporting**

Providers are responsible for reporting both critical and reportable incidents involving a recipient to the APD regional office as they occur, but no later than the next business day. Providers must submit incident reports and follow-up reports to the APD regional office.

An oral report must be followed by submission of the incident which can be downloaded from the APD Web site. The provider must take immediate action to resolve the situation and ensure the recipient's health and safety.

Critical incidents include:

- Unexpected recipient death.
- Life threatening injury.
- Any sexual activity, as described in section 393.135 F.S., between provider and a recipient regardless of consent of the recipient, incidents of nonconsensual sexual activity between recipients, or sexual activity involving a child.
- The unexpected absence or unknown whereabouts, beyond one hour, of a recipient who is a minor or an adult who has been adjudicated incompetent
- Negative new media reports regarding a provider or recipient arrest for a violent criminal offense.
- Verified report of abuse, neglect, exploitation, or abandonment.

Anyone who knows or suspects instances of abuse, neglect, or exploitation must immediately report such suspicions or knowledge to the Florida Abuse Hotline at 1-800-96-ABUSE (1-800-962-2873), or TTY at 1-800-453-5145.

Reportable incidents include:

- Recipient death that does not constitute an unexpected death.
- Physical altercations occurring between a recipient and a member of the community, a recipient and a provider or provider employee, or two or more recipients, that may result in law enforcement contact.
- Recipient injury requiring medical attention.
- The unexpected absence or unknown whereabouts of a legally competent adult recipient beyond eight hours.
- Recipient suicide attempt.
- Commitment of a recipient to mental health services pursuant to Chapter 394, F.S., also known as the Baker Act.
- Recipient arrest for a non-violent criminal offense, or the arrest of a provider, or licensee.
- Other incident jeopardizing health, safety, or well-being of recipient.

Although reactive strategies are not reported as part of critical or reportable incidents, they must be documented and reported in accordance with Rule 65G-8.010, F.A.C.

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**General Information**, continued

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**Incident Reporting**, continued

Providers must report critical incidents to the appropriate APD regional office by telephone or in person within one hour of becoming aware of the incident. If this occurs after normal business hours or on a weekend or holiday the person reporting may call the APD after-hours designee. It must be within the provider's discretion and judgment to determine the appropriateness of waiting until the following morning. 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. A supervisor may be the one to make the verbal report. The oral report must be followed by an APD Incident Reporting Form. The Incident Reporting Form must be submitted to the APD regional office at the earliest opportunity, but no later than the next business day.

The provider must take immediate action in the situation to resolve the situation and ensure the individual's health and safety. The provider must report incidents classified as Reportable within one business day to the APD regional office through the completion of an incident reporting form.

Providers must complete and submit incident reports and follow-up reports electronically on the APD Incident Reporting Form. The Incident Reporting Form should be completed in full electronically and submitted by electronic mail to the APD regional office. The first page should be typed by the person with firsthand knowledge of the incident. Incident reporting forms must be typed clearly, objectively and in order of the event occurrence.

Any and all follow-up measures taken by the provider to protect recipients, gain control or manage the situation must be noted on the second page of the incident reporting form, which may be completed at a later date, not to exceed five business days. The measures must specify what actions will be taken to mitigate a recurrence of the same type of incident.

The reporter must also provide immediate notification to the recipient's support coordinator and to a parent or guardian if applicable. If the child is in the custody of the DCF, the child's family services counselor (or DCF after-hours on-call staff) must be notified.

The provider must take immediate action in the situation to resolve the emergency and ensure the individual's health and safety. This action may include, but not be limited to, calling 911, or performing Cardiopulmonary Resuscitation (CPR) or the Heimlich maneuver. Anyone who knows or suspects that a recipient of APD, or vulnerable adult, has been the victim of abuse, neglect, or exploitation is required to immediately and personally report such suspicions or knowledge to the Florida Abuse Hotline.

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**General Information**, continued

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**Waiver Support  
Coordination  
Notification  
Requirements**

WSCs must 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 a recipient's loss of Medicaid must immediately notify the recipient's providers and appropriate APD regional office. Any provider that becomes aware of a recipient's loss of Medicaid benefits must immediately contact the recipient's support coordinator.
- The recipient plans to move out of the region, state, or country.
- The recipient plans to discontinue receiving services from the provider, waiver, or APD, either temporarily or permanently.
- Changes in the WSC's contact information including e-mail address, physical address, or phone number.
- Breach of recipient's confidential information. Notification must 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. Providers will also notify the WSC of changes to their provider's contact information. WSCs will notify providers when they become aware of any of the above-listed issues.

WSCs working with recipients and their families are required to locate and develop natural and community supports. WSCs should work with recipients and their families, along with other providers and APD staff, to identify and develop community-based resources. These could include assistance from family, friends, colleagues, churches, businesses, etc., who might be approached directly with requests to support a recipient outside of a formal organizational program of assistance. WSCs also have a key role in promoting recipients to be competitively employed, based on the recipient's interests, talents, and abilities.

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**Residential  
Habilitation**

It is the provider's responsibility to provide adequate staffing levels to meet the health and safety needs of recipients, even if the staffing levels are above the identified minimum staffing levels for the recipients in the home.

Providers of standard behavior focus residential habilitation services must provide a level of service consistent with the minimum direct care staff hours per person per day. Staffing ratios must be established by the provider using the available total minimum direct care staff hours per person per 24 hour day, per the Table below, consistent with the support and training needs of recipients receiving residential habilitation services for functional, behavioral, or physical needs.

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**General Information**, continued

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**Residential Habilitation**, continued

The provider will meet or exceed the minimum hours needed per day for each recipient, or provide the required staffing over a seven 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 must 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 service hours counted must be provided by the action of recipient 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 number of all available staff hours is multiplied by seven to establish a weekly minimum total. Providers have the flexibility in how staff resources are used in order to provide more efficient and effective services, provided minimum staffing levels are maintained.

For example: The calculation to determine the daily and weekly minimum staff hours for six recipients receiving the service and living in the same home, all authorized at the moderate level of supports is as follows:

The minimum number of direct care staff hours per person per 24 hour day for the moderate level is six hours.

“Six recipients multiplied by six direct care staff hours per person per 24 hour day equals 36 available direct care staff hours per day; multiplied by seven equals 252 available direct care staff hours per week.”

If recipients are engaged in the receipt of other services during the day, the residential habilitation provider can modify the staffing patterns 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.

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**General Information**, continued

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**Hierarchy of Reimbursement**

Services must not be authorized under the iBudget Waiver if they are available from another source.

It is the WSC's responsibility 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.
- Third Party Payer, such as private insurance.
- Medicare.
- Other Medicaid programs, such as Medicaid State Plan or Medicaid managed care plan.

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., Florida Medicaid Developmental Disabilities Individual Budgeting Waiver Disposable Incontinence Medical Supplies Fee Schedule.

If a recipient 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 recipient.

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**Financial Requirements**

- The provider agrees to notify APD in writing prior to any filing for bankruptcy protection.
  - Appropriate to the type and scope of services rendered, the provider agrees to maintain a separate checking account for any personal funds of any and all recipients in the care of, or receiving services from, the provider. If a single trust account is maintained for all recipients' personal funds, a separate accounting must be maintained for each recipient's funds, which reconciles monthly to the account's total as noted on the bank statement and is retained by the provider for review by APD or AHCA. The provider further understands and agrees that at no time should any recipient's personal funds be co-mingled with any other funds, including those of the provider or any of its employees. The provider must maintain on file a written consent to manage personal funds, signed by the recipient or his legal guardian. The provider must maintain on file receipts for individual purchases of \$25.00 or more.
  - Neither the provider nor its employees, in their official capacity, will receive any financial benefit as a result of being named the beneficiary of a life insurance policy covering a recipient served by the provider.
  - Neither the provider nor its employees, in their official capacity, will benefit financially by borrowing or otherwise using the personal funds of a recipient served by the provider.
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## Life Skills Development Level 1 – Companion

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**Description** Life Skills Development Level 1 - Companion services consist of non-medical care, supervision, and socialization activities provided to recipients age 21 years or older. This service must be provided in direct relation to the achievement of the recipient's goals as specified in 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. These services can be scheduled on a regular, long-term basis.

Activities can be volunteer activities performed by the recipient as a pre-work activity or activities that connect a recipient to the community.

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**Who Can Receive** Recipients must be 21 years or older.

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**Who Can Provide** Companion services may be provided by licensed home health or hospice agencies. Providers can also be solo or agency providers who are not required to be licensed, certified, or registered.

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**Service Requirements** 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.

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

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**Place of Service** Companion services can be provided in the following settings:

- Recipient's own home
- Recipient's family home
- Licensed facility (if the recipient is engaged in a community activity as long as the companion service is not duplicative of what is required by the residential provider licensing requirement)

Companion services cannot be received in the home of the provider or in the home of a relative or friend of the provider.

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**Limitations and Exclusions** Companion service providers are not reimbursed separately for transportation and travel costs. These costs are integral components of companion services and are included in the rate.

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## Life Skills Development Level 2 – Supported Employment

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<b>Description</b>	Supported employment services provide training and assistance to help 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 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 receives help in securing employment according to the recipient’s knowledge, skills, abilities, supports needed, desired goals, and planned outcomes. This service is conducted in a variety of settings, including work sites in which individuals without disabilities are employed.
<b>Who Can Receive</b>	A recipient seeking supported employment must first exhaust available resources through the Division of Vocational Rehabilitation (DVR), and if the recipient is under the age of 22 years, they must first exhaust available resources through the public school system.
<b>Who Can Provide</b>	Providers of supported employment services can be either solo providers or agency providers who are enrolled to provide supported employment.
<b>Service Requirements</b>	Supported employment providers will focus on the recipient’s knowledge, skills, abilities, supports needed, and use of any federal Social Security work incentive programs to maximize income, as well as provide consultation to the employer on ways to support the recipient in order to sustain paid employment. To generate additional funding to support a recipient’s employment goals, supported employment coaches must ensure that the recipients they serve are aware of, and utilize the various work incentives and employment planning tools that are available, in particular, Impairment Related Work Expenses (IRWE), the Plan to Achieve Self Sufficiency (PASS), and others that will benefit the individual.

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## Life Skills Development Level 2 – Supported Employment, continued

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### Service Requirements, continued

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. The individual model can apply to either employment in the general work force or in establishing a business that will to be operated by the recipient. There are two phases under the individual model.
  - Phase 1 is defined as time-limited supports needed to obtain a job and reach stabilization, and is typically paid for by the Division of Vocational Rehabilitation. Reimbursable 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.
    - 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. If the recipient continues to perform the job satisfactorily, the services move into extended, ongoing support services (Phase 2).

During Phase 1, the provider is expected to provide varying intensities of services to each recipient. The service intensity must be sufficient to support the recipient in finding a job within three months. The provider must furnish:

- On-the-job training which begins with high intensity support and fades to achieve stabilization.
  - Job development, which must be done with the recipient's input
  - Weekly updates to the job seeker regarding progress in attaining employment.
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**Life Skills Development Level 2 – Supported Employment**, continued

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**Service Requirements,**  
continued

The APD regional operations manager or designee must approve waiver funded job development period, if it exceeds three months at Phase 1. This will include review of written justification from the provider of the reasons that employment has not been achieved.

- Phase 2 is defined as long-term, ongoing supports needed to maintain employment indefinitely. Reimbursable support activities include:
  - Ongoing, systematic contacts with recipients to determine the need, intensity, and frequency of supports needed to maintain productivity, social inclusion, and continued employment
  - Remedial, on-the-job training, to meet productivity expectations, consultation and refinement of natural supports or other elements important to maintaining employment
  - 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
  - Efforts to expand work responsibilities within current employment for the purpose of increasing hours, pay, benefits, etc.
  - Social Security wage reporting and work incentive instruction to maximize income

Phase 2 supports assume periodic life changes that can 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 must be used only if these alternative resources are not available.

Recipients who sustain employment without incident over a number of years with the help of natural supports should no longer require a high level intensity of supports. In these instances, the supports intensity is may be faded in consultation with the employer, the recipient, and the provider.

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**Life Skills Development Level 2 – Supported Employment**, continued

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**Service Requirements,**  
continued

- Group supported employment models are defined as follows:
  - Enclave - A group approach to employment where one to eight recipients 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 recipients with disabilities are in the community in businesses or other community settings with supervision by the provider.
  - Entrepreneurial - A self-employment approach where a small group starts a business or micro-enterprise created specifically by, or for, the recipients.

Group models should be considered a bridge to individual supported employment and should be time-limited based on the recipient's interest. Generally, group models are needed only when constant paid supervision of a recipient is required.

- The supported self-employment model of service is defined as working for oneself with direct control over the work and services undertaken and can include micro-enterprise or micro-credit arrangements such as proprietorships, partnerships, and corporations. Those recipients that select supported self-employment must contribute to the development of a business service or 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 through the local supported employment liaison (EL), or the regional employment coordinator (REC) for tracking purposes. If the WSC finds that the recipient has gone to DVR on their own, the recipient must notify the EL or REC within five business days for tracking purposes. The WSC will be responsible for providing the information required to DVR and following APD guidelines to determine eligibility and vocational goals.

Any recipient determined eligible for services through DVR will generally be provided funding and supports by DVR. If DVR deems a recipient ineligible for DVR services, then services may be provided through APD.

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**Life Skills Development Level 2 – Supported Employment**, continued

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**Service Requirements,**  
continued

All of the above information must be documented initially in the employment stability plan (ESP) 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.

Providers of supportive employment services will notify the recipient's WSC of any changes affecting the recipient's income within five days.

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**Place of Service**

Supported employment services may be provided in the following settings:

- Recipient's place of employment in the community
- In a setting mutually agreed to by the recipient, the provider, and the employer

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

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**Limitations and Exclusions**

Transportation of a recipient to and from a job is not a reimbursable component of Supported employment services. Separate payment for transportation services furnished by the supported employment provider will not be made when rendered as a component of this service.

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 must 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.

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

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**Life Skills Development Level 2 – Supported Employment**, continued

**Limitations and Exclusions,**  
continued

The recipient should have no more than 64 quarter hour units of this service per day or a maximum of the equivalent of 112 hours per week of all life skills development services combined. Under the individual employment approach, service intensity should diminish across time and billing should reflect fading services consistent with each recipient's demonstrated need.

Recipients needing transportation can receive transportation services when no other community, natural, or generic support is available to provide transportation.

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**Reimbursement**

To be eligible for reimbursement of supported employment services, the provider must properly complete, maintain, and submit (along with the supported employee's billing information) the APD ESP. The ESP must be completed and used by the provider as requested by APD and must include the following:

- Documentation of attempts to develop 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
- Documentation of the recipient's employment outcome (including the attained job or position, benefits received, rate of pay, number of hours worked weekly, and other quality indicators as requested by APD)
- Notes regarding ongoing instructions on the reporting of wages and work incentives to the Social Security Administration on a monthly and quarterly basis
- Use and purpose of work incentives utilized or reasons for the lack thereof
- Documentation of number of units of supported employment services provided during the time frame for which the billing is being submitted

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**Life Skills Development Level 3 – Adult Day Training**

**Description**

Life Skills Development Level 3 - Adult Day Training (ADT) 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 skills, social skills, and employment. The training, activities, and routine established by the ADT must be meaningful to the recipient and provide an appropriate level of variation and interest.



**Life Skills Development Level 3 – Adult Day Training**, continued

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**Who Can Receive**

This service generally begins at the age of 22 years when a recipient is out of the public school system or when they have graduated from the public school system, receiving a standard diploma. Recipients who are age 22 years or older who have not graduated are also eligible.

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**Who Can Provide**

Providers of ADT services must be designated by the APD regional office as ADT providers.

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**Service Requirements**

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

This training must 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.

Documentation of services rendered is not considered a billable activity. Adult day training services can be provided as an adjunct to other services included in the life skills development family on a 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 ADT services at a different time of the day or week.

Adult day training 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.

Off-site models include services that teach specific job skills and other services directed at meeting specific employment objectives. Adult day training models include:

- Enclave - A group approach to training where no more than ten recipients 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 recipients 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 recipient with disabilities to set up and work in a small business created especially by or for the recipient. Such models include self-employment and micro-enterprise. Any profits earned from this model must be used to either pay the recipients, per federal guidelines, or reinvested in the business or both.
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**Life Skills Development Level 3 – Adult Day Training**, continued

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**Service Requirements,**  
continued

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

The recipient can choose to attend an ADT program in the frequency that is desired within the budget allocation and as approved on the service authorization.

The provider must render services at a time mutually agreed upon by the recipient and the provider. This will allow a recipient the flexibility to determine when to attend the ADT program for limited hours or only on certain days. Billing is by the hour for the number of hours attended each day by the recipient.

A recipient can begin receiving services at the age of 16 years without a standard diploma if the public school system is willing to provide and pay for this service throughout the recipient's legal age of eligibility.

The only services that can be provided at the same time and at the same facility are behavior analysis, physical therapy, occupational therapy, speech therapy, or skilled nursing, at the request of, or convenience of, the recipient at a time agreed upon by the provider.

Behavior assistant services (BAS) cannot be provided as a discrete service in the ADT facility, except for limited situations in which the recipient exhibits extreme and dangerous behavior and requires the service for a short term period to help the recipient transition and to train ADT staff to implement the behavior program.

Any recipient receiving ADT service who is performing productive work either on-site or off-site, must be financially compensated commensurate with members of the general workforce doing similar work per wage and hour regulations of the United States Department of Labor.

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**Place of Service**

Adult day training services must be provided in the community whenever possible or designated ADT center.

Whenever possible, services should be offered in community-integrated settings, but can be offered at an ADT center.

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### Life Skills Development Level 3 – Adult Day Training, continued

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#### Limitations and Exclusions

Adult day training providers are paid separately for transportation services only when the service is authorized in the cost plan, the provider is enrolled as a transportation provider, and transportation is provided between a recipient's place of residence and the training site.

Transportation between ADT sites, if the activities provided are a part of the respective services, will be included as a component and in the rate paid to the provider of ADT services. Adult day training staff responsible for transporting recipients must meet the minimum requirements of a transportation provider. Adult day training staff is responsible for assisting recipients into and out of facilities when they have been transported in vehicles not owned or operated by the ADT center. Drivers of such vehicles are responsible for ensuring the recipient's safe entry into and exit from the vehicle.

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#### Reimbursement

The stepped rate published for ADT is based on one extra hour of staff time to accommodate the variance in recipient schedules for attendance.

Adult day training services and ADT off-site services will be billed based on the stepped rate for the services.

Life Skills Development Level 3 - ADT services must be billed at the standard rate level for the service. The standard rate is paid when a recipient 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.

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 services, the following will apply:

- 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 ADT provider and who exhibits the characteristics required for 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 regional office local review committee (LRC) 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 on a regular schedule as determined appropriate by the LRC chairperson.
    - The ADT provider must maintain a copy of the Behavior Analysis Service Plan being implemented by the ADT.
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**Life Skills Development Level 3 – Adult Day Training**, continued

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**Reimbursement,**  
continued

- Indicators of a one staff-to-three individual staffing rate ratio level include a recipient that either:
  - Requires an intense level of personal care support services (which include assistance with eating, positioning, assistance with lifting, or total physical assistance as indicated on an APD-approved assessment).
  - Is on a behavior services plan that is implemented by the ADT provider, and exhibits the characteristics required for behavior focus 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.
- Indicators of a one staff-to-five individual staffing ratio level include a recipient that either:
  - Routinely requires prompts, supervision, and physical assistance to perform basic personal care tasks such as eating, bathing, toileting, grooming, transitioning, and personal hygiene as identified in the current abilities section of the APD-approved assessment.
  - Is on a behavior services plan that is implemented by the ADT 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.

Support provided to groups of nine or ten recipients 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 recipients and the recipients are paid less than minimum wage, the service must be billed as ADT off-site.

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 must 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.

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## Consumable Medical Supplies

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### Description

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 waiver must meet all of the following conditions:

- Relate to a recipient's developmental disability
- Not covered by the Medicaid state plan
- Meet the definition of medical necessity

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

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 must be in addition to any medical equipment and supplies furnished under the Medicaid state plan and must exclude those items that are not of direct medical or remedial benefit to the recipient.

Medical or surgical items are consumable, expendable, disposable, or non-durable and appropriate for use in the recipient's home.

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### Who Can Provide

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

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**Consumable Medical Supplies**, continued

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**Service Requirements**

Waiver support coordinators will access incontinence supplies for recipients through the Medicaid state plan pursuant to Rule 59G-13.086, F.A.C., Florida Medicaid Developmental Disabilities Individual Budgeting Waiver Disposable Incontinence Medical Supplies Fee Schedule.

