



agency for persons with disabilities
State of Florida

FAMILY AND SUPPORTED LIVING WAIVER

SERVICES DIRECTORY
REVISED SEPTEMBER 2005

The Family and Supported Living Waiver Services Directory is not a Medicaid Coverage and Limitations Handbook

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FSL Services Directory
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ATTACHMENTS

- Attachment A – Medicaid Waiver Services Agreement
- Attachment B – Core Assurances
- Attachment C – AHCA Contact Directory
- Attachment D – APD District Contact Directory
- Attachment E – Cost Plan Worksheet

Family and Supported Living Waiver Services Directory

Section 1: Purpose and Provider Requirements

I. Legal Authority for Family and Supported Living Waiver

Medicaid home and community-based services (HCBS) waiver programs are authorized under Section 1915(c) of the Social Security Act and governed by Title 42, Code of Federal Regulations (C.F.R.), Part 441.300.

Chapter 409, Florida Statutes (F.S.) and Section 59G-8.200, Florida Administrative Code (F.A.C.), authorize the Florida Medicaid FSL waiver.

The Agency for Health Care Administration (AHCA) has final authority on all policies, procedures, rules, regulations, manuals, and handbooks pertaining to the Waiver. The Agency for Persons with Disabilities (APD) is authorized by AHCA, to operate and oversee the Waiver in accordance with the Interagency Agreement for Medicaid between AHCA and APD regarding the Family and Supported Living Home and Community-Based Services Waiver.

II. Family and Supported Living Waiver Defined

The Family and Supported Living (FSL) Waiver is a Medicaid program that provides home and community-based supports and services to eligible persons with developmental disabilities living in their own home or family home. The FSL Waiver is funded by the federal Centers for Medicare and Medicaid Services (CMS), and matching state dollars. The Waiver is operated by the Florida Agency for Persons with Disabilities, under the authorization of the Agency for Health Care Administration's Division of Medicaid.

This policy has been approved by AHCA prior to issuance.

III. Purpose of Family and Supported Living Waiver

The purpose of the FSL Waiver is to promote, maintain and restore the health of eligible consumers with developmental disabilities; to minimize the effects of illness and disabilities through the provision of needed supports and services in order to delay or prevent institutionalization, and to foster the principles of self-determination as a foundation for services and supports.

The intent of the FSL Waiver is to provide a viable choice of services that allow eligible consumers to live as independently as possible in their own home or in

the community and to achieve productive lives as close to normal as possible as opposed to residing in an Intermediate Care Facility for the Developmentally Disabled (ICF/DD) or other institutional settings.

The FSL Waiver embraces the principles of self-determination for the consumer, including:

- freedom to exercise the same rights as all citizens.
- authority to exercise control over authorized funds needed for one's own support including the re-prioritization of these funds when necessary.
- responsible use of public funds.
- self-advocacy to speak and advocate for oneself and others who cannot do so in order to gain independence and ensure that all individuals with a developmental disability are treated equally.

Consumers enrolled in the FSL Waiver receive services that enable them to:

- Have a safe place to live.
- Have a meaningful day activity; activities may occur during the day or evening. (See General Definitions, Section 3, Services Directory)
- Receive medically necessary medical services.
- Receive medically necessary supplies and equipment.
- Receive transportation required to access necessary services.

Consumers have freedom of choice of providers. The Waiver is designed around consumer choice. Accordingly, consumers may select enrolled, qualified service providers and may change providers at any time. However, the FSL Waiver services cannot be used to cover any co-payments for Medicaid services or services provided by other means.

Once a consumer has an approved cost plan, the funds allocated to that support plan follow the consumer. All consumers on the FSL Waiver must have a cost plan prepared and updated annually. Each consumer's annual Cost Plan budget may not exceed the total annual dollar cap for FSL Waiver services. The cost of full support coordination must be included in the cost plan budget. All consumers receive full support coordination unless the consumer receives supported living coaching services. If supported living coaching is provided consumers receive limited support coordination. However, full support coordination must be included in the cost plan budget in the event full services are needed during the year.

The Cost Plan may also reflect Supported Living Subsidies and Supported Living startup funds from General Revenue. These amounts are not considered a part of the total annual dollar cap of the FSL Waiver. Area offices have authority to review all initial Cost Plans and make determinations regarding exceeding individual service dollar caps based on medical necessity. The FSL Waiver Cost

Plan Worksheet must be completed to provide documentation (Attachment E). Subsequent revisions to Cost Plans that exceed individual service dollar caps, based on medical necessity, must be reviewed and approved by the Central Program Office or contracted entity designated by the APD for prior service authorization reviews.

Within the funds allocated in the support plan, the consumer is free to change enrolled, qualified providers as desired to meet the goals and objectives set out in the support plan.

Freedom of choice includes consumer responsibility for selection of the most cost effective combination of services and supports within the total dollar cap to accomplish the consumer's goals.

IV. Purpose of the Family and Supported Living Services Directory

This Services Directory is intended for use by eligible providers who furnish FSL Waiver services to consumers enrolled in the Waiver. It must be used in conjunction with the Florida Medicaid Provider Reimbursement Handbook, Non-Institutional 081, which contains information about the Medicaid program in general, as well as specific procedures for record keeping and submitting claims for payment. Rates for FSL services are the same as the standard rates for the DS/HCBS Waiver. Those rates, which are currently the subject of rulemaking, may be found on the Agency for Persons with Disabilities website. Attachment C contains Agency for Health Care Administration Area Offices contact information.

V. General Provider Requirements for the Family and Supported Living Waiver

A. Enrollment Requirements: FSL Waiver provider applicants must meet specific qualifications and requirements before becoming eligible to provide FSL Waiver services. In addition, provider applicants must possess a high degree of ethical principles and have no adverse history with the Agency for Persons with Disabilities, the Agency for Health Care Administration, all predecessor agencies, or any other regulatory agency that causes the AHCA or APD to question whether the health, safety and welfare of a Waiver participant would be jeopardized during the delivery of an approved Waiver service.

Medicaid FSL Waiver providers must:

- Be certified as eligible by the Agency for Persons with Disabilities' Area Office to enroll as a FSL Waiver provider.
- Not be currently suspended from Medicare or Medicaid in any state.
- Meet provider qualification and responsibility requirements described in Section 1 of this Services Directory.

- Be enrolled with the Medicaid fiscal agent as a FSL Waiver provider.
- Have a current signed FSL Waiver Services Agreement with APD.
- Be at least 18 years of age.

B. Statewide Enrollment Requirement: All FSL Waiver providers are enrolled on a statewide basis unless they indicate a geographic preference on the FSL Waiver application or the Area Office restricts enrollment to specified geographic areas. FSL Waiver providers may be restricted to the provision of services within specific geographic areas based on a lack of provider capacity sufficient to meet projected service needs and concerns regarding the provider's quality of care or other issues that may negatively impact consumers as determined by the Area Office in accordance with Federal and State statutes and rules. See Attachment D for area and region contact information.

C. Family Members enrolled as FSL Waiver Providers Limitations: Parents, consumers, spouses, guardians and guardian advocates of waiver participants are specifically excluded from payment for any services.

Relatives not legally responsible for the care of the consumer may provide respite care or transportation. The relative must meet the same qualifications as other providers of the same waiver service.

Reasons for using a relative not legally responsible for the care of the consumer for respite care or transportation must be documented and include lack of available providers or the ability to meet specific scheduling needs of a consumer that other providers cannot meet. Convenience to the consumer, caregiver or family alone is not adequate justification.

D. Provider Eligibility Certification: The Area Office determines if the provider applicant meets the qualifications and requirements for enrollment as a Waiver provider. This determination includes a review of previous employment history and other relevant information. The area shall notify the provider in writing if the provider is denied enrollment as a provider of Waiver services. Any individual or agency desiring to enroll in Medicaid as an FSL Waiver provider shall submit an application for enrollment to the Area Office. This services directory provides detailed information on each service available through the FSL Waiver including provider qualifications, limitations, and required documentation. Providers should carefully review each service they wish to provide before completing a Waiver provider application. Application for enrollment consists of a Florida Medicaid Provider Enrollment Application and a FSL Waiver Provider Application.

The FSL Waiver Provider Application includes a Medicaid Waiver Services Agreement, Core Assurances and Family and Supported Living Waiver Services Directory. All FSL Waiver provider applicants must agree to comply with requirements found in the Family and Supported Living Medicaid Waiver Services Agreement and attached Core Assurances as well as service specific

requirements specified in this services directory incorporated by reference into the Core Assurances as a condition of enrollment.

The Medicaid forms in the application packet and payment for the background screening if required are forwarded to the APD Central Office for further processing. The Medicaid fiscal agent completes final processing and enrollment.

The Area Office receives verification from the APD Central Office when the provider applicant is enrolled in Medicaid as a Waiver provider. The Area Office then sends the provider a certificate indicating their status as a Medicaid enrolled FSL Waiver provider.

E. Background Screening of Providers: Direct service provider applicants, as defined in ch. 393.063(15), F.S., must comply with the requirements of a level 2 screening in accordance with section 435.04, F.S. Compliance with this requirement may be accomplished through one of two ways:

- Background screenings pursuant to ch. 393.0655, F.S.

Applicants must submit a fingerprinting card, an affidavit of good moral character, a caretaker information sheet and a check for the current fee amount for processing. If the applicant had a screening within 12 months of the time of application and can provide a copy of the report, then the applicant does not need to repeat the screening.

- Background screenings pursuant to Chapter 409.907, F.S.

Applicants must submit the Medicaid fingerprint card, the enrollment application and a check for the current fee amount made payable to the Medicaid fiscal agent for processing.

Screening is performed at the time of enrollment and every five years thereafter. It is the responsibility of the provider to ensure this request for screening or re-screening is submitted for processing in a timely manner.

F. Agency and Solo provider certification. Prior to July 1, 2001, agency and solo provider applicants may have received certificates from the Area Office prior to completion of Medicaid enrollment. Effective July 1, 2001, eligibility for agency and solo providers to provide services will be established when the Medicaid enrollment is completed. When an applicant for enrollment in the waiver has been determined eligible, passed necessary background screening requirements, and is enrolled in Medicaid, the APD will issue a certificate of eligibility. This certificate will list the waiver services the applicant is eligible to provide and the effective date of Medicaid enrollment with the assigned Medicaid

provider number. Once the certificate of eligibility is received, the provider may render waiver services and receive reimbursement for those services from Medicaid. No waiver-reimbursed service may be rendered until the provider receives notification of his enrollment in Medicaid.

Providers wishing to expand their status from a solo provider to an agency provider, or a provider desiring to obtain certification in additional waiver services, must be approved by the Area in order to expand. A provider must have attained an overall score in the service area in question of at least 85% on their last quality assurance monitoring conducted by AHCA, the APD or an authorized agent of AHCA or APD in order to be considered for expansion.

Medicaid providers that specialize in services to consumers who have a developmental disability may apply and be approved eligible to provide additional services if they employ staff who meet the qualifications for that service. For example, an agency that serves consumers with a developmental disability that is certified to provide Supported Living Coaching services may also provide other FSL Waiver services.

Providers should contact the APD Area Office in their areas for information on becoming a Waiver service provider. All providers must participate in the direct deposit program for Medicaid payments and must have an active saving or checking account.

Note: Refer to the Florida Medicaid Provider Reimbursement Handbook Non-Institutional 081, for information concerning general Medicaid provider qualifications and refer to Attachments A, B, C, and D for additional information.

G. HIPAA Provider Requirements. Florida Medicaid has implemented all of the requirements contained in the federal legislation known as the Health Insurance Portability and Accountability Act (HIPAA). As trading partners with Florida Medicaid, all Medicaid providers, including their staff, contracted staff and volunteers, must comply with HIPAA privacy requirements effective April 14, 2003. Providers who meet the definition of a covered entity according to HIPAA must comply with HIPAA Electronic Data Interchange (EDI) requirements effective October 16, 2003. This Services Directory contains information regarding changes in procedure codes mandated by HIPAA. The Florida Medicaid Provider Reimbursement Handbooks contain the claims processing requirements for Florida Medicaid including the changes necessary to comply with HIPAA.

For more information regarding HIPAA privacy in Florida Medicaid see the Florida Medicaid Provider General Handbook. For more information regarding claims processing changes in Florida Medicaid because of HIPAA requirements, see the current version of the Florida Medicaid Provider Reimbursement Handbook, Non-Institutional 081. For information regarding changes in EDI

requirements for Florida Medicaid because of HIPAA requirements, contact the Medicaid fiscal agent EDI help desk.

VI. Provider Requirements for Services offered in the FSL Waiver

A. Adult Day Training Provider Qualifications: Providers of adult day training services shall be designated, by the Area Office, as Adult Day Training centers. Unless waived in writing by the Area, the provider shall meet the following minimum qualifications for staff and staffing ratio:

- The manager or director will not have full-time responsibility for providing direct services.
- The program director will possess at a minimum a bachelor's degree from an accredited college or university and two years related experience.
- Instructors (supervisors) will possess at least an associate's degree and two years experience in a related field.
- Related experience will substitute on a year-for-year basis for the required college education.
- Direct service staff will work under appropriate supervision.
- The staffing ratio will not exceed 10 consumers per direct service staff for adult day training facility-based programs. Administrative staff and those not providing direct service to the consumer are not considered direct service staff.
- Direct service staff must be at least 18 years of age and possess at least a high school diploma or equivalent and two years of related experience.
- Direct Service Provider is defined in General Definitions, Section 3.

Adult Day Training Requirements. Proof of training in the areas of Cardiopulmonary Resuscitation (CPR), AIDS and infection control is required for all staff within 30 days of initially providing adult day training services. Proof of annual or required updated training shall be maintained on file for review.

The provider is responsible for all training requirements outlined in the Core Assurances. Staff is required to attend eight hours of annual in-service training related to implementation of individually tailored services. Attachment B contains provider training requirements. Contact local area or region office to obtain a list of available training sessions.

Adult Day Training Projected Service Outcomes. Projected services outcomes are goals used to determine, through monitoring and review, the accomplishments of providers and the effectiveness of service provision.

- Consumers receiving services demonstrate an increase in abilities consistent with their support plan.

- Consumers who have a stated support plan goal to be employed in the community have been provided with specific information, opportunities for exploration, and the necessary support to make progress toward this goal on supported employment or other competitive employment opportunities.
- Consumers who have a stated support plan goal to be involved in the community in another type of arrangement such as volunteer work have been provided with specific information, opportunities for exploration, and necessary support to make progress towards the goal.
- All consumers served who have responded to the annual satisfaction survey are satisfied with the services based on the results or that the provider has addressed any concerns raised during the survey.
- Consumers achieve support plan goals throughout the year.
- Consumers demonstrate freedom of choice including being informed about rights and service options.

B. Behavior Analysis Provider Qualifications. Licensure or certification must be on active status at the time services are provided. Providers of this service must have one or more of the following credentials:

- Level 1 Board Certified Behavior Analyst; Florida Certified Behavior Analyst with expanded privileges; 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 more than three years of experience post certification or licensure.
- Level 2 Board Certified Behavior Analyst; Florida Certified Behavior Analyst with expanded privileges; 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 less than three years of experience; or a Florida Certified Behavior Analyst with a Masters or Doctorate, regardless of experience.
- Level 3 Board or Florida Certified Associate Behavior Analyst or a Florida Certified Behavior Analyst with bachelors or high school diploma, regardless of experience.

