CHAPTER 65G-4
SERVICE DELIVERY PRACTICE AND PROCEDURE

65G-4.001 Definitions for Behavioral Services: Practice and Procedure.

(1) Area Behavior Analyst means a behavior analyst employed by, or under contract with an area office of the Agency who holds a doctorate from an accredited university program with behavior analysis as a primary focus, is a board certified behavior analyst, has completed a dissertation that had behavior analysis as its central focus and has at least one year of experience in the provision of behavior analysis services for persons with developmental disabilities. However, if no one with these qualifications is available, then the individual must be a certified behavior analyst with at least the education and experience requirements for taking the board's behavior analyst examination.

(2) Behavior analysis refers to the use of scientific methods to produce socially significant improvements in behavior. This process entails gathering information to analyze or describe the link between behavior and environment. It includes assessment of the environment and consequences that are maintaining the behavior targeted for change. It also encompasses changing the situations in the environment that trigger problem behavior and arranging situations that will provide the opportunity for desirable behaviors to occur. Behavior Analysis interventions teach or increase occurrence of skills to replace the behavior targeted for change and arrange delivery of consequences for desirable and undesirable behavior. A behavior analytic intervention also includes strategies and approaches to maintain the gains of the intervention over time and in varied settings. Behavior change interventions are based on the principles and laws of behavior. Behavior analytic interventions require monitoring and evaluation for effectiveness through direct observation and quantification of the behavior targeted for change. Caregivers and family members are actively involved in the behavior analysis process and are taught how to implement specific techniques or changes in the environment. Behavior analysis does not rely on cognitive therapies and expressly excludes psychological testing, neuropsychology, psychotherapy, sex therapy, physchoanalysis, hypnotherapy and long term counseling as treatment modalities.

(3) Behavior analysis services – The use of behavior analysis to assist a person or persons to learn new behavior, to increase existing behavior, to reduce existing behavior, and to emit behavior under precise environmental conditions. The term "behavior analysis services" includes the terms "behavior analysis service plan," "behavioral programming," "behavioral supports," "behavior modification programs," "behavior intervention plans," "behavior plans," and "behavioral programs," as well as those interventions designed to ameliorate dangerous behavior as described in subsection 65G-4.010(3), F.A.C., below. These services are supported in documentation showing that they are applied, behavioral, analytic, technological, conceptually systematic, and effective relative to the definitions of these terms found in "Some Current Dimensions of Applied Behavior Analysis" by D. M. Baer, M. M. Wolf, and T. R. Risley and available in the *Journal of Applied Behavior Analysis*, Volume 1, 1968. This article is incorporated by reference and may be found online at http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1310980/pdf/jaba00083-0089.pdf.

(4) Certification Body – A nonprofit corporation whose standards for certification of behavior analysts and assistant behavior analysts adheres to the national standards of boards that determine professional credentials to meet the needs of behavior analysts, state governments and consumers of behavior analysis services. The certification procedure of the nonprofit corporation must undergo regular psychometric review and validation pursuant to a job analysis survey of the profession and standards established by content experts in the field.

(5) Certified Behavior Analyst – A behavior analyst certified by a certification body, including a Board Certified Behavior Analyst – Doctoral level, a Board Certified Behavior Analyst, a Board Certified Assistant Behavior Analyst and a Florida Certified Behavior Analyst.

(6) Consultation – Monthly contacts between a Board Certified Assistant Behavior Analyst (BCaBA) and a consulting Board Certified Behavior Analyst (BCBA), during which the behavior analysis services provided by the BCaBA are evaluated. At the time consultation is provided, the consulting BCBA shall not be the BCaBA's subordinate, employee, spouse or family member. The consulting BCBA shall not be considered an employee of the BCaBA if the only compensation received by the consulting BCBA consists of payment for consultation. Monthly contacts may include the BCaBA's presentation of behavior analysis services designed by the BCaBA, with a focus on graphic displays of data, at local review committee meetings, established in rule 65G-4.008, F.A.C.

(7) Contingent exercise – Bodily exertion or effort that is not topographically related to the misbehavior, involving a repeated series of physical movements required as a consequence for inappropriate behavior.

(8) Desensitization – A method for teaching an individual to exhibit calm or incompatible behavior during the gradual and systematic presentation of increasing levels of an aversive or feared stimulus resulting in the ability to tolerate the formerly feared stimulus.

(9) Dietary manipulations – Procedures involving the alteration of dietary variables including the quantity or type of food eaten and liquids consumed, the caloric density of the diet, the oral stimulation involved in eating, and the temporal distribution of the daily diet.

(10) Extinction – A procedure in which reinforcement of a previously reinforced behavior is discontinued.

(11) Facility – Can be a publicly or privately established residential operation serving individuals with behavioral service needs.

(12) Functional Communication Training (FCT) – a procedure in which a functional form of communication is taught and reinforcement is provided contingent upon communication, while withholding reinforcement for other behavior.

(13) Positive practice overcorrection – Activities that involve repeated performance of a desirable alternative behavior related to

a targeted inappropriate behavior.

(14) Provider – 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. Only those providers holding a certificate on active status from a recognized certification organization for behavior analysis shall use the title, "certified behavior analyst." Individuals performing behavior analysis services shall limit their practice to areas of documented expertise and in accordance with their education, training, and certification or licensure, unless otherwise demonstrating evidence of supervision by an individual meeting the requisite education, training, and certification.

(15) Regular psychometric review and validation – A certification process which complies with recognized national standards in the testing and certification industry to ensure the certification examinations are fair, valid and reliable and in conformance with recognized standards such as those of the International Organization for Standardization (ISO) or the National Commission for Certifying Agencies (NCCA).

(16) Response blocking – The use of physical intervention upon occurrence of an undesirable behavior in such a way as to interrupt the normal form of responding.

(17) Response cost – A procedure in which a specified amount of available reinforcers are removed from the individual's reserve upon occurrence of a specified behavior.

(18) Restitutional overcorrection – Activities that involve correcting the effects of a specified behavior to a better condition than present prior to the occurrence of the specified behavior.

(19) Time-out – These procedures include the withdrawal of the opportunity to earn positive reinforcement or the loss of access to positive reinforcers for a specified period of time.

(20) Token Economy – A behavior change system in which identified behaviors are reinforced by a symbolic medium of exchange, or token, which is later used by a participant in the "purchase" of backup reinforcers, including objects or activities.

Rulemaking Authority 393.13(4)(g)3., 393.17 FS. Law Implemented 393.13(4)(g)3., 393.17 FS. History–New 9-23-96, Formerly 10F-4.023, 65B-4.023, Amended 4-4-12.

65G-4.0011 Recognized Certification Organizations for Certified Behavior Analysts.

All providers of behavior analysis services must either be licensed to practice in accordance with Chapter 490 or 491, F.S., or certified under a nonprofit corporation meeting the qualifications under Section 393.17(2), F.S. All providers of behavior analysis services must submit to the Agency for Persons with Disabilities proof of their active licensure or certification in order to provide behavior analysis services. Pursuant to Rule 65G-4.001, F.A.C., and as required by Section 393.17(2), F.S., the Agency recognizes the certification for behavior analysts awarded by the following organizations: Behavior Analyst Certification Board, Inc.

Rulemaking Authority 393.17(2) FS. Law Implemented 393.17(2) FS. History–New 4-4-12.

65G-4.002 Service Delivery.

(1) The Agency shall provide all clients with appropriate supports and services in accordance with their support plan. Implementation of this policy, however, is subject to availability of funds.

(2) Clients of the Agency shall be integrated within local communities to the greatest extent possible. To this end, generic and specialized community services rather than Agency services shall be used whenever this will serve the best interest of the client. For referral purposes, each area office shall have a current descriptive directory of community resources.

(3) Programs and services provided by or for the Agency shall adhere to the policies, standards and procedures specified and made reference to in this chapter. The Agency shall make every effort to ensure that services provided are of good quality and at least comparable to those provided to persons in the community without disabilities.

(4) Medicaid providers should be reminded that all contracts for programs and services provided to the Agency shall include any terms and requirements established in the Developmental Disabilities Waiver Services Coverage and Limitations Handbook as required by Rules 59G-13.083, and 65G-4.008, 65G-4.009, 65G-4.010, F.A.C.

Rulemaking Authority 373.13(4)(g)3., 393.501(1) FS. Law Implemented 373.13(4)(g)3., 393.17 FS. History–New 1-1-77, Formerly 10F-4.08, 10F-4.008, 65B-4.008, Amended 4-4-12.

65G-4.0021 Tier Waivers.

Rulemaking Authority 393.0661(3) FS. Law Implemented 393.0661(3) FS. History–New 10-20-08, Repealed 11-21-10.

65G-4.0022 Tier One Waiver.

Rulemaking Authority 393.0661(3) FS. Law Implemented 393.0661(3) FS. History–New 10-20-08, Repealed 11-21-10.

65G-4.0023 Tier Two Waiver.

Rulemaking Authority 393.0661(3) FS. Law Implemented 393.0661(3) FS. History–New 10-20-08, Amended 7-15-09, Repealed 11-21-10.

65G-4.0024 Tier Three Waiver.

Rulemaking Authority 393.0661(3) FS. Law Implemented 393.0661(3) FS. History–New 10-20-08, Repealed 11-21-10.

65G-4.0025 Tier Four Waiver.

Rulemaking Authority 393.0661(3) FS. Law Implemented 393.0661(3) FS. History–New 10-20-08, Repealed 11-21-10.

65G-4.0026 Tier Waivers.

Rulemaking Authority 393.0661(3) FS. Law Implemented 393.0661(3) FS. History–New 3-7-10, Amended 9-28-11, Repealed 1-19-16.

65G-4.0027 Tier One Waiver.

Rulemaking Authority 393.0661(3) FS. Law Implemented 393.0661(3) FS. History–New 3-7-10, Repealed 1-19-16.

65G-4.0028 Tier Two Waiver.

Rulemaking Authority 393.0661(3) FS. Law Implemented 393.0661(3) FS. History–New 3-7-10, Repealed 1-19-16.

65G-4.0029 Tier Three Waiver.

Rulemaking Authority 393.0661(3) FS. Law Implemented 393.0661(3) FS. History–New 3-7-10, Repealed 1-19-16.

65G-4.00291 Tier Four Waiver.

Rulemaking Authority 393.0661(3) FS. Law Implemented 393.0661(3) FS. History–New 3-7-10, Repealed 1-19-16.

65G-4.003 Certification as a Behavior Analyst.