Consumable medical supplies covered by the waiver include:

- Diapers, including pull-ups and disposable briefs, for recipients age 21 years or older.
  - Wipes for recipients age 21 years or older, if the recipient requires incontinent supplies.
  - Surgical masks and are:
    - Worn by a recipient with a compromised immune system as a protection from infectious disease.
    - 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, advanced registered nurse practitioner (ARNP), or physician assistant (PA) must renew the prescription quarterly.
  - Disposable or washable bed or chair pads and adult-sized bibs.
  - Ensure<sup>®</sup> or other food supplements not covered by the Medicaid Durable Medical Equipment and Medical Supplies Program State Plan services when determined necessary by a physician, physician's assistant, ARNP, or licensed dietitian. Recipients requiring continued nutritional supplements must have a dietician's assessment documenting such need.
  - Feeding tubes and supplies. This excludes supplies for a recipient who qualifies for food supplements under Florida Medicaid's DME and medical supplies services or the Medicare program.
  - Dressings that are required for a caregiver to change wet to dry dressing over surgical wounds or pressure ulcers.
  - Hearing aid batteries, cords, and routine maintenance and cleaning prescribed by an audiologist.
  - Bowel management supplies, which 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.
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**Consumable Medical Supplies**, continued

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**Limitations and Exclusions**

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.

No more than ten items per day can be purchased and (some items have additional limitations as indicated in this handbook.

Items not contained on this list that meet the definition of consumable medical supplies can be approved through exception by the APD regional office. To request an exception, a physician, ARNP, or PA must prescribe the item. The statement from a physician, ARNP, or PA must:

- Delineate how the item is medically necessary.
- Show how it is directly related to the recipient's developmental disability, and why, without the item, 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.

Requests for consumable medical supplies will be reviewed by the APD regional office in consultation with the APD state office to determine medical necessity and whether the requested item fairly meets the service definition.

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.

A prescription submitted for supplies, diet products, 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, cotton balls or Q-tips, does not convert that item from general utility items to consumable medical supplies covered under the iBudget Waiver.

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's parent or legal representative. Recipients, their family members, or legal representative will not be reimbursed for any supplies they purchase.

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## Consumable Medical Supplies, continued

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### Limitations and Exclusions, continued

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, except when it is determined that the recipient's health and safety needs cannot be met within the limits for incontinence supplies set by Medicaid state plan. To request an exception for additional incontinence supplies, a physician, ARNP, or physician assistant must prescribe or provide a statement describing why the additional amount(s) of the item(s) would be medically necessary for the recipient's health and how they are directly related to the recipient's developmental disability. The regional medical case manager must concur before the additional item(s) can be approved.

Items of general use whether prescribed by a physician, ARNP, or PA 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, cough syrups, clothing, etc., are excluded from coverage.

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

Note: For more information regarding durable medical equipment, see The Florida Medicaid Durable Medical Equipment and Medical Supply Services Coverage and Limitations Handbook.

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## Durable Medical Equipment and Supplies

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### Description

Durable medical equipment 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
  - Is appropriate for use in the home
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**Durable Medical Equipment and Supplies**, continued

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**Who Can Provide**

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.

Home health agencies and durable medical equipment companies must provide a surety 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, in accordance with section 409.907, F.S.

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**Service Requirements**

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

The following can be provided under the waiver:

- 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, family, or legal representative 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.

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**Durable Medical Equipment and Supplies**, continued

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**Service Requirements,**  
continued

If a recipient, family, or legal representative 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.

- A wheelchair carrier for the back of the car is limited to one carrier for a five-year period.
- A standard wheelchair. 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 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 (e.g., cardiac insufficiency or emphysema) that prevents walking for sufficient lengths of time. This condition must be documented by a physician, ARNP, or a PA 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.
  - Payments for repair to wheelchairs after the warranty expires can be approved by the APD regional office in consultation with the APD state 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 and sport wheelchairs.
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## Durable Medical Equipment and Supplies, continued

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### Service Requirements, continued

- Strollers, subject to the same criteria and limitations for wheelchairs, as stated above, except reimbursement for a stroller will be limited to \$1,600.
  - Only one stroller 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 state office, if not covered by Medicare or Medicaid DME and medical supplies 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 must not exceed \$2,000. Payments for repair to lifts after the warranty expires can be approved by the APD regional office.

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. Medical necessity is usually limited to necessary access to a recipient bedroom and bath. Only one system will be allowed for any recipient. If the recipient moves, it will be determined if the recipient should move the current system or purchasing a new system. A new assessment and determination must be made. The cost must not exceed \$10,000. Repair payments for ceiling lifts, after the warranty expires, can be approved by the APD regional office in consultation with the APD state office.

- 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 must not exceed \$1,000.
  - Bidet, limited to recipients who are able to transfer onto commodes independently, but whose physical disability limits or prevents thorough cleaning. The bidet and installation cost must not exceed \$1,000.
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**Durable Medical Equipment and Supplies**, continued

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**Service Requirements,**  
continued

- 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.

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 must 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. The air purifier unit cost must 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 RESNA certified provider.
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**Durable Medical Equipment and Supplies**, continued

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**Service Requirements,**  
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 therapist, 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 PA.
- Hypoallergenic covers for mattress and pillows, ordered by a physician, who documents necessity based upon severe allergic reaction to airborne irritants.
- Generators, when one of the following are documented:
  - 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.
  - 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 intermittent 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

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**Service Requirements,**  
continued

Items not contained on this list that meet the definition of DME can be approved through exception by the APD regional office in consultation with the APD state office. To request an exception, a physician, ARNP, or PA must prescribe the item.

The statement from a physician, ARNP, or PA 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 state 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.

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 PA recommending or prescribing a stationary bicycle or hot tub does not convert that item from personal fitness or recreational choice equipment to DME covered under the 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.

Note: For additional information on Medicaid state plan coverage, see to the Florida Medicaid Durable Medical Equipment and Medical Supply Services Coverage and Limitations Handbook.

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**Durable Medical Equipment and Supplies**, continued

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**Limitations and Exclusions**

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. However, prone or supine standers may be approved by exception for recipients who are medically homebound and their treating physician medically prescribes standing on a daily basis.

Also excluded are experimental equipment, weighted vests and other weighted items, 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.

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 or legal representatives 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.

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

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**Reimbursement**

Recipients, their family members or their legal representative must not be reimbursed for equipment they purchase. 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.

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## Environmental Accessibility Adaptations

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### 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.

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.

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### Who Can Provide

Providers of EAA services include licensed general or independent licensed contractors, electricians, plumbers, carpenters, architects, and engineers.

Other professionals who can provide EAA assessments include providers with experience in the field of environmental accessibility adaptation assessment, with a RESNA certification, and an occupational license.

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### Service Requirements

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.

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 will be provided and billed and a total limit of \$20,000.00 cannot be exceeded over a five-year period.

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**Environmental Accessibility Adaptations**, continued

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**Service Requirements,**  
continued

This determination includes all of 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.
- The environmental accessibility adaptation enables the recipient to function with greater independence in the home and, without it, the recipient would require institutionalization.

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 the residence. The cost of adaptation must 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.

Environmental accessibility adaptations must be separated into two categories. Minor adaptations must be defined as those EAA costing under \$3,500 for all adaptations in the home. Major adaptations must 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 must 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.

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**Place of Service**

Environmental accessibility adaptations must 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.

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**Environmental Accessibility Adaptations**, continued

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**Limitations and Exclusions**

A recipient's rental property is limited to minor adaptations. 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, must approve all proposed environmental accessibility adaptations in writing.

The written agreement between the recipient, the recipient's family, or the recipient's legal representative, and the landlord, must specify any requirements for restoration of the property to its original condition if the recipient moves, 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 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.

If a recipient, family, or legal representative 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.

The evaluation must demonstrate that the environmental accessibility adaptation recommended is a "prudent purchase." Each EAA 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.

Adaptations or improvements to the home, which are of general utility and are not of direct medical or remedial benefit to the recipient, are excluded.

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 such as cabinets, shelving, or closets; standard home fixtures such as sinks, commodes, tubs, stoves, refrigerators, microwaves, dishwashers, clothes washers and dryers, wall, window and door coverings, 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.

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## **Environmental Accessibility Adaptations**, continued

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### **Reimbursement**

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 than three 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.

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## **Personal Emergency Response Systems**

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### **Description**

A personal emergency response system (PERS) 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. The need for a personal emergency response system must be addressed in the recipient's support plan.

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### **Who Can Receive**

A PERS 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.

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**Personal Emergency Response Systems**, continued

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**Who Can Provide**

PERS providers must be licensed electrical contractors, alarm system contractors, contract agencies for Community Care for the Elderly (CCE) as authorized by Chapter 430, F.S., Community Care for Disabled Adults (CCDA) programs as 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.

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**Place of Service**

A PERS must be provided in the recipient's own home or apartment or the family's home or apartment. If a mobile "help" button is available, then the recipient must wear it while engaged in a community activity.

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**Limitations and Exclusions**

A cell phone does not meet the definition of a PERS. This service does not include the cost for the telephone or telephone line but does include the cost of the monthly service fee and any installation fee.

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**Personal Supports**

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**Description**

Personal supports services provide assistance and training to the recipient in activities of daily living, such as eating, bathing, dressing, personal hygiene, and preparation of meals. When specified in the support plan, this service can also 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, and supervision. 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.

Personal supports are designated to encourage community integration. Personal supports in supported living are also designated to teach the recipient about home-related responsibilities.

This service can also include respite services to a recipient age 21 years or older living in their family home. The provider, to the extent properly qualified and licensed, assists in maintaining a recipient's own home and property as a clean, sanitary and safe environment.

This service is provided in support of a goal included the support plan or an identified need to support or maintain basic health and safety and is not purely diversional in nature.

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**Personal Supports**, continued

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**Who Can Receive**

Personal supports for individuals in the family home are limited to adults 21 years or older. Personal supports can be provided to recipients age 18 years or older who are in a supported living situation or living in their own home.

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**Who Can Provide**

Providers of personal supports can be a licensed home health or hospice agency, a licensed residential facility, or a solo provider.

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**Place of Service**

Personal supports are provided in the recipient's own home, family home, licensed residential facility if being used as respite, or when or 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 ICF/IID or other institutional environment.

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 daily rate for the service.

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**Limitations and Exclusions**

The recipient's support plan must 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.

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 activity is provided to recipients living in their family home or in their own homes in groups not to exceed three.

If the recipient resides in supported living arrangements and receives both personal supports and supported living coaching then the provider 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, implementation plan, or both.

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**Personal Supports**, continued

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**Limitations and Exclusions**, continued

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.

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

- To facilitate an overnight visit with family or friends away from the foster or group home.
- 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 ensure the recipient's personal support 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 a recipient living in a licensed group home is employed and needs personal supports services at the employment site.

The provider or the provider's immediate family must not be the recipient's landlord or have any interest in the ownership of the housing unit.

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**Reimbursement**

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

Services can be billed by the quarter hour or by the day. If it is more cost effective to bill the daily rate as opposed to the hourly rate, the recipient has the option to adjust the cost plan to use the most cost-effective unit for service provision.

Personal supports services that are provided on an hourly basis, instead of on a daily basis, must 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.

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**Personal Supports**, continued

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**Reimbursement**,  
continued

Up to 6 hours or 24 quarter hours above the daily rate may be approved to provide additional supports that must be billed by the quarter hour. Personal Supports billed by the quarter hour above the daily rate may be approved under the following circumstances:

- Recipient requires additional supervision due to intense behavioral challenges that make the recipient a danger to themselves or others. In this situation, the recipient must have a behavioral services plan that is implemented by the personal support provider, and the recipient requires visual supervision during all waking hours and intervention as determined by a certified behavioral analyst. The behavioral services plan and its effects on the behavior must be re-viewed by the LRC on a regular schedule as determined appropriate by the LRC.
- Recipient requires temporary additional supervision and assistance to recover from a medical condition, procedure, or surgery. The additional supports may only be approved on a time limited basis during the recipient's recovery. This must be documented by medical information signed by the recipient's physician.
- Recipient requires total physical assistance to include lifting and transferring, in at least three of the basic personal care areas of eating, bathing, toileting, grooming, and personal hygiene, due to physical, cognitive or behavioral limitations. Also, the recipient must require physical assistance during sleep hours to meet their health and safety needs.

A provider or employees of a provider do not have to daily a recipient's home for the daily rate to be applied for the service.

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 as the most cost effective measure. For recipients receiving personal supports for respite in a licensed facility personal supports should be billed at the 1:1 day rate.

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## **Respite Care**

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### **Description**

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.

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### **Who Can Receive**

Respite care is a service that provides supportive care and supervision to recipients under the age of 21 years when the primary caregiver is unable to perform the duties of a caregiver.

Respite care for recipients age 21 years or older is available as a part of the personal supports service family.

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### **Service Requirements**

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. 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.

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.

Some recipients may require respite care provided by a licensed nurse. These recipients have complex medical conditions which require medically necessary nursing services. If a licensed nurse provides this service, a prescription for skilled respite from a physician, ARNP, or PA is required. Skilled respite will be reimbursed at the licensed practical nurse (LPN) level.

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### **Place of Service**

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

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**Respite Care**, continued

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**Limitations and Exclusions**

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

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

Respite services are only available to recipients under the age of 21 years 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.

Providers of respite care 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).

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**Reimbursement**

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.

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**Residential Habilitation (Standard)**

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**Description**

Residential habilitation service provides 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 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 focused residential habilitation or intensive behavioral residential habilitation.

Behavior focused and intensive behavior residential habilitation may only be provided in APD licensed facilities which have been designated as behavior focus or intensive behavior homes by APD.

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**Residential Habilitation (Standard)**, continued

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**Who Can Provide**

In order to perform this service, eligible providers must be the owner or operator of a licensed residential facility.

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

Direct care staff providing residential habilitation must be age 18 years and older, must have one year supervised experience working in a medical, psychiatric, nursing, or child care setting, or in working with recipients who have developmental disabilities, or have 30 semester hours, 45 quarter-hours, or 720 classroom hours of college or vocational school.

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**Service Requirements**

Providers must provide adequate staffing levels to meet the health and safety needs of recipients, even if the staffing levels are above the identified minimum staffing levels for the recipients in the home.

Providers are required to maintain a minimum level of staffing consistent with the minimum direct care staff hours per recipient per 24 hour day. Staffing ratios must be established by the provider at or above the available total minimum direct care staff hours per recipient per 24 hour day, consistent with the support and training of recipients receiving residential habilitation services for functional, behavioral, or physical needs. The provider will meet or exceed the minimum staffing levels on a per day basis for each home providing residential habilitation or must provide the required staffing over a seven day period for each home to accommodate for recipient absences from the home, and to establish optimal coverage on weekends. 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 focused residential, or intensive behavioral residential habilitation must be verified and approved by the APD regional office in consultation with the APD state office.

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**Residential Habilitation (Standard),** continued

**Service Requirements,**  
continued

<b>Direct Care Staff Hours per Recipient per 24 Hour Day</b>		
<b>Level of Disability</b>	<b>Min Hours per Day</b>	<b>Min Hours per Week</b>
Basic Level	2	14
Minimal Level	4	28
Moderate Level	6	42
Extensive 1 Level	8	56
Extensive 2 Level	11	77

Adjustments can be made to full time equivalent (FTE) calculations based on the number of hours in the shift, i.e. if the shift is ten hours instead of eight hours. Deviations of FTE calculations must be prior approved in writing by the APD regional office.

Hours counted must be provided by residential habilitation staff or by other staff who are providing direct care or direct time spent on recipient training, intervention, or supervision.

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 number of all available staff hours is multiplied by seven to establish a weekly minimum total. Providers have flexibility in how staff resources are used in order to provide efficient and effective services, provided minimum staffing levels are maintained.

If recipients are engaged in the receipt of other services during a period of time during the day, the residential habilitation provider can modify staffing patterns 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.

**Place of Service**

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

**Residential Habilitation (Standard),** continued

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**Limitations and Exclusions**

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

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

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**Reimbursement**

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.

The three different rate components for residential habilitation services are day, daily, and month.

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 daily rate may provide up to 24 hours of supports in a licensed home with three or less individuals.

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**Residential Habilitation (Standard),** continued

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**Reimbursement,**  
continued

Providers furnishing residential habilitation in a licensed home can be reimbursed at the monthly rate if the recipient resides in the home for a minimum of 24 days in the month. Providers can be reimbursed 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 must not bill on a date the recipient was not present. Providers must use the last date the recipient was present as the date of service.

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**Residential Habilitation (Behavior Focused)**

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**Description**

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 service characteristics as described below. This level of service must be approved for a recipient only when it has been determined through use of the APD approved instrument by the APD regional behavior analyst or designee, and through the support planning process, that a recipient requires residential habilitation services with a behavioral focus.

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

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 must have 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.

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**Who Can  
Receive**

Residential habilitation services with a behavior focus are appropriate for recipients exhibiting at least one of the following behavioral issues, within the past twelve months, as documented 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.
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## Residential Habilitation (Behavior Focused), continued

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### Who Can Receive, continued

- 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.
  - Engages in behavior that creates a life threatening situation, including 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 or Baker Act within the past twelve months.
  - Engaged in public displays of inappropriate sexual behavior.
  - Engaged in threats of inappropriate sexual behavior or sexually provocative behavior towards another person, or is vulnerable to exploitation due to being sexually active.
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### Who Can Provide

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 face-to-face monitoring of behavioral services as described in the approved behavioral programs implemented within the residential program; as evidenced by a timesheet, a contract identifying hours meeting the handbook requirement, or a behavioral service provider invoice, or some other form of documentation. The behavior analyst overseeing behavioral services must be able to demonstrate 1) that staff monitoring has been conducted as required; 2) graphs of recipients' target and replacement behaviors are current, 3) staff have successfully completed all required trainings, 4) staff are trained in recipient behavior analysis support plans, and 5) that all behavior analysis support plans have been developed, revised and reviewed by the LRC as required in Chapters 65G-4 and 65G-8, F.A.C.

Providers of behavior focused residential habilitation must be designated by APD as a behavior focused provider and meet the provider and staff qualifications identified above for standard residential habilitation, as well as ensuring the following:

- 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 an intellectual disability.
    - Receive 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.
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**Residential Habilitation (Behavior Focused), continued**

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**Who Can Provide,**  
continued

- 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 must 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
    - Data collection, recording, and documentation
- 

**Service Requirements**

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.

At least annually thereafter, and prior to the development of the recipient’s support plan, the APD regional 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 must 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.

Providers of residential habilitation and behavior focus residential habilitation in a licensed facility must 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 considered for transitioning to the next appropriate 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 transition within or from behavior focused residential habilitation to the next lower level of treatment service serve as guidelines under which the treatment team should consider a less structured, more open environment, including levels of involvement from direct care staff, staff supervisors, and professional care providers.

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**Residential Habilitation (Behavior Focused), continued**

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**Service Requirements,**  
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 intensity.
  - The behaviors intended to replace the problem behavior now occur more often in the presence of the environmental conditions that previously evoked behavioral excesses.
  - The 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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**Place of Service**

Residential habilitation (behavior focused) services must be licensed residential facilities pursuant to section 393.067, F.S.

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**Residential Habilitation (Intensive Behavior)**

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**Description**

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

The goal of intensive behavior residential habilitation service is to prepare the recipient for full or partial reintegration into the community, with an expanded array of skills and behaviors, with a focus on independent adaptive functioning, and developing a healthy lifestyle, while participating in engaging and productive activities.

Treatment within intensive behavioral residential habilitation also includes medical oversight by psychiatric and nursing services when recipients routinely use psychotropic medications or emergency medications for the management of behavior, mood, or thought processes.

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**Residential Habilitation (Intensive Behavior),** continued

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**Who Can Provide**

Providers of intensive behavioral residential habilitation services must meet the behavior focused provider and staff qualifications, as well as ensuring:

- All adjunct services (behavioral, psychiatric, and nursing) are included in the service, or separately billed to the recipient's private insurance policies, or sources of reimbursement other than the Medicaid waiver program, or APD.
  - All direct-care service needs are met without an increase in 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, a master's level board certified behavior analyst, or a practitioner licensed under Chapter 490 or Chapter 491, F.S. with training and experience providing behavior analysis services to special populations. 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 must be an enrolled professional authorized to provide behavior analysis services. Only individuals who are board certified behavior analysts – doctoral level, board certified behavior analysts (BCBA), board certified assistant behavior analysts (BCaBA), Florida certified behavior analysts or persons licensed in accordance with Chapter 490 or 491, F.S., on active status, and demonstrating supervision as required, may be providers of behavior analysis services, under Rule 65G-4.001, F.A.C.
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**Staffing Requirements**

For residential providers:

- The ratio of behavior analyst-to-recipient is no more than one full-time analyst to 20 recipients.
  - 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 in the behavioral focused residential habilitation section of this handbook.
  - All direct service staff will receive training in an APD-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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## Residential Habilitation (Intensive Behavior), continued

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### Service Requirements

Intensive behavioral residential habilitation must provide the recipient with aggressive, consistent implementation of a program of treatment and training unique to the needs of the individual and participation in training opportunities available to all recipients in the home, as well as health services, and related services that are directed toward:

- The acquisition of the behaviors necessary for the recipient to function with as much self-determination and independence as possible.
- The reduction or replacement of high-risk behavior problems.

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.