Behavior Analysis Training Requirements. The provider is responsible for all training requirements outlined in the Core Assurances.

Refer to Appendix C for provider training requirements.

C. Behavior Assistant Services Provider Qualifications. Providers of this service must have at least:

1. A high school diploma and be at least 18 years of age;
2. Two years of experience providing direct services to recipients with developmental disabilities or at least 120 hours of direct services to recipients with complex behavior problems, as defined in Chapter 65B-4.031(2), F.A.C., or 90 classroom hours of instruction in applied behavior

- analysis from non-university non-college classes or university or college courses; and
3. 20 contact hours of instruction in the following content areas:
 - a. Introduction to applied behavior analysis basic principles and functions of behavior;
 - b. Providing positive consequences, planned ignoring, and stop-redirect-reinforce techniques;
 - c. Data collection and charting; and
 - d. Either a certificate of completion or a college or university transcript and a course content description, verifying the applicant completed the required instruction, will be accepted as proof of instruction.

The 20 contact hours of instruction required under number three above may be obtained within the 90 classroom hours of instruction used to meet requirements under number two above.

Behavior Assistant Training Requirements. Proof of training in the areas of Cardiopulmonary Resuscitation (CPR), AIDS and infection control is required within 30 days of initially providing behavior assistant services. Proof of annual or required updated training shall be maintained on file for review. The provider is responsible for all training requirements outlined in the Core Assurances.

Refer to Appendix C for provider training requirements.

D. Consumable Medical Supplies Provider Requirements. Providers of consumable medical supplies include home health or hospice agencies, pharmacies, medical supply companies, durable medical equipment suppliers and vendors such as discount stores and department stores.

Independent vendors may also provide these services.

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

Home health and hospice agencies shall be licensed by the Agency for Health Care Administration in accordance with ch. 400, Part IV or Part VI, F.S.

Pharmacies shall hold a permit to operate, issued by the Department of Health, in accordance with ch. 465, F.S.

Medical supply companies and durable medical equipment suppliers, shall hold local occupational licenses or permits, in accordance with ch. 205, F.S., and shall be currently licensed by the Agency for Health Care Administration.

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

C. Environmental Accessibility Adaptation Provider Requirements.

Providers of environmental accessibility adaptation (EAA) services include licensed general or independent licensed contractors, electricians, plumbers, carpenters, architects and engineers.

Any enrolled EAA provider who provides the construction work must present a Qualified Business number, as required in ch. 489.119, F.S. In accordance with ch. 489.113, F.S., sub-contractors of a qualified business shall hold the required state certificate or registration in that trade category.

Engineers shall be licensed by the Department of Business and Professional Regulation, in accordance with ch. 471, F.S., and must have one year of experience in environmental adaptation assessment and remodeling or be RESNA certified.

Architects shall be licensed by the Department of Business and Professional Regulation, in accordance with ch. 481, F.S., and must have one year of experience in environmental adaptation assessment and remodeling or be RESNA certified.

Contractors and electricians shall be licensed by the Department of Business and Professional Regulation, in accordance with ch. 489, F.S.

Plumbers shall be licensed by the Department of Business and Professional Regulation, in accordance with ch. 553, F.S.

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

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

D. In-Home Support Services Provider Requirements.

In-Home Support Qualifications. Providers of In-Home Support services are independent vendors who are either individuals or employees of agencies must be at least 18 years of age and have at least a high school diploma or equivalent and one year of experience working in a medical, psychiatric, nursing or childcare setting or working with consumers who have a developmental disability. College, vocational or technical training equal to 30

semester hours, 45 quarter hours or 720 classroom hours may substitute for the required experience. Licensure or registration is not required.

In-Home Support Training. Proof of training in the areas of Cardiopulmonary Resuscitation (CPR), AIDS and infection control is required within 30 days of initially providing in-home supports. Proof of annual or required updated training shall be maintained on file for review. The provider is responsible for all training requirements outlined in the Core Assurances. Attachment B contains provider training requirements. Contact local area or region office to obtain a list of available training sessions.

E. Personal Emergency Response (PERS) Provider Requirements.

PERS Qualifications. Providers shall be licensed electrical contractors, alarm system contractors, contract agencies for Community Care for the Elderly (CCE), Community Care for Disabled Adults (CCDA) Programs, or hospitals. Freestanding equipment may be purchased from independent vendors, such as discount or home improvement stores, but these vendors may NOT provide monitoring.

Electrical or alarm system contractors shall be licensed by the Department of Business and Professional Regulation, in accordance with ch. 489, Part II, F.S.

Hospitals shall be licensed by the Agency for Health Care Administration, in accordance with ch. 395, F.S.

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

F. Respite Care Provider Requirements.

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

Independent vendors may also provide this service. Independent vendors and employees of agencies may be registered or licensed practical nurses or persons with at least one year of experience working in a medical, psychiatric, nursing or child care setting or working with consumers with developmental disabilities. College or vocational or technical training equal to 30 semester hours, 45 quarter hours or 720 classroom hours may substitute for the required experience.

Home health agencies, hospice agencies and nurse registries shall be licensed by the Agency for Health Care Administration, in accordance with ch. 400, Part IV or Part VI, F.S.

Independent vendors, who are not nurses, are not required to be licensed or registered if they bill for and are reimbursed only for services personally rendered by the provider. An agency using more than one employee to provide services and billing for their services, shall be registered as a homemaker, sitter, or companion provider in accordance with ch. 400, F.S.

Nurses who render respite care services as independent vendors shall be licensed or registered by the Department of Health, in accordance with Chapter 464, F.S.

Respite Training. Proof of training in the areas of Cardiopulmonary Resuscitation (CPR), AIDS and infection control is required within 30 days of initially providing respite care services. Proof of annual or required updating training shall be maintained on file for review.

The provider is responsible for all training requirements outlined in the Core Assurances. Attachment B contains provider training requirements.

G. Support Coordination Provider Requirements.

Support Coordination Qualifications. Providers of support coordination services may be either single (solo) providers or agency providers.

- Solo providers and support coordination supervisors employed by agencies shall meet the minimum education qualifications described in the State of Florida Career Service Class Specification for a Senior Human Services Counselor Supervisor, class code 5949, effective 03/06/2000. Minimum qualifications include a bachelor's degree from an accredited college or university and three years of professional experience in developmental disabilities, special education, mental health, counseling, guidance, social work or health and rehabilitative services. A master's degree can substitute for one year of the required experience.
- Support coordinators who are employed by agencies shall meet the minimum education and experience qualifications described in the State of Florida Career Service Class Specification for a Human Services Counselor III, class code 5940, effective 03/06/2000. Minimum qualification include a bachelor's degree from an accredited college or university and two years of professional experience in developmental disabilities, special education, mental health, counseling, guidance, social work or health and rehabilitative services. A master's degree can substitute for one year of the required experience.

- For applicants who have other employment at the time of application to become a waiver provider and intend to remain in the current employment, the application must include a statement addressing a plan for dual employment. The plan should address the type of employment held at the time of the application, the total number of hours involved in that employment on a weekly basis, a plan for the manner in which the applicant may be contacted by consumers receiving services during the hours employed in the other job, how conflicting priorities, emergencies and meetings will be handled. The plan shall also address any long-range plan for reducing or terminating the other employment should a full waiver caseload be assumed. The Area Office shall approve the dual employment plan as a part of the waiver enrollment process. If it is determined that the applicant cannot be available to meet the needs of consumers on their caseload, the applicant may be denied. In no instance may the dual employment include providing services to consumers with developmental disabilities, unless services are provided within the role of case manager or support coordination. All dual employment must comply with ch. 112, F.S.

Support Coordination Training

Pre-Service Requirements. A minimum of 60 hours of pre-service training is required for solo providers and for the director and managers and the waiver support coordinator supervisor of provider agencies. This pre-service training shall consist of 34 hours of statewide pre-service training that is conducted by the APD, or by a trainer certified by APD, and 26 hours of Area training. The Area training shall include orientation to the Area staff and responsibilities, Area resources, ABC training and general Area operational procedures. The Area training content must be approved by the Central office to ensure statewide uniformity and must be provided by the Area within 90 days of the completion of the statewide pre-service training. Contact local area or region office to obtain a list of available training sessions.

Support coordinators employed by agencies are required to receive the same number of hours of training and are to be trained on the same topics covered in the statewide training; however, this training may be conducted by the support coordination agency. Agency trainers must attend a train-the-trainer session conducted by the APD and mandatory refresher courses, as required by the APD. Agency trainers, and the agency training plan, must be prior approved by the APD.

Proof of annual or required updated training requirements shall be maintained on file for review.

The provider is responsible for all training requirements outlined in the Core Assurances. Attachment B contains provider training requirements.

Continuing Support Coordination Training. All support coordinators and agency supervisors, director or managers shall attend 24 hours of job-related in-service training annually. Internal management meetings, held by agency providers, shall not apply toward the 24 hours required unless approved by the Area. For support coordination supervisors and employees of agency providers, 12 hours of the 24 hours in-service requirements must be provided by trainers outside of the agency.

All support coordinators shall attend Personal Outcome Measures training conducted by the APD or an APD certified training within 90 days of receiving a certificate of enrollment from the Area. This training shall satisfy the annually required 24 hours of job related training for that year. Support coordinators who have not completed the Personal Outcome Measures training must have a trained support coordinator in attendance when conducting the Personal Outcome Measures interview, as part of the annual support plan.

Documentation of all training will be maintained on file by the solo provider or the agency provider and be available for monitoring and review. Contact local area or region office to obtain a list of available training sessions.

Support Coordination Projected Service Outcomes. Projected Service Outcomes are goals used to determine, through monitoring and review, the effectiveness of service provision. Outcomes should be measured considering individual skills and circumstances.

- Consumers receiving services from the support coordinator shall maximize freedom of choice in all areas of their lives, including setting personal goals, being fully informed about service options and making all possible decisions with regard to the conduct of their lives.
- Consumers receiving services demonstrate an increase in abilities, self-sufficiency and changes in their lives consistent with their personal goals.
- Consumers achieve or make progress toward their personal goals on their support plan.

Consumers are satisfied with their support coordination services based on the results of the annual satisfaction survey or are satisfied that their concerns raised during the survey have been addressed.

H. Supported Employment Provider Requirements.

Supported Employment Qualifications. Providers of Supported Employment services may be either independent vendors, solo providers, or agency vendors.

Independent vendors, solo providers, and employees of agencies who render this service shall have a bachelor's degree from an accredited college or university with a major in business, nursing, education or a social, behavioral or

rehabilitative science. In lieu of a bachelor's degree, a person rendering this service shall have an associate's degree from an accredited college or university with a major in business, nursing, education, or a social, behavioral or rehabilitative science and two years of experience. Experience in one of the previously mentioned fields shall substitute on a year-for-year basis for the required college education.

Licensure and registration is not required.

Supported Employment Training. Agency providers are required to attend twelve hours of pre-service training and eight hours of annual in-service training related to Supported Employment. Agency employees and independent vendors and solo providers enrolled after March 1, 2004 are required to attend 18 hours of pre-service training prior to assuming job responsibilities and eight hours of annual in-service training. Training will include the approved curriculum entitled "Supported Employment and Natural Supports, A Florida Training Curriculum, 2001 Edition" or an equivalent training curriculum as approved by the APD.

Individual vendors must attend at least one Supported Employment related conference or workshop prior to certification and eight hours of annual in-service training related to Supported Employment. Proof of annual or required updated training shall be maintained on file for review.

The provider is responsible for all training requirements outlined in the Core Assurances. Attachment B contains provider training requirements. Contact local area or region office to obtain a list of available training sessions.

Supported Employment Projected Service Outcomes. Projected service outcomes are goals used to determine, through monitoring and review, the accomplishments of providers and the effectiveness of service provision.

- Provider assists consumers in securing employment according to their desired outcomes including type of work environment, activities, hours of work, level of pay and supports needed.
- Consumers in the individual model during follow along (phase 2) do not need paid job coaching in excess of 20% of the consumer's average work hours.
- Consumers receiving Supported Employment services achieve goals on their support plan throughout the year.
- Consumers receiving this service are assisted in progressing on their chosen career path.
- All consumers who have responded to the annual satisfaction survey are satisfied with their services or the provider has addressed any concerns raised during the survey.

I. **Supported Living Coaching Provider Requirements.**

Supported Living Coaching Qualifications. Providers of Supported Living Coaching services may be independent vendors, solo providers or employees of agencies.

Independent vendors, employees of agencies and solo providers who render these services shall have a bachelor's degree from an accredited college or university with a major in nursing, education, or a social, behavioral or rehabilitative science. In lieu of a bachelor's degree, a person rendering these services shall have an associate's degree from an accredited college or university with a major in nursing, education or a social, behavioral or rehabilitative science and two years of experience. Experience in one of the previously mentioned fields shall substitute on a year-for-year basis for the required college education.

Supported Living Coaching Training. Agency employees, independent providers and solo providers are required to attend eighteen hours of pre-service training prior to assuming job responsibilities, and eight hours of annual in-service training. At a minimum, training will consist of a detailed review of the most recent publication of "A Guide to Supported Living in Florida," an overview of affordable housing options and home modifications and ch. 65B-11, F.A.C. The pre-service training content must be approved by the APD Central Office to ensure statewide uniformity.

At a minimum, providers of Supported Living Coaching services must also complete training covering CPR, Infection Control, AIDS and HIV and maintain current certification.

Proof of annual or required updated training shall be maintained on file for review. The provider is responsible for all training requirements outlined in the Core Assurances. Attachment B contains provider training requirements. Contact the local area or region office to obtain a list of available training sessions.

Supported Living Coaching Projected Service Outcomes. Projected service outcomes are goals used to determine through monitoring and review the accomplishments of providers and the effectiveness of service provision.

- Consumers in supported living are the lessee or owner of the home in which they reside.
- All consumers who have responded to the annual satisfaction survey are satisfied with the services or the provider has addressed any concerns raised during the survey.
- Supported living consumers live in homes occupied by no more than two other consumers with developmental disabilities and in areas in which

persons with disabilities account for no more than 10% of the houses or 10% of the units in an apartment complex unless otherwise waived by the APD.

- Consumers are supported to live in their own homes.
- Consumers who use the supports increase their level of participation or independence in the community.
- Consumers demonstrate freedom of choice in all areas of their lives as evidenced by setting personal goals, being fully informed about service options, and making all possible decisions with regard to the conduct of their lives.
- Consumers achieve goals on their support plan.

J. Transportation Provider Requirements. In order to provide and be reimbursed for transportation under the Medicaid Home and Community-Based Services Waiver, transportation providers may be Community Transportation Coordinators (CTC) for the Transportation Disadvantaged, limited transportation providers, Public Transit Authorities that run the community's fixed-route fixed-schedule public bus system, group homes and other residential facilities, adult day training programs to which the consumers are being transported, and other public, private for-profit and private not-for-profit transportation entities. The manner in which each of these types of providers may be used is specified in ch. 427, F.S., and is described below.