Rulemaking Authority 393.13(4)(g)3., 393.17 FS. Law Implemented 393.13, 393.17 FS. History–New 9-23-96, Formerly 10F-4.024, 65B-4.024, Repealed 4-4-12.

65G-4.004 Certification as an Associate Behavior Analyst.

Rulemaking Authority 393.13(4)(g)3., 393.17 FS. Law Implemented 393.13, 393.17 FS. History–New 9-23-96, Formerly 10F-4.025, 65B-4.025, Repealed 4-4-12.

65G-4.005 Renewal of Behavior Analysis Certification.

Rulemaking Authority 393.13(4)(g)3., 393.17 FS. Law Implemented 393.13, 393.17 FS. History–New 9-23-96, Formerly 10F-4.026, 65B-4.026, Repealed 4-4-12.

65G-4.006 Approved Continuing Education.

Rulemaking Authority 393.13(4)(g)3., 393.17 FS. Law Implemented 393.13, 393.17 FS. History–New 9-23-96, Formerly 10F-4.027, 65B-4.028,

Repealed 4-4-12.

65G-4.007 Behavior Analysis Certification Fees.

Rulemaking Authority 393.13(4)(g)3., 393.17 FS. Law Implemented 393.17 FS. History–New 9-23-96, Formerly 10F-4.028, 65B-4.027, Repealed 4-4-12.

65G-4.008 Behavior Analysis Services Oversight System Organization.

(1) The Agency will establish and maintain a behavioral services program including a senior clinician, the Agency Senior Behavior Analyst (ASBA), to assume direction for standards of behavioral practice as provided in this chapter, develop and manage systems of quality, utilization and cost containment for statewide behavioral practice. The ASBA holds a doctorate from an accredited university program with behavior analysis as a primary focus, is a board certified behavior analyst, has completed a dissertation that had behavior analysis as its central focus and has at least one year of experience in the provision of behavior analysis services for persons with developmental disabilities. However, if no one with these qualifications is available, then the ASBA must be a certified behavior analyst with at least the education and experience established by the designated certification board. The behavioral services program will also include the support of at least one master's level board certified behavior analyst. The ASBA will direct:

(a) Area Behavior Analysts, who will be recruited, appointed, given clinical supervision and annually evaluated in conjunction with their functional supervisor in the area to which they are assigned.

(b) Committees.

1. The Local Review Committees (LRC) working in conjunction with the ASBA shall adopt the model LRC bylaws to establish guidelines for committee function, including the establishment of time frames for scheduling, reviewing, and approving, as well as tracking for efficient program review and approval, charter content, committee membership, meeting participants, confidentiality requirements and development of a process to resolve provider and LRC disputes.

2. The Peer Review Committee (PRC) working in conjunction with the ASBA shall adopt the model PRC bylaws to establish membership, as well as annual projects including, at minimum, review of behavioral practices in at least one Developmental Disability Center, at least one state operated forensic facility, at least one area community residential behavioral provider, at least one Local Review Committee, and other services as identified by the Agency.

3. Behavior Analysis Practices Committee (BAPC) shall be established to meet at least annually with membership from Area and Developmental Disabilities Centers Behavior Analysts, the PRC, providers of behavior analysis and behavior assistant solo service providers and agency providers, as well as behavioral residential services providers to assure that common operational requirements established in Rules 65G-4.008, 65G-4.009, and 65G-4.10, F.A.C., are implemented consistently statewide, including the qualifications and processes for establishing individuals and agencies as behavior analysis providers, behavior analysis agencies and residential behavioral providers, establishing consensus standards for LRC operation, standards for behavioral assessment content and behavior analysis support plan program content, standards for graphic display of data, documentation, billing, as well as behavioral services practice and service sanctions to ensure service quality to meet the changing needs of service recipients and provider requirements.

(2) A statewide peer review committee (PRC) and local review committees (LRCs) shall be appointed by the Agency to provide oversight of behavior analysis services.

(a) The Agency will establish the composition, function and procedures to be followed by the committees in the form of Model bylaws incorporated by reference in subsection (5) of this rule.

(b) Each committee shall be chaired by a person who holds a doctorate from an accredited university program with behavior analysis as a primary focus, is a board certified behavior analyst, has completed a dissertation that had behavior analysis as its central focus and has at least one year of experience in the provision of behavior analysis services for persons with developmental disabilities. However, if no one with these qualifications is available, then the chairperson must be a certified behavior analyst with at least the education and experience requirements for taking the board's behavior analyst examination.

(c) Local review committees may establish subcommittees within varied locations outside the area office or within large facilities, upon mutual agreement between an area office and a provider, or between a primary facility campus and remote locations, and operate under the rules governing local review committees. Subcommittees shall ensure that at least two participating members are certified behavior analysts who are not employed or contracted by the facility, and who have no interest in the behavior programs

produced by it. Members whose programs are reviewed in the course of the LRC meeting must abstain from decisions regarding their programs. The LRC shall remain responsible for the decisions of the subcommittees.

1. A sufficient number of LRCs shall be established to allow for the timely and thorough review of behavior analysis services.

2. Programs developed, implemented and submitted by a BCBA to the LRC chairperson following implementation may proceed forward until a decision is rendered by the LRC chairperson.

3. A provider submitting a behavior analysis services plan will be notified by the LRC chairperson within 21 days that the plan has been received with preliminary review completed.

4. Within 30 days of receipt of a behavior analysis services plan the LRC chairperson will notify the provider of the date the plan will be reviewed by the committee, if needed.

5. Behavior analysis services plans must be reviewed and a decision rendered within 90 days of receipt by the LRC chairperson.

6. At the time of review by the LRC, a decision will be rendered:

a. To "approve," and a review date established, or

b. To "approve with modifications" and a review date established. Behavior analysis services plans developed, implemented and submitted by a BCBA may proceed forward and modifications submitted by the provider to the LRC chairperson within 30 days without further LRC review, until the next established review date, or

c. To "not approve" Behavior analysis services plans that are not approved must be revised by the provider, and resubmitted within 14 working days. Based upon the modifications the LRC chairperson must render a decision orally and in writing within seven working days of receipt, in the language of the provider, and in English.

7. Each LRC will be chaired by an individual meeting the qualifications set forth in paragraph (2)(b), above, who is either an employee of the Agency or under contract to provide this service. Under no circumstances may the chair participate in the LRC review of his or her own services, services provided by or to a family member, or related services.

(3) The PRC shall conduct onsite reviews of behavior analysis services including the operations of local review committees; provide training and technical assistance related to client and systemic behavior analysis services issues; and provide recommendations regarding laws and regulations that affect behavior analysis services.

(4) Each area office, and each developmental disabilities center, hereafter referred to as "facility," shall have a local review committee that shall oversee behavior analysis services provided to clients in their area or facility as specified in paragraphs (a)-(c), below:

(a) The committee shall review behavior analysis services programs as required in Rule 65G-4.010, F.A.C., to ensure that behavioral programs are implemented as required and with the intended improvement in target behaviors.

1. The person who designed the services or a certified or licensed designee, who has sufficient knowledge of the plan and its implementation, shall be present during the initial committee review. A person with primary responsibility for the ongoing implementation and monitoring of the services shall be present at all future meetings at which the services are reviewed by the committee.

2. Any person can request that a behavior analysis services plan be brought before the committee for its review to ensure compliance with Chapter 393, F.S., and Chapter 65G-4 or 65G-8, F.A.C. Providers should also be aware of the requirements in the Developmental Disabilities Waiver Services Coverage and Limitations Handbook (in Rule 59G-13.083, F.A.C.)

(b) The committee shall monitor behavior analysis services in accordance with a monitoring schedule approved by the committee. Approval of services includes the determination by the LRC chairperson that the individual designing and implementing the behavior analysis services is in compliance with subsection 65G-4.001(14), F.A.C., above, or is appropriately supervised.

(c) If reactive strategies (as that term is defined in subsection 65G-8.001(15), F.A.C., continue without the implementation of required behavioral programs or behavior analysis services requiring review are not presented to the LRC or are not found to be in accordance with Florida law, the committee chairperson shall request that the Agency notify the behavior analyst, and when appropriate, the residential provider and behavior analyst's supervisor, of the services, orally at the time of review and in writing within ten days of review in the language of the provider or supervisor, and in English, of each area of non-compliance.

1. Absent emergency circumstances that threaten public health, safety or welfare, the provider shall have twenty (20) days within which to demonstrate compliance or present to the committee chairperson in writing evidence showing that the services being provided are in compliance with Florida Statutes and the Agency rules. The provider may present whatever evidence appropriate to demonstrate that the provider is in compliance with Chapter 393, F.S., Chapter 65G-4 or 65G-8, F.A.C. Providers should also be aware of the requirements of the Developmental Disabilities Waiver Services Coverage and Limitations Handbook in Rule 59G-

13.083, F.A.C.

2. If emergency circumstances exist for the recipient of behavioral services the committee chairperson may give instruction to the provider on how to proceed with services or to cease and desist from continued behavior analysis services, with other recommendations for necessary safeguards and supports.

3. If, however, the committee determines that the behavior analyst, and when appropriate, the residential provider, is not in compliance with Chapter 393, F.S., or Chapter 65G-4 or 65G-8, F.A.C. the committee chairperson shall report all facts and circumstances to the Agency in writing within five (5) days of the provider's response and request a final decision be made by the Agency. Providers should also be aware of the requirements of the Developmental Disabilities Waiver Services and Limitations Handbook in Rule 59G-13.083, F.A.C.

4. Within twenty (20) days of such report, the Agency shall notify the committee, in writing, and the provider, in writing and orally in the language of the provider and in English, of its decision. In the event the Agency finds the provider is not in compliance with Florida Statutes or the Agency rules, the Agency shall allow the provider an additional ten (10) days to modify services to meet requirements. If modifications are not made within the time allotted, the Agency shall consider whether a recoupment action should be initiated, provider status should be revoked, supervision be required, complaint be submitted to the designated certification or licensing board, or the requirement that the services being provided be discontinued.