Recipients receiving intensive behavioral 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 is necessary if, within the past six months, the recipient:

- Engaged in behavior that caused injury to self or others that required emergency room or other inpatient care from a physician or other health care professional.
  - Engaged in a behavior that creates a life-threatening situation, such as, excessive eating or drinking, vomiting, ruminating, eating non-nutritive substances, refusing to eat, swallowing excessive amounts of air, and severe insomnia.
  - Engaged in unauthorized fire setting.
  - 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, either mechanically, manually or by commitment to a crisis stabilization unit, three or more times in a 30-day period, or six times across the applicable six-month period.
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## Residential Habilitation (Intensive Behavior), continued

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### Service Requirements, continued

- Engaged in behavior that resulted in the recipient's arrest and confinement.
- Engaged in sexual behavior with any person who did not consent or is considered unable to consent to such behavior, or engaged in sexual behavior that caused injury to self or others requiring emergency room or other in-patient care from a physician or other health care professional.
- If the supervision and environment is such that the recipient lacks opportunity for engaging in these serious behaviors, the behavior analyst providing services must provide data, probes or other documented evidence to the regional behavior analyst providing oversight for services, showing that the behavior would likely occur at least every six months if the recipient were without the supervision or environment provided.

Intensive behavioral services for a recipient must be approved and authorized by APD through the APD approved assessment. The APD regional behavioral analyst or designee will determine individual characteristics have been met for intensive behavioral residential habilitation. At least annually thereafter, the regional behavioral analyst or designee will re-evaluate the recipient through use of the approved assessment to confirm that the recipient continues to meet service eligibility criteria and service level.

The review process for service approval must 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 a recipient based upon their Global Behavioral Service Need Matrix (or IB matrix score) identified in Rule 59G-13.081, F.A.C., and specific service needs. Evaluation and authorization must occur prior to service delivery, for new services, within 30 days for existing services, and at least annually thereafter.

Arrangement of contingencies designed to improve or maintain performance of activities of daily living must also be included. This would occur when a recipient does not bathe regularly and as a result, the recipient becomes socially isolated. The objective in this case would typically be to establish acceptable bathing routines in the absence of more formal and sophisticated behavioral programming. 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 services must include a written transition plan to decrease services or the level of service, as behavior improves and when applicable, a medical condition improves. Environmental changes or adjustments that are made as the person's behavior and medical condition improves must 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 re-integration into the community, with established behavioral repertoires with an expanded array of skills and behaviors, such as developing a healthy lifestyle filled with engaging and productive activities.

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## Residential Habilitation (Intensive Behavior), continued

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### Service Requirements, continued

Intensive behavior services are 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 level of treatment service. The conditions under which a recipient can be ready for transitioning should be considered on a person-by-person basis.

One or more of 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 a higher level of intensive behavior residential habilitation to a lower level of intensive behavior residential habilitation or even behavior focused residential habilitation, serve as guidelines under which the treatment team must recommend a less restrictive, less structured, more open environment. The goal of any behavioral residential habilitation service is to prepare recipients for integration into their local community to the greatest extent possible, with desirable improvement with a marked decrease in challenging behaviors such that they have greater community inclusion and integration.

Conditions to be considered when planning for transition include:

- The behavioral excesses that made treatment necessary occur at reduced rates and with reduced intensity (the behaviors do not typically occur as a function of new environmental conditions).
- The behaviors intended to replace the problem (behavior now occurs 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.

When the conditions identified above are met, the recipient should be transitioned to a lower level of intensive residential habilitation and should no longer require intensive behavior residential habilitation treatment.

Treatment would continue with the focus shifting to ensure the recipient's gains are maintained or improved in settings that afford greater access to unplanned, encounters with untrained people.

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**Residential Habilitation (Intensive Behavior), continued**

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**Reimbursement**

The following service characteristics identified below must be met in order to receive an intensive behavioral residential habilitation rate:

- The APD service authorization must 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 of intensive behavioral residential habilitation or less intense service category, such as behavior focused residential habilitation, can be possible.
  - Behavior assistant services must not be provided as an additional billable service in conjunction with intensive behavioral residential habilitation.
  - Minimum staffing requirements for intensive behavior residential habilitation services must be determined at the time the rate for the service is established, but no less than the rate established for behavior focused extensive 2.
  - Providers of residential habilitation services and their employees must 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 in their emergency procedure curriculum.
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**Special Medical Home Care**

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**Description**

Services provided to recipients with complex medical conditions requiring an intensive level of nursing care residing in a foster or group home. This can include recipients who are ventilator dependent, require tracheostomy care, or have a need for deep suctioning to maintain optimal health.

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**Who Can Provide**

Nurses and certified nurse assistants must perform services within the scope of their license or certification.

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**Special Medical Home Care, continued**

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**Service Requirements**

Rates for this service must be approved and authorized through the APD state office. Authorization for each recipient in the home requires review by the APD state office nursing staff. Authorized rates for service can vary based on the specific service needs of the recipient. Service authorization must occur prior to service delivery and at least every six months by the APD state 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.

The service is provided for 24 hours per day, with nursing services and medical supervision for all the recipients residing in the home. The foster or group home must have APD state office authorization and must 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 for nursing, medical supervision, and residential habilitation. It does not include other wellness and therapeutic support services.

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**Limitations and Exclusions**

This service does not include recipients whose only need is for gastrostomy tube feedings or medications, wound care, or insulin injections without other intensive needs.

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. This may include recipients who have intensive medical needs. They may be ventilator dependent, require tracheostomy care, or have a need for deep suctioning to maintain optimal health, or have other complex medical needs that require 24 hours per day nursing services. For new providers rendering services after the promulgation of this handbook, the service is limited to recipients age 21 and older.

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**Supported Living Coaching**

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**Description**

These services can include assistance with locating appropriate housing; the acquisition, retention, or improvement of skills related to activities of daily living (e.g., 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.

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**Who Can Receive**

Supported living coaching services provide training and assistance in a variety of activities to recipients who live in their own homes or apartments.

Recipients are limited to adults age 18 years or older.

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**Supported Living Coaching**, continued

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**Who Can Provide**

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

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**Service Requirements**

In order to identify the types of training, assistance, and intensity of support needed for the recipient, the provider must complete a Functional Community Assessment. This assessment is designed to assist the provider in becoming familiar with the recipient and the recipient's capacities and needs. The 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, 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](http://www.apd.myflorida.com/customers/supported-living/living-guide/index.htm).

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](http://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. These updates must include a review of the recipient's overall health, safety, and well-being.

For each recipient served, the supported living provider must 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](http://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 must assist the recipient in completing the financial profile and submitting it to the WSC no more than ten days from the onset of services and updated following the selection of housing by the recipient or if the financial situation changes.

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**Supported Living Coaching**, continued

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**Service Requirements,**  
continued

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; any time the recipient's finances change; and annually thereafter.

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

The provider must render supported living coaching services at the time and place mutually agreed to by the recipient and provider. The provider must have an on-call system in place that allows recipients access to services for emergency assistance 24 hours per day, seven days per week. The provider must specify a backup person to provide services in the event that the provider is unavailable. Telephone access to the provider or the backup provider must 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 encourages maximum physical integration into the community.

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.

Supported living coaching services can be made available to recipients who are in the process of looking for a residence within 90 days before moving, 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 recipients 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.

The homes of individuals receiving supported living coaching services must meet requirements set forth in Rule 65G-6.004, F.A.C.

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 or licensed residential facility during the search process and may be receiving residential habilitation services.

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**Supported Living Coaching**, continued

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**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.

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**Limitations and Exclusions**

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. This provision applies to new providers. 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.

An exception can be requested by the recipient to the APD regional office to request a waiver to allow supported living services to be provided on the property of a family member, in a separate structure, with a separate lease.

Supported living coaching services are not to be provided during the same period of time as residential habilitation services or when the recipient is living in the family home, 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.

An acceptable arrangement may not include the recipient's parents, step-parents, guardian, or guardian advocate living in the same residence.

Supported living coaching services may not be provided by a supported living coach who is living in a recipient's home.

The supported living coaching provider or the provider's immediate family must not be the recipient's landlord or have any interest in the ownership of the housing unit as stated in Rule 65G-5.004, F.A.C. If renting, the name of the recipient receiving supported living coaching must appear on the lease either singularly or with a roommate or a guarantor.

A recipient receiving supported living coaching service must live with no more than two other people who have developmental disabilities and must have control over daily routines.

Supported living coaching services are limited to the amount of duration as scope of the services described in the recipient's support plan and current approved cost plan.

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## Support Coordination

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### Description

Waiver 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 the 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 Medicaid state plan services, third party payers, and natural supports. They also can include generic resources through other state, federal, and local government and community programs and supports, available to all residents that support people at home, work, and develop meaningful relationships and community membership.

The iBudget Florida system places a special emphasis on the WSCs' working with recipients and families to locate and develop natural and community supports. This will require going beyond the generic resources available from established non-profits. Instead, WSCs will need to work with recipients 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 a recipient outside of a formal organizational program of assistance.

WSCs are responsible for supporting a recipient's self-direction, working creatively to meet their needs, and being vigilant about monitoring the recipient's health and safety.

The iBudget Waiver 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. The waiver is to be the payer of last resort. Waiver services are only one element of the supports for a recipient. Recipients, families, legal representatives, WSCs, and providers are responsible for seeking non-waiver supports to augment and even replace waiver-paid services.

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

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**Support Coordination**, continued

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**Description**,  
continued

Waiver support coordinators must use a person-centered approach to identify a recipient's goals and plan and implement supports and services to achieve them (e.g., conversations with the recipient and those who know the recipient best along with 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](http://www.apd.myflorida.com).

All levels of WSCs must help the recipient monitor and manage the recipient's budget allocation. They are limited, full, and enhanced. If recipients are eligible for more than one, they can choose the level that best meets their needs.

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

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

Individuals must use all resources available to them prior to using their budget allocation. WSCs are responsible for supporting individuals' self-direction, working collaboratively with others to meet the individual's 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.

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**Support Coordination**, continued

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**Who Can Receive**

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

- Full
    - All recipients age 21 years or 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 individuals with developmental disabilities, a nursing facility, or the Developmental Disabilities Defendant Program 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
  - Recipients or their legal representatives may choose limited support coordination
    - For individuals over the age of 21 years, limited support coordination can be selected only after the recipient has 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
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**Who Can Provide**

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

When the WSC submits a complete application including a Level II background clearance and an APD state-wide pre-service training verification, the APD regional office will determine that the applicant is 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 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 II background screening results that indicate no disqualifiers.

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**Support Coordination**, continued

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**Full Support Coordination**

Full support coordination provides significant support to a 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 must 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, seven days per week.
- Provide basic information to recipients about the waiver and iBudget system and refer the recipient to the APD regional office where more detailed training is available.
- Assist the recipient with identifying, interviewing, selecting, and coordinating service providers.
- Determine if the services being provided meet the recipient's expectations. This can be accomplished through conversations with the recipient, and those who know and support the recipient, through reviews of service providers' documentation, and by monitoring the recipient's involvement in and satisfaction with the services being provided.
- 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, seven 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 recipient's budget allocation.

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

- Provide basic information to the recipient about the APD iBudget Waiver system, and make referrals to the APD regional office where the recipient can receive more detailed training.
  - Complete the support plan and cost plan yearly.
  - Make adjustments to cost plan as requested by recipient.
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**Support Coordination**, continued

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**Limited Support Coordination**, continued

- Provide information and referrals on locating, selecting, and coordinating waiver providers, Medicaid state plan, community, natural, and other supports. The recipient, recipient's family, and other persons supporting the recipient must locate, select, and coordinate the supports and services, notifying the WSC of their decisions.
- Provide guidance in evaluating quality of services and satisfaction with services and providers.
- Maintain contacts as defined in this section.
- Accurately complete the eligibility worksheet within 365 calendar days of the previous year.

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

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**Enhanced Support Coordination**

Enhanced support coordination services consist of activities that assist the recipient in transitioning from a nursing facility or an ICF/IID, to the community, or for assisting recipients who need a more intensive level of support coordination.

When a transition is involved, enhanced support coordination is intended to be time limited for three months prior to discharge from the above named facilities, and for 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. If the recipient'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 will 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 these activities with the facility's discharge planning processer.

The WSC must develop an initial support plan for the recipient, taking into account 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.

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**Support Coordination**, continued

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**Enhanced Support Coordination**, continued

Waiver support coordinators 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 must 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 must have, at a minimum, weekly face-to-face contact with the recipient for the first 30 days following discharge from the facility. The WSC providing enhanced support coordination is on call twenty-four hours per day, seven days per week for the recipient.

The WSC must 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 in excess of the three months approved for transition. If transition does not occur, the WSC cannot bill for WSC services.

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**Service Requirements**

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. If an individual treating provider number is not issued within 90 days of application, the individual WSC or hiring agency should contact the APD regional office to determine the status of their application.

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

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**Standard Caseload Size**

The standard caseload size for WSCs is 43 full-time recipients per support coordinator. A recipient who receives limited WSC is counted as a half-time recipient on the caseload. Waiver support coordinators who provide limited support coordination can have a caseload greater than 43 recipients, not to exceed the equivalent of 43 full-time recipients.

Supervisors of support coordination must 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 and support coordination needs of the recipient are met.

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.

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**Support Coordination**, continued

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**Vacancies and Leaves of Absence**

No later than five days after a vacancy occurs or a leave of absence is 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 provisions 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. 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. Failure to notify the APD regional office of the vacancy within the required timeframes will result in recoupment of funds received by the provider.

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 transitioning to another enrolled provider.

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**Dual Employment**

Waiver support coordination 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 submit to the APD regional office for review and approval 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.

Should an enrolled WSC provider, agency manager, or supervisor who is dual employed choose to expand the caseload size, an update to the dual employment plan must be submitted to the APD regional office that specifically addresses the manner in which contact will be maintained and how competing priorities will be 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.

The APD regional office must 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.

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**Support Coordination**, continued

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**Dual Employment,**  
continued

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.

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, seven-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.

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

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

Unless an exception is granted by APD, WSCs do not have the option as a provider to decline to serve recipients who choose services. If the recipients are within the geographic boundaries approved by APD, the WSC has the capacity to serve them. Exceptions made by the APD regional office must be approved in writing by the APD state office. If a recipient wants to interview a WSC as a possible service provider, the WSC must be available to meet the recipient at a location that is convenient to the recipient.

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, seven 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 WSC's on-call system must be approved by the APD regional office as a part of the application process.

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**Support Coordination**, continued

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

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Each WSC is required to identify a backup WSC to provide ongoing services during the 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 must be available to their recipients without telephone toll charges.

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

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**Prohibited Activities**

The provider, its board members, and its employees or subcontractors must 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 must not:

- 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 of a recipient served by the provider.
  - Be the legal representative or representative payee for any benefits received by a recipient served by the provider.
  - 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 a recipient from a service provider who is a family member of the provider or any employee of the provider.
  - 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.
  - Assume control of a recipient's finances or assume possession of an recipient's checkbook, investments, or cash.
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**Support Coordination**, continued

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**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, must 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.

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**Support Coordination Quality Assurance**

Owners of support coordination agencies must have a comprehensive internal quality assurance management plan to actively monitor and supervise treating WSCs employed by their agency. This plan should include a systematic method of inspecting and reviewing all required documentation and activities. The agency owner must provide ongoing technical assistance and training to their employees in order to ensure that they are fulfilling all requirements as effectively and professionally as possible. This includes processing 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 that 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.

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**WSC Access to Agency Electronic Systems**

The WSC provider is responsible for the cost of the electronic access to APD's intranet site, as well as entering, updating, and ensuring the accuracy of all demographic and recipient-related information pertinent to the recipient in the ABC and iBudget Waiver systems. 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.

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**Support Coordination**, continued

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**WSC 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.

The WSC provider is responsible for the cost of the electronic VPN access to the APD network as well as entering, updating, and ensuring the accuracy of all demographic and recipient-related information pertinent to the recipient in the ABC and iBudget waiver systems. Information includes recipient address, county of residence, disability information, program component, legal representative name and address (if applicable), employment information and type of benefits received. Each WSC must have their own unique account.

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**Transition of Recipients between Support Coordinators**

If a recipient requests a new support coordination provider, the change must occur at the beginning of a month unless otherwise approved by the APD regional office.

If, while serving a recipient, the recipient chooses another WSC or provider, the current WSC must 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 must assist the recipient in making a smooth transition to the new provider.

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**Central Record**

Central records are the property of APD and must be relinquished to APD immediately upon request. The Agency for Persons with Disabilities retains the right to review, retrieve, or take possession of a recipient's record at any time.

If 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 must ensure that all appropriate central record information is transferred to the new provider or to the APD regional office 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.

The provider must maintain each recipient's central record in accordance with Chapter 393, F.S.

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.

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**Support Coordination**, continued

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**Billing Requirements**

For reimbursement purposes, the WSC provider must meet certain basic billing requirements (which may be maintained electronically). These include:

- Support coordination notes that document the support coordination services rendered. These notes must be specific to each 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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**Recipient Contact Requirements**

The purpose of a face-to-face visit with the recipient is to discuss progress, changes, or both, to the recipient's goals, status of any unresolved 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 in achieving their goals. Face-to-face contacts must 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 per the recipient's wishes.
- Promote advocacy or informed choice for the recipient.
- Follow up and resolve concerns or conflicts.

Waiver support coordinators are required to meet face-to-face with recipients based on the WSC level. For full support coordination, WSCs must have two billable contacts monthly with the recipient or on the behalf of the recipient; for limited support coordination, WSCs must have one billable contact monthly with the recipient or on the behalf of the recipient; and for enhanced support coordination, WSCs must have at least four billable contacts monthly with the recipient or on the behalf of the recipient in order to bill Medicaid.

Face-to-face visit requirements for recipients receiving supported living services:

- The WSC must:
    - Conduct monthly face-to-face visits with one a face-to-face visit in the recipient's home at least once every three months. This face-to-face visit will include a supported living quarterly review.
    - 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.
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**Support Coordination**, continued

**Recipient Contact Requirements**, continued

Additionally, for recipients receiving supported living services, 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, including Florida Medicaid, to determine continued waiver eligibility at the time of the quarterly meeting.
- For recipients living in an ALF:
  - WSCs must conduct monthly face-to-face visits, with every other month face-to-face contact at the facility. Recipients residing in ALFs must receive full support coordination.
- For recipients residing in a licensed residential facility:
  - WSCs must conduct monthly face-to-face visits with 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 WSC must conduct a 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. At least one of the face-to-face visits must be in the home. The need for more frequent face-to-face visits can be determined by the recipient, family, or primary caregiver. The WSCs must 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 if over the age of 18 years.
- 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.

**Support Coordination**, continued

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**Recipient  
Contact  
Requirements,**  
continued

- 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, at least one that will be at the recipient's residence and at least two additional billable activities during the same month.
- 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.

Waiver support coordinators 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. 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 do 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, or providers do not qualify as contacts.

For recipients who are not receiving assistance with financial management from the supported living provider, the WSC will review financial status and benefits with the responsible party to ensure that benefits are correct and protected.

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.

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**Support Coordination**, continued

**Recipient Contact Requirements**, continued

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If there is an issue for which no solution can be determined at the meeting, it will be referred within five business days to the APD regional office for review if it impacts the person's stability in the community.

When a direct service provider not otherwise licensed to administer medication supervises the self-administration of medication to a recipient or administers medication to a recipient, it is the responsibility of the WSC to ensure that the direct service provider has taken and passed an APD approved Medication Administration Training course, and has a current medication administration validation certificate as required by Chapter 65G-7, F.A.C., on file, and that it is updated annually.

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**Support Plan Development and Update 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 invited by the recipient to participate in the support plan meeting. At a minimum, it involves 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 office to ensure that the APD's online iBudget Waiver system has accurately generated service authorizations.
  - Accurately complete the waiver eligibility worksheet regarding eligibility for Medicaid and Medicaid home and community-based waiver services.
  - Ensure that Medicaid eligibility is maintained by providing all necessary assistance to the recipient to maintain Medicaid benefits as a part of the support plan. With the recipient's permission, the WSC must review the recipient's personal funds to determine if funds are properly accounted for and are not in excess of the Medicaid asset limit.
  - 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 happened in the life of the recipient during the previous year.
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**Support Coordination**, continued

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**Support Plan Development and Update Requirements**, continued

- Provide information to recipients currently in ADTs, sheltered workshops, or segregated work environments to apprise them of the options available for work activities, volunteer activities, and training. The WSC must request a Benefits Planning Query (BPQY) from the Social Security Administration for each recipient who indicates an interest in working, for the purpose of monitoring income and assets, and to determine the impact on Medicaid eligibility.
- The BPQY will be discussed with the recipient, the family, and legal representative, and will be placed in the recipient's central record (can also be in the form of a case note). The BPQY will be requested only if the recipient experiences an impact on income and benefits.
- For recipients in supported living or a licensed residential facility who are taking two or more medications for seizure management or psychotropic medications, the WSC will document in the support coordination progress notes, all attempts and efforts to ensure a review is completed annually by a licensed psychiatrist, neurologist, or an ARNP, or PA 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 services provided to the recipient to ensure the services are consistent with the service authorization plan and are reflecting progress of the recipient's goals.
- Review claims information to ensure claims are consistent with the service authorization plan.
- Assist with managing APD budget allocations to ensure that recipients have sufficient funds to meet their Medicaid services needs throughout the year. If the WSC becomes aware that the service limits have been exceeded, or if the WSC feels the recipient's budget allocation will be depleted before the end of the year, the WSC will work with the recipient to adjust utilization to better cover the year and still meet needs. The WSC must immediately notify the APD regional office if an adjustment to utilization is not complied with by recipient and provider.
- Monitor service provision to ensure the recipient's health and safety.
- Monitor progress on goals and recipient satisfaction with services and providers.