Pursuant to ch. 427, F.S., transportation services shall be purchased from community transportation coordinators utilizing the public, private for-profit, or private not-for-profit transportation operators within each county's coordinated transportation system. Ch. 427, F.S., allows for the use of other providers, the circumstances for the use of which are specified in ch. 41-2, F.A.C., and are described herein specifically for the Home and Community Based Services Waiver.

With the exception of limited transportation providers and Public Transit Authorities that run the community's fixed-route, fixed-schedule public bus system, all transportation providers are required to adhere to the driver, vehicle and passenger safety standards set forth in ch. 41-2, F.A.C. All providers must adhere to the requirements of this Services Directory.

Drivers shall be at least 18 years of age and possess a current, valid commercial or non-commercial driver's license appropriate to the vehicle and for the purpose it is being used, in accordance with ch. 316, F.S. Transportation providers shall hold applicable licenses issued by the Department of Highway Safety and Motor Vehicles, in accordance with ch. 322, F.S.

When it is better suited to the unique and diverse needs of a consumer, either limited transportation providers or the local fixed-route, fixed-schedule public bus system may be used to transport consumers. These options are to be used prior to obtaining transportation services from the CTC.

Limited Transportation providers are relatives, friends, and neighbors. They are not “for hire” entities. They are reimbursed at the state mileage rate. They are encouraged to adhere to the specific driver, vehicle and passenger safety standard in ch. 41-2, F.A.C. The Area is not required to contact or obtain authorization from the CTC in order to use the services of a limited transportation provider. The CTC has no responsibility for overseeing service delivery of such providers. The Area is responsible for this oversight.

Transportation Qualifications. When transportation providers are relatives, controls must be in place to ensure that the payment is made to the relative only in return for specific services rendered, and there is adequate justification as to why the relative is being paid for the service rather than being a natural support.

Public Transit Authorities that operate the community’s fixed-route, fixed-schedule public bus system may enroll in the FSL/HCBS Waiver to facilitate the purchase of monthly or other frequency bus passes. If natural supports are unavailable, this transportation option is to be used for consumers who can use the fixed-route, fixed-schedule public bus system to go to some or all of their waiver services. Bus passes are to be purchased for consumers who can utilize the bus system to go to their waiver service sites whenever the cost of the trips to be taken during the month, if taken by para transit, would exceed the cost of the monthly bus pass. Public Transit Authorities are not required to meet the standards set forth in ch. 41-2, F.A.C., however, they are required to adhere to minimum safety standards set forth in ch. 14-90, F.A.C. The Area is not required to contact or obtain authorization from the CTC in order to use the services of the fixed-route fixed-schedule bus system. Drivers of fixed-route, fixed-schedule buses are not considered caretakers within the context of ch. 393, F.S. Therefore, they are not required to be level 2 background screened. The CTC has no responsibility for overseeing service delivery of such providers.

Group homes or other residential facilities in which consumers live may enroll as transportation providers to transport the consumers to and from their waiver services. Adult day training agencies that consumers regularly attend may enroll as transportation providers to transport the consumers to and from the agencies’ programs. In order to use group homes, residential facilities, or adult day training (ADT) agencies as transportation providers, the Area must obtain written authorization from the CTC. The authorization will result in a written agreement that sets forth the roles and responsibilities of the CTC, the group home, residential facility or ADT agency and the area for complying with vehicle and passenger safety standards adhering to monitoring and overseeing service delivery and any necessary reporting to ensure compliance with ch. 427, F.S. This arrangement will benefit the providers by enabling them to purchase new or replacement vehicles on state contract through the Department of Transportation.

Transportation providers that are not part of the coordinated transportation system may transport waiver consumers. The Area must document the reasons why a provider that is not part of the coordinated transportation system is necessary to provide services. The documentation determines the procedures that the APD Area Office must follow to certify the provider as a waiver provider. The provider must follow all roles and responsibilities of the APD Area Office and the CTC.

If the CTC determines it is unable to provide or arrange the required transportation for a consumer, transportation providers who operate outside the coordinated transportation system (e.g., taxi companies, private for-profit or not-for-profit transportation companies) may be used to transport the consumer to and from waiver services. These providers must meet the driver, vehicle and passenger safety standards specified in ch. 41-2, F.A.C.

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

Section 2A: Participant Requirements

I. Family and Supported Living Waiver Participants

- A. **Eligibility.** Participants in the waiver must meet the eligibility requirements of the APD in accordance with ch. 393, F.S. must meet the level of care criteria for placement in an Intermediate Care Facility for the Developmentally Disabled (ICF/DD), and must be eligible for Medicaid under one of a variety of categories described in the Florida Medicaid Reimbursement Handbook, Non-Institutional 081. Attachment C contains contact information.

The FSL Waiver is not a residential placement waiver and therefore the FSL Waiver would not pay residential expenses. The FSL Waiver is intended for consumers living in their own home or family home. Consumers must understand the options and alternatives to receiving services on the FSL Waiver. If the consumer is not willing or able to move into their own home or family home, the FSL Waiver is not the appropriate program to best meet their needs. Consumers enrolling in the FSL Waiver may be eligible to receive General Revenue funded Supported Living stipends.

1. **Medicaid.** Consumers who are not already eligible for Medicaid benefits through Supplemental Security Income (SSI), MEDS-AD, or TANF at the time they apply for Family and Supported Waiver services must complete or have a designated representative complete and submit a Request for Assistance (RFA) to the local Department of Children and Families. Refer to the Florida Medicaid Provider General Handbook for information on verifying consumer eligibility. Attachment C contains contact information.
2. **Level of Care.** Consumers who are eligible for Medicaid benefits must also meet one of the following Developmental Disabilities Program eligibility requirements, in accordance with ch. 393, F.S.
 - The consumer's intelligence quotient (IQ) is 59 or less; or
 - The consumer's IQ is 60-69 inclusive and the consumer has a secondary handicapping condition, that includes cerebral palsy, spina bifida, Prader-Willi syndrome, epilepsy, autism; or ambulation, sensory, chronic health, and behavioral problems; or the consumer's IQ is 60-69 inclusive and the consumer has severe functional limitations in at least three major life activities including self-care, learning, mobility, self-direction, understanding and use of language, and capacity for independent living; or

- The consumer is eligible under a primary disability of autism, cerebral palsy, spina bifida, or Prader-Willi syndrome. In addition, the condition must result in substantial functional limitations in three or more major life activities, including self-care, learning, mobility, self-direction, understanding and use of language, and capacity for independent living.

B. Enrollment into the FSL Waiver. Once Medicaid and the waiver eligibility requirements are met, the APD Area Office reviews the consumer's request for home and community-based supports and services. That office will determine if: 1) a waiver vacancy is available; 2) enrollment in the waiver is contingent on the consumer consenting to waiver participation with the understanding the FSL Waiver must keep waiver services to under the annual dollar cap. The determination will be made in accordance with legislatively appropriated funding and established annual priorities.

If in the best professional judgment of the area office staff, an applicant for the FSL Waiver is determined to be ineligible for FSL Waiver services, the area office will send a due process letter. The due process letter will indicate the applicant is not appropriate for the FSL Waiver and the reason for the denial.

Consumers eligible for FSL Waiver services will be prioritized in accordance with the DS/HCBS Waiver wait list in accordance with Appendix F of the DS/HCBS Waiver Medicaid Coverage and Limitations Handbook. (Note: Crisis criteria only relates to the DS/HCBS Waiver.) Consumers will be given the opportunity to choose to participate in the FSL Waiver in order of position on the DS/HCBS Waiver wait list. Consumers served by the FSL Waiver stay on the waiting list for the DS/HCBS Waiver while receiving FSL Waiver services. The APD Central Office maintains the statewide list of all consumers determined eligible and waiting for waiver services.

A consumer's enrollment in the waiver continues indefinitely unless one of the following conditions exist, in which case dis-enrollment will occur:

- The consumer does not adhere to the total dollar cap for the FSL Waiver.
- The consumer or guardian chooses to terminate participation in the program.
- The consumer moves out of state or country.
- The consumer becomes ineligible for the waiver because of a loss of eligibility for Medicaid benefits and this loss is expected to extend for a lengthy period.

- The consumer receives services under another Medicaid Waiver program.
- The consumer no longer needs waiver services.
- The consumer does not annually meet level of care for admission to an Intermediate Care Facility for the Developmentally Disabled (ICF/DD).
- The consumer no longer lives in their own home or family home.
- The consumer dies.

C. Medical Necessity. The Agency for Persons with Disabilities determines if Family and Supported Living Waiver services are medically necessary. The consumer or the legal guardian must choose to receive home and community-based supports and services.

Waiver services shall only be provided when the service or item is medically necessary. Ch. 59G-1.010(166), (a)(c) of the F.A.C. defines medical necessity as:

- “Medically necessary” or “medical necessity” means that medical or allied care, goods or services furnished or ordered must meet the following conditions.
- Be necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain.
- Be individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the patient’s needs.
- Be consistent with generally accepted professional medical standards as defined by the Medicaid program and not be experimental or investigational.
- Be reflective of the level of service that can safely be furnished; or which no equally effective and more conservative or less costly treatment is available statewide.
- Be furnished in a manner not primarily intended for the convenience of the consumer’s caretaker, or the provider.

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.

1. **Determining Medical Necessity.** An appropriate, qualified professional shall make the determination that the standards for medical necessity set forth in ch. 59G-1.010 (166), (a)(c), F.A.C., are met, and that the requested service meets the service definition, as contained in the approved FSL Waiver. When a requested service is determined to be medically necessary, it shall

be approved within the limit of the total annual dollar cap. If sufficient information is not available, or obtainable from the Waiver Support Coordinator, to determine that the service is medically necessary, a written request for more information will be sent to the consumer, family, or guardian. If it is determined that the service is not medically necessary (i.e., the request does not conform to the standards set forth in Rule 59G-1.010 (166)(a)(c) F.A.C.), a written denial of the service and notice of due process will be sent to the consumer, family or guardian. A Medicaid consumer may appeal decisions by the Area Office by requesting a Medicaid Fair Hearing in accordance with ch. 42, 431.221(d) of the Code of Federal Regulations. The consumer has 90 days from the date that notice of due process was mailed to file an appeal. A prescription for a service or item that has general utility or that is generally available to the public does not change the character of the item for coverage purposes under the Waiver. It is the general use and not the specific use that governs coverage.

- D. Authorization of Services.** The services described in this Services Directory represent all approved services that may be purchased for a consumer participating in the FSL Waiver who needs the service to reach an outcome described on the support plan. In order for a consumer to receive a service, it must be identified on a consumer's support plan and cost plan, also known as the plan of care, and be approved by the Area Office before the service may be provided. Providers of FSL Waiver services are limited to the amount, duration and scope of the services described on the consumer's support plan and current approved cost plan.

Family and Supported Living Waiver services shall not be reimbursed when the date of service is prior to the consumer's enrollment into the Family and Supported Waiver.

Consumers enrolled in the FSL Waiver will be provided with those services that have been determined to be medically necessary with reasonable promptness. The Agency for Persons with Disabilities will make reasonable efforts to provide those Waiver services for which a determination of medical necessity has been made within 90 days of the date of the consumer's enrollment in the waiver or request for a support or service to the extent that sufficient provider capacity exists.

- 1. Availability of Other Sources.** Supports and services are developed and delivered in natural community settings. Additionally, the supports and services authorized under the Waiver should be used to supplement the supports already provided by

family, friends, neighbors, and the community. Replacement of such natural and free supports with government-funded services, including educational and vocational services, is contrary to the intent of the waiver program. State and federal funds are the means of last resort and are only utilized when a family or community support is unavailable or while a support is being developed. Only by involving the consumer in community inclusive supports and experiences can full integration into community life be accomplished.

When a service must be purchased, those available under the Medicaid State Plan must be utilized before accessing services through the Waiver. The Waiver cannot supplant or replace a benefit available through Medicaid State Plan services. It is a federal requirement to access state plan coverage before the provision of Waiver services. As stated in section 4442.3, State Medicaid Manual:

“No service may be provided under the waiver if it is already provided under the State Plan unless the nature or the amount of the service, when provided under the waiver, would not be covered if provided under the State Plan. For example, if the waiver provides for the coverage of home health aide services, the maximum number of visits allowed under the waiver could be greater than the limit contained under the State Plan. The amount chargeable for waiver services is that amount incurred after any limits in State plan services have been reached. Similarly, if the State proposed to provide home health aide services, which were defined more broadly than those available under the State Plan, these could be included as waiver services.”

To obtain specific information about Medicaid State Plan coverage, refer to the Medicaid Coverage and Limitation Handbook. The Handbook can be downloaded from the Medicaid fiscal agent web site <http://floridamedicaid>. Attachment C contains contact information.

Section 2B: FSL Service Descriptions, Limitations

II. Adult Day Training

A. Adult Day Training. Day training programs for adults are intended to support the participation of consumers in daily, meaningful, valued routines in the community, which may include work-like settings but exclude services directed at teaching specific job skills or meeting employment in the general work force.

Adult day training services stress training in the activities of daily living, self-advocacy, adaptive, and social skills and are age and culturally appropriate. The service expectation is to achieve the outcomes (goals) defined by each consumer and to attain and support participation in less restrictive settings. The training, activities, and routine established by the adult day training program shall be meaningful to the consumer and provide an appropriate level of variation and interest. This training is provided in accordance with a formal implementation plan and developed under the direction of the consumer, reflecting the consumer's goal(s) from the current support plan.

Services shall be facility-based and usually furnished for a minimum of six hours per day on a regularly scheduled basis for one or more days per week. Four of the six hours must be spent in training and program activities. Services may also be provided in the community if the activity is reflected in the consumer's support plan and included in the implementation plan. Adult day training services may be provided as an adjunct to other services included on a consumer's support and cost plan. For example a consumer may receive supported employment or other services for part of a day or week and adult day training services at a different time of the day or week. Adult day training services will only be billable for the prorated share of the day or week that the consumer actually attended that service.

Mobile crews, enclaves and entrepreneurial models that do not meet the standards for Supported Employment and provided in groups of four or more consumers are included as ADT-Off Site services.

Any consumer receiving adult day training or ADT-Off Site services must be paid for performing productive work that benefits the organization or would have to be performed by someone else if not performed by the consumer. Consumers who are working must be paid commensurate with members of the general work force doing similar work per wage and hour regulations of the Department of Labor.

At a minimum, providers will conduct an annual orientation informing consumers of supported employment and other competitive employment opportunities in the community.

Adult day training services must be provided in a designated adult day training center or other training sites in the community as agreed to by the consumer and provider.

ADT-Off Site models include the following services that teach specific job skills and other services intended to meet specific employment objectives:

- Enclave - A group approach to training where consumers with disabilities work either as a group or dispersed throughout an integrated work setting with supervision by the provider.
- Mobile Crew - A group approach to training where a crew (lawn maintenance, janitorial) of consumers with disabilities are in a variety of community businesses or other community settings with supervision by the provider.
- Entrepreneurial - A group approach to training where consumers with disabilities work in a small business created specifically by or for the consumers.