5. If modifications are not made within the time allotted in subparagraph 4., and the agency must take one of the actions in subparagraph 4., the agency shall consider whether any of the following occurred:

a. Falsification of Documentation.

b. Absence of documentation, such as graphs, behavioral assessments, behavior plans and required summaries.

c. Lack of program monitoring as approved by the LRC.

d. Failing to maintain a current behavior plan for an individual served.

e. Failure to present behavior plan/s requiring LRC review.

f. Failure to revise behavior plans based upon LRC recommendations or upon analysis of data and consistent with Chapter 65G-4, F.A.C.

g. Failure to address behaviors related to health and safety.

h. Failure to provide adequate supervision to behavior analysts and behavior assistants working under such service delivery arrangement.

i. Failure to resubmit behavior plan revisions within time constraints established by the LRC.

j. Repeated deficiencies that display lack of competence.

k. Repeated use of restricted measures for problem behavior as itemized in subsection 65G-8.006(9), F.A.C., or use of reactive strategies without an LRC approved behavior analysis services plan as set forth in Rule 65G-8.006, F.A.C.

l. Consistent pattern of failure to return phone calls or email, reply to any correspondence or show up for scheduled service visits and cannot be located.

m. Failure to report abuse of a minor, or adult with disabilities as mandated by Florida Law.

n. Failure to report immediately to law enforcement of potentially life threatening situations such as possession of explosives, fire arms, weapons, toxic material or illegal substances by individuals with impaired judgment and behavioral issues.

o. Felony or misdemeanor related to the practice of behavior analysis or the health and safety of an individual.

p. Failure to abide by ethical guidelines of their professional certification or licensing body.

q. Assessment Report past due 30 day limit.

r. Behavior plan past due 90 day limit.

s. Documentation not submitted to the waiver support coordinator.

t. Non-Compliance with standards of Behavior Focused and Intensive Behavior homes, including a current behavior plan developed or revised within the year and reporting of reactive strategies.

u. Falsifying billing or billing at a higher rate than the analyst's qualifications warrant.

v. Billing for services in school settings.

w. Failure to comply with Rules 65G-4.008, 4.009, 4.010, F.A.C., or Chapter 393, F.S.

x. Providers should also be aware of the requirements of the Developmental Disabilities Waiver Services and Limitations Handbook in Rule 59G-13.083, F.A.C.

6. Following a committee report set forth above, the Agency, after consideration of the factors set forth in subparagraph 5.,

above, may require additional supervision of the provider's services. The requirement for additional supervision may be a prerequisite for allowing the provider to continue to serve as an authorized behavior analysis services provider. Such required supervision shall include the following conditions:

a. Supervision must be provided by a Board Certified Behavior Analyst – Doctoral level, or a Board Certified Behavior Analyst, or a person licensed under Chapter 490 or 491, F.S., (Psychologist, School Psychologist, Clinical Social Worker, Marriage and Family Therapist or Mental Health Counselor), with evidence (e.g. work samples) of at least three years of experience in the application of Applied Behavior Analysis procedures approved by a local review committee, to persons with exceptional needs post certification or licensure,

b. Face-to-face meetings for up to two hours every two weeks or two hours per 40 hours of the provider's contact with clients. These meetings shall be between the provider and a board certified behavior analyst or a person licensed under Chapter 490 or 491, F.S., during which the supervisor directs and evaluates the behavior analysis services,

c. The supervisor shall not be, at the time supervision is provided, the provider's subordinate or employee, spouse or family member. The supervisor shall not be considered an employee of the provider if the only compensation received by the supervising behavior analyst consists of payment for supervision; and,

d. The provider's presentation of behavior analysis services designed and implemented by the provider, with a focus on graphic displays of data, at local review committee meetings, established in Rule 65G-4.008, F.A.C., may be substituted for up to 25 percent of the total supervision time required.

(5) Forms incorporated by Reference.

(a) Model LRC Bylaws are hereby incorporated by reference as Form APD-CBA – 1 (10/10).

(b) Model PRC Bylaws are hereby incorporated by reference as Form APD-CBA – 2 (10/10).

Anyone may acquire a copy of the model bylaws by contacting the ASBA at the APD Central Office, 4030 Esplanade Way, Tallahassee, Florida 32399, email: apd_info@apd.state.fl.us, phone: (850)488-4257.

Rulemaking Authority 393.125, 393.13(4)(g)3., 393.17 FS. Law Implemented 393.066, 393.13(4)(g)3. FS. History–New 9-23-96, Formerly 10F-4.029, 65B-4.029, Amended 4-4-12.

65G-4.009 Design, Implementation and Monitoring of Behavior Analysis Services.

(1) Providers of behavior analysis services shall provide services only as certified and as provided by law.

(2) All aspects of behavior analysis services shall be integrated with other relevant services and supports being provided to the client by the provider within the scope of authorized behavioral services.

(3) The selection of behavior analysis procedures and decisions by the provider to make environmental changes that obviate the need for the use of behavior change procedures shall be based upon information obtained through direct and indirect functional assessment or functional analysis designed to identify patterns of behavior and the functional relationships between the behavior or behaviors targeted for change and the environment. The assessment shall contain at minimum:

(a) Operational definitions of all behaviors targeted for change;

(b) Description of conditions under which the behavior is most likely and least likely to occur;

(c) Measures of current level of behavior targeted for change;

(d) Other relevant personal, social, medical, pharmacological or historical information that may impact on behavior targeted for change, if any;

(e) Putative functional relationships between targeted behavior and environment; and,

(f) Recommendations for procedures to decrease maladaptive behavior and increase relevant appropriate alternative behavior.

(4) Behavior analysis services designed by the provider to decrease behavior shall include procedures for increasing functional replacement behavior, or acquisition of adaptive skills to serve as a functional alternative to the behaviors targeted for change.

(5) Behavior analysis procedures that are the least intrusive to the client and the most likely to be effective shall be used by the provider.

(6) Medical treatment to address purely medical etiologies or physical or occupational therapies to address behavior~~s~~ that are related to physical limitations shall be provided concurrent with, or prior to, the implementation of behavior analysis services by the provider.

(7) Behavior analysis services shall not be provided continuously without appropriate considerations for maintenance and generalization of behavior change in relevant settings or a designation of criteria for termination of the interventions or services.

(8) The provider shall ensure that persons responsible for implementing, monitoring and providing behavior analysis services receive performance-based training that prepares them to properly implement the behavior analysis procedures involved, within the circumstances under which the services will be provided.

(9) The provider shall take reasonable steps to ensure data collection for behaviors targeted for increase and decrease during the entire period services are in effect. Graphic displays of weekly data for behaviors targeted for change shall be maintained and updated by the provider.

(10) The LRC shall approve the provider's behavior analysis services plan and specify the requirements for reporting of findings and data to the committee for behavior analysis services approved by the committee.

(a) Behavior analysis services plans are to be written as succinctly as is possible to effectively serve as a guide to those who will be implementing the plan.

(b) The behavior analysis services plan shall include, either in text or by reference to appropriate documents:

1. Identifying information for the individual affected by the plan.

2. The name, signature and certification or licensure information of the individual who developed, supervises or approves the implementation of the procedures described in the plan.

3. Objective statements of goals relative to behavior reduction and behavior acquisition resulting in program termination.

4. Rationale for intervention being warranted, and selection of proposed interventions, consistent with assessment results.

5. Medical, social and historical information including previous treatment programs relevant to the current problems being addressed.

6. How and where behavioral services will be integrated with daily routines and other relevant services.

7. Identification of behaviors targeted for reduction.

8. Identification of behaviors targeted for acquisition or as replacement.

9. Data collection methods for behaviors targeted for reduction and acquisition.

10. Intervention procedures for behaviors targeted for reduction and acquisition.

11. Description of performance-based training for persons implementing procedures.

12. Techniques for maintaining and generalizing behavioral improvements, as well as criteria for the reduction and fading of behavioral services.

13. When employed, rationale for use of ancillary support staff, such as behavior assistants; a description of training, their routine or duties, performance monitoring and fading of services.

14. Methods of monitoring for programmatic fidelity and effectiveness, including but not limited to:

a. Data analysis and interpretation.

b. Direct observation in the setting(s) where the plan is implemented, including the observation of the implementation of procedures or simulated implementation.

c. Discussions with supervisors, and observations of individuals who implement the behavior analysis procedures involved.

d. Schedule or frequency of monitoring, and who, by function or assignment, will conduct monitoring.

e. Determination that the services are in accordance with Florida Statutes and the Agency rules.

15. Signatures of informed participants as may be required by law and individuals authorized to approve the procedures.

(c) Modifications to the behavior analysis service plan which include procedures listed in Rule 65G-4.010, F.A.C., approved by the LRC shall be documented and submitted by the provider to the committee chairperson within one week after the changes are made, for determination of need for committee review. A summary of the effects of and modifications to behavior analysis services plan shall be written by the provider at least annually. This summary will include a graphical display of data collected over the year with appropriate annotation of program modifications.

Rulemaking Authority 393.13(4) FS. Law Implemented 393.13(4)(g)3. FS. History–New 9-23-96, Formerly 10F-4.030, 65B-4.030, Amended 4-4-12.

65G-4.010 Behavior Analysis Services Approval.

(1) All written plans describing behavior analysis services consistent with subsection 65G-4.009(10), F.A.C., shall be submitted to the local review committee chairperson within five working days following implementation.

(2) All behavior analysis services designed to include restricted procedures or those services designed to address those actions of the individual which, without behavioral, physical, or chemical intervention can be expected to result in outcomes identified in

subsection 65G-4.010(3), F.A.C., below and will be provided or supervised by a Certified Behavior Analyst as defined in subsection 65G-4.001(5), F.A.C., or a person licensed pursuant to Chapter 490 or 491, F.S.: In those cases where it is unclear whether behavior analysis services meet either criteria, the provider must contact the LRC chairperson to determine the need for LRC review.

(3) Written plans describing behavior analysis services must be submitted to the LRC chairperson, when:

(a) Behavior analysis services include restricted procedures such as:

1. The contingent delivery or removal of events to reduce the probability of occurrence of a problem behavior, including but not limited to: extinction or withholding of reinforcement for those behaviors referenced in paragraph 65G-4.010(3)(b), F.A.C., response blocking for more than 15 seconds, contingent exercise, restitutional overcorrection, positive practice overcorrection, time-out and response cost.

2. The removal of an aversive event contingent upon the display of a behavior targeted for increase, including but not limited to, Functional Communication Training using removal of demands or noise as a reinforcer, and desensitization programs.

3. Access to abundant amounts of an event or stimulus so that it loses potency as a reinforcer, and severely restricted access to an event or stimulus to increase its potency as a reinforce.

4. Behavioral protective devices, as defined in subsection 65G-8.001(4), F.A.C., and electronic devices for monitoring and signaling.

5. Dietary manipulations.

(b) Behavior analysis services address behaviors that:

1. Have resulted in self-inflicted, detectable damage, or resulted in external or internal damage requiring medical attention or are expected to increase in frequency, duration, or intensity resulting in self-inflicted, external or internal damage requiring medical attention.