The WSC must accurately complete the Waiver Eligibility Worksheet regarding eligibility for Medicaid and Medicaid Home and Community-Based Waiver services every 365 days. This may be done at the time of the support plan, if the support plan coincides within the 365 days.

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**Support Coordination**, continued

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**Support Plan Development and Update Requirements**, continued

On an as-needed basis, the WSC will:

- Make changes to the recipient's support plan and cost plan through the online iBudget Waiver system, along with required documentation. Justification can be provided in the iBudget notes to APD unless major changes in services are being requested. Significant changes to services should then be reflected in the Cost Plan Adjustment Worksheet showing services and reallocation of funding for services within iBudget allocation. If required, goals should be provided on this form. If the change negatively affects a provider, the support coordinator must 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.
  - Submit supplemental funding requests as needed.
  - Update the support plan when there is a significant change to the goal or a new goal is added. The updates can be handwritten on the current plan with a copy of the affected page(s) provided to the recipient or legal representative.
  - Provide notice to the recipient regarding APD determinations that can impact 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.
  - If a recipient's Medicaid eligibility is terminated, the WSC must immediately work with the recipient to have Medicaid reinstated. Additionally, the WSC should immediately notify all providers. (If a person is not eligible for Medicaid, all service authorizations for that person will be rejected by the Medicaid billing system. Upon reinstatement of Medicaid, the WSC must re-submit a service authorization to each provider.
  - Provide a printed or scanned copy of the full iBudget waiver cost plan to the recipient, the legal representative, or both, no later than ten working days following the support plan effective date. The printed cost plan should include the first page showing the annual budget allocated amount, the reserve amount, and the 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 or hand delivered during a face-to-face meeting if that meeting is within the ten day timeframe identified above.
  - Provide to the recipient, the legal representative, or both, via secure e-mail, U.S. mail, or hand-delivered, a copy of all annual changes made to the support plan, along with an APD approved cost plan.
  - Document in the progress notes the date and method by which the support plan and the cost plan were provided to the recipient or legal representative.
  - File a copy of the support plan and the cost plan signature pages in the recipient's central record.
  - Address and resolve issues identified by meeting with the recipient and pertinent providers.
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**Support Coordination**, continued

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**Recipients Newly Enrolled on a Waiver**

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

For new iBudget Waiver recipients, the WSC will provide the recipient with information about the concepts of the waiver, 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](http://www.apd.myflorida.com)) and other available assessments as a basis for working with the recipient to develop the recipient's initial support plan 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 45 consecutive days of the recipient's selection of the WSC. Copies of the support plan will be given to the recipient and legal representative no later than ten working days following the effective date of the annual support plan. The WSC will document in the WSC progress notes the date the plan was submitted to APD.

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

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**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 completing, facilitating completion, and scheduling the APD approved assessment by notifying the recipient and attending the meeting (if requested by the recipient). When requests for assistance in facilitating scheduling the assessment or requests for access to central records are received from the APD regional office, the WSC will comply within 48 hours.

The WSC must 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<sup>st</sup> 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, or review. Alternatively, the WSC must 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.

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**Support Coordination**, continued

**WSC Activities  
Required for  
Recipients  
Enrolled in the  
Waiver**

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Prior approval by the APD regional office is required for the redistribution of waiver funding for the following service families: residential services, support coordination, and therapeutic supports and wellness.

The iBudget HCBS Waiver allows flexibility to move funding within the following service families without prior approval from the APD: life skills development, personal supports, supplies and equipment, dental, and transportation. All service changes to flexible services must be in accordance with those preapproved flexible services currently approved in the recipient's iBudget. If other flexible services are needed that are not currently preapproved, the WSC must contact the regional office for approval.

The WSC can make these changes in the service authorizations as requested by the recipient or legal representative and can move funding from one quarter to the next or from a future quarter to the current quarter as needs change. The WSC can move unused units of a service from one quarter to the next quarter up to the end of the fiscal year depending on the needs of the recipient. For a change in service providers requested by the recipient or legal representative, the WSC must do the following:

- Contact the outgoing service provider by phone prior to a change being made in order to reconcile what units have been provided but not yet billed.
  - Change the service authorization to reflect the number of units that are appropriate to be billed for the remainder of the service authorization period. The notice of change in service authorization should be given in advance and be for at least 15 days (unless mutually agreed upon for less time. Best practice would be for agreements to be in writing between the WSC and provider).
  - Contact the recipient or legal representative to verify the time frame of the change in a service provider.
  - Document in the "Notes" section of the iBudget electronic system that the outgoing provider has been notified of the service authorization end date.
  - Send the outgoing provider:
    - A new service authorization showing the end date of service and utilization approved for the time period that remains, if any.
    - A new service authorization showing the end date of service and the units approved for the total time period of the service authorization.
  - If no services were ever provided or billed by the outgoing provider, a cancelled service plan (no services have been provided or billed on that service plan) must also be sent to the outgoing provider to ensure services are not provided.
  - Notify the new provider of the service authorization.
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**Support Coordination**, continued

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**WSC Activities  
Required for  
Recipients  
Enrolled in the  
Waiver**, continued

- In situations that require a more immediate change to the service authorization, the WSC must do the following:
  - Call the outgoing service provider.
    - The outgoing provider must:
      - Document, via secure e-mail, the phone notification of the change.
      - Wait to provide services until he receives the revised approved iBudget service authorization from the WSC.
    - Document the conversation in both the provider's and WSC's case notes.
    - Send a secure e-mail communication to the provider authorizing changes. This may only be done when regional office staff does not need to approve the change.
    - Provide written approved service authorization to the outgoing provider as quickly as possible. This process is reserved strictly for those situations in which advanced written notice is not possible due to immediate service change needs of the recipient.
  - For a change in residential services provider, the WSC should ensure a smooth transition from one provider to another to allow medication, Social Security, Medicaid, and critical issues be addressed before the transfer occurs. This does not include the need for a transfer due to health and safety needs.

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

Funding to address emergency situations will be reviewed and approved by APD if the situation cannot be accommodated within the current allocation.

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. 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. The service should be reviewed to determine whether a more appropriate service should be requested.

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**Support Coordination**, continued

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**WSC Activities  
Required for  
Recipients  
Enrolled in the  
Waiver**, continued

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.

The WSC must 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.

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 must 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 must record any verbal approvals in a case notes. In addition, the WSC must certify that the individual or legal representative has 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 must 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 must 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 must 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 must notify the APD regional office of the emergency situation. The WSC must 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.

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**Support Coordination**, continued

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

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. For recipients receiving a supported living subsidy from APD, the WSC will review and update the financial profile on a quarterly basis, or more frequently as needed. 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.

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**Responsibilities for Recipients in Supported Living Arrangements**

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.

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.

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**Support Coordination**, continued

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**Responsibilities for Recipients in Supported Living Arrangements**, continued

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 must 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.
  - 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.
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**Support Coordination**, continued

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**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, on different days of the week.

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**Limitations and Exclusions** 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 recipient'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. The WSC should make sure that available supports are accessed through Medicaid and Medicare. If the recipient 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 cannot request or authorize services, units, or rates not consistent with this handbook and APD fee schedules.

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**Behavior Analysis Services**

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

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## Behavior Analysis Services, continued

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**Description,**  
continued

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

The services are designed to facilitate ongoing changes in the 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 as is the monitoring of procedural integrity and program effectiveness.

In order to determine when and in what situations the recipient's challenging behavior occurs, the recipient's behavior is assessed to identify 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.

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

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

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

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**Description,**  
continued

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

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

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

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

In addition, indirect activities that occur when the 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 a recipient's behavior plan to the APD LRC, and attending meetings relevant to the recipient's treatment, including the recipient's treatment team, psychiatrist, and school related meetings. Providers can only bill for indirect services up to a maximum of 25 percent of the total units for the cost plan year. In those cases, where service hours are limited to four hours or less per month, an average of one hour per month maximum can be billed for indirect services.

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

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

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**Behavior Analysis Services**, continued

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**Place of Service** These services can be provided in the recipient's place of residence, while providing 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.

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**Limitations and Exclusions** A recipient must receive no more than 16 quarter hour units of behavior analysis service per day. A unit is defined as a 15 minute time period or portion thereof. This service can be provided concurrently (at the same time and date) with another service. These services are not to be provided in the school system or take the place of services required under provisions of the Individuals with Disabilities Education Act (IDEA).

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.

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**Behavior Assistant Services**

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**Description** The primary purpose of behavior assistant services (BAS) is to provide support in implementing the BASP created by the waiver behavior analyst or provider. 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 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 and to evaluate a caregiver's maintenance of skills needed for behavior program implementation.

Behavior assistant services can only be provided under the supervision of a behavioral services provider. Supervision should include observation of the behavior assistant working with the recipient, their caregivers, or other providers. The behavior assistant must maintain documentation signed by the behavior analyst providing supervision.

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**Behavior Assistant Services**, continued

**Description,**  
continued

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

In the initial stages of treatment, the BAS 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 method.

In addition to training and systematically transferring the implementation of the plan to the caregivers, BAS also include monitoring of caregivers implementing the behavior plan, data collection, copying of forms and documents, 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.

In all instances of BAS, the daily progress notes must thoroughly document the recipient's activities, as well as observations, data collection, and planning.

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

- Health and safety needs are a direct result of the recipient's challenging behaviors pose a documented risk to the recipient or the community, and can result in a loss of the current living environment and placement in a more restrictive setting. Documentation can include police reports, hospitalization reports, medical reports, incident reports, or other records that will substantiate the severity and frequency of the behavior.
- Other paid or unpaid services or supports requiring time-limited instruction on learning how to carry out the behavior plan effectively.
- For a time-limited period during transitional residential changes, such as movement from intensive behavior residential habilitation to behavior focused residential habilitation, 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 IDEA.

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**Behavior Assistant Services**, continued

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**Behavior Analysis Services Plan**

The BASP should include methods for evaluating the proficiency of caregivers in the behavior plan implementation, and a time-based fading plan within 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 BASP must be designed, implemented or monitored and approved in accordance with Rules 65G-4.009 and 65G-4.010, F.A.C.

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**Place of Service**

These services can be provided in the recipient's place of residence or setting(s) relevant to the behavior problems being addressed (typically with the primary caregivers present). Behavior assistant services cannot be provided in any school setting.

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**Limitations and Exclusions**

Behavior assistant services are to be time limited. Once paid or unpaid supports gain the skills and abilities needed to assist the recipient in functioning more independently and in less challenging ways, the behavior assistant services should be faded out and discontinued.

Behavior assistant services are limited to a maximum of 32 quarter hours per day. Recipients requiring over 24 quarter hours per day must have monthly reviews by the LRC chair or regional behavior analyst. Review of this service may occur as a desk review with required submission of behavioral graphs and evidence of caregiver competency provided by the supervising behavior analyst.

The behavior assistant must maintain evidence of required monthly "supervision" on a supervision log, showing the date, time started, and time ended with signatures of both the behavior assistant and the supervising behavior analyst.

In addition, to continue initial authorization or renew the behavior assistant service after six months, the supervising behavior analyst must present copies of supervision logs at the time of periodic LRC status reviews or when renewal of BAS are requested, otherwise continuation or renewal of BAS will be denied.

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## Dietitian Services

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### Description

Dietitian services are those services prescribed by a physician, ARNP, or PA 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 a 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.

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### Service Requirements

Dietitian services require an annual order or prescription from a physician, ARNP, or PA, and must 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 service is prescribed.

Recipients requiring nutritional supplements must have a dietitian's assessment documenting such need that is updated at least annually.

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](http://www.mymedicaid-florida.com).

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### Place of Service

This service can be provided in the:

- Provider's office.
  - Recipient's home.
  - Community setting.
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## Private Duty Nursing

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**Description** Private duty nursing services are prescribed by a physician, ARNP, or PA and consist of individual, continuous nursing care provided by registered or licensed practical nurses.

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**Service Requirement** 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.

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**Place of Service** Private duty nursing services are provided primarily in the recipient's own home or family home. An exception to private duty nursing place of service would be for those recipients who require continued nursing services in order to attend adult day training or other daily service sites.

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**Limitations and Exclusions** This service is limited to recipients age 21 years or older who are eligible for active nursing interventions on a continuous basis for over two consecutive hours per episode. This service is normally provided on a one-to-one basis. 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. This service can be provided concurrently with some other services, with prior written approval from the APD regional office.

Private duty nursing services are not be used for ongoing medical oversight or monitoring of direct care staff or caregivers in a licensed facility, the recipient's own or the family home.

Note: For more information on Medicaid state plan coverage, see the Florida Medicaid Home Health Services Coverage and Limitations Handbook.

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## Residential Nursing Services

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<b>Description</b>	Residential nursing services are services prescribed by a physician, ARNP, or PA and consist of individual, continuous nursing care provided by registered or licensed practical nurses.
<b>Service Requirements</b>	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.
<b>Place of Service</b>	Residential nursing services must be provided in a licensed residential facility, group, or foster home considered to be the recipient's place of a residence. An exception to residential nursing place of service would be for those recipients who require continued nursing services in order to attend adult day training or other daily service sites.
<b>Limitations and Exclusions</b>	<p>Residential nursing must 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.</p> <p>This service is for recipients who require ongoing nursing intervention for of over three continuous hours.</p> <p>To be eligible for this service, a recipient must require active nursing intervention, on a continuous basis. 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.</p> <p>Residential nursing are not be used for the ongoing medical oversight or monitoring of direct care staff or caregivers in a licensed facility, the recipient's own home, or the family home.</p> <p>Note: For more information on Medicaid state plan coverage, see the Florida Medicaid Home Health Services Coverage and Limitations Handbook.</p>

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**Residential Nursing Services**, continued

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<b>Reimbursement</b>	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.
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**Skilled Nursing**

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<b>Description</b>	Skilled nursing is a service prescribed by a physician, ARNP, or PA and consists of part-time or intermittent nursing care visits, provided on a daily basis by registered or licensed practical nurses.
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<b>Service Requirements</b>	A nursing assessment must be performed to determine the need for the service, or to evaluate the recipient in order to develop a care plan. 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.
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<b>Place of Service</b>	Skilled nursing services are provided at the recipient's place of residence and other waiver service sites, such as an adult day training program.
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<b>Limitations and Exclusions</b>	The recipient cannot receive more than four visits per day from a licensed practical nurses, registered nurse, or a combination of both. 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.
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Skilled nursing services cannot 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. This service must be billed at the rate for the level of nurse providing the service.

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](http://www.mymedicaid-florida.com).

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**Skilled Nursing**, continued

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<b>Reimbursement</b>	The rate for skilled 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. Skilled nursing services for individual's under the age of 21 years cannot be reimbursed without an AHCA exception letter allowing for the provision of the service under the Waiver. Exception letters must be renewed annually.
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**Occupational Therapy**

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<b>Description</b>	Occupational therapy is a service prescribed by a physician, ARNP, or PA that is necessary to produce specific functional outcomes in self-help, adaptive, 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 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.
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Occupational therapy is a one-on-one service with a recipient age 21 years and older.

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<b>Place of Service</b>	These services are provided in the therapist's office, in the recipient's residence, or anywhere in the community.
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<b>Limitations and Exclusions</b>	Occupational therapy is a one-on-one service with a recipient. A recipient cannot receive more than eight quarter hours per day.
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## Physical Therapy

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### Description

Physical therapy is a service prescribed by a physician, ARNP, or PA 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-on-one service with a recipient age 21 years or older.

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### Place of Service

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

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### Limitations and Exclusions

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

A recipient cannot receive more than eight quarter hour units per day. 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](http://www.mymedicaid-florida.com).

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## Respiratory Therapy

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**Description** Respiratory therapy is a service prescribed by a physician, ARNP, or PA 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-on-one service with a recipient age 21 years or older.

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

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**Limitations and Exclusions** A recipient cannot receive more than eight quarter hour units per day.

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## Speech Therapy

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**Description** Speech therapy is a service prescribed by a physician, ARNP, or PA and is necessary to produce specific functional outcomes in the communication skills of a recipient with a speech, hearing, language disability, or service necessary to remediate swallowing disorders and oral motor functions.

Speech therapy is a one-on-one service with a recipient age 21 years or older.

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**Service Requirements** The service can also include a speech therapy assessment (does not require a prescription). In addition, this service must 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.

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**Speech Therapy**, continued

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**Place of Service**

This service is provided in the:

- Therapist's office.
- Recipient's place of residence.
- Community.

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**Limitations and Exclusions**

Speech therapy and assessment services are available through state plan Medicaid Therapy Services for recipients under the age of 21 years.

A recipient cannot receive more than eight quarter hour units per day. Speech therapy assessments are limited to one per year. Assessments for augmentative communication devices and assessments for training are covered by the State Plan Medicaid Therapy services for all Medicaid recipients.

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**Specialized Mental Health Counseling**

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**Description**

Specialized mental health services focus on the unique treatment of psychiatric disorders and rehabilitation for impairments for recipients with developmental disabilities and mental illness and restoration to the best possible functional level. These services include specialized individual, group, and family therapy provided to recipients using techniques appropriate to this population.

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

Specialized mental health counseling services also 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 services and supports necessary to enhance emotional and behavioral functions.

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**Specialized Mental Health Counseling**, continued

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**Place of Service** These services are provided in the provider's office, the recipient's place of residence, or anywhere in the community.

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**Limitations and Exclusions** This service excludes hippo therapy, equine therapy, horseback riding therapy, music therapy, and other forms of recreation therapy.

A recipient cannot receive more than eight quarter hour units per day.

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**Transportation Services**

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**Description** This service provides transportation to and from the recipient's home and community-based waiver services, enabling the recipient to receive the supports and services identified in 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 waiver must 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, are 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 must be encouraged using 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 as required in Chapter 427, F.S.

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**Who Can Provide** Transportation to waiver services for eligible recipients must be:

- Taxi
  - Private vehicle
  - Private non-profit agencies
  - Private for profit agencies
  - Multi-load passenger van
  - Mass transit and public transportation systems
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**Transportation Services**, continued

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**Service Requirements**

Transportation providers delivering waiver services to recipients must not charge the recipient a co-payment.

Should the APD regional office utilize transportation providers that are not in the coordinated transportation system, the regional office must contact the community transportation coordinators (CTC) in the recipient's county of residence.

Note: For information regarding transportation service requirement, see the Non-Emergency Transportation Services Coverage and Limitations Handbook.

When a recipient requires an escort to provide assistance, the 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.

When paid vendors are family members, the payment is made to the relative for specific services rendered. Adequate justification is required and approved by the APD regional office. Documentation must be maintained in the WSC's file for the recipient, as well as in the provider's file.

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.

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**Place of Service**

Transportation is provided anywhere in the community.

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**Limitations and Exclusions**

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:

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

Budget Waiver funds must not be used when the recipient's trip is for a Medicaid state plan service.

When a provider is reimbursed by the trip, a recipient cannot receive more than two, one-way trips per day.

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**Transportation Services**, continued

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**Reimbursement**

Providers must utilize 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 recipients transported.

Monthly billing is permissible for actual expenses incurred. Limited transportation providers will be reimbursed at the state mileage rate.

Providers may bill for their service by the mile, by the one-way trip, or by the month.

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**Dental Services**

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**Description**

Adult dental services cover dental treatments and procedures including 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's state plan dental services.

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**Service Requirements**

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.

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**Place of Service**

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

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**Limitations and Exclusions**

Adult dental services are limited to recipients age 21 years or older. Adult dental services covered by the waiver must not duplicate services provided by Medicaid's state plan dental services.

Adult cleanings are limited to two per year.

A recipient must not receive more than ten quarter-hour units of this service per day. The need for best health would be mentioned on the support plan but the need for dental services would be one of the services needed to achieve that goal.

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**Dental Services**, continued

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**Reimbursement**

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

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**CHAPTER 3**  
**REIMBURSEMENT AND FEE SCHEDULE**

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**Overview**

**Introduction**

This chapter describes reimbursement information for iBudget Waiver services.

**In This Chapter**

This chapter contains:

<b>TOPIC</b>	<b>PAGE</b>
Overview	3-1
Reimbursement Information	3-1
Service Authorization	3-4

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**Reimbursement Information**

**Procedure Codes**

The procedure codes listed in this handbook or the CMS-1500 are Healthcare Common Procedure Coding System (HCPCS) Levels I and II. Both levels are part of the nationally standardized code sets.

Level I of the HCPCS is comprised of Current Procedural Terminology (CPT), a numeric coding system maintained by the American Medical Association. All rights reserved. The CPT is a uniform coding system consisting of descriptive terms and identifying codes that are used primarily to identify medical services and procedures furnished by physicians and other health care professionals. CPT codes are identified using five numeric digits.