B. Adult Day Training Limitations. The Adult day training services maximum annual dollar amount is \$1,000. The stepped rate published for ADT and ADT-Off Site services is a daily rate based on seven hours of staff time to accommodate the variance in consumer schedules for attendance. The provider shall render services at a time mutually agreed to by the consumer and the provider. This will allow a consumer the flexibility to determine when to attend the ADT program for limited hours or only on certain days. Services for consumers attending ADT for less than a full day will be billed by the quarter hour for the number of quarter hours attended each day the consumer is present. To the extent that a consumer requires more than \$1,000 of adult day training, additional adult day training services may be approved through exception by the APD.

Consumers attending full time, six hours, will be billed at the daily rate for each full day the consumer is present. This service generally begins at the age of 22 when a consumer is out of the public school system or when the consumer graduated from the public school system, receiving a standard diploma. However, a consumer can begin at the age of 16 without a standard diploma if the public school system is willing to provide funding for this service throughout the person's legal age of eligibility. Consumers over the age of 22 who have not graduated shall also be eligible.

Adult day training services are limited to the amount, duration, and scope of the service described on the consumer's support plan and current approved cost plan. The staffing ratio shall not exceed ten consumers per direct care staff.

A consumer may not receive a combination of ADT or Supported Employment services that exceeds 35 hours per week. A consumer may not receive more than a total of 35 hours a week of a paid support or a combination of paid supports designed to be used as a meaningful day activity.

1. Adult Day Training Special Considerations. Adult day training providers are paid separately for transportation services only when they are enrolled as a transportation provider and transportation is provided between a consumer's place of residence and the training site. Transportation between day training sites, if the activities provided are a part of day training services, will be included as a component part of the adult day training services and included in the rate paid to the provider of the adult day training service.

ADT staff is responsible for assisting consumers into and out of facilities when they have been transported in vehicles not owned or operated by the ADT. Drivers of such vehicles are responsible for ensuring the consumer's safe entry to and exit from the vehicle.

When the supervisor of a mobile crew or enclave does not meet the qualifications for a supported employment coach, even when the consumer meets the criteria for supported employment, the support must be billed as adult day training off site.

Adult Day Training Services and ADT-Off Site Services, will be billed based on the published stepped rate for the services at the 1 staff to 10 consumer ratio rate level. Exceptions to this rate level shall be made only when it has been determined through use of the APD approved assessment and the support planning process that a consumer requires a different support-staffing ratio. The Area or Region Program Administrator or their designee shall make these decisions. The rate and staffing ratio shall be identified in the consumer's support plan and cost plan, and on the authorization for service submitted to the provider by the Area. The rate ratio is determined by what is the usual and customary service delivery pattern and does not fluctuate with incidental absences of one or more consumers included in the rate ratio.

If the support is provided to larger groups with more than eight consumers, regardless of the wage, the service will be billed as

adult day training off site. If the support is provided in groups of eight or less and the consumers are paid less than minimum wage, the service shall be billed as adult day training off site.

Payment shall not be made for any time period the consumer is absent from the service.

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

Exceptions may be made to the \$1,000 service limit based on medical necessity and through the prior authorization process. However, the combined total of all FSL services **shall not** exceed the total annual dollar cap annually.

III. Behavior Analysis Services

A. Behavior Analysis Services Description. Behavior analysis services are provided to assist a person or persons to learn new behavior that are directly related to existing challenging behaviors or functionally equivalent replacement behaviors for identified challenging behaviors. Services may also be provided 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 programming" and "behavioral programs." Behavior analysis includes the design, implementation and evaluation of systematic environmental modifications for the purposes of producing socially significant improvements in and understanding of human behavior based on the principles of behavior identified through the experimental analysis of behavior. It includes the identification of functional relationships between behavior and environment. It uses direct observation and measurement of behavior and environment. Contextual factors, establishing operations, antecedent stimuli, positive reinforcement and other consequences are used, based on identified functional relationships between behavior and environment, in order to produce practical behavior change.

Behavioral services must include procedures to insure generalization and maintenance of behaviors. The services are designed to engineer environmental modifications including ongoing styles of interactions, and contingencies maintained by significant others in the recipient's life. Training for parents, caregivers and staff is also part of the services when these persons are integral to the implementation or

monitoring of a behavior analysis services plan. Services should be provided for a limited time and discontinued as the significant others gain skills and abilities to assist the recipient to function in more independent and less challenging ways.

Behavior analysis does not rely on cognitive therapies and expressly excludes psychological testing, neuropsychology, psychotherapy, sex therapy, psychoanalysis, hypnotherapy and long-term counseling as treatment modalities. Provision of behavioral services must comply with Chapter 65B-4.030(9)(10), F.A.C. Services provided by behavior analysts with limited experience in the problem area or by behavior analysts who are not Board Certified Behavior Analysts with three years of experience or licensure under Chapter 490 or 491, F.S., should receive oversight and approval of services with a more experienced behavior analyst or with the above described highest level of certification.

B. Behavior Analysis Services Limitations. A recipient shall receive no more than 16 units of service per day. A unit is defined as a 15 minute time period or portion thereof. This service may be provided concurrently (at the same time and date) with another service.

Refer to Appendix A for rate methodology information.

The total maximum annual dollar amount for Behavior Analysis Services and Behavior Assistant Services is \$4500. To the extent that a consumer requires more than \$4500 of behavior analysis services, additional behavior analysis services may be approved through exception by the APD.

Behavior Analysis Services Place of Service. These services may be provided in the provider's office, the recipient's place of residence or anywhere in the community. However, in all cases, behavior analysis services must also be provided in the setting(s) relevant to the behavior problems being addressed.

Behavior Analysis Services Special Considerations. Behavior analysis and assessment services are described more fully in Chapter 65B-4, F.A.C., which is available through the Area Office. As stated in 65B-4.031, F.A.C., approval for behavior analysis services for behaviors meeting the characteristics described in 65B-4.031, F.A.C., will be obtained from certified behavior analysts meeting educational and experience requirements or persons licensed pursuant to Chapter 490 or 491, F.S., prior to implementation of the services.

Refer to Appendix E for contact information.

IV. Behavior Assistant Services

A. Behavior Assistant Services Described. Behavior assistant services are one-on-one activities related to the delivery of behavior analysis services, as defined under Behavior Analysis Services and Assessment, and are designated in and required by a behavior analysis service plan. Activities include monitoring of behavior analysis services, the implementation of behavioral procedures for acquisition of replacement skills and reduction of problematic behaviors, data collection and display (e.g., graphics) as authorized by a recipient's behavior analysis service plan and assist the person certified as a behavior analyst or licensed under Chapter 490 or 491, F.S., in training of caregivers. The behavior analysis service plan must be designed, implemented and monitored in accordance with Chapter 65B-4.030, F.A.C., and approved in accordance with Chapter 65B-4.029, F.A.C.

Behavior assistant services are designed for recipients for whom traditional residential habilitation services have been documented unsuccessful or are considered to be inappropriate for health or safety reasons and for children who require behavioral services but for whom providing services in the family home will likely be more effective and least restrictive. Services should be provided for a limited time and discontinued as the support persons gain skills and abilities to assist the recipient to function in more independent and less challenging ways. Behavioral assistant services for children should supplement and support, transfer stimulus control and generalize behavior change, the acquisition and reduction plans designed and implemented by the primary source of services for children, the education system.

Refer to Appendix A for rate methodology information.

B. Behavior Assistant Services Limitations.

The total maximum annual dollar amount for Behavior Analysis Services and Behavior Assistant Services is \$4500. To the extent that a consumer requires more than \$4500 of behavior assistant services, additional behavior assistant services may be approved through exception by the APD.

Behavior Assistant Services Place of Service. These services may be provided in the provider's office, the recipient's place of residence or anywhere in the community. However, in all cases, behavior assistant services must also be provided in the setting(s) relevant to the behavior problems being addressed.

Behavior Assistant Services Special Considerations. The services of a Behavior Assistant must be approved by the responsible Behavior Analysis Services Local Review Committee Chairperson, as defined in Chapter 65B-4.029, F.A.C., and monitored by a person who is certified in behavior analysis or licensed under Chapters 490 or 491, F.S., in accordance with Chapter 65B-4.030(10), F.A.C.

V. Consumable Medical Supplies

A. Consumable Medical Supplies Described. Consumable medical supplies are those non-durable supplies and items that enable consumers to increase their ability to perform activities of daily living. Consumable medical supplies are of limited usage and must be replaced on a frequent basis. Supplies covered under the Developmental Services Home and Community-Based Services waiver must meet all of the following conditions: a) be related to a consumers special medical condition, b) not be provided by any other program, c) be the most cost-beneficial means of meeting the consumers need, and d) not primarily for the convenience of the consumer, caregiver, or family. Consumable medical supplies covered are listed below.

B. Consumable Medical Supply Limitations. The Consumable Medical Supplies maximum annual dollar amount is \$800. To the extent that a consumer requires more than \$800 of consumable medical supplies, additional consumable medical supplies may be approved through exception by the APD.

Consumable medical supplies will not duplicate supplies provided by the Medicaid State Plan. Refer to the Medicaid Durable Medical Equipment – Medical Supplies Coverage and Limitations handbook for additional information on Medicaid State Plan coverage. Supplies not available under the Medicaid State Plan, or available in insufficient quantity to meet the needs of the consumer, may be purchased by the waiver. All supplies shall have direct medical or remedial benefit to the consumer and are related to the consumer's developmental disability.

If multiple vendors are enrolled to provide this service, the consumer shall be encouraged to select from among the eligible vendors based on an item's availability, quality and best price. No more than ten items per day may be purchased.

Consumable medical supplies covered by the FSL Waiver are listed below. Some items have specific requirements or limitations.

1. Adult diapers or adult disposable briefs.
2. Wipes.

3. Disposable gloves, when a consumer requires personal care that exposes the caregiver to body fluids. Latex-free gloves will be authorized when the consumer's or the caregiver's physician certified that the consumer or the caregiver has a latex allergy or that there is a probable expectation the consumer or caregiver may have a latex allergy (i.e., consumers with spina-bifida).
4. Surgical masks, when prescribed by a physician and are:
 - a. Worn by the consumer with a compromised immune system as a protection from infectious disease; or
 - b. Worn by a caregiver who must provide a treatment that requires strict, sterile procedure in when they are trained to provide care to a consumer who has a compromised immune system and who must be protected at all cost from exposure to any airborne organisms or substances. The physician must renew the prescription quarterly.
5. Disposable or washable bed/chair pads and adult sized bibs.
6. Ensure, or other food supplements, when determined necessary by a licensed dietitian. Consumers that require nutritional supplements must have dietitian's assessment documenting such need. The assessment shall include documentation of weight fluctuation. Total parenteral nutrition (TPN) is available through the Medicaid pharmacy program.
7. Feeding tubes and supplies not covered by Medicaid and prescribed by a physician. Excludes supplies for a consumer who qualifies for food supplements under the Medicaid pharmacy program or Medicare program.
8. Dressings, not covered by Medicaid, required for a caregiver to change wet to dry dressing over surgical wounds or pressure ulcers, and prescribed by a physician.
9. Hearing aid batteries, cords and routine maintenance and cleaning prescribed by an audiologist.
10. Bowel management supplies such as laxatives, suppositories and enemas determined necessary for bowel management by the consumer's physician.

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

The request will be reviewed by the area's Medical Case Manager, Medical Case Management Team, or contractual entity, when appropriate, to determine compliance with the standards for medical necessity set forth

in Rule 59G-1.010 (166), F.A.C., and to determine whether the requested item fairly meets the service definition.

Consumable medical supplies are “medical” in character and purpose, and must be directly and specifically related to the consumer's disability. Items of general utility or which are generally available to the general population without a prescription are not covered as consumable medical supplies. Items of general use, such as toothbrushes, toothpaste, toothpicks, floss, deodorant, feminine hygiene supplies, bath soap, lotions, razors, shaving cream, mouthwash, shampoo, conditioner, cream rinse, tissues, aspirin, all over-the-counter medications, over the counter nasal sprays, creams, ointments, vapor rub, powder, clothing, and the like, are not covered.

Supplies for investigational or experimental use are not covered.

The fact that a prescription has been submitted for an item does not change its character for purposes of coverage in this category. For example, if a physician prescribes Tylenol or any other over the counter medication does not change the character of the item for purposes of coverage in this category. Similarly, the fact that a physician or dietitian prescribes a vitamin does not convert the item of one of general utility to a covered consumable medical supply. It is the general character and not the specific use of the item that governs for purposes of coverage under this category.

A prescription submitted for supplies, diets, over-the-counter medications, vitamins, herbs, etc. which has general utility or is generally available to the general population without a prescription, does not change the character of the item for purposes of coverage in this category. For example, a physical therapist, occupational therapist or physician recommending or prescribing items like Tylenol, Ginko Biloba, vitamins, gluten-free foods, cotton balls or Q-tips, does not convert that item from general utility items to consumable medical supplies covered under the waiver. Items covered in this category generally include only those items that are specifically designed for a medical purpose, and are not used by the general public or for other general utility uses. It is the general character and not specific use of the item that governs for purposes of coverage under this category.

Supplies may be ordered for 3 months at a time.

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

Educational supplies are not consumable medical supplies and are not covered by the waiver. These supplies are expected to be furnished by

the local school system. Consumers or their family members shall not be reimbursed for consumable medical supplies they purchase.

Consumable Medical Supplies Special Considerations. Exceptions may be made to the \$800 service limit based on medical necessity and through the prior authorization process. To the extent that a consumer requires more than \$800 of consumable medical supplies, additional consumable medical supplies may be approved through exception by the APD. However, the combined total of all FSL services **may not** exceed the total annual dollar cap.

IV. Environmental Accessibility Adaptations

A. Environmental Accessibility Adaptations Described. Environmental accessibility adaptations (EAA) are those physical adaptations to the home, required by the consumer's support plan, which are "medically necessary" to avoid institutional placement of the consumer and enable them to function with greater independence in the home. Home Accessibility Assessment is an independent assessment by a professional rehabilitation engineer or other specially trained and certified professional to determine the most cost-beneficial and appropriate accessibility adaptations for a consumer's home.

Home accessibility assessments may also include pre-inspection of up to 3 houses a consumer or family is considering for purchase, review of ceiling lift and track systems, van conversions, and oversight and final inspection of any approved EAA.

If the construction is not completed by the independent assessor, the assessor can still provide construction oversight and a final inspection. The assessment may also include pre-purchase inspection of up to three homes identified by a consumer or family to determine the best design to meet the consumer's needs and any potential adaptations that may be required to make the home accessible.

Environmental accessibility adaptations shall be made only to a consumer's family home or consumer's own home, including rental houses or apartments.

B. Environmental Accessibility Adaptation Limitations. The Environmental Accessibility Adaptations maximum annual dollar amount is \$2,000. To the extent that a consumer requires more than \$2,000 of environmental accessibility adaptations, additional environmental accessibility adaptations may be approved through exception by the APD.

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

Environmental accessibility adaptations covered under this waiver includes the installation of ramps and grab-bars, widening of doorways, modification of bathroom facilities or installation of specialized electric and plumbing systems required to accommodate the medical equipment and supplies, which are necessary for the welfare of the consumer.