2. Have occurred or are expected to occur with sufficient frequency, duration or magnitude that a life-threatening situation might result, including excessive eating or drinking, vomiting, ruminating, eating non-nutritive substances, refusing to eat, holding one’s breath, or swallowing excessive amounts of air.

3. Have resulted in detectable damage, or external or internal damage to other persons that requires medical attention or are expected to increase in frequency, duration or intensity resulting in external or internal damage to other persons that requires medical attention.

4. Have resulted or are expected to result in major property damage or destruction.

5. Have resulted or are expected to result in arrest and confinement by law enforcement personnel.

6. Have resulted in the need or meet the characteristics for behavioral services in a Behavior Focused or Intensive Behavior Residential Habilitation program.

7. Have resulted in the need for additional staffing or Behavior Assistant Services in one or more settings.

8. Have resulted in the repeated use of reactive strategies without a formal approved behavior plan.

(c) Behavioral programs or manuals implemented as group contingencies or behavior change systems, including behavioral program manuals, level systems and token economies, are implemented.

Rulemaking Authority 393.13(4)(g)3. FS. Law Implemented 393.13(4)(g)3. FS. History–New 9-23-96, Formerly 10F-4.031, 65B-4.030, Amended 4-4-12.

65G-4.011 Determination of Intellectual Disability in Capital Felony Cases: Intelligence; Tests to be Administered.

(1) When a defendant convicted of a capital felony is suspected of having or determined to have intellectual disability, intelligence tests to determine intellectual functioning as specified below shall be administered by a qualified professional who is authorized in accordance with Florida Statutes to perform evaluations in Florida. The test shall consist of an individually administered evaluation, which is valid and reliable for the purpose of determining intelligence. The tests specified below shall be used.

(a) The Stanford-Binet Intelligence Scale.

(b) Wechsler Intelligence Scale.

(2) Notwithstanding this rule, the court, pursuant to Section 921.137, F.S., is authorized to consider the findings of the court appointed experts or any other expert utilizing individually administered evaluation procedures which provide for the use of valid tests and evaluation materials, administered and interpreted by trained personnel, in conformance with instructions provided by the producer of the tests or evaluation materials. The results of the evaluations submitted to the court shall be accompanied by the

published validity and reliability data for the examination.

Rulemaking Authority 921.137(1) FS. Law Implemented 921.137(1) FS. History–New 1-13-04, Formerly 65B-4.032.

65G-4.012 Determination of Intellectual Disability: Intelligence Tests to Be Administered.

(1) For the purposes of chapters 393 and 916, F.S., the Stanford-Binet Intelligence Scale or the Wechsler Adult & Infant Intelligence Scale, administered by or under the direct supervision of a psychologist or school psychologist licensed under Chapter 490, F.S., shall be used to determine intellectual disability and the level of intellectual functioning.

(2) Notwithstanding subsection (1), if, given the condition of the individual to be tested, the Stanford-Binet Intelligence Scale or the Wechsler Adult & Infant Intelligence Scale are not valid and reliable as determined by the person authorized to administer such tests as specified in subsection (1), an alternative test or evaluation procedure, administered and interpreted in conformance with instructions provided by the producer of the tests or evaluation materials, may be used. The results of the testing or evaluation must include reference to published validity and reliability data for the specified test or evaluation procedure.

Rulemaking Authority 393.063(38), 916.106, 393.501(1) FS. Law Implemented 393.063(38), 916.106 FS. History–New 6-13-06, Formerly 65B-4.033.

65G-4.014 Eligibility for Agency Services – Definitions.

(1) Autism means a condition which meets the requirements of Section 393.063, F.S., that the condition is:

(a) Pervasive, meaning always present and without interruption;

(b) Neurologically based, meaning that the condition is not the result of physical impairment;

(c) A developmental disability with age of onset during infancy or childhood;

(d) With extended duration, meaning that the condition reasonably can be expected to continue indefinitely into the future;

(e) Causes severe learning disorders resulting in both severe communication disorders affecting both verbal and nonverbal skills, and severe behavior disorders. Autism is characterized by an individual evidencing at least six of the following twelve features from the following subparts 1 and 2, with at least one feature from subpart 2:

1. Severe communication disorders, which may include:

a. A delay in, or total lack of, the development of spoken language (not accompanied by an attempt to compensate through alternative modes of communication such as gesture or mime),

b. Stereotyped and repetitive use of language or idiosyncratic language,

c. For those applicants with speech, marked impairment in the use of multiple nonverbal behaviors such as eye-to-eye gaze, facial expression, body postures, and gestures to regulate social interaction,

d. Failure to develop peer relationships appropriate to developmental level,

e. A lack of spontaneous seeking to share enjoyment, interests, or achievements with other people (e.g., by a lack of showing, bringing, pointing out objects of interest, or achievements to others),

f. Lack of social or emotional reciprocity,

g. Marked impairment in the ability to initiate or sustain a conversation with others in individuals with adequate speech, or

h. Impaired imaginative ability evidenced by a lack of varied, spontaneous make-believe play or social imitative play appropriate to developmental level.

2. Severe behavior disorders, which are restricted, repetitive and stereotyped patterns of behavior, interests, and activities which may include:

a. Encompassing preoccupation with one or more stereotyped and restricted patterns of interest that is abnormal either in intensity or focus,

b. Apparently inflexible adherence to specific, nonfunctional routines or rituals,

c. Stereotyped and repetitive motor mannerisms (e.g., hand or finger flapping or twisting, or complex whole-body movements), or

d. Persistent preoccupation with parts of objects.

(2) Cerebral Palsy – means a group of disabling symptoms of extended duration that result from damage to the developing brain during the prenatal period and characterized by paralysis, spasticity, or abnormal control of movement or posture, such as poor coordination or lack of balance, which is manifest prior to three years of age. For purposes of the rule, cerebral palsy also means the presence of other significant motor dysfunction appearing prior to age 18 due to perinatal or external events such as anoxia, oxygen

deprivation, or traumatic brain injury. Excluded from this definition is motor dysfunction caused by medical events, including stroke or progressive diseases such as muscular dystrophy. The impairment from cerebral palsy must constitute a substantial handicap which is reasonably expected to continue indefinitely.

(3) Mental Retardation or Intellectual Disability – is evidenced by the concurrent existence of:

(a) Significantly subaverage general intellectual functioning evidenced by an Intelligence Quotient (IQ) two or more standard deviations below the mean on an individually administered standardized intelligence test; and,

(b) Significant deficits in adaptive functioning in one or more of the following areas:

1. Communication skills,

2. Self-care, home living,

3. Social and interpersonal skills,

4. Use of community resources and self-direction,

5. Functional academic skills,

6. Work, leisure, health and safety awareness and skills,

(c) Which are manifested prior to age 18; and,

(d) Constitute a substantial handicap which is reasonably expected to continue indefinitely.

(4) Prader-Willi Syndrome – means a genetic disorder which is most often associated with a random deletion of chromosome 15. Commonly associated characteristics include insatiable appetite, chronic overeating, hypotonia, short stature, obesity, and behavioral issues. Individuals diagnosed with Prader-Willi syndrome generally have mental retardation; however, an individual with Prader-Willi syndrome can be determined as eligible for services without an accompanying diagnosis of mental retardation.

(5) Spina Bifida – For the purposes of agency eligibility, spina bifida refers to a confirmed diagnosis of spina bifida cystica or myelomeningocele.

(6) Down Syndrome – means a condition caused by the presence of extra chromosomal material on chromosome 21. This disorder is often associated with impairment in cognitive ability, characteristic physical growth and features, and congenital medical conditions.

(7) Eligibility Rules – Rules 65G-4.014 through 65G-4.017, F.A.C., inclusive, which apply to eligibility determinations for services provided through the Agency for Persons with Disabilities for individuals with developmental disabilities.

(8) DD Waiver – Home and Community-Based Services (HCBS) waiver authorized by 42 U.S.C. 1396n(c)(1) of the federal Social Security Act and Section 409.906, F.S., that provides a package of Medicaid-funded home and community-based supports and services to eligible persons with developmental disabilities who live at home or in a home-like setting.

(9) Agency Services – home and community based supports and services to eligible persons funded through general revenue allocations or sources other than the DD Waiver.

Rulemaking Authority 393.065(10), 393.066(8), 393.501 FS. Law Implemented 393.065, 393.066 FS. History–New 5-16-12.

65G-4.015 Eligibility for Agency Services Criteria.

In order to be determined eligible for agency services the applicant must:

(1) Be at least three years of age.

(2) Be a resident of and domiciled in the state of Florida in accordance with Sections 222.17(1) and (2), F.S. Domicile may not be established in Florida by a minor who has no parent domiciled in Florida, or by a minor who has no legal guardian domiciled in Florida, or by any alien not classified as a resident alien. Dependents of active duty military personnel stationed in the state of Florida are exempt from residency and domicile requirements.

(3) Have a confirmed diagnosis of one of the following developmental disabilities as defined in this these rules, Rules 65G-4.014, 4.015, 4.016 and 4.017, F.A.C.:

(a) Autism;

(b) Cerebral palsy;

(c) Mental retardation or intellectual disability;

(d) Prader-Willi syndrome;

(e) Spina Bifida;

(f) Down Syndrome;

(g) Phelan-McDermid Syndrome, or

(h) Children between 3 and 5 years of age who are at high risk of later diagnosis of one of the disabilities listed above. Such high-risk children shall not be placed on the waiting list for waiver services until a confirmed diagnosis of a qualifying disability is given.

(4) DD Waiver services are only available (conditioned upon the wait list) to persons who meet the requirements of 42 CFR §435.217(b)(1) for receiving home and community-based services. It is mandatory that the determination is made that without DD Waiver services these individuals would otherwise require the level of care furnished in a hospital, nursing home, or an Intermediate Care Facility for People with Intellectual Disabilities (referred to in the CFR as an "ICF/MR").

(5) This rule shall be reviewed, and if necessary, renewed through the rulemaking process five years from the effective date.

Rulemaking Authority 393.065(10), 393.066(8), 393.501 FS. Law Implemented 393.065, 393.066 FS. History–New 5-16-12, Amended 6-3-20.

65G-4.016 Application Process.

(1) Application for services from the agency shall be made by submitting an application by hand delivery, U.S. Postal Service, or facsimile to the agency office in the service area where the applicant resides. The Application for Services (Form 10-007, 2007), is available on the agency website at www.APD.myflorida.com, http://www.apd.myflorida.com/customers/application/ or by contacting the agency. The application is available in English and Spanish and is hereby incorporated by reference, http://www.flrules.org/Gateway/reference.asp?No=Ref-01203.