Level II of the HCPCS is a standardized coding system used primarily to identify products, supplies, and services not included in the CPT codes. HCPCS Level II codes are also referred to as alpha-numeric codes because they consist of a single alphabetical letter (A – V) followed by four numeric digits.

**Billing Requirements**

Providers cannot bill for services when a recipient is not in attendance, except as noted in the description section of that service. A provider must 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 the Agency for Persons with Disabilities (APD). Services authorized to bill concurrently with another service include behavior analysis, behavior assistant, private duty nursing, skilled nursing, and residential nursing provided the services are not duplicative. 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.

**Reimbursement Information**, continued

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**Provider  
Responsibility**

When presenting a claim for payment under the Medicaid program, a provider must supervise the provision of, and be responsible for, goods and services that:

- Have actually been provided to the recipient by the provider prior to submitting the claim (documentation should also be completed and maintained in the provider's file).
  - 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 laws.
  - Are documented by records made at the time the goods or services were provided.
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**Billing for Life  
Skills  
Development**

The number of daily hours is counted by hours and minutes. Minutes must be rounded at the end of the billing period to the nearest hour. For example, if a recipient attends an ADT for three days per week at two hours and 30 minutes per day:

- Daily billing would calculate to two hours per day.
- Weekly billing would calculate to 7.5 hours and would be billed at seven hours for that week.

When billing hourly, the recipient must be in attendance for at least one hour before the provider can bill for service.

Thereafter, providers must use the following billing instructions:

- Rounding down should occur for less than 30 minutes and rounding up should occur for more than 30 minutes
  - Rounding should occur at the time of billing by adding all hours for the billing period and then rounding as described above
  - No more than eight hours per day or a total of 2,064 hours per year can be provided and billed
  - No more than 112 hours per week of all life skills development combined can be provided
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**Reimbursement Information**, continued

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**Billing Procedures**

Each provider is required to submit all claims (paper or electronic) for waiver services directly to the Medicaid 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 as 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, the 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.

When billing hourly for adult day training, the recipient must be in attendance for at least 30 minutes in order to bill for the full hour. Thereafter, providers must use the following billing instructions:

- Rounding down should occur for 30 minutes or less
- Rounding up should occur for 31 minutes to 60 minutes

Note: For specific claim form billing instructions and procedures, see the Florida Medicaid Provider Reimbursement Handbook, CMS-1500.

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**Service Rates**

All rates are determined based on the availability of appropriated funding from the Florida Legislature. The iBudget Waiver services rates are standardized and established through Rule 59G-13.081, F.A.C. 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.

Note: For rate information, see the Florida Medicaid Developmental Disabilities Individual Budgeting Waiver Services Provider Rate Table. The current rate table is posted on the Medicaid fiscal agent's Web site at [www.mymedicaid-florida.com](http://www.mymedicaid-florida.com). Select Public Information for Providers, then Provider Support, and then Fee Schedules.

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## Service Authorization

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### Requirements

The provider must have an Agency for Persons with Disabilities (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 the waiver support coordinators (WSCs) at least quarterly, or as they change.

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. The 'Comments' section is not intended to be used for monitoring but for general guidance.

Any changes to the description of the amount, frequency, duration, intensity and scope of the service must be submitted to the provider in writing.

Waiver support coordinators must verify that the service authorization is correct according to the authorized amount of services in the APD iBudget system. In addition, other providers must review their service authorization and if adjustments or corrections are needed, they must contact the WSC immediately for issuance of a corrected authorization. If corrections are needed, the service provider should immediately contact the WSC for resolution.

The service authorization in the iBudget system is issued quarterly to providers and contains monthly allotments for the specific services they provide. This specifies the frequency, intensity, and duration of services. The service authorization must be in approved status in order for the service to be provided.

In order to allow flexibility of service for the recipient, the service authorization covers a three-month period, during which the recipient may schedule services according to their needs. Service units not spent as of June 30 of a fiscal year cannot be carried over to the next fiscal year.

For example, a recipient is going to change work hours and does not need the same level of employment support for one particular month. The WSC can place 10 units in January, skip February, and place 10 units in March, with no notes to specify otherwise. This allows the provider to provide and bill for 20 units of service within those three months.

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**Service Authorization**, continued

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**Documentation**

The notes section of the service authorization is used to further specify the recipient's preferred use of the service, e.g., to attend ADT three days per week or as preferred, not to exceed 60 days for the quarter. If no note is provided, the service provider will provide services and bill units of service from month to month to meet changing needs of the recipient up to the total identified on the quarterly service authorization.

The service provider must document the preference of the recipient and notify the WSC if a pattern develops that may require a change to a service authorization. The WSC should discuss changes with the recipient to determine whether the new pattern of services will continue or was temporary. Changes cannot be made for the convenience of the provider nor to ensure that the provider is able to bill out the entire quarterly service authorization if the recipient does not want that level of service. If the recipient confirms their preference to the WSC to continue this new service pattern, the WSC will adjust the following quarter's service authorization.

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**Service Change Needed**

As a recipient's needs change, the frequency, intensity, or duration of the service may change. The quarter represents the maximum approved costs for the services authorized during those three months. The WSC may adjust a service authorization to meet the recipient's individual's change in needs throughout the quarter as long as the changes remain within the annual budget allocation. It is critical that the WSC monitor any increase in service utilization to ensure that there are sufficient units to meet the needs for the entire quarter. The total funding amount for the quarter cannot be exceeded. For example, consumable medical supplies are approved at \$600 per quarter, which averages \$200 per month. However, if a short-term need arises that increases the monthly amount, the WSC would need to adjust the service authorization to accommodate this need. If the cost for the short-term need does exceed the quarterly budget for that service, another service must be reduced in order for the individual's total quarterly budget to remain the same.

If changes are needed during the quarter, the WSC will update the cost plan and send the updated authorization to the provider prior to the effective date of the service change. Advance notice of at least 15 days prior to the implementation of the service change should be the standard practice. With verbal agreement of the recipient and the legal representative, WSC, and provider, a change may occur more rapidly. Providers must not implement any change until they have received an approved copy of the revised iBudget service authorization.

If there are no notes on the service authorization, there is a maximum flexibility for service provision to meet the individual's needs within the rule requirements, service rates and maximum allowable budget for the quarterly service authorization.

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APPENDIX A  
BILLING AND DOCUMENTATION REQUIREMENTS



## DOCUMENTATION REQUIREMENTS

The following documentation must be maintained by providers. Items with an asterisk (\*) must also be provided to the WSC prior to billing. A copy can be 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, reference checks, education, training and experience, licensure, registration or certification as applicable. A provider must document requests for information from other providers, but must not be determined non-compliant due to lack of follow up by the sending provider.

Note: The quarterly time period begins on the effective date of the support plan. The third quarterly summary is the annual report. A provider may choose to do a monthly summary each month rather than a quarterly summary. The quarterly summary is based on applicable service logs or daily progress notes, all of which must be maintained by the provider.

The quarterly summary for Behavior Analysis Services should include 1) a summary of program monitoring and relevant factors affecting behavior; 2) objective summary of results or graphs; 3) analysis of data and summary of progress, identifying whether each target behavior has improved or not since the last quarter and since baseline; and 4) recommendations, if any. The annual report provides recommendations for the coming year, including a plan of fading based upon behavioral criteria.

<b>Billing and Reimbursement Requirements</b>	
<b>Adult Dental Services</b>	<ul style="list-style-type: none"> <li>• Copy of claim(s) submitted for payment including invoice for services.</li> <li>• All treatment records.</li> <li>• Copy of treatment plan.*</li> </ul>
<b>Life Skills Development</b>	<p><b>Life Skills Development - Level 1 (Companion)</b></p> <ul style="list-style-type: none"> <li>• Copy of claim(s) submitted for payment.</li> <li>• Service log (sent monthly).*</li> </ul> <p><b>Life Skills Development - Level 2 (Supported Employment)</b></p> <ul style="list-style-type: none"> <li>• Copy of claim(s) submitted for payment.</li> <li>• Service log (sent monthly).*</li> <li>• A quarterly summary for each quarter of the support plan year.*</li> <li>• The third quarterly summary also serves as the annual report and must include a summary of the previous three quarters.</li> <li>• It is the responsibility of the support coordinators to maintain documentation, in the form of a letter from the Division of Vocational Rehabilitation (VR) services or a case note detailing the date of contact with a named VR representative, and a summary of the conversation, etc., indicating a lack of available VR funding for supported employment.</li> <li>• An Employment stability plan, also known as the Individualized Plan for Employment (IPE), must be completed at the time of the 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:                         <ul style="list-style-type: none"> <li>– 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"> <li>• A letter from VR.</li> <li>• Documentation detailing contact with a named VR representative to include the date and summary of the conversation.</li> <li>• Claims for services are to be made upon completion of each individual benchmark.</li> </ul> </li> </ul> </li> <li>• Copy of claim(s) submitted for payment.</li> </ul>

DOCUMENTATION REQUIREMENTS, continued

<b>Billing and Reimbursement Requirements</b>	
<b>Life Skills Development, continued</b>	<p>The WSCs will follow the guidelines in the “Allocation, Budget and Contract Control (ACLM5) Screen Instructions”, when entering employment data. Updates to the recipient data on the ACLM5 screen will be made by WSCs as follows:</p> <ul style="list-style-type: none"> <li>• Quarterly for recipients who are not working and who are to receiving supported employment. These quarterly updates will include justification for the lack of employment.</li> <li>• Monthly for recipients who are not working and are receiving supported employment services. These quarterly updates will include justification for the lack of employment.</li> <li>• Monthly for recipients who are working and who are receiving supported employment services.</li> <li>• Quarterly for recipients who are working and who are not receiving supported employment services.</li> </ul> <p><b>Life Skills Development - Level 3 (Adult Day Training - ADT)</b></p> <ul style="list-style-type: none"> <li>• A quarterly summary for 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.*</li> <li>• 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.</li> <li>• 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) vehicle registration, and, (3) automobile insurance. Subsequent to enrollment, the provider is responsible for keeping this documentation up-to-date.</li> <li>• Daily attendance log.</li> <li>• 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 receipt of the support plan for continuation of services and annually thereafter. A copy of the implementation plan, signed by the recipient, must be furnished to the recipient, the recipient’s 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 must be documented in notes or quarterly summaries, as specified in each service. (For monitoring purposes, if the provider exceeds the 30 days, a 90% compliance rate will be accepted; however, if the provider exceeds 45 days the standard of 100% must apply). *</li> <li>• Service logs (sent monthly).*</li> </ul>

DOCUMENTATION REQUIREMENTS, continued

<b>Billing and Reimbursement Requirements</b>	
<b>Personal Supports</b>	<ul style="list-style-type: none"> <li>• Copy of claim(s) submitted for payment.</li> <li>• Copy of service log (sent monthly).*</li> <li>• 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.</li> <li>• 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) vehicle registration, and (3) automobile 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.</li> <li>• If used for skilled respite, prescription for service.</li> </ul>
<b>Respite-Recipients Under the Age of 21 in Family Home Only</b>	<ul style="list-style-type: none"> <li>• Copy of claim submitted for payment.</li> <li>• Service log (sent monthly).*</li> <li>• If used for skilled respite, prescription for service.</li> </ul>
<b>Residential Habilitation (Standard)</b>	<ul style="list-style-type: none"> <li>• Copy of claim(s) submitted for payment.</li> <li>• Daily attendance log (sent monthly).*</li> <li>• 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 receipt of the support plan for continuation of services and annually thereafter. A copy of the implementation plan, signed by the recipient, must be furnished to the recipient, the recipient's 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 must be documented in notes or quarterly summaries, as specified in each service.*</li> <li>• 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.*</li> <li>• 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.</li> <li>• 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) vehicle registration, and (3) automobile insurance. Subsequent to enrollment, the provider is responsible for keeping this documentation up-to-date.</li> </ul>

DOCUMENTATION REQUIREMENTS, continued

<b>Billing and Reimbursement Requirements</b>	
<p><b>Residential Habilitation (Behavior Focused)</b></p>	<ul style="list-style-type: none"> <li>• Copy of claim(s) submitted for payment.</li> <li>• Daily attendance log (sent monthly).*</li> <li>• 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 receipt of the support plan for continuation of services and annually thereafter. A copy of the implementation plan, signed by the recipient, must be furnished to the recipient, the recipient's 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 must be documented in notes or quarterly summaries, as specified in each service.*</li> <li>• 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, the Local Review Committee's (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.*</li> <li>• 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.</li> <li>• 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) vehicle registration, and (3) automobile insurance. Subsequent to enrollment, the provider is responsible for keeping this documentation up-to-date.</li> <li>• A copy of the current behavior analysis service plan (BASP) and the most recent behavioral assessment.*</li> </ul>
<p><b>Residential Habilitation (Intensive Behavior)</b></p>	<ul style="list-style-type: none"> <li>• Copy of claim(s) submitted for payment.</li> <li>• Daily attendance log (sent monthly).*</li> <li>• 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 receipt of the support plan for continuation of services and annually thereafter. A copy of the implementation plan, signed by the recipient, must be furnished to the recipient, the recipient's 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 must be documented in notes or quarterly summaries, as specified in each service.*</li> <li>• 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.*</li> <li>• 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.*</li> <li>• 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) car insurance. Subsequent to enrollment, the provider is responsible for keeping this documentation up-to-date.</li> </ul>

DOCUMENTATION REQUIREMENTS, continued

<b>Billing and Reimbursement Requirements</b>	
<p><b>Special Medical Home Care</b></p>	<ul style="list-style-type: none"> <li>• Service logs (sent monthly).*</li> <li>• Copy of claim(s) submitted for payment.</li> <li>• Nursing Care Plan and revisions.*</li> <li>• Nursing Assessment (must be completed at the time of the first claim submission and annually thereafter).*</li> <li>• 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 (sent monthly).*</li> <li>• Prescription for service and annually thereafter.*</li> <li>• List of duties to be performed by the nurse.</li> </ul>
<p><b>Supported Living Coaching</b></p>	<ul style="list-style-type: none"> <li>• Copy of claim(s) submitted for payment.</li> <li>• Daily progress notes (sent monthly) for the dates of service billed, 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. For monitoring purposes a 90% compliance rate is acceptable for each of these elements. However, if a health or safety issue is omitted, the 100% compliance rate applies). These progress notes must be placed in the recipient’s record prior to claim submission.*</li> <li>• 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’s effective date for continuation of services and annually thereafter. A copy of the implementation plan, signed by the recipient or the recipient’s legal representative, must be furnished to the recipient, the recipient’s legal representative and to the WSC at the end of this 30-day period.*</li> <li>• 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.*</li> <li>• 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"> <li>– The frequency of the supported living service.</li> <li>– How home, health, and community safety needs will be addressed and the supports needed to meet these needs, including a personal emergency disaster plan, which must be updated annually and any time the recipient moves to a different residence.</li> <li>– The method for accessing the provider 24 hours per day, seven days per week for emergency assistance.</li> <li>– A description of how natural and generic supports will be used to assist in supporting the recipient.</li> <li>– The Functional Community Assessment.</li> </ul> </li> </ul>

DOCUMENTATION REQUIREMENTS, continued

<b>Billing and Reimbursement Requirements</b>	
<b>Supported Living Coaching</b> , continued	<ul style="list-style-type: none"> <li>• A financial profile that includes strategies for assisting the recipient with 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 whether the recipient needs a monthly subsidy, which must be approved by the APD regional office.</li> <li>• Up-to-date information regarding the demographic, health, medical and emergency information for the recipient, and a complete copy of the recipient's current support plan. If the support plan has not been provided by the WSC, there should be documentation of attempts to obtain a copy.</li> <li>• 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) vehicle registration, and (3) automobile insurance. Subsequent to enrollment, the provider is responsible for keeping this documentation up-to-date.</li> </ul>
<b>Consumable Medical Supplies</b>	<ul style="list-style-type: none"> <li>• A copy of the claim(s) submitted for payment.</li> <li>• A copy of the service log (sent monthly),* listing supplies purchased.*</li> <li>• The original prescription for the supply (if prescribed).*</li> </ul>
<b>Durable Medical Equipment and Supplies</b>	<p>Prior to the provider submitting the claim for payment, the recipient's WSC must document that the equipment was received and that it works according to the manufacturer's description, either by conducting a site visit or obtaining verbal verification from the recipient, the family or the recipient's legal representative.</p> <ul style="list-style-type: none"> <li>• Copy of a pre-approved claim(s) form submitted for payment.</li> <li>• Original prescription for the medical equipment, if prescribed by a physician, advanced registered nurse practitioner (ARNP) or PA.*</li> <li>• Service log listing equipment provided and documenting the WSC's verification that the equipment was received and works, per manufacturer's description, prior to submission of claim for payment (sent monthly).*</li> </ul>
<b>Environmental Accessibility Adaptations</b>	<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, the family or the recipient's legal representative.</p> <p>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 the family or the recipient's legal representative, or conduct a site visit.</p> <ul style="list-style-type: none"> <li>• Copy of claims submitted for payment.</li> <li>• 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 (sent monthly).*</li> <li>• Original prescription for adaptations and medical equipment.*</li> </ul>
<b>Personal Emergency Response Systems (Unit and Services)</b>	<ul style="list-style-type: none"> <li>• Copy of claim(s) submitted for payment.</li> <li>• Service log or invoice, detailing services provided (sent monthly).*</li> </ul>

DOCUMENTATION REQUIREMENTS, continued

<b>Billing and Reimbursement Requirements</b>	
<p><b>Support Coordination-Limited, Full, and Enhanced</b></p>	<p>Providers of support coordination services must participate in a 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"> <li>• 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 fully participate in community life and addressed the concerns of the recipient, and the family or the recipient’s legal representative. The notes should clearly and adequately detail services provided in sufficient detail.</li> <li>• A copy of all of the recipient’s support plans filed in the recipient’s central record.</li> <li>• Documentation, in the central record, that the basic billing requirements were met for the months in which the provider was reimbursed for services.</li> <li>• 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.</li> <li>• Current and correct demographic information for the recipient, including current health and medical information and emergency contact information.</li> <li>• Eligibility worksheet.</li> <li>• Documentation, in the form of a letter from the Division of Vocational Rehabilitation (VR) services or a case note detailing the date of contact with a named VR representative, and a summary of the conversation, etc., indicating a lack of available VR funding for supported employment.</li> </ul>
<p><b>Transportation</b></p>	<ul style="list-style-type: none"> <li>• Copy of claim(s) submitted for payment.</li> <li>• Trip logs (sent monthly).*</li> </ul>
<p><b>Behavior Analysis Services</b></p>	<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"> <li>• Copy of claim(s) submitted for payment.</li> <li>• Daily progress notes for dates of service billed (sent monthly).*</li> <li>• Graphic display of acquisition and reduction target behaviors (submitted quarterly).*</li> <li>• Behavior analysis service plan within 90 days of first billed date of service.*</li> <li>• 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.*</li> <li>• Copy of assessment report required if an assessment was authorized and billed.*</li> </ul>

DOCUMENTATION REQUIREMENTS, continued

<b>Billing and Reimbursement Requirements</b>	
<b>Behavior Assistant Services</b>	<ul style="list-style-type: none"> <li>• Copy of claim(s) submitted for payment.</li> <li>• Copy of current Behavior Analysis Services Plan (BASP).*</li> <li>• Daily progress notes for dates of service billed (sent monthly).*</li> <li>• Monthly evidence of required supervision by behavior analyst.</li> <li>• Copy of that data that is provided to the behavior analyst at least monthly.</li> <li>• 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.*</li> <li>• Behavior assessment.*</li> </ul>
<b>Dietitian Services</b>	<ul style="list-style-type: none"> <li>• Copy of claim(s) submitted for payment.</li> <li>• Daily progress notes for days service was rendered and billed (sent monthly).*</li> <li>• Monthly nutritional status report.</li> <li>• Dietitian assessment.</li> <li>• Individual dietary management plan.*</li> <li>• 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.*</li> <li>• Original prescription for service and annually thereafter.*</li> </ul>
<b>Occupational Therapy</b>	<ul style="list-style-type: none"> <li>• Copy of claim(s) submitted for payment.</li> <li>• Daily progress notes for days service was rendered and billed (sent monthly).*</li> <li>• Monthly summary note. This does not substitute for daily progress notes.</li> <li>• Assessment report (if requesting reimbursement for assessment).*</li> <li>• 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.*</li> <li>• Original prescription for service and annually thereafter.*</li> </ul>
<b>Physical Therapy</b>	<ul style="list-style-type: none"> <li>• Copy of claim(s) submitted for payment.</li> <li>• Daily progress notes for days service was rendered and billed (sent monthly).*</li> <li>• Monthly summary note. This does not substitute for daily progress notes.</li> <li>• Assessment report (if requesting reimbursement for assessment).*</li> <li>• 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.*</li> <li>• Original prescription for service and annually thereafter.*</li> </ul>