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

Environmental accessibility adaptations (EAA) are approved when they are medically necessary. The APD must approve exceptions. To submit an exception request, the appropriate professional must complete and assessment documenting how the specific EAA is medically necessary, how it's directly related to the consumer's developmental disability, how it's directly related accessibility issues within the home, and how, without the selected EAA, the consumer can not continue to reside in the their current residence. The request will be reviewed by an appropriate, qualified professional to determine whether the standards for medical necessity set forth in Rule 59G-1.010(166), F.A.C., are met and to determine whether the requested item fairly meets the service definition. The request will be reviewed by the area's Medical Case Manager, Medical Case Management Team, or contractual entity, when appropriate, to determine compliance with the standards for medical necessity.

Environmental accessibility adaptations include only adaptations to an existing structure, and must be provided in accordance with applicable state and local building codes. Adaptations, which add to the total square footage of the home, are excluded from this benefit.

C. Environmental Accessibility Adaptation Special Considerations.

Environmental accessibility adaptations shall be determined "medically necessary" before approved. This determination includes the following considerations:

- There are no less costly or conservative means to meet the consumer's need for accessibility with the home.

- The environmental accessibility adaptation is individualized, specific and consistent with the consumer's needs and not in excess of his or her needs.
- The environmental accessibility adaptation enables the consumer to function with greater independence in the home, and without which, the consumer would require institutionalization.

Environmental accessibility adaptations that are required to support proper functioning of medical equipment, such as electrical upgrades, are limited to the requirements for the safe operation of the specified equipment and not intended to correct existing code violations in the consumer's home.

Environmental accessibility adaptations shall be approved for a consumer's own home or family home (whether owned or leased), as needed, to make the home accessible to the consumer. No more than five units shall be billed per day. Once adaptations are made to a consumer's residence, adaptation to another residence cannot be made until five years after the last adaptation to the first residence except for extenuating circumstances, such as total loss of residence. The FSL waiver does not cover routine repairs to the existing EAA or general repairs to the home or residence. The waiver program cannot be used to fund corrections to an existing code violation(s) to the home.

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

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

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

The report must demonstrate that the environmental accessibility adaptations recommended are a “prudent purchase.” Prudent purchase is a combination of quality and cost, where quality is measured by the ability to meet the consumer’s accessibility need and cost is measured by the most reasonable and economical approach necessary to meet that need. Each environmental accessibility adaptation must be the most reasonable alternative, based on the results of the review of all options, including a change in the use of rooms within the home or alternative housing.

Environmental accessibility adaptations must be cost-beneficial. Once the most reasonable alternative has been identified and specifications been developed, three competitive bids must be obtained for all EAA to a home costing \$3,500 and over, to determine the most economical option. If three bids cannot be obtained, documentation of the efforts made to secure three bids and an explanation of why less were obtained must be provided. For EAA to a home costing between \$1,000 and \$3,499 at least two competitive bids must be obtained. If two bids cannot be obtained documentation of why efforts made to secure the two bids and an explanation why less were obtained must be provided. For EAA to a home costing under \$1,000 only one bid is required, as long as it can be demonstrated that the bid is consistent with local market valuation.

Environmental accessibility adaptations do not include those adaptations or improvements to the home that are: of general utility, are considered to be standard housing obligations of the owner or tenant, are considered to be experimental or are not of direct medical or remedial benefit to the consumer on the waiver. Routine maintenance of the adaptations and general repair and maintenance to the home is the responsibility of the owner or landlord and is not a covered waiver service.

Examples of items not covered include replacement of carpeting and other floor coverings, roof repair, driveways, decks, patios, fences, swimming pools, spas/hot tubs, sheds, sidewalks, central heating and air conditioning, raised garage doors, storage (i.e., cabinet, shelving, closets),

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standard home fixtures (i.e., sinks, commodes, tub, stove, refrigerator, microwave, dishwasher, clothes washer and dryer, wall, window and door coverings, etc.), furnishings (i.e., furniture, appliances, bedding) and other non-custom items which may routinely be found in a home. Also, specifically excluded are any adaptations that will add square footage to the home.

Exceptions may be made to the \$2,000 service limit based on medical necessity and through the prior authorization process. However, the combined total of all FSL services **may not** exceed the total annual dollar cap.

V. In-Home Support Services

A. In-Home Support Services Described. In-home supports are services that provide a consumer in a supported living situation with up to 24-hours-a-day assistance from a support worker or support workers. The support worker may live in the consumer's home or apartment and share living expenses (rent, utilities, phone, etc.) with the consumer. In home supports may be provided in the consumer's family home for the sole purpose of providing assistance with daily living activities and personal care to the consumer. No other members of the household may benefit from this support and it is not intended to replace natural supports already in place in the home. The support worker provides companionship and may assist with or perform activities of daily living and other duties for consumers requiring a continual level of oversight or assistance in order to maintain the consumer in supported living. In-home support services must be specifically identified in a plan of care that reflects a consumer's need for training, re-training or assistance with functional and adaptive skills and is designed to enable the consumer to attain or maintain their maximum functional level.

Specific skills may include eating, bathing, dressing, personal hygiene, housekeeping chores (such as bed making, dusting and vacuuming) and other household activities such as budget management and interpersonal skills building. In-home support services shall be coordinated with any day training programs or supported employment programs identified in the plan of care. Payment will not be made for in-home support services furnished by a member of the consumer's family.

The in-home support services are separate and not a replacement for the services performed by a supported living coach. Some consumers in supported living may need only the services of an in-home support worker or only the services of a supported living coach. Other consumers may need both services. When both services are used, the providers must coordinate their activities to avoid duplication.

In-home support services are provided in the consumer's own home or family home. The in-home support services worker may also accompany the consumer to activities in the community.

B. In-Home Support Limitations. The In-Home Support Services maximum annual dollar amount is \$5,000. In-home support services may be billed up to 365 days a year when the consumer is present. To the extent that a consumer requires more than \$5,000 of in-home supports, additional in-home supports may be approved through exception by the APD.

1. In-Home Support Special Considerations. The in-home support provider or the provider's immediate family shall not be the consumer's landlord or have any interest in the ownership of the housing unit, as stated in Rule 65B-11.005(2)(c), F.A.C. If renting, the name of the consumer receiving in-home support services must appear on the lease either singularly, with a roommate or a guarantor.

In-home supports provided by a provider or an employee of a provider who is living in a consumer's home must be billed at the live-in published stepped rate for the service. The live-in rate shall be determined based on from one to three consumers in the home receiving the service. The live-in rate includes a relief factor for primary staff performing the support. Additional in-home supports above the live-in rate may be approved by the Area with concurrence from the APD Central Office based on the support needs of the consumer. Additional supports above the live-in rate shall be billed by the quarter hour.

When the in-home support worker lives in the consumer's home and the home is considered the support worker's primary residence, the support worker or provider will pay an equal share of the room and board for the home. The equal share determination shall be made prior to any in home subsidy calculation for the consumer(s). The primary live-in support worker may be named on the lease along with all other residents and must pay rent. In-home support staff providing relief for the primary live-in support worker are not required to participate in room and board or be a named party on the lease.

The consumer has the option to negotiate with the support worker for a share of the household expenses during the time that the support worker shares the living arrangement when it is not the primary residence.

In-home support services that are provided on an hourly basis instead of live-in shall be billed by the quarter hour in accordance with the published stepped rate for in-home supports awake staff for up to eight hours a day. If in-home hourly supports are required in excess of eight hours a day, or 32 quarter hour units, the service must be billed at the in-home, live-in daily rate. When periodic additional staff assistance is required for in-home, live-in services, an in-home hourly support service may be billed for up to eight hours a day in addition to the live-in support if approved by the area with concurrence from the APD Central Office. The rate for the

service will be determined based on one to three consumers in the home receiving the service. The rate ratio is determined by what is the usual and customary service delivery pattern and does not fluctuate with incidental absences of one or more consumers included in the rate ratio.

The in-home support services worker is prohibited from paying rent or the cost of other living expenses directly to the consumer since such financial transactions could jeopardize the consumer's eligibility status as a Medicaid consumer. The support worker should instead, pay their portion of the rent directly to the landlord and their portion of other living expenses (utilities, phone, etc.) directly to the service companies.

When a consumer receives supported living coaching and in-home support services, the providers must work together and with the Area to avoid duplication of services.

In-home support providers are not reimbursed separately for transportation and travel costs. These costs are integral components of in-home support services and are included in the basic rate.

Exceptions may be made to the \$5,000 service limit based on medical necessity and through the prior authorization process. However, the combined total of all FSL services **shall not** exceed the total annual dollar cap.

VI. Personal Emergency Response System (PERS)

A. PERS Services described. A Personal Emergency Response System is an electronic communication system that enables a consumer to secure help in the event of an emergency. The consumer may also wear a portable "help" button that allows for mobility while at home or in the community. The system is connected to the person's phone and programmed to signal a response center. When the "help" button is activated; qualified personnel are dispatched to the person's location.

A Personal Emergency Response System shall be provided in the consumer's own home or apartment or the family's home or apartment. A mobile "help button" is also available for the consumer to wear while engaged in a community activity.

B. PERS Limitations. The Personal Emergency Response Systems services maximum annual dollar amount is \$300. To the extent that a

consumer requires more than \$300 for a personal emergency response system, additional dollars may be approved through exception by the APD.

A Personal Emergency Response System is limited to those consumers who live alone, or who are alone for significant parts of the day, and have no regular caregiver for extended periods of time, and otherwise requires extensive routine supervision. Consumers living in licensed residential facilities are not eligible to receive this service. A cell phone does not meet the definition of a Personal Emergency Response System. This service does not include the cost for the telephone or telephone line.

1. **PERS Special Considerations.** A Personal Emergency Response system is available only for at risk consumers who require a limited degree of supervision, but live alone or are alone for periods of time without a caregiver.

VII. Respite Care

A. Respite Care Described. Respite care is a service that provides supportive care and supervision to a consumer when the primary caregiver is unable to perform these duties due to a planned brief absence, an emergency absence or when the caregiver is available but temporarily physically unable to care for or supervise the consumer for a brief period.

This service may be provided in the consumer's own home or family home. The consumer may also go to a licensed group home, foster home, or assisted living facility to receive the service. Overnight respite care can be provided only in the consumer's own home, family home, or licensed facility.

B. Respite Care Limitations. The Respite Care services maximum annual dollar amount is \$1,000. To the extent that a consumer requires more than \$1,000 of respite care services, additional respite care services may be approved through exception by the APD.

Respite care service providers are not reimbursed separately for transportation and travel cost. These costs are integral components of respite care services, and are included in the basic fee. If the provider plans to transport the consumer in his or her private vehicle, at the time of enrollment the provider must be able to show proof of: 1) a valid driver's license; 2) car registration; and 3) insurance. Subsequent to enrollment, the provider is responsible for keeping this documentation up to date and

is responsible for notifying the Area Office of all traffic violations, with the exception of parking tickets, immediately.

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

C. Respite Care Special Considerations.

Relatives living outside the consumer's home and enrolled as a Medicaid waiver provider may provide respite care services and be reimbursed for the services. The relative must meet the same qualifications as other providers of the same service. With regard to relatives providing this service, safeguards must be taken to ensure that the payment is made to the relative as a provider, only in return for specific services rendered, and there is adequate justification as to why the relative is the provider of care. An example of a valid reason may be a general lack of enrolled providers due to the rural setting.

Most consumers who require respite care services do not need the services of a registered or licensed practical nurse. Nurses should only be employed to perform this service when the consumer has a complex medical condition and medical necessity is shown for this level of care. If a nurse provides this service, a prescription will be necessary and medical necessity must be demonstrated.

Exceptions may be made to the \$1,000 service limit based on medical necessity and through the prior authorization process. However, the combined total of all FSL services **shall not** exceed the total annual dollar cap.

VIII. Support Coordination

A. Support Coordination Services Described. Support coordination is the service of advocating, identifying, developing, coordinating and accessing supports and services on behalf of a Consumer or assisting the consumer or family to access supports and services on their own. These services may be provided through waiver and other Medicaid State Plan services, as well as needed medical, social, educational, other appropriate services, and community resources regardless of the funding source through which access is gained. The support coordinator is responsible for assessing a consumer's needs, preferences and future goals (outcomes). From that information, the support coordinator assists the consumer in developing a support plan and cost plan.

Once a consumer's support plan is developed and the cost plan is approved by the Area, the support coordinator assists the consumer to

meet his or her support plan outcomes and personal goals by linking the consumer with natural and generic supports and services available through family, friends, and community resources. When natural or generic supports are unavailable, or are in the process of development, the support coordinator assists the consumer in locating services available through local, state or federal sources, including Medicaid, the Family and Supported Living waiver and the APD as authorized.

Support coordinators promote the health, safety, and well-being of the consumer; assist the consumer to identify and access formal and informal support systems; assist the consumer to increase or maintain the capacity to direct formal and informal resources; promote advocacy or informed choice for the consumer; provide information regarding the Medicaid fair hearing process; increase the consumer's involvement in the community; assist the consumer to achieve personal goals.

Support coordinators promote the dignity and respect for each consumer with regard to the consumer's personal privacy, sharing personal information and making decisions.

B. Support Coordination Limitations.

Support coordinators must accept all consumers who select the provider for **full support coordination** services and not reject any consumer referred to them or who selects them from within the geographic boundaries previously approved by the area. The APD may grant exceptions to this requirement in writing. Support coordinators may elect to participate in **limited support coordination**.

Limited support coordination is available to all consumers enrolled in the family and supported living waiver. However the following situations apply.

Support coordinators may elect to participate in limited support coordination. Support coordinators wishing to participate should notify the area office. Perspective participant names will be placed on a list and provided to consumers upon request.

Support coordinators may serve two consumers in limited support coordination for every one person in full support coordination not to exceed a total of 36 total cases.

Support coordinator with a caseload of consumers in **full support coordination** shall maintain a caseload of no more than 36 consumers, or as specified by the Florida Legislature, even when that total includes consumers who are not participants in the waiver or are not consumers of

the Agency for Persons with Disabilities. Support coordination services are rendered in a ratio that does not exceed one certified full-time equivalent (FTE) waiver support coordinator position to every 36 persons. "Full Time Equivalent" (FTE) means a person who is providing support coordination services for 30-36 consumers.

Support coordinators may serve two consumers in **limited support coordination** for every one person in full support coordination not to exceed a total of 36 total cases. The Agency for Persons with Disabilities may grant exceptions to situations in which caseload size must go over 36 total cases for a 60 day pend.

Supervisors of waiver support coordinators within group providers shall limit their caseloads to less than 36 persons and must ensure that adequate supervision is also provided for support coordination employees.

When a provider is planning to expand services, providers may temporarily exceed the above ratios for a period not to exceed 60 consecutive days.

The support coordination supervisor must notify the Area in writing of any vacancies or leave of absences granted with a list of consumers affected by this vacancy within 5 days of each occurrence. Vacancies due to termination or resignation of a support coordinator resulting in caseloads temporarily exceeding the maximum of 36 may be for a period of no more than 60 consecutive days per vacancy. Failure of the provider to notify the Area of the vacancy within the required timeframe could result in recoupment of funds received by the provider.