(2) Upon receipt of a completed, signed, and dated Application for Services, the area agency staff shall review the application and supporting documentation and, within 45 days for children under the age of 6 and 60 days for individuals 6 years of age and older, shall notify the applicant of the final determination of eligibility for agency services. If requests for collateral information or additional evaluations are necessary to determine eligibility, the time may be extended for no more than an additional ninety (90) days.

(3) If an applicant is unable to produce an existing evaluation that establishes eligibility or if there is concern that the information provided is inaccurate, incorrect, or incomplete, the agency area office will be responsible for obtaining an evaluation to establish eligibility. Professional diagnoses under Rule 65G-4.017, F.A.C., must document all criteria for eligibility as set forth in Rules 65G-4.014-.017, F.A.C. The evaluation process includes only those assessments necessary to determine eligibility that were administered by a person qualified to administer the instrument(s).

(4) When the eligibility determination is complete, the agency area office shall notify the applicant in writing within five (5) business days of the decision. If the applicant is determined ineligible for agency services, the agency area office shall notify the applicant of the right to appeal the decision in accordance with Chapter 120, F.S.

(5) If the applicant is determined to be ineligible to receive services from the agency, the agency area office shall offer suggestions regarding other programs, agencies, or services for which the applicant may be eligible.

(6) If a category of covered conditions in this rule is not also covered by the state's Medicaid developmental disabilities waiver (DD waiver) at the time an individual is determined to be eligible, those individuals will be placed on the waiting list and may be provided services funded through general revenue allocations or sources other than the DD Waiver.

Rulemaking Authority 393.065(10), 393.066(8), 393.501 FS. Law Implemented 393.065, 393.066 FS. History–New 5-16-12.

65G-4.017 Establishing Eligibility.

(1) Establishing Eligibility – Autism. A diagnosis of autism, as defined by Rule 65G-4.014, F.A.C., may only be made by one or more of the following who has specific training and experience in making such diagnosis:

(a) A Florida-licensed psychiatrist;

(b) A Florida-licensed psychologist;

(c) A board-certified pediatric neurologist who is qualified by training and experience to make a diagnosis of autism;

(d) A board-certified developmental pediatrician, or

(e) Collateral information received from another state may be accepted if the evaluator is licensed through the same credentials required for licensure in Florida for the professions listed in paragraph (1)(a), above.

(2) Establishing Eligibility – Cerebral Palsy. Diagnosis is confirmed by written documentation from one or more of the following:

(a) A medical doctor;

(b) A doctor of osteopathy, or

(c) Medical records documenting a diagnosis of cerebral palsy before the age of 18.

(3) Establishing Eligibility – Mental Retardation or Intellectual Disability. To establish that an individual has mental retardation the following criteria shall be applied:

(a) A single test or subtest should not be used alone to determine eligibility. If a person has significantly different (statistically defined) scores on different scales of a test or tests, or a great deal of variability on subtest scores of an IQ test, the full-scale score may not indicate mental retardation and should not be relied on as a valid score. In that instance, closer scrutiny is required to make an appropriate differential diagnosis. This may include review of school records, school placement, achievement scores, medical records, medication history, behavior during testing and the psychosocial situation at the time of testing. Closer scrutiny must also be required when there is a great deal of variability between IQ scores on different IQ tests or different administrations of the same IQ test. Nothing here is intended to preclude clinical judgment from appropriately determining that a single full-scale IQ score of 70 or below, or two or more standard deviations below the mean, on an individually administered intelligence test is sufficient to establish eligibility.

(b) The performance measures for this category of adaptive functioning deficits must be validated by the professional judgment of a psychologist who is experienced in working with people who have retardation, who has specific training and validation in the assessment instrument that is used, and who is one of the following:

1. A Florida-licensed psychologist,
2. A Florida-licensed school psychologist,
3. A certified school psychologist.

(c) Any standardized test may be submitted as proof. However, the applicant must demonstrate that any test not presumptively accepted by the agency is valid. The following are presumptively accepted standardized tests of intelligence to establish eligibility for mental retardation:

1. Stanford-Binet Intelligence Test (all ages),
2. Wechsler Preschool and Primary Scale of Intelligence (under six years of age),
3. Differential Ability Scales – Preschool Edition (under six years of age),
4. Wechsler Intelligence Scale for Children (WISC) (children up to 15 years, 11 months),
5. Differential Ability Scales (children up to 15 years, 11 months),
6. Wechsler Adult Intelligence Scale (WAIS),
7. Test of Nonverbal Intelligence-3 (TONI-3),
8. Comprehensive Test of Nonverbal Intelligence-2 (C-TONI 2),
9. Universal Nonverbal Intelligence Test (UNIT),
10. Leiter International Performance Scale-Revised (Leiter-R).

(d) The following tests of adaptive functioning are presumptively accepted in the determination:

1. Vineland Adaptive Behavior Scales,
2. AAMR Adaptive Behavior Scale,
3. Adaptive Behavior Assessment System (ABAS),
4. Adaptive Behavior Evaluation Scale (ABES).
5. Scales of Independent Behavior-Revised

(e) In all cases, assessments or evaluations for eligibility should be obtained from appropriately licensed professionals with experience and training in the instruments and population for whom eligibility is to be determined.

(4) Establishing Eligibility – Prader-Willi Syndrome. Diagnosis is confirmed by written documentation from one or more of the following:

(a) A medical doctor;

(b) A doctor of osteopathy, or

(c) Medical records that document a diagnosis of Prader-Willi syndrome before the age of 18.

(5) Establishing Eligibility – Spina Bifida. Diagnosis is confirmed by written documentation from one or more of the following:

(a) A medical doctor;

(b) A doctor of osteopathy, or

(c) Medical records that document a diagnosis of spina bifida cystica or myelomeningocele before the age of 18.

(6) Establishing Eligibility – Down Syndrome. Evidence under this category requires medical records documenting a

chromosome analysis (also referred to as a karyotype) finding the individual has an extra genetic material on their number 21 chromosome.

(7) Establishing Eligibility – Phelan-McDermid Syndrome. The diagnosis of Phelan-McDermid Syndrome must be confirmed utilizing genetic testing, with written documentation from a:

(a) Medical doctor, or

(b) Doctor of osteopathy.

(8) Establishing Eligibility – High-Risk Children, 3 to 5 years of age. Evidence under this category requires a determination by an APD area office that a medical diagnosis of developmental delay evidenced by the child indicates a high probability that the child is likely to have an eventual diagnosis of a qualifying condition under Rule 65G-4.014, F.A.C., if early intervention services are not provided, or the child has one or more physical or genetic anomalies associated with a developmental disability, such as:

(a) Genetic or chromosomal disorders (such as Down syndrome or Rett syndrome);

(b) Metabolic disorders (such as phenylketonuria);

(c) Congenital malformations (such as microcephaly or hydrocephaly);

(d) Neurological abnormalities and insults;

(e) Congenital and acquired infectious diseases;

(f) Chronic or catastrophic illnesses or injuries;

(g) A parent or guardian with developmental disabilities who requires assistance in meeting the child's developmental needs, or

(h) Other conditions or genetic disorders generally associated with developmental disabilities, such as tuberous sclerosis, congenital syphilis, fetal alcohol syndrome, or maternal rubella, as documented by a physician.

(i) If a child between three and five years of age already has been determined to have a developmental disability in one of the five categories identified in Chapter 393, F.S., that child shall be eligible for services from the agency under the appropriate diagnosis and shall be added to the waiting list.

(j) If a child served under the category of high risk does not have a confirmed diagnosis by his or her fifth birthday, they shall be given a notice of case closure and the case will be closed at the agency. The agency shall make the child's parent or guardian aware of appropriate agencies, programs or school programs which the agency is aware of which might be able to assist the child.

(9) This rule shall be reviewed, and if necessary, renewed through the rulemaking process five years from the effective date.

Rulemaking Authority 393.065(10), 393.066(8), 393.501 FS. Law Implemented 393.065, 393.066 FS. History–New 5-16-12, Amended 6-3-20.

65G-4.0210 Definitions.

Rulemaking Authority 393.501(1), 393.0662 FS. Law Implemented 393.0662 FS. History–New 10-2-13, Repealed 1-19-16.

65G-4.0211 General Provisions.

Rulemaking Authority 393.501(1), 393.0662 FS. Law Implemented 393.0662 FS. History–New 10-2-13, Repealed 1-19-16.

65G-4.0212 Establishing the Final iBudget Allocation Amount.

Rulemaking Authority 393.501(1), 393.0662 FS. Law Implemented 393.0662 FS. History–New 10-2-13, Repealed 1-19-16.

65G-4.0213 Definitions.

For the purposes of this chapter, the term:

(1) "Agency" means the Agency for Persons with Disabilities.

(2) "Allocation Algorithm" means the mathematical formula based upon statistically validated relationships between client characteristics (variables) and the client's level of need for services provided through the Waiver as set forth in Rule 65G-4.0214, F.A.C., and as provided in Section 393.0662(1)(a), F.S.

(3) "Allocation Algorithm Amount" means the result of the Allocation Algorithm apportioned according to available funding.

(4) "Amount Implementation Meeting Worksheet" or "AIM Worksheet" means a form used by the Agency for new Waiver enrollees, and upon recalculation of a client's algorithm, to:

(a) Communicate a client's Allocation Algorithm Amount;

(b) Identify proposed services based upon the Allocation Algorithm Amount; and

(c) Identify additional services, if any, should the client or their legal representative feel that any Significant Additional Needs of the client cannot be met within the Allocation Algorithm Amount. The Amount Implementation Meeting Worksheet – APD Form 65G-4.0213 A, effective 7-1-21, is hereby adopted and incorporated by reference, and is available at http://www.flrules.org/Gateway/reference.asp?No=Ref-12459.

(5) "Approved Cost Plan" means the document that lists all Waiver services that have been authorized by the Agency for the client, including the anticipated cost of each approved Waiver service, the provider of the approved service, and information regarding the provision of the approved service.

(6) "Available Service" means a support that is covered, authorized, or provided by a government program not operated by the agency, a community program, a third party such as a private health insurance company, or provided by a natural support.

(7) "Client" has the same meaning as provided in Section 393.063(7), F.S.

(8) "Client Advocate" has the same meaning as provided in Section 393.063(8), F.S, and includes legal counsel if designated by the client or the client's legal representative.

(9) "Client Review" means the Agency's review of information submitted by a WSC to determine if the request meets significant additional needs criteria.