DOCUMENTATION REQUIREMENTS, continued

<b>Billing and Reimbursement Requirements</b>	
<p><b>Private Duty Nursing</b></p>	<ul style="list-style-type: none"> <li>• Copy of claim(s) submitted for payment.</li> <li>• Copy of the nursing care plan with annual updates.*</li> <li>• Daily progress notes for days service was rendered and billed (sent monthly).*</li> <li>• Individual nursing assessment and annually thereafter.</li> <li>• Monthly summary, which includes details regarding health status, medication, treatments, medical appointments, and other relevant information.</li> <li>• Original prescription for the service and annually thereafter.*</li> <li>• List of duties to be performed by the nurse.</li> </ul> <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 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>
<p><b>Residential Nursing</b></p>	<ul style="list-style-type: none"> <li>• Copy of claim(s) submitted for payment.</li> <li>• Copy of the nursing care plan with annual updates.*</li> <li>• Daily progress notes for days service was rendered and billed (sent monthly).*</li> <li>• Individual nursing assessment and annually thereafter (sent monthly).*</li> <li>• Monthly summary, which includes details regarding health status, medication, treatments, medical appointments, and other relevant information.*</li> <li>• Original prescription for the service and annually thereafter.*</li> <li>• List of duties to be performed by the nurse.</li> </ul> <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> <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>
<p><b>Respiratory Therapy</b></p>	<ul style="list-style-type: none"> <li>• Copy of claim(s) submitted for payment.</li> <li>• Daily progress notes for days service was rendered and billed (sent monthly).*</li> <li>• 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. The third quarterly original prescription for service and every six months thereafter.*</li> <li>• Assessment report, if a claim is submitted for an assessment.*</li> <li>• Original prescription for service and annually thereafter.*</li> </ul>

DOCUMENTATION REQUIREMENTS, continued

<b>Billing and Reimbursement Requirements</b>	
<b>Skilled Nursing</b>	<ul style="list-style-type: none"> <li>• Copy of claim(s) submitted for payment.</li> <li>• Nursing care plan with annual updates.*</li> <li>• Daily progress note for dates of service rendered.*</li> <li>• Individual nursing assessment (must be completed at time of first claim submission and annually thereafter).</li> <li>• Original prescription for service and annually thereafter.*</li> <li>• Monthly summary, which includes details regarding health status, medication, treatments, medical appointments, and other relevant information.*</li> <li>• List of duties to be performed by the nurse.</li> <li>• Exception letter from AHCA for skilled nursing services (if applicable).</li> </ul> <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 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>
<b>Speech Therapy</b>	<ul style="list-style-type: none"> <li>• Copy of claim(s) submitted for payment.</li> <li>• Daily progress note for dates of service rendered.*</li> <li>• 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.*</li> <li>• Original prescription for the service and every six months thereafter.*</li> <li>• Assessment report, if a claim is submitted for an assessment.*</li> </ul>
<b>Specialized Mental Health Counseling</b>	<ul style="list-style-type: none"> <li>• Copy of claim(s) submitted for payment.</li> <li>• Daily progress note for dates of service rendered.*</li> <li>• Monthly summary note.*</li> <li>• Assessment and treatment plan, even if preliminary, or plan for further action, must be completed at the time of the first claim submission and a final treatment plan at the subsequent claim submission.*</li> <li>• Prescription.*</li> </ul>

APPENDIX B  
IBUDGET TRAINING REQUIREMENTS FOR IBUDGET WAIVER  
PROVIDERS

## IBUDGET TRAINING REQUIREMENTS FOR IBUDGET WAIVER PROVIDERS

With the promulgation of this handbook, Agency for Persons with Disabilities (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). However, provider staff employed prior to the promulgation continue to be held to the qualifications that were in rule at the time of their employment. A chart follows this section and provides additional details on the new course titles, course descriptions, time frames for successfully completing courses, trainer qualifications, documentation of successful completions, and the frequencies in which courses need to be completed.

Provider staff, management staff, and solo providers rendering services prior to the promulgation will have one year from the date of this handbook's promulgation to come into compliance with new training requirements not previously completed in this Appendix. The use of trainers certified by the named entities contained in the following chart are effective immediately: AIDS/HIV/Infection Control, First Aid, CPR and HIPAA. After the promulgation of this handbook, new provider staff, management staff, and solo providers starting services must comply with the requirements in this Appendix.

For Required Basic and Required Pre-Service Certification, emphasis is being placed on whether the trainee successfully completes the course in lieu of the number of hours the trainee completes. Successful completion is defined as attending and participating in all required sessions, completing all applicable assignments, and successfully passing any required course test(s) with a score of 85% or better. Trainees who do not successfully complete a course will not be issued a certificate of successful completion. Students may retake a test one time if no passing score was achieved the first attempt. After taking the test for the second time, if no passing score is achieved, the student will be required to wait for 30 days prior to retaking the test.

While required courses no longer identify a number of hours the trainee must complete, In-Service training is still based on the number of hours the trainee completes. Providers are ultimately responsible to ensure that each of their staff is providing services in a competent and appropriate manner in accordance with required training materials, which is the intended outcome.

Within one year of the promulgation of this handbook the use of recorded (e.g., CDs or DVDs) or self-paced training for any required training will no longer be acceptable. At that point core competency web-based testing will be available on APD's Web site.

APD's calendar listing classroom trainings which are provided by APD may be found on APD's Web site. For required courses, go to <http://ptc.apd.myflorida.com/AvailableTraining.aspx?TrainingType=2>.

For in-service courses, go to <http://ptc.apd.myflorida.com/AvailableTraining.aspx?TrainingType=1>.

### **I. Required Training**

#### **A. Basic Training**

Except for staff listed in the "Exemptions" (Section D below), all Direct Service Providers must successfully complete all the basic training courses as noted on Table 1 except Requirements for All Waiver Providers.

All solo providers and management staff of provider agencies of services covered by this handbook must successfully complete only the following course which is noted on Table 1:

- Requirements for All Waiver Providers

Two courses must be completed by Direct Service Providers under certain circumstances and are noted on Table 1:

- Medication Administration and Validation
- Behavioral Emergency Procedures

The first additional training involves providers who will be administering or assisting in the administration of any medication. This training is entitled “Medication Administration and Validation” and includes a successful validation component. The second training involves staff serving a recipient with a challenging behavior that necessitates the use of reactive strategies during a behavioral emergency. This training is entitled “Behavioral Emergency Procedures” and is based upon a competency-based training curriculum approved by the APD and also contains a validation component.

### **B. Pre-Service Certification Training**

The following providers must successfully complete Pre-Service Certification Training before providing the following waiver services. They must also successfully complete the Required Basic Training within the same time frame as other Direct Service Providers.

- Life Skills II (Supported Employment Coaching)
- Support Coordination
- Supported Living Coaching

Support Coordinators will not be issued a letter of enrollment until all Pre-Service Certification training is completed.

To generate additional funding to support an individual's employment goals, supported employment coaches and waiver coordinators must assist the people they serve to be aware of the various work incentives and employment planning tools that are available, in particular, the Plan to Achieve Self-Sufficiency (PASS). To ensure that all supported employment coaches, supported living coaches and waiver support coordinators are aware of these various incentives and tools, all existing supported employment coaches, supported living coaches and waiver support coordinators must successfully complete APD's pre-service employment course, “Introduction to Social Security Work Incentives”, within one year of the promulgation of this Handbook. This course is available in a classroom version as well as web-based version. Successful completion of either version meets this requirement.

### **C. In-Service Training**

Providers are not limited to taking in-service courses only from APD and should take full advantage of conferences and professional presentations whenever possible. To determine whether or not a course would count toward required in-service training, refer to Appendix C for each specific provider type.

### **D. Exemptions**

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 Service Providers who hold professional certificates for the services listed below must only complete Core Competencies, Zero Tolerance, and HIPAA. Independent or solo providers and management staff for these services must complete Requirements for all Waiver Providers:

- Behavior Analysis
- Dietician
- Occupational Therapy
- Physical Therapy
- Private Duty Nursing
- Residential Nursing Services
- Respiratory Therapy
- Skilled Nursing
- Specialized Medical Home Care providers who are Registered Nurses or Licensed Practice Nurses
- Specialized Mental Health Counseling
- Speech Therapy

## **II. Certificates of Successful Completion**

Documentation of successful completion of required provider training is defined differently for classroom training (face-to-face), non-classroom (web-based training video, etc.), and validation training as defined as follows.

### **A. Classroom Training**

If training is taken in a classroom setting, with the promulgation of this handbook, emphasis is being shifted from attending a specific number of course hours, to successfully completing required courses.

1. The only acceptable proof of the successful completion of the following APD Required Training classroom courses will be the standardized certificate developed by APD which will be provided electronically to all certified trainers. Included on that certificate will be evidence that the trainer has appropriate credentials (a copy of the trainer's certification card provided by APD). Currently the titles of those courses are:

- Direct Care Core Competencies
- Zero Tolerance
- APD Waiver Provider Requirements
- Requirement for all Waiver Providers
- Supported Employment Pre-service: Best Practices in Supported Employment
- Supported Employment Pre-service: Introduction to Social Security Work Incentives
- Supported Living Pre-Service Training
- Waiver Support Coordinator Pre-Service Training and Regional Specific Training

When all classroom APD Required Training courses are standardized, corresponding certificates will exist for each course, will be required for each course, and will be provided electronically to each certified trainer. Between the time this handbook is promulgated and one year from that date, the following elements must be included on the certificate for non-standardized courses:

- The participant's name (printed or typed)
- Title of the course
- Date training occurred
- Name of the trainer (printed or typed) and signature
- Evidence that the trainer has appropriate credentials (for APD courses a copy of the trainer's certification card provided by APD)

For every classroom APD Required Training course taught the following documentation must be completed and maintained (either by hard copy or electronically) by the trainer for a minimum of seven years:

Daily sign-in sheet (for each day of class) that must include:

- Printed or typed name of attendee
- Initials of attendee by their printed name
- Date of the training (which must match the title on the certificate)
- Trainer typed or printed name and signature
- Location where the training occurred (same as certificate)
- Original test for each attendee with scores noted
- Copy of certificates of persons who successfully completed the course

For the classroom APD Required Training course taught by a trainer certified by the American Red Cross, American Heart Association, the American Safety and Health Institute and the Emergency Care Safety Institute, the only acceptable proof of a successful course completion is a standard certificate developed by those organizations with the attendees name either typed or printed on the card or certificate.

2. There are several acceptable ways to document the successful completion of classroom In-Service Training. However, the following elements must be included on all classroom training documentation in order to be acceptable:

- Participant's printed name and signature
- Title of the course
- Date training occurred (day and date as well as beginning and ending time)
- Printed name of the trainer and signature\*
- A statement by the participant as to how this training related to the services provided and what knowledge was gained from this training

\*If it is not possible to get the trainer's signature on documentation for attendance of presentations at conferences or by professionals at other venues, an original agenda or brochure noting the title of the specific course and evidence of attendance.

## **B. Non-classroom Training**

If the training is web-based, the only acceptable proof of the successful completion of APD Required Training or Required Pre-Service Training will be the printed certificate or transcript generated by the entity that provides the training. Approved web-based trainers include the American Red Cross, the American Heart Association, the American Health and Safety Institute, the Emergency Care & Safety Institute, The National Council, EMS Safety Services, Inc., Tallahassee Community College, the Attain, Inc., The Centers for Medicare and Medicaid, MedEd America and the Training Resource Network (TRN). Links to all these courses are provided on Table 1.

1. At a minimum the certificate, transcript or card for non-classroom APD Required Training must contain the following elements:

- Participant's name
- Title of the course (if not titled as in the handbook, then written confirmation of the course content may be required)
- Date(s) or period over which training course was completed and notation that course was successfully completed
- Name of approved entity providing training

2. If an individual uses a CD or video to meet their non-classroom In-Service Training requirement, the following documentation is necessary:

- Photocopy of label or training outline (including the title of the course and sponsoring entity)
- Printed name and signature of participant
- Date training occurred

- Length of training (if not noted on CD label)
- A statement as to how this training related to the services provided by the participant and what new knowledge was gained from this training

If a Provider uses a CD or video for group staff training, documentation must contain at a minimum the classroom documentation elements noted In Section II B. 2. Additionally the provider must keep a daily sign-in sheet (for each day of class) that includes the same elements as in Section II A.

### **C. Validation Training**

For Medication Administration Validation, the certificate must include all the requirements listed in Rule 65G-7, F.A.C., which at the time of this promulgation include the following:

- The name of the person being validated
- The date of assessment and validation
- A description of the medication routes and procedures that the person 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

Any changes to Chapter 65G-7, F.A.C requirements will take precedent over this handbook.

For behavioral emergency procedures, validation is completed under competency demonstration as part of the training, and 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

Any changes to Chapter 65G-8, F.A.C requirements will take precedent over this handbook.

The provider or provider agency must maintain on file a copy of all certificates of Direct Service Providers 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. The provider is also required to furnish a copy of training documentation to any existing employee upon request. The employee should maintain their own copy for personal records.

### **III. Trainers**

Qualification to be a trainer of APD courses is explained on Table 1. Column 4 of each section provides a general description, with footnotes providing details as needed.



TABLE 1

Section 1: Required of all Direct Service Providers - Each Course has a Standardized Curricula Developed by APD				
Course Title	Course Content	Time Frame	Trainer Qualifications <sup>1</sup>	Frequency
Direct Care Core Competencies (DCCC)  link to web-based course = <a href="http://apdcares.org/providers/training/tcc.htm">http://apdcares.org/providers/training/tcc.htm</a>	1. Basic Person-centered Planning	Within 30 days of providing services	Trainers must be certified in writing by APD or APD staff	Once – However, poor provider reviews will result in being required to retake course
	2. Introduction to Developmental Disabilities			
	3. Maintaining Health and Safety			
	4. Individual Choices, Rights and Responsibilities			
	5. Roles and Responsibilities of Direct Support Professionals (currently a section within Introduction to Developmental Disabilities)			
Zero Tolerance  link to web-based course = <a href="http://apdcares.org/providers/training/tcc.htm">http://apdcares.org/providers/training/tcc.htm</a>	1. Defining Abuse, Neglect and Exploitation	Prior to providing services	Trainers must be certified in writing by APD or APD staff	At initial employment and every 3 years thereafter
	2. Recognizing the signs and symptoms of abuse, neglect and exploitation			
	3. Reporting to the Abuse Hotline			
	4. Prevention and Safety Planning			
Overview of APD Waiver Provider Requirements	1. Overview of Medicaid Waivers 2. Overview of current APD Waiver 3. Provider Qualification and Enrollment (under current waiver) 4. Services Coverage and Limitations (under current waiver) 5. Other relevant information provided in current handbooks 6. APD Regional and field office liaisons for specific types of providers 7. Incident Reporting	Within 30 days of providing services	Trainers must be certified in writing by APD or APD staff	Once - However poor provider reviews must result in being required to retake course

<sup>1</sup>Trainer Qualifications - next page

Qualifications for Trainers of Required Courses

In order for a person to be a trainer of the above APD required courses, they must meet the following criteria:

1. Either the agency they work for or the independent provider must have been a certified APD waiver provider for a minimum of the past 3 years;
2. Either the agency or the independent provider must have a rating of 86% or better for the past 3 years by APD's quality improvement organization (QIO);
3. Either the agency or the independent provider must have had no alerts within the past 3 years;
4. Either the agency or the independent provider must have no founded allegations of Medicaid fraud in the last 3 years;
5. Either the agency or the independent provider must be a provider in good standing with licensure requirements, if applicable;
6. 90% of the people trained by the trainer over a 1 year period must successfully complete the course taught;
7. Must agree to abide by APD regulations related to training (see agreement at end of table); and
8. Must have previously successfully completed the course being taught. Upon notification from APD that the course has been significantly updated, the trainer must have successfully completed the new course, in order to maintain their training certification.

A trainer may lose his certification to train under the following circumstances:

- A. If there is a break in service provision greater than three months;
- B. If the independent provider's QIO score or their agency's QIO score drops below 86%;
- C. If the independent provider or agency has an alert;
- D. If the independent provider or agency has a founded allegation of Medicaid fraud;
- E. If the independent provider or agency falls from good standing with APD licensure;
- F. If less than 90% of the people trained within any year do not successfully complete the course taught; or
- G. If the trainer does not abide by the APD Trainer Agreement related to training. (See below page.)

APD Trainer Agreement

As a certified trainer of APD required courses, by signing this agreement, I agree to the following:

1. Use only APD approved and provided training course materials when applicable and refer all people trained to the proper APD web-based test site;
2. Report to APD state office on a semi-annual basis the number of people who have received training from me in the last six months and the number who successfully complete the course taught. The average will be calculated for the current 6 months & for the previous 12 months;
3. Report to APD central office
  - (a) Immediately if my or my agency's QIO score drops below 86%;
  - (b) Immediately if I or my agency has an alert;
  - (c) Immediately if I or my agency has a founded allegation of Medicaid fraud;
  - (d) Immediately if I or my agency falls from good standing with APD licensure; OR
  - (e) Annually report QIO score, that no alerts have occurred, no Medicaid fraud and no licensure issues.

\_\_\_\_\_ (date)

\_\_\_\_\_ (signature)

Typed Name of Trainer

Required of Provider Direct Care Staff -				
Acceptable Agency Courses Noted Below				
Course Title	Acceptable Agency Organization Course Title Location	Time Frame	Trainer Qualifications	Frequency
AIDS/HIV/Infection Control	<b>American Health and Safety Institute</b> - course title Blood borne Pathogens - <a href="http://www.hsi.com/takeaclass/">http://www.hsi.com/takeaclass/</a>	Within 90 days of providing services	Certified by American Health and Safety Institute, American Red Cross, EMS Safety Services, Inc., Emergency Care and Safety Institute, or National Safety Council for courses noted. TCC course is web-based.	Direct Service Providers must possess valid certificate at all times  NOTE: different organizations offer varying lengths of certification
	<b>American Red Cross</b> - course titled Blood borne Pathogens - <a href="http://www.redcross.org/take-a-class">http://www.redcross.org/take-a-class</a>			
	<b>EMS Safety Services, Inc.</b> - course title Blood Borne Pathogens - <a href="http://www.emssafetyservices.com/">http://www.emssafetyservices.com/</a>			
	<b>Emergency Care and Safety Institute</b> - course title Blood borne and Airborne Pathogens Interactive - <a href="https://www.ecsinstitute.org/courses/">https://www.ecsinstitute.org/courses/</a>			
	<b>Florida Department of Health</b> - Materials can be requested by mail. To obtain a copy of the DVD and Study Guide, <i>HIV/AIDS in the News, 2009</i> , write: HIV/AIDS 101 Video, Florida Department of Health, Bureau of HIV/AIDS, Prevention Section, 4052 Bald Cypress Way, Bin #A90, Tallahassee, Florida 32399-1715			
	<b>National Safety Council</b> - course titles Blood borne & Airborne Pathogens or Basic Life Support For Health Care & Professional Rescuers Blood borne & Air Borne Pathogens - <a href="http://www.nsc.org/products_training/Pages/Home.aspx">http://www.nsc.org/products_training/Pages/Home.aspx</a>			
	<b>Tallahassee Community College</b> - course title AIDS/HIV and Blood borne Pathogens - <a href="https://www.tcc.fl.edu/Current/Academics/WorkforceDevelopment/APDTraining/Pages/default.aspx">https://www.tcc.fl.edu/Current/Academics/WorkforceDevelopment/APDTraining/Pages/default.aspx</a>			

First Aid	<p><b>American Health and Safety Institute</b> - course titles Basic First Aid or CPR, AED &amp; Basic First Aid (if comprehensive course is taken for CPR certification, too, it must be taken in a classroom) <a href="http://www.hsi.com/takeaclass/">http://www.hsi.com/takeaclass/</a></p>	Within 90 days of providing services	Certified by American Health and Safety Institute, American Heart Association, American Red Cross, EMS Safety Services, Inc., Emergency Care and Safety Institute or National Safety Council for courses noted by title	Direct Service Providers must possess valid certificate at all timesNOTE: different organizations offer varying lengths of certification
	<p><b>American Heart Association</b> - course titles - Heartsaver First Aid with written test, Heartsaver First Aid with written test or Heartsaver First Aid Online Part 1 with written test - <a href="http://www.heart.org/HEARTORG/CPRAndECC/FindaCourse/Find-a-Course_UCM_303220_SubHomePage.jsp">http://www.heart.org/HEARTORG/CPRAndECC/FindaCourse/Find-a-Course_UCM_303220_SubHomePage.jsp</a></p>			
	<p><b>American Red Cross</b> - course titled First Aid - <a href="http://www.redcross.org/take-a-class">http://www.redcross.org/take-a-class</a></p>			
	<p><b>EMS Safety Services, Inc.</b> - course title CPR/AED and First Aid Community Rescuer Training Course (classroom) - <a href="http://www.emssafetyservices.com/">http://www.emssafetyservices.com/</a></p>			
	<p><b>Emergency Care and Safety Institute</b> - course titled First Aid - <a href="https://www.ecsinstitute.org/courses/">https://www.ecsinstitute.org/courses/</a></p>			
	<p><b>National Safety Council</b> - course title First Aid, CPR &amp; AED (this web-based course will NOT be accepted for CPR) - <a href="http://www.nsc.org/products_training/Pages/Home.aspx">http://www.nsc.org/products_training/Pages/Home.aspx</a></p>			