Vacancies, due to a support coordinator submitting a written request to the Area for leave based on the Family and Medical Leave Act, resulting in caseloads temporarily exceeding the maximum of 36, may be for a period of no more than 60 working days, per vacancy.

If the support coordination provider cannot fill a reported vacant position within the time allotted, the area must be notified prior to the 60th consecutive or 60th working day, whichever is applicable to the situation. Upon receipt of this notification the Area will provide 14 calendar days notice to the affected consumers and agency of the need to select a different waiver support coordination provider. This notification will enable the Area to inform the affected consumers of the impending change in their support coordination provider. This notification will allow sufficient time for the consumer to choose an available provider from within or outside the current agency and the provider to complete needed paperwork and take any other necessary actions. It will also allow the consumer time to adjust to the anticipated changes. Vacancies resulting in

caseloads exceeding the maximum of 36 for more than the above stated number of days, may subject the provider to recoupment of funds and the consumers served to transition to another enrolled support coordination provider, chosen by the consumer. All caseload transfers will be accomplished by the Area working with the provider to identify those consumers affected by the vacancy and who will cause the temporary support coordinator to exceed the maximum caseload of 36.

Expansion of services includes increasing the number of consumers served by a solo practitioner or an agency, as well as a solo practitioner changing or expanding their status from solo practitioner to an agency. A provider must have attained a score of at least 85% on the minimum service requirements on the last quality assurance monitoring conducted by the AHCA or their authorized representative, and be approved by the area in order to expand services.

The provider and all its employees who supervise staff, train staff, or conduct support coordination activities shall remain free from influences that interfere with the consumer's choice of supports and services. This includes but is not limited to the following:

- The provider and its employees do not currently and shall not while certified to render support coordination services provide direct services within the State of Florida other than support coordination or related administrative activities to consumers who receive services from the APD;
- The provider, its board members and its employees shall be legally and financially independent from and free-standing of persons or organizations providing direct services within the State of Florida other than support coordination and related administrative activities to consumers who receive services from the APD;
- The provider and its employees shall not be a subsidiary of or function under the direct or indirect control of persons or organizations providing direct services within the State of Florida other than support coordination and related administrative activities to consumers who receive services from the APD;
- The provider shall not, nor shall employees of the provider be the guardian, apply to be the guardian, or be affiliated with an organization or person who is the guardian of a consumer served by the provider;
- The provider shall not nor shall employees of the provider render support coordination services to a consumer who is a family member of the provider or any employee of the provider unless the consumer

receives services in a area where the family member is not certified to provide support coordination;

- The provider shall not nor shall employees of the provider secure paid services on behalf of a consumer from a service vendor who is a family member of the provider or any employee of the provider. Exceptions to this prohibition may be made in writing by the APD;
- The provider and its employees shall not assume control of the consumer's finances or assume possession of a consumer's checkbook or cash, nor shall they become representative payee for consumer benefits.

C. Support Coordination Special Considerations.

Support coordination services may be rendered in any community location conducive to the contact or activity being provided, including the support coordinator's office, the consumer's residence, a library, a park, or any other community location. In order to get to know each consumer well, support coordinators are encouraged to interact with and observe each consumer in a variety of settings, during different times of the day and on different days of the week.

Support coordination may be provided while a consumer is a temporary patient in a hospital or nursing facility. The waiver support coordinator may not duplicate the services of the hospital or nursing facility case manager or discharge planner and may not bill until after the consumer is discharged.

Support coordinators must participate in monitoring reviews conducted by the APD, AHCA, or an authorized representative of the state. Support Coordinators are expected to meet the needs of the consumers receiving services regardless of the number of contacts it takes to meet those needs. Support coordinators should not assume that meeting the basic billing requirements would necessarily result in a successful monitoring review and approval to continue services.

The support coordinator will be responsible for the cost to access any APD or AHCA required management, billing information, or data collection systems.

D. Support Coordination Support and Service Planning Requirements.

The support coordinator must be available to meet the consumer's needs and to perform the responsibilities for support coordination. The support coordinator shall have an on-call system in place that allows consumers to

access Support Coordination services 24-hours per day, 7 days per week. The area office must approve this on-call system.

Any time a back-up support coordinator is used during the provider's absence, the back-up support coordinator shall be a certified and enrolled support coordinator. The name and contact information for the back-up support coordinator shall be clearly communicated to the consumer and to the area office. Access to the provider or back up provider shall be available, without toll charges to the consumer.

It is the responsibility of the support coordinator to, at least annually and more frequently if indicated, ensure that ADT consumers are given information about and appropriate referrals to other employment services and employment opportunities available in their community, so that the consumer can make a meaningful choice about the type of day activity or employment which is appropriate for him or her.

The support coordinator will complete activities that assist the consumer in determining the consumer's own future. At least once annually the provider will assist the consumer, primary caregiver, or legal guardian to:

- Complete or update tools including the Personal Outcome Measures and the Individual Cost Guidelines (ICG) necessary to assist in identifying personal goals, needs and services prior to the development of the support plan and make decisions and informed choices;
- Complete the support plan and cost plan including required signatures;
- Complete the Waiver Eligibility Work Sheet.

In accordance with Chapter 393.0651(7), F.S., the provider shall complete an annual report of progress.

The support coordinator will submit for approval no later than twenty (20) calendar days prior to the support plan effective date a new annual support plan with supporting documentation and complete in ABC a new cost plan. Copies of the support plan and cost plan will be provided to the consumer or his or her guardian at any time they are requested but at a minimum within ten (10) calendar days of the effective date of the support and cost plan. As part of the annual support planning process, the support coordinator will update the needs assessment as necessary and complete a new needs assessment every three years.

A copy of support plan information pertinent to the provider and an approved service authorization will also be provided to other providers of

services to authorize and initiate service delivery within ten (10) calendar days of the effective date of the support plan. Through conversations with the consumer, those who know the consumer well, and through review of the service vendor's documentation, the support coordinator monitors the consumer's involvement in purchased services to determine if the activities meet the consumer's expectations as identified through use of the Personal Outcome Measures. Along with other planning sources, the support coordinator will determine that these services are age and culturally appropriate, address the need for which they are intended, provide appropriate challenges, motivation and experiences to meet the consumer's identified goals.

All consumers on the FSL Waiver must have a Cost Plan prepared and updated annually. Each consumer's annual Cost Plan budget shall not exceed the total annual dollar cap in FSL Waiver services. The cost of full support coordination must be included in the cost plan budget.

Consumers living in their family home may choose full support coordination or limited support coordination. Consumers living in their own home without a supported living coach must receive full support coordination. If supported living coaching is provided, consumers receive limited support coordination. However, full support coordination must be included in the cost plan budget in the event full services are needed during the year.

The Cost Plan may also reflect Supported Living Stipends and Supported Living startup funds from General Revenue. The Agency for Persons with Disabilities or its contracted Prior Service Authorization agent will review all initial Cost Plans and make determinations regarding exceeding individual service dollar caps based on medical necessity. The FSL Waiver Cost Plan Worksheet must be completed (Attachment E). Subsequent revisions to Cost Plans that exceed individual service dollar caps, based on medical necessity, must be reviewed and approved by the area or the contracted entity designated by the APD for prior service authorization reviews.

Support coordinators must help consumers and their families prioritize services within the total annual dollar cap.

In the event that a cost plan is submitted that exceeds the total annual dollar cap, the cost plan must be denied, as being out of compliance with the FSL Waiver requirements and a due process letter will be sent to the consumer.

Throughout the year a consumer's service and support needs may change necessitating an update in their cost plan. While it is not necessary to

update the support plan, a comprehensive description of these changes and sufficient information concerning the change in service needs should be thoroughly documented in the support coordinator's progress notes. Updates to the cost plan shall be initiated when the support coordinator becomes aware of the need for change. The updated cost plan is submitted to the Area, for review and approval within 5 working days of the date the support coordinator becomes aware of the need for change. The Area or an authorized agent of the agency may request copies of the support coordinator's progress notes, which support and describe the need for an updated cost plan. The Area will respond within 10 days of their receipt of the updated cost plan, with a statement of approval or denial. Within 5 working days of receiving the Area's response, the support coordinator will notify the service provider of the updated changes to the consumer's cost plan.

The information relating to the change in condition, need, or revised supports should be incorporated into the support plan at the time of the annual update. The Service Authorizations must be revised by the support coordinator to reflect the needs of the person and the services to be provided. The provider shall assist the consumer in using family, neighborhood, and community supports and services funded by private, city, and county sources prior to seeking services funded by federal and state sources. The support coordinator shall assist the consumer in using Medicaid State Plan services prior to seeking services funded by the Family and Supported Living Waiver. When services must be purchased by a source other than the Family and Supported Living Waiver, the support coordinator shall work cooperatively with the Area in locating service vendors who meet the needs of the consumer in the most cost-beneficial manner possible.

When services must be purchased by the Family and Supported Living Waiver, the support coordinator shall locate potential service vendors who are qualified to meet the needs of the consumer in the most cost beneficial manner possible. The support coordinator assures that purchased supports and services do not exceed the annual limits of the current approved cost plan(s) for consumers served.

The support coordinator assures that purchased supports and services do not exceed the annual limits of the current approved cost plan(s) for each consumer. Further, no combined total of the maximum annual service dollar amounts may exceed the total annual dollar cap.

If paid services are used, the provider shall review with service vendors the goals to be achieved for the consumer and note these discussions in the consumer's progress notes. The agreed upon goal(s) shall be reflected in the support plan for that consumer. The support coordinator

prints the Maintain Services for Cost Plan Screen (ACLMSP) from the ABC System and sends it to the provider. The goals are also reflected in the implementation plan developed by the provider.

The support coordinator shall maintain each consumer's Central Record in accordance with APD procedures. The Central Record remains the property of the APD. The APD retains the right to review, retrieve, or take possession of a consumer's Central Record at any time.

The support coordinator shall assist the consumer in maintaining their Medicaid eligibility. The support coordinator shall also notify other service providers and the APD when it is determined that a consumer receiving services is ineligible for Medicaid. The support coordinator will work with providers and the APD to plan for alternative funding sources.

The support coordinator is responsible for entering, updating, and assuring the accuracy of information pertinent to the consumer in the ABC system, including demographic information.

The support coordinator shall comply with all written procedures established by the APD regarding the transition of consumers from one support coordinator to another.

If, while serving a consumer, the consumer chooses another support coordination provider, the current provider shall render quality services for the consumer until the end of the month, when the transfer to the new support coordination provider takes place, unless otherwise instructed by the APD. Additionally, the current provider shall assist the consumer in making a smooth transition to the new support coordination provider. When a new support coordination provider is selected by the consumer, or the support coordination services agency is downsized, or the support coordination services are terminated (either voluntarily or involuntarily) the support coordinator shall assure that all appropriate Central Record information is transferred to the new provider or to the Area, as directed, within two (2) weeks of the effective date of the action.

Special Considerations for Limited Support Coordination

Consumers who have a supported living coach will be eligible for limited support coordination only. However, the full support coordination rate must be included in the consumer's budget for their cost plan, even if they have a supported living coach and receive limited support coordination services.

When a consumer receiving supported living coaching and support coordination services, the providers must work together and with the area office to avoid duplication of services.

Consumers receiving limited support coordination services will need to review the status of this service after six (6) months. If there is no need to move to full support coordination the dollars remaining in the last six (6) months can be used for other services that are medically necessary. The support coordinator will prepare a cost plan update to request this change.

The requirement for the consumer to be on the HCBS Waiver for one year prior to enrolling in limited support coordination is waived for people receiving limited support coordination and supported living coaching in the Family and Supported Living Waiver.

Consumers living in their own home without supported living coaching services may not receive limited support coordination during the first year of participation on the waiver.

Consumers on the Family and Supported Living Waiver who receive limited support coordination services must return to full support coordination for the remainder of the cost plan year if they exceed the 9 hour limit set forth in the limited support coordination model.

Consumers must agree to remain in full support coordination for the remainder of the support plan year, if a change back to full support coordination is needed.

If the consumer must return to full support coordination, supported living coaching will continue for the remainder of the support plan year.

The support coordinator is not responsible for provider development and recruitment in the limited support coordination model. However, the support coordinator will initially arrange providers, and authorize the use of Medicaid enrolled providers.

The support coordinator is not responsible for any of the following in the limited support coordination model:

- a) oversight of delivery or supports and services,
- b) review and follow-up of the Medicaid Monthly Summary, or
- c) monitoring of progress and follow-up of Personal Outcome Measures

Documentation Requirements for Limited Support Coordination

The support coordinator must conduct two (2) face-to-face visits per year (including at least one home visit) and two (2) other billable activities as outlined in the Family and Supported Living Waiver Handbook or Services Directory. The face-to-face contact conducted in the support plan development period may count as one face-to-face contact. The second face-to-face contact shall occur toward the middle of the support plan year.

The initial support plan package (Individual Cost Guidelines (ICG), Support Plan, Cost Plan and Personal Outcome Measures (POMs) will be billed during the three months surrounding the development of the support planning documents at the full rate of \$148.39 per month. During these three months all services will remain the same as those in full support coordination.

Limited support coordination will then be billed at \$45 per month for the remainder of that cost plan year, i.e. for a total of nine (9) months. Activities will continue to be recorded and tracked in progress notes up to the 9-hour maximum, which may be accumulated over the remaining nine months. Activities should be tracked using quarter hour increments.

IX. Supported Employment Service

A. Supported Employment Described. Supported employment services provide training and assistance in a variety of activities to support consumers in sustaining paid employment at or above minimum wage unless the consumer is operating a small business. The supported employment provider assists with the acquisition, retention or improvement of skills related to accessing and maintaining such employment or developing and operating a small business. With the assistance of the supported employment provider, the consumer is assisted in securing employment according to their desired outcomes including the type of work environment, activities, hours of work, level of pay and supports needed. Supported employment is conducted in a variety of settings including work sites in which individuals without disabilities are employed.

Supported employment includes activities needed to sustain paid work at or above minimum wage for consumers receiving waiver services, including supervision and training. This training can focus on both the consumer's needs as well as providing consultation to the employer to enhance supports natural to the workplace rather than imposing paid supports. Supported employment providers will immediately notify the consumer's waiver support coordinator of any changes affecting the consumer's income. The service provider shall work with both the consumer and the respective support coordinator to maintain eligibility under the FSL/HCBS waiver, as well as health and income benefits through the Social Security Administration and other resources.

Models of supported employment services shall include:

1. Individual Model – One person at a time approach to obtaining competitive employment through the support of a job coach, employment specialist, or consultant for job development, intensive training (Phase I) and systematic follow-along supports (Phase 2). The individual model can apply to either employment in the general work force or in development and operation of establishing a business to be operated by the consumer.

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

- (a) A situational assessment to determine a person's employment goals, preferences and skills;
- (b) Job development for a specific consumer matching the person with a job that fits personal expectations;

(c) Intensive, systematic on-the-job training and consultation focused on building skills needed to meet employer productivity requirements, learning behaviors and acceptance in the social environment of the job setting and building job related supports with the employer from those naturally occurring at that work site and other job related supports.