(10) "Community Supports" means resources or services accessible to a client as a member of the community. This includes, but not limited to, resources available through organizations such as faith-based, cultural, geographic, non-profit, for-profit, and community groups.

(11) "Handbook" means the Florida Medicaid Developmental Disabilities Waiver Services Coverage and Limitations Handbook, as adopted by Rule 59G-13.070, F.A.C. (effective October 2020) and available at https://www.flrules.org/Gateway/reference.asp?No=Ref-12102.

(12) "Health and Safety" includes emotional, behavioral, mental, and physical health and safety.

(13) "iBudget" means the Home and Community-Based Services Medicaid Waiver program under Section 409.906, F.S., that consists of the Waiver service delivery system utilizing individual budgets required pursuant to Section 393.0662, F.S., and under which the Agency for Persons with Disabilities operates the Home and Community-Based Services Waiver.

(14) "iBudget Amount" means the total amount of funds that have been approved by the Agency, pursuant to the iBudget Rules, for a client to spend for Waiver services during a fiscal year.

(15) "iBudget Rules" means Rules 65G-4.0213 through 65G-4.0218, F.A.C., and are the rules which implement and interpret iBudget Amounts.

(16) "Legal Representative" means:

(a) For clients under the age of 18 years, the legal representative or health care surrogate appointed by the Florida court to represent the child or anyone designated by the parent(s) of the child to act on the parent(s)' behalf (e.g., due to military absence).

(b) For clients age 18 years or older, the legal representative could be the client, anyone designated by the client 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 744, F.S.

(17)(a) "Medically necessary" or "medical necessity," as defined in the Handbook, means that the medical or allied care, goods, or services furnished or ordered must 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.

(b) 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.

(18) "Natural Support" means unpaid supports that are or may be provided voluntarily to the client in lieu of Waiver services and supports. Any determination of the availability of natural supports includes, but is not limited to consideration of the client'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 client.

(19) "Person-centered planning" – means a planning approach directed by a client with long term care needs, intended to identify the strengths, capacities, preferences, needs, and desired outcomes of the client. The client or legal representative determines the other participants in this process for the purposes of assisting the client to identify and access a personalized mix of paid and non-paid services and supports that will assist him/her to achieve personally-defined outcomes in the most inclusive community setting and to facilitate health, safety, and well-being.

(20) "Qualified Organization" means an organization which employs support coordinators who serve clients that receive Agency services and is determined by the Agency to have met all of the requirements of Section 393.0663(2), F.S., the Developmental Disabilities Individual Budgeting Waiver Services Coverage and Limitations Handbook, and Chapter 65G-14, F.A.C.

(21) "Questionnaire for Situational Information" or "QSI" effective 5-21-15 means an assessment instrument used by the Agency to determine a client's needs in the areas of functional, behavioral, and physical status. The QSI is adopted by the Agency as the current valid and reliable assessment instrument and is hereby incorporated by reference. The QSI is available at: http://www.flrules.org/Gateway/reference.asp?No=Ref-07075.

(22) "QSI Assessor" – means an Agency employee who has been certified by the Agency in the administration of the QSI.

(23) "Service Authorization" – means an Agency notification that authorizes the provision of specific Waiver services to a client and includes, at a minimum, the provider's name and the specific amount, duration, scope, frequency, and intensity of the approved service.

(24) "Service Families" means eight categories that group services related to: Life Skills Development, Supplies and Equipment, Personal Supports, Residential Services, Support Coordination, Therapeutic Supports and Wellness, Transportation and Dental Services. The Service Families include the following services:

(a) Life Skills Development, which includes:

1. Life Skills Development Level 1 (companion services),
2. Life Skills Development Level 2 (supported employment); and
3. Life Skills Development Level 3 (adult day training).

(b) Supplies and Equipment which includes:

1. Consumable Medical Supplies,
2. Durable Medical Equipment and Supplies,
3. Environmental Accessibility Adaptations; and
4. Personal Emergency Response Systems (unit and services).

(c) Personal Supports, which includes:

1. Services formerly known as in-home supports, respite, personal care and companion for clients age 21 or older, living in their own home or family home and also for those at least 18 but under 21 living in their own home; and
2. Respite Care (for clients under 21 living in their family home).

(d) Residential Services, which includes:

1. Standard Residential Habilitation,
2. Behavior- Focused Residential Habilitation,
3. Intensive- Behavior Residential Habilitation,
4. Enhanced Intensive Behavior Residential Habilitation,
5. Medical Enhanced Intensive Behavior Residential Habilitation,
6. Live-In Residential Habilitation,
7. Special Medical Home Care; and
8. Supported Living Coaching.

(e) Waiver Support Coordination.

(f) Therapeutic Supports and Wellness, which includes:

1. Private Duty Nursing,
2. Residential Nursing,
3. Skilled Nursing,

4. Dietician Services,
5. Respiratory Therapy,
6. Speech Therapy,
7. Occupational Therapy,
8. Physical Therapy,
9. Specialized Mental Health Counseling,
10. Behavior Analysis Services; and
11. Behavior Assistant Services.
(g) Transportation; and
(h) Dental Services, which consists of Adult Dental Services.

(25) "Significant" means of considerable magnitude or considerable effect.

(26) "Significant Additional Needs" or "SANs" means, as provided in Section 393.063(39), F.S., an additional need for medically necessary services which would place the health and safety of the client, the client's caregiver, or the public in serious jeopardy if it is not met. The term also includes services to meet an additional need that the client requires in order to remain in the least restrictive setting, including, but not limited to, employment services and transportation services. The Agency may provide additional funding only after the determination of a client's initial allocation amount and after the WSC has documented the availability of non-Waiver resources on the Verification of Available Services form. Examples of SANs that may require long-term support include, but are not limited to, any of the following:

(a) A documented history of significant, potentially life-threatening behaviors, such as recent attempts at suicide, arson, nonconsensual sexual behavior, self-injurious behavior requiring medical attention, dementia, or age-related behaviors that present significant health and safety risks,

(b) A complex medical condition that requires active intervention by a licensed nurse on an ongoing basis that cannot be taught or delegated to a non-licensed person,

(c) A need for total physical assistance with activities of daily living such as eating, bathing, toileting, grooming, dressing, personal hygiene, lifting, transferring or ambulation;

(d) Permanent or long-term loss or incapacity of a caregiver;

(e) Loss of services authorized under the state Medicaid plan or through the school system due to a change in age;

(f) Significant decline in medical, behavioral or functional status;

(g) Lack of a meaningful day activity needed to foster mental health, prevent regression or engage in meaningful community life and activities;

(h) One or more of the situations described in Rule 65G-1.047, F.A.C., Crisis Status Criteria; and

(i) Risk of abuse, neglect, exploitation, or abandonment that can be mitigated with Waiver services.

(27) "Significant change in condition or circumstance" means a significant change or deterioration in a client's health status, an actual or anticipated change in the client's living situation, a change in the caregiver relationship or the caregiver's ability to provide supports, loss of or deterioration of his or her home environment, or loss of the client's spouse or caregiver. Examples of a significant change include:

(a) A deterioration in health status that requires that the client receive services at a greater intensity or in a different setting to ensure that client's health or safety;

(b) Onset of a health, environmental, behavioral, or medical condition that requires that the client receive services at a greater intensity or in a different setting to ensure the client's health or safety; or

(c) A change in age or living setting resulting in a loss of services funded or otherwise provided from sources other than the Waiver. This may include a change in living setting which requires a different service array or a change in the availability or health status of a primary caregiver that prevents that caregiver from continuing to provide support.

(28) "Support plan" means an individualized and person-centered plan of supports and services designed to meet the needs of a client enrolled in the iBudget. The plan is based on the preferences, interests, talents, attributes and needs of a client, including the availability of natural supports.

(29) "Temporary basis" means a time period of less than 12 months.

(30) "Verification of Available Services" means a form completed by the WSC to enable the Agency to certify and document that the client has utilized all available services through the Medicaid State Plan, school-based services, private insurance, other

benefits, and any other resources, such as local, state, and federal government and non-government programs or services and natural or community supports, that might be available prior to requesting Waiver funds. The Verification of Available Services documents and verifies that the iBudget Waiver is the payer of last resort. A valid and accurate Verification of Available Services is a condition precedent to the authorization of services. The Verification of Available Services – APD Form 65G-4.0213 B, effective 7-1-21, is hereby adopted and incorporated by reference and is available at http://www.flrules.org/Gateway/reference.asp?No=Ref-12445.

(31) "Waiver" means the iBudget operated by the Agency.

(32) "Waiver Support Coordinator" or "WSC" means an employee of a qualified organization as defined in Section 393.0663, F.S., who is selected by the client or the client's legal representative to assist the client and family in identifying their capacities, needs, and resources; finding and gaining access to necessary supports and services; coordinating the delivery of supports and services; advocating on behalf of the client and family; maintaining relevant records; and monitoring and evaluating the delivery of supports and services to determine the extent to which they meet the needs and expectations identified by the client, family, and others who participated in the development of the support plan with person-centered planning.

(33) "WSC Job Aid for Cost Plans and Significant Additional Needs Documentation" means a form that identifies the documentation required for each service requested in the cost plan. The documentation identified by this form is a material part of each request. The WSC Job Aid for Cost Plans and Significant Additional Needs Documentation – APD Form 65G-4.0213 D, effective 7-1-21, is hereby adopted and incorporated by reference and is available at http://www.flrules.org/Gateway/reference.asp?No=Ref-12447.

(34) This rule shall be reviewed, and if necessary, renewed through the rulemaking process five years from the effective date.

Rulemaking Authority 393.501(1), 393.0662 FS. Law Implemented 393.063, 393.0662, 409.906 FS. History–New 7-7-16, Amended 7-1-21.

65G-4.0214 Allocation Algorithm.

(1) To establish the Allocation Algorithm Amount for any client who has not previously had a QSI assessment, a QSI assessment must be completed prior to calculating the Allocation Algorithm Amount under subsection (2).

(a) The QSI assessor shall arrange for a face to face meeting with the client and, if available, the client's legal representative. The WSC shall attend the face to face meeting with consent of the client or the client's legal representative. If the client or the client's legal representative is not capable of fully responding to all of the assessment questions, at least one participant with day-to-day knowledge of the client's care should participate.

(b) A copy of the completed QSI evaluation and scores shall be provided to the client and WSC.