CPR	<p><b>American Red Cross</b> - classroom course titled CPR/AED for Professional Rescuers and Health Care Providers - <a href="http://www.redcross.org/take-a-class">http://www.redcross.org/take-a-class</a></p>	Within 90 days of providing services	Certified by American Health and Safety Institute, American Heart Association, American Red Cross, EMS Safety Services, Inc., Emergency Care and Safety Institute or National Safety Council for courses noted by title	Direct Service Providers must possess valid certificate at all times. NOTE: different organizations offer varying lengths of certification Even though most courses endorsed include training in automated external defibrillators (AED) there is no requirement for waiver providers to have AEDs on site or available.
	<p><b>American Heart Association</b> - classroom course title Heartsaver CPR, AED with written test, or Heartsaver First Aid, CPR and AED with written test - <a href="http://ahainstructornetwork.americanheart.org/AHA/ECC/classConnector.jsp?pid=ahaecc.classconnector.home">http://ahainstructornetwork.americanheart.org/AHA/ECC/classConnector.jsp?pid=ahaecc.classconnector.home</a></p>			
	<p><b>American Health and Safety Institute</b> - course titled CPR and AED - <a href="http://www.hsi.com/takeaclass/">http://www.hsi.com/takeaclass/</a></p>			
	<p><b>EMS Safety Services, Inc.</b> - classroom course titled CPR/AED and First Aid Community Rescuers Training - <a href="https://www.ecsinstitute.org/courses/">https://www.ecsinstitute.org/courses/</a></p>			
	<p><b>Emergency Care and Safety Institute</b> - classroom course titles CPR and AED; Health Care Provider CPR; and Standard First Aid, CPR and AED (classroom only) - <a href="https://www.ecsinstitute.org/courses/">https://www.ecsinstitute.org/courses/</a></p>			
	<p><b>National Safety Council</b> - classroom course titles NCS First Aid, CPR &amp; AED; and NCS CPR and AED - <a href="http://www.nsc.org/products_training/Pages/Home.aspx">http://www.nsc.org/products_training/Pages/Home.aspx</a></p>			

Developmental Disabilities Individual Budgeting Waiver Services Coverage and Limitations Handbook

HIPAA	<u>Web-based Only</u>	Within 30 days of providing services	NA	Annually
	<p><b>Attain, Inc.</b> - course title Health Insurance Portability and Accountability Act (HIPAA) - <a href="http://learn.myattain.org">http://learn.myattain.org</a></p> <p>OR</p> <p><b>CMS</b> - course title Health Insurance Portability and Accountability Act (HIPAA) EDI Standards <a href="https://cms.meridianksi.com">https://cms.meridianksi.com</a> (registration site)</p>			
Medication Administration and Validation	<p>Must comply with 65G-7 FAC and approved in writing by APD state office - <a href="http://apd.myflorida.com/providers/training/">http://apd.myflorida.com/providers/training/</a></p>	<p>Must be success-fully completed by any direct care staff who administers or supervises the administration of medication</p>	<p>Classroom trainers must be certified in writing by APD and possess an APD course approval number issued by APD state office</p>	<p>As defined in 65G-7, F.A.C.</p>
Behavioral Emergency Procedures	<p>Curricula developed by private vendors consistent with 65-G8, Reactive Strategies, F.A.C, as well as reviewed approved in writing by APD state office - <a href="http://apd.myflorida.com/providers/training/">http://apd.myflorida.com/providers/training/</a></p>	<p>Within 30 days of providing services for direct care staff serving individuals with challenging behaviors who are in need of behavioral emergency procedures</p>	<p>Classroom trainers must be certified in writing by the private vendor whose course has been approved by APD state office</p>	<p>As defined in 65G-8, F.A.C.</p>

Section 2: Required of all Independent or Solo Providers and Management Staff of All Agencies

Each course has a Standardized Curricula Developed by APD

Course Title	Course Content	Time Frame	Trainer Qualifications	Frequency
Requirements for all Waiver Providers	1. Overview of Medicaid Waivers	Prior to providing services	Trainers must be APD staff	Once – However, poor provider reviews must result in being required to retake course
	2. Overview of current APD Waiver			
	3. Provider Qualification and Enrollment (under current waiver)			
	4. Services Coverage and Limitations (under current waiver)			
	5. Other relevant information provided in current handbooks			
	6. Compliance with Federal and State laws			
	7. Administrative Programmatic Requirements			
	8. Provider Self Assessments			
	9. Elements of Waiver Services Agreement			
	10. APD Regional and field office liaisons for specific types of provider			
	11. Zero Tolerance			
	12. Incident Reporting			
	13. Overview of Chapters 65G-7 and 8, F.A.C.			

Section 3: A102Pre-service Training Requirements for Specific Service Providers -

Each Course has a Standardized Curricula Developed by APD

Course Title	Course Content	Time frame	Trainer Qualification <sup>2</sup>	Frequency
<p>Supported Employment Pre-service - Best Practices in Supported Employment and Introduction to Social Security Work Incentives</p> <p>link to web-based course = <a href="https://trn-store.com/content/florida-required-supported-employment-pre-service">https://trn-store.com/content/florida-required-supported-employment-pre-service</a></p>	<b>1. Best Practices</b>	Prior to providing services	Classroom trainers must be certified in writing by APD	Once - However poor provider reviews must result in being required to retake course
	A. Introduction to Supported Employment			
	B. Rules and regulations Governing Supported Employment			
	C. Discovery: What is It and How to Use It			
	D. Preparing Resumes, References and Cover Letters			
	E. Marketing			
	F. Job Coaching			
	<b>2. Introduction to Social Security Work Incentives</b>			
	A. Introduction/Overview			
	B. Advocacy			
	C. Eligibility (SSI, SSDI)			
	D. Effects of Earned Income on SSDI			
	E. Effects of Earned Income on SSI			
	F. SSI and SSDI Work Incentives			
G. Resources				
H. Glossary				
Supported Living Pre-service	1. Introduction to Supported Living	Prior to providing services	Classroom trainers must be certified in writing by APD	Once - However poor provider reviews will result in being required to retake course
	2. Roles of Various Providers			
	3. Coaching Services and Requirements			
	4. The Planning Process			
	5. Documentation			
	6. Supporting People to Succeed			
	7. Enhancing Quality			

<sup>2</sup>Trainer Qualifications - on page 9 of this table



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WSC Pre-Service	1. Overview of APD	Prior to signing provider agreement	Classroom trainers must be certified in writing by APD	Once - However poor provider reviews must result in being required to retake course
	2. In-depth person-centered planning			
	3. Legal Rights and Ways to Provide Decision-making Assistance			
	4. Ethics, Advocacy and Choice			
	5. Overview of current waiver handbooks			
	6. Support Plans and Cost Plans			
	7. APD's current automated requirements and how to access			
	8. APD Regional and field office liaisons			
	9. Monitoring: Your Role with your Recipients and Being Monitored Yourself			
	10. Overview of medication administration and behavior emergency procedures			
WSC Region-Specific Training	<ol style="list-style-type: none"> <li>1. APD's current automated requirements and how to access</li> <li>2. APD Regional and field office liaisons</li> </ol>	Within 90 days of providing services	Classroom trainers must be certified in writing by APD	Once - However poor provider reviews must result in being required to retake course

<sup>2</sup>Qualifications for Trainers of Pre-Service Courses

In order for a person to be a trainer of the above APD pre-service courses, they must meet the following criteria:

1. Either the agency they work for or the independent provider must have been a certified APD waiver provider for a minimum of the past 3 years;
2. Either the agency or the independent provider must have a rating of 86% or better for the past 3 years by APD's quality improvement organization (QIO);
3. Either the agency or the independent provider must have no founded allegations of Medicaid fraud in the last 3 years;
4. Either the agency or the independent provider must be a provider in good standing with licensure requirements, if applicable;
5. 90% of the people trained by the trainer over a 1 year period must successfully complete the course taught;
6. Must agree to abide by APD regulations related to training (see agreement at end of table); and
7. Must have previously successfully completed the course being taught. Upon notification from APD that the course has been significantly updated, the trainer must have successfully completed the new course, in order to maintain their training certification.

A trainer may lose his certification to train under the following circumstances:

- A. If there is a break in service provision greater than 3 months;
- B. If the independent provider's QIO score or their agency's QIO score drops below 86%;
- C. If the independent provider or agency has an alert;
- D. If the independent provider or agency has a founded allegation of Medicaid fraud;
- E. If the independent provider or agency falls from good standing with APD licensure;
- F. If less than 90% of the people trained within any year do not successfully complete the course taught; or
- G. If the trainer does not abide by the APD Trainer Agreement related to training. (See below page.)

APD Trainer Agreement

As a certified trainer of APD required courses, by signing this agreement, I agree to the following:

1. Use only APD approved and provided training course materials and refer all people trained to the proper APD web-based test site;
2. Report to APD statewide provider training coordinator in state office on a semi-annual basis the number of people who have received training from me in the last six months and the number who successfully complete the course taught. The average will be calculated for the current 6 months & for the previous 12 months;
3. Report to APD statewide provider training coordinator in state office
  - (a) Immediately if my or my agency's QIO score drops below 86%;
  - (b) Immediately if I or my agency has a founded allegation of Medicaid fraud;
  - (c) Immediately if I or my agency falls from good standing with APD licensure; OR
  - (d) Annually report QIO score, no Medicaid fraud and no licensure issues.

\_\_\_\_\_ (date)

\_\_\_\_\_ (signature)  
 Typed Name of Trainer

APPENDIX C  
SERVICE SPECIFIC TRAINING REQUIREMENTS

SERVICE SPECIFIC TRAINING REQUIREMENTS

Service	Specific Training Requirements
<p><b>Adult Dental</b></p>	<p><b><i>Required Basic Training</i></b>                      Providers of adult dental services, as defined in this handbook, must only comply with required training and continuing education related to their certification or licensure in order to maintain current active status.</p> <p><b><i>Continuing Education</i></b>                      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><b>Behavior Analysis Services</b></p>	<p><b><i>Required Basic Training</i></b>                      Direct service providers of this service must complete Core Competencies, Zero Tolerance, and HIPAA as listed in Appendix B – Table 1 and within noted timeframes. Independent or Solo providers and management staff of agencies providing this service must complete Requirements for all Waiver Providers as listed in Appendix B – Table 1 and within noted timeframes. The new employee or provider must successfully complete all required training before working alone with recipients.</p> <p><b><i>Continuing Education</i></b>                      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><b>Behavior Assistant Services</b></p>	<p><b><i>Required Basic Training</i></b>                      Providers of this service must successfully complete all required basic training courses and within timeframes noted in Appendix B – Table 1. Behavioral Emergency Procedures Training must be successfully completed if the recipient being served requires reactive strategies. All new employees must successfully complete all required training before working alone with recipients.</p>
<p><b>Consumable Medical Supplies</b></p>	<p><b><i>Required Basic Training</i></b>                      Providers of consumable medical supplies, as defined in this handbook, must only comply with required training and continuing education credits related to their certification or licensure in order to maintain current active status.</p>

<p><b>Dietician Services</b></p>	<p><b><i>Required Basic Training</i></b>                  Direct service providers of this service must complete Core Competencies, Zero Tolerance, and HIPAA as listed in Appendix B – Table 1 and within noted timeframes. Independent or Solo providers and management staff of agencies providing this service must complete Requirements for all Waiver Providers as listed in Appendix B – Table 1 and within noted timeframes. The new employee or provider must successfully complete all required training before working alone with recipients.</p> <p><b><i>Continuing Education</i></b>                  Dietician providers, as defined in this handbook, must only comply with required training and continuing education credits related to their licensure in order to maintain current active status as a dietician.</p>
<p><b>Durable Medical Equipment and Supplies</b></p>	<p><b><i>Required Basic Training</i></b>                  Providers of durable medical equipment and supplies, as defined in this handbook, must only comply with required training and continuing education credits related to their certification or licensure in order to maintain current active status.</p>
<p><b>Environmental Accessibility Adaptation</b></p>	<p><b><i>Required Basic Training</i></b>                  Providers of environmental accessibility adaptation services, as defined in this handbook, must only comply with required training and continuing education related to their certification or licensure in order to maintain current active status.</p>
<p><b>Life Skills Development 1, 2, 3</b></p>	<p><b><u>Life Skills Development - Level 1 (Companion)</u></b></p> <p><b><i>Required Basic Training</i></b>                  Providers of this service must successfully complete all required basic training courses and within timeframes noted in Appendix B – Table 1. Depending on the needs of the individual being served, Medication Administration Training and Validation, Behavioral Emergency Procedures Training, or both, may also need to be successfully completed prior to service provision. All new employees must successfully complete all required training before working alone with recipients.</p> <p><b><i>Annual In-Service Training Requirement</i></b>                  Four hours of annual in-service training must be successfully 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. Documentation of completion for in-service is defined in Appendix B, Section II. A.</p>

<p><b>Life Skills Development</b> 1, 2, 3, continued</p>	<p><b><u>Life Skills Development - Level 2 (Supported Employment)</u></b></p> <p><b><i>Required Basic Training</i></b> Providers of this service must successfully complete all required basic training courses and pre-service training requirements and within timeframes noted in Appendix B – Table 1. If a provider will administer medication, they must successfully complete Medication Administration Training and Validation. Behavioral Emergency Procedures Training must be successfully completed prior to service provision if a provider is working with a recipient who requires reactive strategies. All new employees must successfully complete all required training before working alone with recipients.</p> <p><b><i>Required Pre-Service Certification Training</i></b> This is one of three 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 – Table 1. Any SE provider who has not successfully completed APD’s course titled “Introduction to Social Security Work Incentives,” must do so within 1 year of the effective date of this handbook in order maintain their certification to provide services.</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 Consultant (CBTAC) by the Florida Department of Education, Division of Vocational Rehabilitation prior to providing those services.</p> <p><b><i>Annual In-Service Training Requirement</i></b> Eight hours of annual in-service training related to employment must be completed by persons providing Life Skills Development - Level 2 (Supported Employment). Documentation of completion for in-service hours is defined in Appendix B Section, II. A. For monitoring purposes this may be met at 90% compliance.</p> <p>Coaches who have never taken Introduction to Social Security Work Incentives and do so for the above requirement may count that as their annual in-service hours.</p>
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<p><b>Life Skills Development</b> 1, 2, 3, continued</p>	<p><b><u>Life Skills Development - Level 3 (Adult Day Training)</u></b></p> <p><b><i>Required Basic Training</i></b> Providers of this service must successfully complete all required basic training courses and pre-service training requirements and within timeframes noted in Appendix B – Table 1. If a provider will administer medication, they must successfully complete Medication Administration Training and Validation. Behavioral Emergency Procedures Training must be successfully completed prior to service provision if a provider is working with a recipient who requires reactive strategies. All new employees must successfully complete all required training before working alone with recipients.</p> <p>In those facilities that perform medication administration or use (or can use) behavioral emergency procedures, 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 Behavioral Emergency Procedures Training and Medication Administration Training and Validation.</p> <p><b><i>Annual In-Service Training</i></b> Eight hours of annual in-service training must be successfully 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. For monitoring purposes this may be met at 90% compliance.</p> <p>Documentation of completion for in-service training is defined in Appendix B, Section II. A.</p>
<p><b>Occupational Therapy</b></p>	<p><b><i>Required Basic Training</i></b> Direct service providers of this service must complete Core Competencies, Zero Tolerance, and HIPAA as listed in Appendix B – Table 1 and within noted timeframes. Independent or Solo providers and management staff of agencies providing this service must complete Requirements for all waiver providers as listed in Appendix B – Table 1 and within noted timeframes. The new employee or provider must successfully complete all required relevant training before working alone with recipients.</p> <p><b><i>Continuing Education</i></b> Occupational therapy providers, as defined in this handbook, must only comply with required training and continuing education related to their licensure in order to maintain current active status as an occupational therapist.</p>

<p><b>Personal Emergency Response System</b></p>	<p><b><i>Required Basic Training</i></b>                  Providers of personal emergency response systems, as defined in this handbook, must only comply with required training and continuing education credits related to their certification or licensure in order to maintain current active status.</p>
<p><b>Personal Supports</b></p>	<p><b><i>Required Basic Training</i></b>                  Providers of this service must successfully complete all required basic training courses and pre-service training requirements and within timeframes noted in Appendix B – Table 1. If a provider will administer medication, they must successfully complete Medication Administration Training and Validation. Behavioral Emergency Procedures Training must be successfully completed prior to service provision if a provider is working with a recipient who requires reactive strategies. All new employees must successfully complete all required training before working alone with recipients.</p> <p><b><i>Annual In-Service Training Requirement</i></b>                  Four hours of annual in-service training must be successfully 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. Documentation of completion for in-service training is defined in Appendix B, Section II. A.</p>
<p><b>Physical Therapy</b></p>	<p><b><i>Required Basic Training</i></b>                  Direct service providers of this service must complete Core Competencies, Zero Tolerance, and HIPAA as listed in Appendix B – Table 1 and within noted timeframes. Independent or Solo providers and management staff of agencies providing this service must complete Requirements for all Waiver Providers as listed in Appendix B – Table 1 and within noted timeframes. The new employee or provider must successfully complete all required training before working alone with recipients.</p> <p><b><i>Continuing Education</i></b>                  Physical therapy providers, as defined in this handbook, must only comply with required training and continuing education credits related to their licensure in order to maintain current active status as a physical therapist.</p>



<p><b>Private Duty Nursing</b></p>	<p><b><i>Required Basic Training</i></b>                  Direct service providers of this service must complete Core Competencies, Zero Tolerance, and HIPAA as listed in Appendix B – Table 1 and within noted timeframes. Independent or Solo providers and management staff of agencies providing this service must complete Requirements for all waiver providers as listed in Appendix B – Table 1 and within noted timeframes. The new employee or provider must successfully complete all required training before working alone with recipients.</p> <p><b><i>Continuing Education</i></b>                  Private duty nurse providers, as defined in this handbook, must only comply with required training and continuing education related to their licensure in order to maintain current active status as a licensed practical nurse or registered nurse.</p>
<p><b>Residential Habilitation (Live-in)</b></p>	<p><b><i>Required Basic Training</i></b>                  Providers of this service must successfully complete all required basic training courses and pre-service training requirements and within timeframes noted in Appendix B – Table 1. If a provider will administer medication, they must successfully complete Medication Administration Training and Validation. Behavioral Emergency Procedures Training must be successfully completed prior to service provision if a provider is working with a recipient who requires reactive strategies. All new employees must successfully complete all required training before working alone with recipients.</p>
<p><b>Residential Habilitation (Behavior Focused)</b></p>	<p><b><i>Required Basic Training</i></b>                  Providers of this service must successfully complete all required basic training courses and pre-service training requirements and within timeframes noted in Appendix B – Table 1. If a provider will administer medication, they must successfully complete Medication Administration Training and Validation. Behavioral Emergency Procedures Training must be successfully completed prior to service provision if a provider is working with a recipient who requires reactive strategies. All new employees must successfully complete all required training before working alone with recipients.</p> <p><b><i>Annual In-Service Training Requirement</i></b>                  Eight hours of annual in-service training related to behavior analysis 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><b>Residential Habilitation (Intensive Behavior)</b></p>	<p><b>Required Basic Training</b>                      Providers of this service must successfully complete all required basic training courses and pre-service training requirements and within timeframes noted in Appendix B – Table 1. If a provider will administer medication, they must successfully complete Medication Administration Training and Validation. Behavioral Emergency Procedures Training must be successfully completed prior to service provision if a provider is working with a recipient who requires reactive strategies. All new employees must successfully complete all required training before working alone with recipients.</p> <p><b>Annual In-Service Training Requirement</b>                      Eight hours of annual in-service training related to behavior analysis 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><b>Residential Habilitation (Standard)</b></p>	<p><b>Required Basic Training</b>                      Providers of this service must successfully complete all required basic training courses and pre-service training requirements and within timeframes noted in Appendix B – Table 1. If a provider will administer medication, they must successfully complete Medication Administration Training and Validation. Behavioral Emergency Procedures Training must be successfully completed prior to service provision if a provider is working with a recipient who requires reactive strategies. All new employees must successfully complete all required training before working alone with recipients.</p> <p><b>Annual In-Service Training Requirement</b>                      Eight hours of annual in-service training must be successfully completed and be related to the implementation of individually tailored services.</p>
<p><b>Residential Nursing</b></p>	<p><b>Required Basic Training</b>                      Direct service providers of this service must complete Core Competencies, Zero Tolerance, and HIPAA as listed in Appendix B – Table 1 and within noted timeframes. Independent or Solo providers and management staff of agencies providing this service must complete Requirements for All Waiver Providers as listed in Appendix B – Table 1 and within noted timeframes. The new employee or provider must successfully complete all required training before working alone with recipients.</p> <p><b>Continuing Education</b>                      Residential nursing providers, as defined in this handbook, must only comply with required training and continuing education related to their licensure in order to maintain current active status as a licensed practical nurse or registered nurse.</p>