Staff is expected to provide varying intensities of services to each supported employee beginning with high intensity and fading to achieve stabilization. Given the nature of this wide variation in level of support intensity and duration needed per person, usual and typical staff to service consumer ratios demonstrate that one staff person can support up to two to three supported employees who are in Phase I at any given point in time. Phase I services typically average 6-8 hours a day per consumer during the first week of services. Average hours of service should fade to 1-2 hours a week in preparation for transition to Phase 2.

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

- (a) Ongoing, systematic contacts with supported employees to determine the need, intensity and frequency of supports needed to maintain productivity, social inclusion and maintain employment;
- (b) Remedial on-the-job training to meet productivity expectations, consultation and refinement of natural supports or other elements important to maintaining employment;
- (c) Related work supports such as accessing transportation and other supports necessary for the consumer to maintain a job or consultation to family members or other members of a consumer's support network including employers and co-workers.

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

During Phase 2 the service levels needed per supported employee vary according to individual needs but typically average 1-2 hours a week per consumer. Usual and typical demonstration of Phase 2 services suggest an expectation of a staff to service consumer ratio of one staff person supporting up to twenty supported employees.

2. Group Models – Including:

- a. Enclave - A group approach to employment where up to eight consumers with disabilities work either as a group or dispersed individually throughout an integrated work setting with supervision by the provider.

(Mobile Crew - A group approach to employment where a crew, such as lawn maintenance or janitorial services, of up to eight consumers with disabilities are in the community, in businesses or other community settings with supervision by the provider.)

- b. Entrepreneurial - A group approach to employment where up to eight consumers with disabilities work in a small business created specifically by or for the consumers.

Providers of supported employment services shall comply with requirements found in the FSL Waiver Services Agreement, attached Core Assurances, and those specified in this Services Directory.

Supported employment services are provided in the consumer's place of employment, in the community, or in a setting mutually agreed to by the supported employee, the employment coach or consultant and the employer.

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

B. Supported Employment Limitations. The Supported Employment maximum annual dollar amount is \$2,500. Supported employment services are limited to the amount, duration and scope of the services described in the consumer's support plan and current approved cost plan. The provider shall render services at a time mutually agreed to by the consumer and the provider. Off-hours support may occur as an alternative or supplement to the on-the-job contacts.

Decisions to change the duration or intensity of the service to less than twice monthly contacts in the individual model of service delivery or to terminate supported employment services shall only be made through consensus between the consumer and his guardian, the Vocational

Rehabilitation counselor, if applicable, the Area or waiver support coordinator, and the provider. If for any reason a consumer has terminated services and requests reinstatement due to the need for ongoing supports he will be given priority for restoration of services. To the extent that a consumer requires more than \$2,500 of supported employment services, additional supported employment services may be approved through exception by the APD.

Consumers working an average of less than 20 hours per week must have at least a quarterly review. Documented attempts to increase work hours or secure an appropriate job must be summarized quarterly in the monthly summary notes. Consumers should not remain in job development status for more than a two month period. For consumers who remain in job development status for more than two months the supported employment coach will justify monthly the reason(s) why employment has not been obtained, and the strategies planned for securing employment.

Phase I supported employment services are limited to eight hours or 32-quarter hour units per consumer per day. Phase 2 supported employment services are limited to eight hours, or 32-quarter hour units per consumer per week. Group model services are limited to eight hours or 32-quarter hour units per consumer per day.

Transportation of consumers to and from a job is not a component of supported employment services, but may be funded under transportation services when no other community, natural, or generic support is available.

Separate payment for transportation services furnished by the supported employment provider will not be made when rendered as a component of this service. The transportation section in this Services Directory provides additional information. Rates for FSL services are the same as the standard rates for the DS/HCBS Waiver.

Supported Employment Special Considerations. Supported employment services furnished under the waiver are not available through programs funded by the Rehabilitation Act of 1973 or Public Law 94-142. Documentation to this effect will be maintained in the file of each consumer receiving this service.

When the supervisor of a mobile crew or enclave does not meet the qualifications for a supported employment coach, although the consumer meets the criteria for supported employment, the support service must be billed as adult day training off-site rather than supported employment.

Supported employment services are defined as competitive employment, which may be performed on a full-time or part-time basis in an integrated setting for which an individual is compensated at or above minimum wage but not less than the customary wage, and at a level of benefits paid by the employer for the same or similar work that is performed by trained, non-disabled individuals.

Providers of supported employment – group model services will bill for each consumer based on the published stepped rate for the service. The group rate shall be determined based on from two to eight consumers receiving the service.

Providers of supported employment – individual model services will bill based on a one to one ratio the rate established for the service in the published rate system.

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

Exceptions may be made to the \$2,500 service limit based on medical necessity and through the prior authorization process. However, the combined total of all FSL services **shall not** exceed the total annual dollar cap.

X. Supported Living Coaching

A. **Supported Living Coaching Described.** Supported living coaching services provide training and assistance in a variety of activities to support consumers who live in their own homes or apartments. These services may include assistance with locating appropriate housing; the acquisition, retention or improvement of skills related to activities of daily living such as personal hygiene and grooming; household chores; meal preparation; shopping; personal finances; and the social and adaptive skills necessary to enable consumers to reside on their own.

Supported living services mean the provision of supports necessary for an adult who has a developmental disability to establish, live in, and maintain a household of his choosing in the community. This includes supported living coaching and other supports.

Functional Community Assessment: The basis for identifying the types of training, assistance, and the intensity of support rendered by the provider. It is a tool designed to assist the provider in becoming familiar with the consumer and his capabilities and needs. This assessment addresses all

areas of daily life including relationships, medical and health concerns, personal care, household and money management, community mobility, recreation and leisure. The supported living provider is responsible for helping the consumer complete a functional community assessment prior to his move to a supported living arrangement. This assessment shall be updated annually.

The Housing Survey: The basis for surveying a prospective home to ensure that it is safe and fully accessible. The supported living coach must forward a copy of the completed survey of the housing that was selected by the consumer, to the consumer's Area within ten working days of the selection. This survey must be updated quarterly and made available for review at the time of the quarterly home visit. These updates shall include a review of the consumer's overall health, safety and well-being status.

Financial Profile: An analysis of the household costs and revenue sources associated with maintaining a balanced monthly budget for the consumer. The analysis will substantiate the need for a monthly subsidy or initial start-up costs and should be a source of information for determining strategies for assisting the person in money management. The supported living coaching provider is to assist the consumer in completing the financial profile and submitting it to the Area no more than ten days following the selection of housing by the consumer. If the financial profile indicates a need for a one time or recurring subsidy, the profile must be submitted to the waiver support coordinator and approved by the Area before the consumer signs a lease.

Supported living coaching services are provided in the consumer's place of residence or in the community.

Providers of supported living services shall comply with requirements found in the FSL Medicaid Waiver Services Agreement, attached Core Assurances, and those specified in this Services Directory.

B. Supported Living Coaching Limitations. Each supported living coach shall maintain a caseload of no more than ten consumers who are receiving supported living coaching services.

The Supported Living Services maximum annual dollar amount is \$3,500. Supported living coaching services are limited to the amount, duration and scope of the services described on the consumer's support plan and current approved cost plan not to exceed 40 quarter-hour units per day. To the extent that a consumer requires more than \$3,500 of supported living coaching services, additional supported living coaching services may be approved through exception by the APD.

The provider shall render supported living coaching services at the time and place mutually agreed to by the consumer and provider. The provider shall have an on-call system in place that allows consumers access to services for emergency assistance 24 hours-per-day, 7 days-per-week. If an individual vendor, the provider must specify a backup person to provide supports in the event the provider is unavailable. The specified backup provider must be a certified, enrolled Medicaid provider and certified as a supported living coaching provider, pursuant to section 65B-11, F.A.C. Telephone access to the provider or the backup provider shall be available without toll charges to the consumer.

Supported living coaching services are limited to adults (age 18 or over) who rent or own their own homes or apartments in the community. The supported living coaching provider or the provider's immediate family shall not be the consumer's landlord or have any interest in the ownership of the housing unit as stated in section 65B-11.005(2)(c), F.A.C. If renting, the name of the consumer receiving supported living coaching services must appear on the lease either singularly, with a roommate, or a guarantor.

Supported living coaching encourages maximum physical integration into the community. The homes of consumers receiving supported living services shall account for no more than ten percent of the housing in the smallest identifiable geographical area in which the homes are located, which may be a city block, subdivision, neighborhood, apartment complex or mobile home park. The consumer's home shall be scattered, noncontiguous, and dispersed throughout that area. Waiver requests, regarding the density requirements can be submitted in writing to the APD.

Consumers receiving supported living coaching services shall live where and with whom they choose. Consumer's receiving supported living coaching services shall live with no more than two other people who have developmental disabilities and shall have control over the household and its daily routines.

Supported living coaching services are provided on a one-on-one basis. The provider will bill for supported living coaching services in accordance with the published rate structure for individual supports for the consumer. If services are provided with two or more individuals present, the amount of time billed must be prorated based on the number of consumers receiving the service.

C. Supported Living Coaching Special Considerations. All consumers on the FSL Waiver must have a Cost Plan prepared and updated annually. Each consumer's annual Cost Plan budget may not

exceed the total annual dollar cap in FSL Waiver services. The cost of full support coordination must be included in the cost plan budget. All consumers receive full support coordination unless the consumer receives supported living coaching services. Full support coordination must be included in the cost plan budget in case full services are needed during the year.

The Cost Plan may also reflect Supported Living In Home Subsidies and Supported Living startup funds from General Revenue. These costs, which are funded by General Revenue, will not be included in the total annual dollar cap for the FSL Waiver. Area offices have authority to review all initial Cost Plans and make determinations regarding exceeding individual service dollar caps based on medical necessity. The FSL Waiver Cost Plan Worksheet must be completed to provide documentation (Attachment E). Subsequent revisions to Cost Plans that exceed individual service dollar caps, based on medical necessity, must be reviewed and approved by the APD Central Program Office or contracted entity designated by the APD for prior service authorization reviews.

When a consumer receives additional services, the providers must work together to avoid duplication of activities with coordination by the Area.

Supported living coaching services may not duplicate services available from programs funded by the Rehabilitation Act of 1973 or Public Law 94-142 or their subsequent updates.

Exceptions may be made to the \$3,500 service limit based on medical necessity and through the prior authorization process. However, the combined total of all FSL services **shall not** exceed the total annual dollar cap.

XI. Transportation

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

Transportation services funded through the FSL waiver shall be used only for consumers who have no other means to get to a service identified on the support plan and approved cost plan. Family members, neighbors, or friends who already transport the consumer or who are capable of transporting the consumer at no cost to the APD shall be encouraged to

continue their support of the consumer. Consumers who are capable of using the fixed-route public transit system to access services on their support plan shall be encouraged to use that method of transportation.

This service is not available for transporting a consumer to school through the 12th grade. Transportation to and from school is the responsibility of the public school system. For other transportation needs not identified on the consumer's support plan and approved cost plan the consumer should be directed to the area Medicaid office, local Community Transportation Coordinator or, if available, the local area's fixed-route fixed schedule public transit (bus system).

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

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

Boarding assistance shall be provided as necessary or as requested by the consumer being transported. Such assistance shall include but not be limited to opening the vehicle door, providing stability to consumer, fastening the seat belt, securing a wheelchair, storage of mobility assistance devices, and closing the vehicle door. Consumers shall not be carried.

Drivers and drivers' assistants shall not assist passengers in wheelchairs up or down more than one step, unless it can be performed safely as agreed by the consumer, consumer's guardian, or consumer's representative. Drivers and drivers' assistants shall not provide any assistance that a prudent person would consider unsafe for either the driver, the driver's assistant or the consumer. Drivers, drivers' assistants or escorts provided by the provider to accompany the consumer shall be trained in CPR, disease transmission, and use of the on-board first aid kit.

In vehicles with passenger-side air bags turned on, any adult under 100 pounds must be transported in the back seat. In vehicles that also have side-impact air bags in the back seat, adults less than 100 pounds must be transported as close to the middle of the back as possible. A first aid kit equivalent to Red Cross Family Pak #4001 and an A-B-C fire extinguisher shall be carried on board the vehicle at all times when transporting consumers.

When the vehicle is in motion, all mobility devices (wheelchairs, scooters, etc.) shall be secured with appropriate tie-downs regardless of whether a person is physically positioned in the mobility device or not. Cell phones,

fire extinguishers, first aid kits, and any other such items that could become airborne in the event of a sudden stop or accident shall be secured.

This service is provided anywhere in the community as long as the service is being provided either between a waiver service and the consumer's home, or between different waiver services.

B. Transportation Limitations. The Transportation Services maximum annual dollar amount is \$1,000. Providers of adult day training, in-home support services, support coordination and supported living coaching may not bill separately for transportation that is an integral part of the provision of their primary service. To the extent that a consumer requires more than \$1,000 of transportation services, additional transportation services may be approved through exception by the APD.

In order to bill for transportation provided between a consumer's place of residence and the site of a distinct waiver service or between waiver service sites the provider must enroll as a transportation provider. When the service at each site is provided by a different provider, they must qualify for and enroll as a transportation provider.

Transportation between habilitation sites operated by the same provider or transportation that is an integral part of the service being received by the consumer is included in the rate paid to the providers of the appropriate types of waiver services.

Transportation services are available through the Medicaid State Plan to transport consumers to Medicaid-eligible medical appointments and services. FSL waiver funds shall not be used when the consumer's trip is for a Medicaid State Plan service.

When a transportation provider is paid by the Medicaid State Plan to transport a Medicaid consumer to an eligible Waiver service, the consumer will be charged a co-payment for which the consumer is responsible. FSL waiver funds cannot be used to pay any co-payment for Medicaid funded transportation services.

When the consumer uses a FSL waiver provider for transportation to a service listed on the support plan and current approved cost plan, and the provider is paid with FSL Waiver funds, the provider shall not charge the consumer a co-payment.

Providers may bill for their service by the mile, by the one-way trip, or by the month. Regardless of how services are billed, all providers except limited service providers must during the rate-setting process define the

charges for their services in terms of cost per vehicle mile. Providers must ensure group trips, ride sharing and multi-loading to the greatest extent possible. If more than one consumer is being transported, the mileage charge will be shared among the number of waiver consumers transported. When a provider is reimbursed by the trip, a consumer shall receive no more than four one-way trips per day or 80 one-way trips per month. Only providers that choose to bill for actual expenses incurred may bill by the month. Limited transportation providers, i.e., family members, friends or neighbors, will be reimbursed at the state mileage rate. Rates for FSL services are the same as the standard rates for the DS/HCBS Waiver.

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

Providers shall not be paid separately for transportation services provided as an integral part of performing the following services: adult day training, in-home support services, support coordination, and supported living coaching.

When paid vendors are also family members, controls must be in place to ensure that the payment is made to the relative only in return for specific services rendered, and there is adequate justification as to why the relative is the paid vendor of the service rather than a natural support.

Exceptions may be made to the \$1,000 service limit based on medical necessity and through the prior authorization process. However, the combined total of all FSL services **shall not** exceed the total annual dollar cap.