(c) Upon receiving QSI results if the client or his or her legal representative identifies an error in the QSI results the WSC shall notify the Agency in writing setting forth the details of the error. At any time, the client or WSC can prepare a statement to be maintained in client's Central File identifying any concerns with the QSI assessment score or responses. If any error is identified in the QSI assessment the Agency shall review the error to determine if any adjustments are needed. The Agency shall inform the WSC of the result of the review and provide a revised Allocation Algorithm Amount, if appropriate, within 15 working days of notification of the error. The WSC shall in turn notify the client or the client's representative.

(d) The client or WSC may request a reassessment any time there has been a significant change in circumstance or condition that would impact any of the questions used as variables in the algorithm determination. The Agency shall arrange for a reassessment at the earliest possible time in accordance with the circumstances, complete the reassessment, and notify the client and WSC of the results within 60 days of the request for reassessment. This section shall not be construed to require the Agency to wait for the completion of a QSI in order to address an emergency situation of the client.

(2) To calculate the Allocation Algorithm for each client, the following weighted values, as applicable, shall be summed, and the resulting total then squared:

(a) The base value for all clients, 27.5720;

(b) If the client is age 21 to 30, 47.8473;

(c) If the client is age 31 or older, 48.9634;

(d) If the client resides in supported or independent living, or the client resides in a licensed facility and does not receive residential habilitation services, 35.8220;

(e) If the client resides in a licensed residential facility that is designated to provide Standard or Live-In residential habilitation services, 90.6294;

(f) If the client resides in a licensed residential facility with a Behavior Focus designation, 131.7576;

(g) If the client resides in a licensed residential facility with an Intensive Behavior designation, 209.4558;

(h) If the client resides in a licensed residential facility that is a Comprehensive Transitional Education Program or provides Special Medical Home Care, 267.0995;

(i) The sum of the scores on the client questions in the QSI Behavioral Status Subscale (Questions 25-30), multiplied by 0.4954;

(j) If the client resides in the family home, the sum of the scores on the client questions in the QSI Functional Status Subscale (Questions 14-24), multiplied by 0.6349;

(k) If the client resides in supported or independent living, the sum of the scores on the client questions in the QSI Functional Status Subscale (Questions 14-24), multiplied by 2.0529;

(l) If the client resides in supported or independent living, the sum of the scores on the client questions in the QSI Behavioral Status Subscale (Questions 25-30), multiplied by 1.4501;

(m) The client's score on QSI Question 16, multiplied by 2.4984;

(n) The client's score on QSI Question 18, multiplied by 5.8537;

(o) The client's score on QSI Question 20, multiplied by 2.6772;

(p) The client's score on QSI Question 21, multiplied by 2.7878;

(q) The client's score on QSI Question 23, multiplied by 6.3555;

(r) The client's score on QSI Question 28, multiplied by 2.2803;

(s) The client's score on QSI Question 33, multiplied by 1.2233;

(t) The client's score on QSI Question 34, multiplied by 2.1764;

(u) The client's score on QSI Question 36, multiplied by 2.6734; and

(v) The client's score on QSI Question 43, multiplied by 1.9304.

(3) The squared result of the sum of the applicable values of paragraphs (2)(a) through (v), above, then apportioned according to available funding, is the client's Allocation Algorithm Amount.

(4) This rule shall be reviewed, and if necessary, renewed through the rulemaking process five years from the effective date.

Rulemaking Authority 393.501(1), 393.0662 FS. Law Implemented 393.063, 393.0662 FS. History–New 7-7-16, Amended 7-1-21.

65G-4.0215 General Provisions.

(1) Medical necessity alone is not sufficient to authorize a service under the Waiver; in addition:

(a) With the assistance of the WSC, the client must utilize all available State Plan Medicaid services, school-based services, private insurance, natural supports, and any other resources that may be available to the client before expending funds from the client's iBudget Amount for support or services. As an example, State Plan Medicaid services for children under the age of 21 typically include personal care assistance, therapies, consumable medical supplies, medical services, and nursing;

(b) The services must be within Waiver coverages and limitations; and

(c) The cost of the services must be within the Allocation Algorithm Amount unless there is a significant additional need demonstrated.

Failure to meet the above criteria shall result in a denial of a request for additional funding.

(2) WSCs shall coordinate with the clients they serve to ensure that services are selected from all available resources to keep the annual cost of services within the client's iBudget Amount while maintaining the client's health and safety.

(3) Prior to authorizing new or increased services or at the time of a medical necessity review, the Agency must certify and document within the client's cost plan that the client has used all available services authorized under the Medicaid State Plan; school-based services; private insurance; local, state, and federal government and non-government programs or services; natural or community supports; and any other benefit or resource that may be available to the client before using funds from the iBudget to pay for supports and services.

(a) The iBudget Waiver is the payor of last resort.

(b) A valid and accurate Verification of Available Services form is a condition precedent to the authorization of services. To enable the Agency to certify and document that the client has utilized all available services pursuant to Section 393.0662(3), F.S., the WSC must complete and submit the Verification of Available Services to the Agency:

1. At the time of any requests to add or increase services, or

2. Upon request from the Agency when it is making determinations of medical necessity for Waiver services.

(4) Cost Plan Flexibility.

(a) After the client's proposed cost plan is approved, he or she may change the services in his or her Approved Cost Plan provided that such change does not jeopardize the health and safety of the client and meets medical necessity.

(b) When changing the services within the Approved Cost Plan, the client and his or her WSC shall ensure that sufficient funding remains allocated for unpaid services that were authorized and rendered prior to the effective date of the change.

(c) Clients enrolled in iBudget will have flexibility and choice to budget or adjust funding among the following services without requiring additional authorizations from the Agency, provided the client's overall iBudget Amount is not exceeded and all health and safety needs are met:

1. Life Skills Development 1,
2. Life Skills Development 2,
3. Life Skills Development 3, within the approved ratio,
4. Durable Medical Equipment,
5. Adult Dental,
6. Personal Emergency Response Systems,
7. Environmental accessibility adaptations,
8. Consumable Medical Supplies,
9 Transportation,
10. Personal Supports up to $16,000,
11. Respite up to $10,000.

(d) Medically necessary services will be authorized by the Agency for covered services not listed above if the cost of such services are within the client's iBudget Amount and in accordance with subsection 65G-4.0215(1), F.A.C. The Agency shall authorize services in accordance with criteria identified in Section 393.0662(1)(b), F.S., medical necessity requirements of Section 409.906, F.S., subsection 59G-1.010(166), F.A.C., Handbook limitations, and the authority under Title 42 of the Code of Federal Regulations, Part 440, Section 230(d).

(e) Service authorization and any modifications to it must be received by the provider prior to service delivery. This includes changes to the authorization as a result of clients redistributing funds within their existing cost plan.

(5) Consumer Directed Care Plus (CDC+): clients enrolled in the CDC+ program are subject to iBudget Rule 65G-4.0214, subsections 65G-4.0215(1), (2) and (7), and Rules 65G-4.0216, 65G-4.0217, 65G-4.0218, F.A.C.

(6) Approval, Denial, or Closure of Applications.

(a) iBudget Waiver providers must have applied through the Agency for Persons with Disabilities to ensure that they meet the minimum qualifications to provide iBudget Waiver services. iBudget Waiver providers must also be enrolled as a Medicaid provider through the Agency for Health Care Administration. However, providers do not have to provide Medicaid State Plan services in order to provide Waiver services.

(b) To enroll as a provider for iBudget Waiver services, the provider must first submit an application to the Agency or Persons with Disabilities using the Regional iBudget Provider Enrollment Application – WSC – APD Form 65G-4.0215 A, effective date 7-1-2021, for Waiver Support Coordinator applications, which is available at http://www.flrules.org/Gateway/reference.asp?No=Ref-12444, or the Regional iBudget Provider Enrollment Application – Non-WSC – APD Form 65G-4.0215 B, effective date 7-1-2021, for all other provider applications, which is available at http://www.flrules.org/Gateway/reference.asp?No=Ref-12590. These forms are hereby incorporated by reference. The qualifications to provide services are identified in the Handbook.

(c) The Agency will review the application and approve or deny complete applications within 90 days of receipt; the Agency will close incomplete applications.

1. The Agency will only consider complete applications that include all required information and meet the requirements delineated in this chapter, the iBudget Handbook, and Section 393.0663, F.S. An application is complete upon the Agency's receipt of all requested information and correction of any error or omission for which the applicant was notified.

2. If the Agency receives an incomplete application, the Agency will notify the applicant. The applicant will have 45 calendar days from the date of the notice to submit the documentation, information, or make any corrections designated in the notice. If the applicant does not complete the application within 45 days of the notice, the application must be closed by the Agency. After an application is closed, all documentation and information submitted will no longer be considered, and a new complete application must be submitted for consideration by the Agency. The closure of an application is not Agency action and will not be considered substantively by the Agency in any subsequent application.

(d) If a Waiver provider wishes to, expand by providing additional services, expand services geographically, or expand from solo to agency, the provider must notify the Agency regional office by submitting a Provider Expansion Request form – APD Form 65G-4.0215 C, effective date 7-1-2021, which is hereby incorporated by reference and is available at http://www.flrules.org/Gateway/reference.asp?No=Ref-12446. The Agency regional office must approve any expansion prior to the provision of expanded services. The qualifications to provide or expand services are identified in the Handbook.

(7)(a) When a client is enrolled in the iBudget**,** that client remains enrolled in the Waiver position allocated unless the client becomes disenrolled due to one of the following conditions:

1. The client or client's legal representative chooses to terminate participation in the Waiver.
2. The client moves out-of-state.
3. The client loses eligibility for Medicaid benefits and this loss is expected to extend for a lengthy period.
4. The client no longer needs Waiver services.
5. The client no longer meets level of care for admission to an ICF/IID.
6. The client 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 setting not otherwise permissible under Waiver requirements.
7. The client is no longer able to be maintained safely in the community.

If an client is disenrolled from the Waiver and becomes eligible for reenrollment within 365 days that client can return to the Waiver and resume receiving Waiver services. If Waiver eligibility cannot be re-established or if the client who has chosen to disenroll has exceeded this time period, the client cannot return to the Waiver until a new Waiver vacancy occurs and funding is available. In this instance, the client is added to the Waiting List of clients requesting Waiver participation. The new effective date is the date eligibility is re-established or the client requests re-enrollment for Waiver participation.

(b) Providers are responsible for notifying the client's WSC and the Agency if the provider becomes aware that any of the conditions of paragraph (a) or (c), exists.