<p><b>Respiratory Therapy</b></p>	<p><b><i>Required Basic Training</i></b>                  Direct service providers of this service must complete Core Competencies, Zero Tolerance, and HIPAA as listed in Appendix B – Table 1 and within noted timeframes. Independent or Solo providers and management staff of agencies providing this service must complete Requirements for all waiver providers as listed in Appendix B – Table 1 and within noted timeframes. The new employee or provider must successfully complete all required training before working alone with recipients.</p> <p><b><i>Continuing Education</i></b>                  Respiratory therapy providers, as defined in this handbook, must only comply with required training and continuing education related to their licensure in order to maintain current active status as a respiratory therapist.</p>
<p><b>Respite- children in family home only</b></p>	<p><b><i>Required Basic Training</i></b>                  Providers of this service must successfully complete all required basic training courses and pre-service training requirements and within timeframes noted in Appendix B – Table 1. If a provider will administer medication, they must successfully complete Medication Administration Training and Validation. Behavioral Emergency Procedures Training must be successfully completed prior to service provision if a provider is working with a recipient who requires reactive strategies. All new employees must successfully complete all required training before working alone with recipients.</p>
<p><b>Skilled Nursing</b></p>	<p><b><i>Required Basic Training</i></b>                  Direct service providers of this service must complete Core Competencies, Zero Tolerance, and HIPAA as listed in Appendix B – Table 1 and within noted timeframes. Independent or Solo providers and management staff of agencies providing this service must complete Requirements for All Waiver Providers as listed in Appendix B – Table 1 and within noted timeframes. The new employee or provider must successfully complete all required training before working alone with recipients.</p> <p><b><i>Continuing Education</i></b>                  Skilled nursing providers, as defined in handbook, must only comply with required training and continuing education related to their licensure in order to maintain current active status as a licensed practical nurse or registered nurse.</p>

<p><b>Specialized Medical Home Care</b></p>	<p><b><i>Required Basic Training</i></b>                  Providers of this service must complete all required basic training courses noted and within timeframes in Appendix B – Table 1 unless certified as a registered nurse (RN), licensed practical nurse (LPN), or certified nursing assistant (CNA). If the provider is a certified RN, or LPN or CNA, they only need to successfully complete Core Competencies, Zero Tolerance, and HIPAA within timeframes noted in Appendix B – Table 1. Independent or Solo providers and management staff of agencies providing this service must complete Requirements for all Waiver Providers as listed in Appendix B – Table 1 and within noted timeframes. All new employees must successfully complete all required training before working alone with recipients.</p> <p>Providers of this service must successfully complete all required basic training courses and pre-service training requirements and within timeframes noted in Appendix B – Table 1. If a provider will administer medication, they must successfully complete Medication Administration Training and Validation. Behavioral Emergency Procedures Training must be successfully completed prior to service provision if a provider is working with a recipient who requires reactive strategies. All new employees must successfully complete all required training before working alone with recipients.</p> <p><b><i>Continuing Education</i></b>                  Specialized medical home care providers, as defined in this handbook must only comply with licensure and continuing education related to their licensure as a CNA, LPN, or RN in order to maintain current active status.</p>
<p><b>Specialized Mental Health Counseling</b></p>	<p><b><i>Required Basic Training</i></b>                  Direct Service Providers of this service must complete Core Competencies, Zero Tolerance, and HIPAA as listed in Appendix B – Table 1 and within noted timeframes. Independent or Solo providers and management staff of agencies providing this service must complete Requirements for all Waiver Providers as listed in Appendix B – Table 1 and within noted timeframes. The new employee or provider must successfully complete all required training before working alone with recipients.</p> <p><b><i>Continuing Education</i></b>                  Specialized mental health counseling providers, as defined in this handbook, must only comply with required training and continuing education credits related to their licensure as a psychiatrist, psychologist, clinical social worker or marriage and family counselor.</p>

<p><b>Speech Therapy</b></p>	<p><b><i>Required Basic Training</i></b>                  Direct Service Providers of this service must complete Core Competencies, Zero Tolerance, and HIPAA as listed in Appendix B – Table 1 and within noted timeframes. Independent or Solo providers and management staff of agencies providing this service must complete Requirements for all Waiver Providers as listed in Appendix B – Table 1 and within noted timeframes. The new employee or provider must successfully complete all required training before working alone with recipients.</p> <p><b><i>Continuing Education</i></b>                  Speech therapy providers, as defined in this handbook, must only comply with required training and continuing education credits related to their licensure in order to maintain current active status as a speech therapist.</p>
<p><b>Support Coordination—                  Limited, Full or                  Enhanced</b></p>	<p><b><i>Required Basic Training</i></b>                  Providers of this service must complete all required basic training courses as noted and within timeframes in Appendix B – Table 1.</p> <p><b><i>Required Pre-Service Certification Training</i></b>                  Support coordination providers must complete the course entitled “Support Coordination Pre-Service,” prior to serving any recipients.</p> <p>Within six months of successfully completing the pre-service training, each new support coordinator must begin providing services. 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 regional 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><b>Support Coordination— Limited, Full or Enhanced, continued</b></p>	<p><b><i>Annual In-Service Training Requirements</i></b>                  All waiver support coordinators, as well as supervisors, directors and managers of agencies must 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 must relate to the purpose of APD waivers and the necessity for waiver support coordinators to assist the 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. The APD course titled Best Practices in Supported Employment should be considered when choosing courses that meet the employment related in-service training requirement.</p> <p>All support coordinators must 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. The hours necessary to complete this course may be counted toward meeting in-service requirements.</p> <p>Internal management meetings conducted by support coordination agencies for their staff must 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. Agency supervisors and management staff may provide a portion of the training on topics in which they received training. Up to 12 hours per year for attendance at support coordination meetings conducted by the regional 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, Section II. A.</p>
<p><b>Supported Living Coaching</b></p>	<p><b><i>Required Basic Training</i></b>                  Providers of this service must successfully complete all required basic training courses and pre-service training requirements and within timeframes noted in Appendix B – Table 1. If a provider will administer medication, they must successfully complete Medication Administration Training and Validation. Behavioral Emergency Procedures Training must be successfully completed prior to service provision if a provider is working with a recipient who requires reactive strategies. All new employees must successfully complete all required training before working alone with recipients.</p> <p><b><i>Required Pre-Service Certification Training</i></b>                  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, Section II. A.</p>

<p><b>Supported Living Coaching</b>, continued</p>	<p><b><i>Annual In-Service Training Requirements</i></b>                  Supported living coaching providers must complete eight hours of annual in-service. Examples of training topics include: 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, Section II. A.</p> <p>All supported living coaches must successfully complete APD’s course entitled “Introduction to Social Security Work Incentives” within one year of receiving their certificate of enrollment as a supported living coach. Coaches who are certified and enrolled at the time this handbook becomes effective must complete this requirement within one year of the handbook’s effective date. The hours necessary to complete this course may be counted toward meeting in-service requirements.</p>
<p><b>Transportation</b></p>	<p><b><i>Required Basic Training</i></b>                  Providers of this service must successfully complete all required basic training courses and pre-service training requirements and within timeframes noted in Appendix B – Table 1. If a provider will administer medication, they must successfully complete Medication Administration Training and Validation. Behavioral Emergency Procedures Training must be successfully completed prior to service provision if a provider is working with a recipient who requires reactive strategies. All new employees must successfully complete all required training before working alone with recipients.</p>

APPENDIX D  
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 Region
Northwest Region Tallahassee Office (850)487-1992 Pensacola Office (850) 595-8351	Bay, Calhoun, Escambia, Franklin, 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, Lake, Marion, Orange, Osceola, Polk, Seminole, 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, Indian River, Martin, Okeechobee, St. Lucie, and Palm Beach
Southern Region (305) 349-1478	Miami-Dade and Monroe

Visit the APD Web site at [www.apd.myflorida.com](http://www.apd.myflorida.com) for current contact information.

Visit the AHCA Web site at [www.ahca.myflorida.com](http://www.ahca.myflorida.com) for the AHCA field offices' contact information.

APPENDIX E  
MEDICAID WAIVER SERVICES AGREEMENT

## MEDICAID WAIVER SERVICES AGREEMENT

**This Agreement** is entered into between the Florida Agency for Persons with Disabilities, hereinafter referred to as “APD,” and \_\_\_\_\_, hereinafter referred to as the “Provider.” Pursuant to the terms and conditions of this Agreement, APD authorizes the Provider to furnish \_\_\_\_\_ Home and Community-Based Services (HCBS) Medicaid waiver services to eligible APD clients, and to receive payment for such services. Services may be authorized by multiple Region offices for multiple service types and service locations within the respective Region pursuant to the standards specified in Florida’s HCBS waivers. The services that may be provided in any APD region or location within a region are limited to the services that the respective Region office has authorized.

The computer hard drives used by APD Waiver Support Coordinators shall implement Full Disk Encryption software. For other types of electronic data storage devices that store confidential APD consumer data, such data shall be encrypted using a minimum of a 128-bit encryption algorithm.

### *I. AGREEMENT DOCUMENTS:*

**A.** The Medicaid Waiver Services Agreement consists of the terms and conditions specified in this Agreement, any attachments, and the following documents, which are incorporated by reference:

- 1. *The Developmental Disabilities Individual Budgeting Medicaid Waiver Coverage and Limitations Handbook***, dated \_\_\_\_\_ [insert date of current handbook], and any updates or replacements thereto. The Handbook can be found at the Medicaid fiscal agent’s Web Portal: <http://www.mymedicaid-florida.com/>. Click on Public Information for Providers, then on Provider Support, and then on Provider Handbooks. The Handbook provides the terms and conditions by which the provider of Developmental Disabilities Individual Budgeting HCBS waiver services agrees to be bound.
- 2. *Attachment* \_\_\_\_\_**, providing individually negotiated unit rates of payment for services not already established and available on APD’s website: <http://apd.myflorida.com/providers/enrollment/>, as referenced in II.E., and any other service or data requirements, as applicable.

**B.** Prior to executing this Agreement and furnishing any waiver services, the Provider must have executed a Medicaid Provider Agreement with the Agency for Health Care Administration (AHCA), and be issued a Medicaid provider number by AHCA. The Provider must at all times during the term of this Agreement, maintain a current and valid Medicaid Provider Agreement with AHCA, and comply with the terms and conditions of the Medicaid Provider Agreement.

### *II. THE PROVIDER AGREES:*

To comply with all of the terms and conditions contained within this Agreement, including all documents incorporated by reference and any attachments.

#### **A. Monitoring, Audits, Inspections, and Investigations**

To permit persons duly authorized by APD, AHCA, or representatives of either, to monitor, audit, inspect, and investigate any recipient records, payroll and expenditure records (including electronic storage media), papers, documents, facilities, goods and services of the Provider which are relevant to this Agreement, and to interview any recipients receiving services and employees of the Provider to assure APD of the satisfactory performance of the terms and conditions of this Agreement.

- 1.** Following such monitoring, audit, inspection, or investigation, APD or its authorized representative, will furnish to the Provider a written report of its findings and, if deficiencies are found, request for development, by the Provider, a Plan of Remediation for needed corrections. The Provider hereby agrees to correct all noted deficiencies identified by APD, AHCA, or their authorized representatives within the specified period of time identified within the report documentation. Failure to correct noted deficiencies within stated time frames may result in termination of this Agreement.
- 2.** Upon demand, and at no additional cost to the APD, AHCA, or their authorized representatives, the Provider will facilitate the duplication and transfer of any records or documents (including electronic storage media), during the required retention period of six years after termination of the Agreement, or if an audit has been initiated and audit findings have not been resolved at the end of six years, the records shall be retained until resolution of the audit findings or any litigation which may be based on the terms of this Agreement, at no additional cost to APD.

3. To comply and cooperate immediately with APD requests for information, records, reports, and documents deemed necessary to review the rate setting process to ensure that provider rates are based on accurate information and reflect the existing operational requirements of each service. Any individual who knowingly misrepresents the information required in rate setting commits a felony of the third degree, punishable as provided in sections 775.082 and 775.083, F.S.
4. To comply and cooperate immediately with any inspections, reviews, investigations or audits deemed necessary by APD's Office of the Inspector General pursuant to section 20.055, F.S.
5. To include the aforementioned audit, inspections, investigations and record keeping requirements in all subcontracts and assignments.

#### **B. Confidentiality of Client Information**

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

#### **C. Indemnification**

1. To be liable for and indemnify, defend, and hold APD, AHCA and all of their officers, agents, and employees harmless from all claims, suits, judgments, or damages, including attorneys' fees and costs, arising out of any act, actions, neglect, or omissions by the Provider, its agents, employees, or subcontractors during the performance or operation of this Agreement or any subsequent modifications thereof, whether direct or indirect, and whether to any person or tangible or intangible property. The Provider shall not be liable for that portion of any loss or damages proximately caused by the negligent act or omission of APD or AHCA.
2. That its inability to evaluate its liability or its evaluation of liability shall not excuse the Provider's duty to defend and to indemnify within 7 days after notice by APD or AHCA by certified mail. After the highest appeal taken is exhausted, only an adjudication or judgment specifically finding the Provider not liable shall excuse performance of this provision. The Provider shall pay all costs and fees, including attorneys' fees related to these obligations and their enforcement by APD or AHCA. APD or AHCA's failure to notify the Provider of a claim shall not release the Provider of these duties.
3. If the provider is an agency or subdivision of the State, its obligation to indemnify, defend, and hold harmless shall be to the extent permitted by section 768.28, F.S. or other applicable law, and without waiving the limits of sovereign immunity.

#### **D. Insurance**

To obtain and maintain at all times continuous and adequate liability insurance coverage during the term of this Agreement. The Provider accepts full responsibility for identifying and determining the type and extent of liability insurance necessary to provide reasonable financial protection for the Provider and APD clients served by the Provider. At all times, the Provider shall maintain with APD a current certificate of insurance describing the types and extent of liability insurance obtained pursuant to this Agreement. The Provider shall cause APD to be named as a certificate holder under each policy of liability insurance maintained by the Provider pursuant to this Agreement. The limits of coverage under each such policy shall not be interpreted as limiting the Provider's liability and obligations under this Agreement. All insurance policies shall be through insurers authorized or eligible to write policies in Florida. Such coverage may be provided by a self-insurance program established and operating under Florida law.

#### **E. Payment**

To accept payment for goods and services at rates periodically established by AHCA and APD. The most current rates are available on APD web site: <http://apd.myflorida.com/providers>. The signatories recognize that APD is limited by appropriation and acknowledge that Florida law requires AHCA and APD to make any adjustment necessary to comply with the availability of moneys and any limitations or directions provided for in the General Appropriations Act, including but not limited to adjusting fees, reimbursement rates, lengths of stay, number of visits, or number of services, or limiting enrollment. (See sections 393.0661, 409.906, 409.908, F.S.)

## **F. Return of Funds**

To be responsible for the timely correction of all billing or reimbursement errors resulting in an overpayment, including reimbursement for services not properly authorized or documented. Reimbursement will be made pursuant to the Florida Medicaid Provider Reimbursement Handbook, CMS-1500. Federal regulations, 42 CFR § 433.312, require refund of overpayments within 60 days of discovery. AHCA will be the final authority regarding the timeliness of the reimbursement process.

## **G. Independent Status**

That the Provider acts at all times in the capacity of an independent service provider and not as an officer, employee, or agent of APD, AHCA, or the State of Florida. The Provider shall not represent to others that it has the authority to bind the APD or AHCA unless specifically authorized in writing to do so. In addition to the Provider, this is also applicable to the Provider's officers, agents, employees, or subcontractors in performance of this Agreement.

## **H. Revocation of Licenses**

In the event the Provider or any employee of the Provider is the holder of any license required to render the services that are subject to this Agreement, the Provider must immediately notify APD if any such license is suspended or revoked.

## **I. Change of Name or Ownership**

The Provider shall notify APD and clients served of any change of name, or change, sale, or transfer of ownership at least sixty (60) days prior to the change, sale, or transfer. Prior to the change, sale, or transfer, the Provider shall complete the change of ownership process with Medicaid. Prior to, or contemporaneously with, the change, sale, or transfer, the Provider must execute a new Medicaid Waiver Services Agreement to ensure no lapse in service delivery. Clients receiving services will be given an opportunity to receive services from the new owner, purchaser, or transferee, or to select another provider.

## **J. Public Records**

The Provider shall: keep and maintain public records that ordinarily and necessarily would be required by APD in order to perform the service under this Agreement; provide the public with access to public records on the same terms and conditions that APD would provide the records, and at a cost that does not exceed the cost provided by law; ensure that public records that are exempt or confidential and exempt from public records disclosure requirements are not disclosed except as authorized by law; and, meet all requirements for retaining public records and transfer, at no cost, to APD all public records in possession of the Provider upon termination of this Agreement, and destroy any duplicate public records that are exempt or confidential and exempt from public records disclosure requirements (all records stored electronically must be provided to the public agency in a format that is compatible with the information technology systems of the public agency). If the Provider does not comply with a public records request, APD shall enforce the contract provisions in accordance with the Agreement.

## **III. TERMINATION:**

### **A. Termination of Agreement Without Cause**

This Agreement may be terminated by either party without cause, upon no less than 30 calendar days notice in writing to the other party unless a lesser time is mutually agreed upon in writing by both parties. Said notice shall be delivered by certified mail, return receipt requested, or in person with proof of delivery.

### **B. Termination of Agreement With Cause**

This Agreement may be terminated for the Provider's unacceptable performance, non-performance or misconduct upon no less than 24 hours notice in writing to the Provider. Waiver by either party of any breach of any term or condition of this Agreement shall not be construed as a waiver of any subsequent breach of any term or condition of this Agreement. If APD determines that the Provider is not performing in accordance with any term or condition in this Agreement, APD may, at its exclusive option, allow the Provider a period of time to achieve compliance. The provisions herein do not limit APD's right to any other remedies at law or in equity.

### **C. Termination of Service Regions or Service Locations**

When a Provider has been authorized to provide multiple service types within a region, or to provide services in multiple regions, or at multiple locations within a region, the Provider's authorization for any

individual service type, region, or location may be revoked, without cause, upon 30 days' prior written notice, without terminating this Agreement.

**IV. GOVERNING LAW:**

This Agreement shall be construed, performed, and enforced in all respects in accordance with all the laws and rules of the State of Florida, and any applicable federal laws and regulations.

**V. AGREEMENT DURATION:**

This Agreement shall be effective \_\_\_\_\_ or the date on which it has been signed by both parties, whichever is later, and shall terminate on \_\_\_\_\_ which is no later than five years from the effective date.

**VI. OFFICIAL REPRESENTATIVES (Names, Address, Telephone Number, and E-mail Address):**

1. The Provider's contact person and street address where financial and administrative records are maintained is:

Name: \_\_\_\_\_  
Telephone Number: \_\_\_\_\_  
Address: \_\_\_\_\_  
E-mail Address: \_\_\_\_\_

2. The representative of the Provider responsible for administration of the services under this Agreement is:

Name: \_\_\_\_\_  
Telephone Number: \_\_\_\_\_  
Address: \_\_\_\_\_  
E-mail Address: \_\_\_\_\_

4. The Agency for Persons with Disabilities contact person for this Agreement is:

Name: \_\_\_\_\_  
Telephone Number: \_\_\_\_\_  
Address: \_\_\_\_\_  
E-mail Address: \_\_\_\_\_

5. Upon change of the representative's names, addresses, telephone numbers, and e-mail addresses, by either party, notice shall be provided in writing to the other party and the notification attached to the originals of this Agreement.

**VII. INTEGRATED AGREEMENT:**

Only this Agreement, any attachments referenced, the Medicaid Provider Agreement, the **Developmental Disabilities Individual Budgeting Medicaid Waiver Coverage and Limitations Handbook**, which are incorporated into this Agreement by reference, contain all the terms and conditions agreed upon by the parties.

There are no provisions, terms, conditions, or obligations other than those contained herein, and this Agreement shall supersede all previous communications, representations, or agreements, either verbal or written between the parties. If any term or provision of the Agreement is found to be illegal or unenforceable, the remainder of the Agreement shall remain in full force and effect and such term or provision shall be stricken.

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**The Provider, by signing below, attests that the Provider has received and read the entire Agreement, inclusive of its attachments and documents as referenced in Section I, A., including the service-specific requirements for enrolled providers, contained in the *Developmental***

***Disabilities Individual Budgeting Medicaid Waiver Coverage and Limitations Handbook and understands each section and paragraph.***

**IN WITNESS THEREOF**, the parties hereto have caused this page Agreement to be executed by their undersigned officials as duly authorized.

**PROVIDER:**

**STATE OF FLORIDA,  
AGENCY FOR PERSONS WITH DISABILITIES**

**SIGNED BY:** \_\_\_\_\_

**SIGNED BY:** \_\_\_\_\_

**NAME:** \_\_\_\_\_

**NAME:** \_\_\_\_\_

**TITLE:** \_\_\_\_\_

**TITLE:** \_\_\_\_\_

**DATE:** \_\_\_\_\_

**DATE:** \_\_\_\_\_

**MEDICAID PROVIDER ID:** \_\_\_\_\_

**(DD WAIVER)**