(c) If a client or legal representative refuses to cooperate with the provision of Waiver services in any of the following ways: develop a cost plan or support plan, participate in a required QSI assessment or other approved Agency needs assessment tool, or refuse to annually sign the Waiver eligibility worksheet that establishes a level of care, then the Agency will review the circumstances to determine if the client should be removed from the Waiver for failing to comply with specific eligibility requirements. Any such decision by the Agency shall provide written notice to the client, the client's legal representative and the WSC, at least 30 days before terminating services.

(d) Clients denied services shall have the right to a fair hearing. Clients are exempted from this provision if they do not have the ability to give informed consent and do not have a legal representative. The Agency shall not remove a client from the Waiver due to non-compliance if it directly impacts the client's health, safety, and welfare.

(8) This rule shall be reviewed, and if necessary, renewed through the rulemaking process five years from the effective date.

Rulemaking Authority 393.501(1), 393.0662 FS. Law Implemented 393.063, 393.0662, 409.906 FS. History–New 7-7-16, Amended 9-12-18, 7-1-21.

65G-4.0216 Establishment of the iBudget Amount.

(1) The iBudget Amount for a client shall be the Allocation Algorithm Amount, as provided in Rule 65G-4.0214, F.A.C., plus any approved Significant Additional Needs funding as provided in Rule 65G-4.0218, F.A.C.

(2) The Agency will determine the iBudget Amount consistent with the criteria and limitations contained in the following provisions: Sections 409.906 and 393.0662, F.S.; and Rules 59G-13.080, 59G-13.081, and 59G-13.070, F.A.C.

(3) Significant Additional Needs Review:

(a) The first time the Allocation Algorithm Amount is calculated, the WSC will discuss the Allocation Algorithm Amount with the client, and, if available, the client's legal representative and, if available and applicable, the client advocate, in order to determine if the client has any Significant Additional Needs.

(b) The WSC shall discuss the services requested with the client or the client's legal representative, and, if available and applicable, the client advocate.

(c) The Agency will conduct a Client Review to determine whether services requested meet health and safety needs and waiver coverage and limitations. The AIM Worksheet must be completed as part of the Client Review and submitted to the Agency within 30 days of receipt of the new Allocation Algorithm Amount.

(d) The Agency will issue a decision of the iBudget Amount within 30 days of receipt of the AIM Worksheet. The client and his or her legal representative will be advised of the Agency's decision for the amount of the client's final iBudget Amount within 30 days.

1. If additional documentation is requested, the deadline for the Agency's response shall be extended to 60 days following the receipt of the original request.

2. The Verification of Available Services form is a material part of the request form. Failure to include the Verification of Available Services form is a basis for denial.

(e) The Agency shall approve an increase to the iBudget Amount if additional funding is required to meet the Significant Additional Needs subject to the provisions of the iBudget Rules. The Agency, upon completion of its review shall notify in writing the client, the WSC and the client advocate, if any, of its decision.

(4) After the iBudget Amount is established, if a client remains in the same living setting and experiences a significant change in condition or circumstances where the proposed needs cannot be met within the current iBudget Amount, the WSC shall request services through the significant additional needs process without the calculation of a new algorithm or the completion of the AIM Worksheet.

(5) iBudget Amounts are pro-rated as appropriate based on the length of time remaining in the fiscal year.

(6) The Agency shall ensure that the sum of all clients' projected expenditures do not exceed the Agency's annual appropriation.

(7) This rule shall be reviewed, and if necessary, renewed through the rulemaking process five years from the effective date.

Rulemaking Authority 393.501(1), 393.0662 FS. Law Implemented 393.063, 393.0662, 409.906 FS. History–New 7-7-16, Amended 7-1-21.

65G-4.0217 iBudget Cost Plan.

(1) When a client's iBudget Amount is determined, the WSC must submit a cost plan proposal, which includes a completed Verification of Available Services form, that reflects the specific Waiver services and supports (paid and unpaid) that will assist the client to achieve identified goals, and the provider of those services and supports, including natural supports. The cost plan proposal is derived from person-centered planning. The Verification of Available Services form is a material part of the cost plan proposal. Failure to include the Verification of Available Services form will result in a denial of the cost plan.

(2) The WSC shall provide documentation for requested services as specified in Section C of the WSC Cost Plan and Significant Additional Needs Job Aid to document medical necessity and compliance with Handbook coverage and limitations.

(3) Each client's proposed iBudget cost plan shall be reviewed and approved by the Agency in conformance with the iBudget Rules and the Handbook. Any conflict between the Handbook and these iBudget Rules shall be resolved in favor of these rules.

(4) For a client to begin receiving a specific Waiver service, that service must have been listed in an Approved Cost Plan and the service authorization must have been issued to the provider prior to the delivery of service.

(5) Clients must budget their funds so that their needs are met throughout the plan year. All clients shall allocate iBudget funding each month for Waiver support coordination services, which is a required service under the Waiver.

(6) This rule shall be reviewed, and if necessary, renewed through the rulemaking process five years from the effective date.

Rulemaking Authority 393.501(1), 393.0662 FS. Law Implemented 393.063, 393.0662, 409.906 FS. History–New 7-7-16, Amended 7-1-21.

65G-4.0218 Significant Additional Need Funding.

(1) Supplemental funding for Significant Additional Needs (SANs) may be of a one-time, temporary, or long-term in nature.

(2) The presence of a significant additional need or significant change in condition or circumstance alone does not warrant an increase in the amount of funds allocated to a client's iBudget as determined by the algorithm.

(3) A client's annual expenditures for home and community-based services Medicaid Waiver services may not exceed the limits of his or her iBudget. The total of all clients' projected annual iBudget expenditures may not exceed the Agency's appropriation for Waiver services.

(4) SANs can only be approved after the determination of a client's initial allocation amount and after the WSC has documented the availability of non-Waiver resources on the Verification of Available Services form. Nothing in this section prohibits the authorization of emergency services on a temporary basis through the Agency. Requests for SANs require:

(a) The client to have a significant additional need as defined in this chapter; and

(b) A significant additional need cannot be created by failing to maintain sufficient funds to cover services previously

authorized in accordance with subsections 65G-4.0215(2) and (5), F.A.C.

(5) The WSC shall submit a SANs request that reflects the specific Waiver services and supports that will assist the client to meet identified needs, with all required supporting documentation as specified in the WSC Job Aid for Cost Plans and Significant Additional Needs Documentation. The documentation identified in the WSC Job Aid is material to the SANs requests. The Agency must close or deny the SANs request without such documentation.

(a) The SANs request shall be submitted indicating how the current budget allocation and requested SANs funds would be used. The request should also include an explanation of why additional funding is needed, and any additional documentation appropriate to support the request.

(b) The SANs request shall be submitted with an updated support plan, which must include an explanation of why additional funding is needed and indicate how the current budget allocation and requested SANs funds would be used. The request must include documentation appropriate to support the request in accordance with the WSC Job Aid for Cost Plans and Significant Additional Needs Documentation form.

(c) Documentation of attempts within the last 30 days prior to submitting the SANs request to locate natural or community supports, third-party payers, or other sources of support to meet the client's health and safety needs must also be documented and verified by the WSC on the Verification of Available Services form.

(d) If there are any concerns about the accuracy of the QSI results, the WSC shall submit this as well.

(6) If a client's iBudget Amount includes Significant Additional Needs beyond what was determined by the Allocation Algorithm, and the Agency determines that the intensity, frequency or duration of the service(s) is no longer medically necessary, the Agency will adjust the client's services to match the current need.

(7)(a) The Agency will not consider incomplete SANs requests due to lacking material information to determine whether SANs criteria are met. A SANs request is incomplete if it does not:

1. Provide detail the client's current approved services, including the number and type of units and dollar amount for each service. The client to staff ratio, if applicable, must also be included;

2. Clearly indicate whether the current approved services are requested to continue on an annualized basis;

3. Clearly identify any new or increased services being requested in the current fiscal year and on an annualized basis, if applicable to that service type;

4. Include a complete Verification of Available Services form;

5. Include documentation to support the information provided in the Verification of Available Services Form, or identify the location of the currently valid documentation in the designated data management system;

6. Place the request in the proper status for submission in the designated data management system; or

7. Include certification that the request meets the criteria for SANs.

(b) The Agency shall close incomplete SANs requests upon receipt.

(8) The Agency will request the documentation and information necessary to evaluate a client's increased funding requests based on the client's needs and circumstances. The documentation will vary according to the funding request and may include the following as applicable: support plans, results from the Questionnaire for Situational Information, cost plans, expenditure history, current living situation, interviews with the client and his or her providers and caregivers, prescriptions, data regarding the results of previous therapies and interventions, assessments, and provider documentation.

(9) Within 30 days of receipt of a request for SANs funding, and adjustments in the client's service array, the Agency shall approve, deny (in whole or in part), or request additional documentation concerning the request.

(a) If the request does not include all necessary documentation, the Agency shall provide the client and WSC with a written notice of what additional documentation is required. The client or WSC shall provide the documentation within 10 days, or notify the Agency in writing that the client wishes the Agency to render its decision based upon the documentation provided.

(b) If additional documentation is requested, the deadline for the Agency's response shall be extended to 60 days following the receipt of the original request. If the client has not received a notice from the Agency approving, denying or requesting additional information within 60 days, the client or WSC may notify the Agency in writing of such failure to issue a timely notice and the Agency shall have 20 days from receipt of the Notice to approve or deny the request.

(c) Failure of the Agency to issue this Notice within 20 days shall mean the requested funding for services are authorized as of the 21st day, and the client and service providers may treat the authorization as an approval.

(10) Individual and Family Supports (IFS) funding may cover temporary emergency services pursuant to Chapter 65G-13,

F.A.C., while requests for Significant Additional Needs are being processed.

(11) This rule shall be reviewed, and if necessary, renewed through the rulemaking process five years from the effective date.

Rulemaking Authority 393.501(1), 393.0662 FS. Law Implemented 393.063, 393.0662, 409.906 FS. History–New 7-7-16, Amended 7-1-21.

65G-4.022 The iBudget Florida Cost Plan.

Rulemaking Authority 393.501(1), 393.0662 FS. Law Implemented 393.0662 FS. History–New 10-2-13, Repealed 1-19-16.

65G-4.024 Cost Plan Changes.

Rulemaking Authority 393.501(1), 393.0662 FS. Law Implemented 393.0662 FS. History–New 10-2-13, Repealed 1-19-16.

65G-4.027 Supplemental Cost Plan Funding.

Rulemaking Authority 393.501(1), 393.0662 FS. Law Implemented 393.0662 FS. History–New 10-2-13, Repealed 1-19-16.