Section 3: Definitions and Documentation Requirements

I. General Definitions

Agency or Group Provider. A business or organization enrolled to provide a waiver service(s) that has one or more staff employed to carry out the enrolled service(s). An agency or group provider for rate purposes is a provider that hires staff to perform the waiver services. The agency rate is used for all services that are directly provided by employees of the provider. All employees of an agency or group provider must meet the qualifications and requirements specified in the provider's agreement and those specified for enrolled service(s). The provider shall maintain a personnel file documenting qualifications of all employees and their background screening results.

AHCA. The Agency for Health Care Administration.

APD. The Agency for Persons with Disabilities (APD), which includes the Central Office located in Tallahassee and its Area Offices located throughout the state.

Area Administrator. The person in charge for the APD in each area or region of the state.

Area. A service area of the Agency for Persons with Disabilities. Attachment D provides additional information.

Core Assurances. The document that specifies administrative and programmatic requirements for FSL Waiver providers. The Core Assurances and the specific service requirements published in this Services Directory are incorporated into the Medicaid Waiver Services Agreement by reference, and provide the terms and conditions by which the provider of waiver services to consumers with developmental disabilities served by the Agency for Persons with Disabilities agrees to be bound. Attachment B provides additional information on Core Assurances.

Direct Provider Billing. This is a standard billing process for Family and Supported Living Home and Community-Based Services (FSL/HCBS) Medicaid Waiver service providers.

Direct Service Provider. As referenced in Section 393.063(15), F. S., a "direct service provider," also known as "caregiver" in Chapters 393 and 415 F.S., or "caretaker" in provisions relating to employment security checks, means a person 18 years of age or older who has direct contact with individuals with developmental disabilities and is unrelated to the individuals with developmental disabilities.

FMMIS. Florida Medicaid Management Information System (FMMIS).

Health Insurance Portability and Accountability Act of 1996 (HIPAA). The Health Insurance Portability and Accountability Act of 1996 (HIPAA) makes health insurance more “portable” so that workers may take their health insurance with them when they move from one job to another, without losing health coverage. This federal legislation also requires the health care industry to adopt uniform codes and forms streamlining the processing and use of health data and claims that will serve to better protect the privacy of people’s health care information and give them greater access to that information.

Independent Vendor. A service provider who meets specified qualifications or holds local occupational licenses.

Job Development. Means the process of developing employer relations and linking consumers with private and public sector labor needs. This process involves exploring job skills and job preferences with the consumer with a disability, as well as networking with the consumer with a disability, the job developer or job coach, and other people who know the consumer seeking employment, and local employers.

Maintain Services for Cost Plan Screen (ACLMSP). An APD Developmental Disabilities Program approved printout of a screen in the ABC System sent to a waiver provider from the Support Coordinator authorizing the provision of specific services or supports to a consumer. Without this documentation, the provider is not authorized to provide the service and cannot submit a claim nor be reimbursed for the service. For the purposes of direct provider billing, the documentation must contain authorization from the Area. Services provided without authorization may be subject to recoupment of funds from the service provider. Support coordinators must ensure service authorizations are provided in writing using the printout of the Maintain Services for Cost Plan Screen.

The Support Coordinator is responsible for authorizing a service at a rate or frequency that has been approved by the APD. If a Support Coordinator authorizes a service at a rate or frequency higher than has been approved by the APD, then the Support Coordinator may be subject to recoupment of funds. If the provider is paid for a service at a rate or frequency that is higher than that which has been approved by the APD, then the provider may also be subject to recoupment of funds.

This authorization is contingent upon the enrolled consumer remaining eligible for Medicaid during the month of service. Upon a consumer’s loss of Medicaid eligibility the authorization is null and void, unless eligibility is re-established. In this instance the provider must contact the Area Support

Coordinator to ascertain whether or not alternative funding is available for the services.

Meaningful Day Activities. Choices made by consumers of how to use their time in order to provide direction, purpose and quality to the individual consumer's daily life. The consumer's choice of meaningful day activities must be based on his interests, skills and talents. Meaningful day activities may involve choices that are not paid for by the waiver, including paid employment, volunteer work and school. Meaningful day activities that are paid for under the waiver include supported employment and adult day training. A consumer may choose a mix of meaningful day activities that directly address identified goals in the consumer's support plan.

Medicaid State Plan Services. The Medicaid State Plan is the state and federal partnership that provides health coverage for selected categories of people with low incomes. Its purpose is to improve the health of people who might go without medical care for themselves and their children. In Florida, the Agency for Health Care Administration (AHCA) develops and carries out policies related to the Medicaid Program. A brief description of the services offered by the Florida Medicaid Program can be found in the Medicaid Summary of Services booklet available from the AHCA website at: <http://www.fdhc.fl.us/Medicaid/>. Printed copies may be obtained from the Medicaid area offices and from Medicaid Contract Management, 2308 Killlearn Center Blvd., Suite 200, Tallahassee, Florida 32309. Attachment C provides contact information.

Medicaid Waiver Services Agreement. The Agency for Persons with Disabilities (APD) Program Medicaid Waiver Services Agreement means the agreement between the APD and providers of waiver services, which consists of Form CF-DD 3064 (Medicaid Waiver Services Agreement), and the Core Assurances for providers of Medicaid Home and Community-Based Waiver Services Programs. Specific service requirements, as defined in the Family and Supported Living Services Directory that are incorporated into the agreement by reference. All providers must complete this agreement to provide services to consumers enrolled in the Family and Supported Living Home and Community-Based Services Waiver Program and comply with the terms and conditions of the agreement. Attachments A and B provide additional information.

Medical Necessity or Medically Necessary. A set of conditions established by the Agency for Health Care Administration (AHCA), for determining the need for and appropriateness of Medicaid funded services for an enrolled consumer.

As defined in Section 59G-1.010(166)(a), F.A.C., as it relates to medical necessity or medically necessary, the medical or allied care, goods, or services furnished or ordered as defined as meeting the following conditions:

- Be necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain;
- Be individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the patient's needs;
- Be consistent with generally accepted professional medical standards as defined by the Medicaid program, according to Chapter 42 of the Code of Federal Regulations, and not be experimental or investigational;
- 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
- Be furnished in a manner not primarily intended for the "convenience" of the consumer, the consumer's caretaker, or the provider.

Projected Service Outcomes. Goals used to determine, through monitoring and review, the accomplishments of providers and the effectiveness of service provision.

Provider of Limited Transportation Service. Family member, friend, or neighbor who provides occasional transportation service to a specific FSL Waiver consumer.

Provider Service Agreement. Prior to providing any services the provider must, in order to be compensated by the Family and Supported Living Home and Community-Based Waiver Program, execute a Medicaid Provider Agreement with the Agency for Health Care Administration (Agency), and be issued a Medicaid provider number by the Agency. The provider must, at all times, maintain a current and valid Medicaid Provider Agreement with the Agency and a current Medicaid Waiver Services Agreement with the APD. The provider must comply with the terms and conditions of the Medicaid Provider Agreement as fully set forth within this agreement. The provider agrees to comply with all the terms and conditions contained within the Agreement documents and those contained in the Family and Supported Living Waiver Services Directory. Attachment A provides additional information.

Residence. The place in which a consumer resides for an extended or a permanent period of time and is considered the consumer's home.

Solo Provider. A solo or independent provider who personally renders waiver services directly to consumers and does not employ others to render waiver services for which the rate is being paid. For example, if the provider is a solo provider and becomes incorporated, the provider is still considered a

solo or independent provider for rate purposes unless they hire another person to perform the specific waiver service for which the rate is being established. If the provider is a solo provider and incorporates and the board hires them to perform the service, they are still considered an independent provider for rate purposes for those services that they directly perform or personally deliver.

II. General Service Documentation Requirements

Overview. Family and Supported Living Waiver services are based on consumer needs that are documented in an approved plan of care. The plan of care includes the support plan and approved cost plan. A person cannot receive Medicaid waiver services until determined eligible and enrolled in the appropriate waiver program.

Medicaid will only reimburse for waiver services, at an approved standard rate, that are specifically identified in the approved plan of care by service type, frequency and duration and for which there is sufficient documentation supporting the provision of a service to the consumer.

Documentation is a written record that supports the assertion that a service has been rendered. When a service is rendered, the provider must document the service and file the documentation appropriately before requesting reimbursement. Appropriate documentation is required in order to receive payment. All documentation must be dated and signed by the provider rendering the service. At a minimum, an updated support plan and cost plan are submitted annually to the Area Office.

A list of the documentation that is required for each service is included in each service description. Please refer to the 'Documentation Requirements' section of each service for a detailed listing of documentation that must be submitted for reimbursement and documentation that must be kept on file by the provider for monitoring and review purposes.

Please refer to the 'Documentation Definitions' contained in this section of this Services Directory for a description of each type of documentation. For the purpose of efficiency, the required elements of the following documentation may be combined on one form:

- Bi-Weekly Contact Log
- Daily Attendance Log
- Daily Progress Notes
- Invoice
- Monthly Summary
- Service Log

- Supported Living Log

It is the responsibility of each service provider to understand and comply with all documentation requirements. Questions regarding further clarification about these requirements should be directed to the APD Area Office.

III. Documentation Definitions

Annual Report. A written report documenting the consumer's progress toward the consumer's support plan goal(s) for the year, as required in Chapter 393, F.S. This report must be submitted to the Area no later than 30 days prior to the support plan year-end date.

Annual Satisfaction Survey. A survey of consumers that addresses their satisfaction with service delivery and the extent to which the consumer's desired outcomes have been achieved as specified in the Core Assurances and as described in Section 65B-11.008, F.A.C., for providers of Supported Living Coaching services.

Bi-weekly Contact Log. Every two weeks a recording of contacts completed for consumers receiving Supported Employment. Contacts may be either at the job site or another setting.

Central Record of Provider File of a Consumer. A file or a series of continuation files kept by the provider in which the following documentation must be recorded, stored and made available for review:

- Consumer demographic data including emergency contact information, parent or guardian contact data, permission forms, and results of assessments, evaluations, and medical and medication information;
- Legal data such as guardianship papers, court orders and release forms;
- Service delivery information including the current support plan, cost plan or written authorization of services and implementation plans as required.

Community Integrated Settings. Local settings that are not limited to or segregated settings for consumers with developmental disabilities that possess the following characteristics: generic, local community resources utilized by people without disabilities and settings that promote direct personal interaction with others.

Cost Plan. The form used by the Area listing all services on the support plan, regardless of funding source, and the anticipated cost of each Waiver service. The Area Office must approve the cost plan prior to service provision. Each time a consumer's support plan is amended the cost plan must be amended and approved in order for the service to be initiated. A support plan and cost plan must be updated at least annually to reflect current needs and situations. Cost plan forms are available from the Area Office. Attachment D contains contact information.

All consumers on the FSL Waiver must have a Cost Plan prepared and updated annually. Each consumer's annual Cost Plan budget may not exceed the total annual dollar cap in FSL Waiver services. The cost of full support coordination must be included in the cost plan budget. All consumers receive full support coordination unless the consumer receives supported living coaching services. If supported living coaching is provided consumers receive limited support coordination, however, full support coordination must be included in the cost plan budget in the event full services are needed during the year.

The Cost Plan may also reflect Supported Living Stipends and Supported Living startup funds from General Revenue. Area offices have authority to review all initial Cost Plans and make determinations regarding exceeding individual service dollar caps based on medical necessity. The FSL Waiver Cost Plan Worksheet must be completed to provide documentation (Attachment E). Subsequent revisions to Cost Plans that exceed individual service dollar caps, based on medical necessity, must be reviewed and approved by the Central Program Office or contracted entity designated by the APD for prior service authorization reviews.

Daily Attendance Log. A complete, monthly listing of the consumers and the dates they participated in the service.

Daily Progress Note. Daily notes of the consumer's progress toward achieving the consumer's support plan goals for the period being billed for or the summary describing the treatment or training provided. For example: November 11, 2003, John had a job interview. This activity supports a goal on his support plan to become employed.

APD Approved Assessment. The APD approved assessment, entitled Individual Cost Guidelines (ICG), is a tool designed to determine the consumers' needs and skills for consumers receiving supports from the State of Florida's Agency for Persons with Disabilities. The ICG is a validated tool that provides a rational basis for the assessment of needs and skills for individuals with developmental disabilities. The instructions for the completion of this assessment are provided by the APD and are

completed at least every three years or as determined necessary by the consumer and the Area due to changing needs of the consumer.

Home. The home of a consumer receiving supported living services is defined as a house, apartment, or comparable living dwelling space meeting community housing standards. See Section 65B-11.005 F.A.C., requirements, which is neither a community care facility nor a health facility that the consumer chooses, owns or rents, controls and occupies as a principle place of residence.

Implementation Plan. A plan developed with direction from the consumer that includes information from the consumer's current support plan, and other pertinent sources. The specific areas of training and strategies to meet support plan goal(s) for each consumer will be addressed in the consumer's implementation plan. Training objectives appropriate to the consumer's programs and services may also be included in the implementation plan.

At a minimum the implementation plan will include:

- The name, address, and contact information of the consumer served.
- The goal(s) from the support plan that the service will address.
- The strategies employed to assist the consumer in meeting the support plan goal(s).
- The system to be used for data collection and assessing the consumer's progress in achieving the support plan goal(s).

The information from this assessment will be used to update and modify the plan to ensure progress toward goal achievement.

At a minimum, the implementation plan will be developed within 30 days of the initiation of the new service or within 30 calendar days of the service authorization effective date for continuation of services and annually thereafter. A copy of the implementation plan, approved by the consumer, shall be furnished to the consumer or guardian and to the Area at the end of this 30-day period. The progress toward achieving the goal(s) identified on the implementation plan shall be documented in daily progress notes or monthly summaries as specified in each service description. Data supporting the consumer's progress, or lack thereof, summarized in the monthly summary shall be available for review.

081 Claim Form. Effective March 3, 2003, the 081-claim form is the standard claim form to be used when submitting claims for reimbursement for FSL/HCBS services provided. This form contains the provider's name, address, provider number, name of consumer of services, consumer's Medicaid ID number, date of birth, etc., and lists service dates, description

of service(s) received, approved procedure code(s), and fees, etc. Claim forms must be complete and legible when submitted to the Medicaid fiscal agent for reimbursement for services rendered. The provider may submit the 081 claim and information to the Medicaid fiscal agent (ACS), either in paper form or electronically by using the free software, WINASAP, supplied by the Medicaid fiscal agent.

Medicaid Waiver Services Agreement. The Medicaid Waiver Services Agreement means the agreement between APD and providers of waiver services that consists of form CF-DS 3064, and the Core Assurances for providers. Specific service requirements as defined in the Family and Supported Waiver Services. Services Directory requirements and rate methodology information are incorporated into the agreement by reference.

All providers must complete this agreement to provide services to consumers enrolled in the Family and Supported Home and Community-Based Services Waiver Program. Please refer to Attachments A, B, and C for additional information.

Monthly Summary. A summary note of the month's activities indicating the consumer's progress toward achieving support plan goals for the services billed that month.

For example: November 2003, during the past month John cooked a dinner item three times each week (12 times). His most successful item was macaroni and cheese, which he chose to prepare at least once a week. He is able to set the timer but still needs some assistance with over-cooking because he tends to get distracted by the television or his housemates. Next month, we will try to increase the variety of items cooked successfully and work on paying attention to cooking times. This activity supports a goal on his support plan to learn how to cook because he wants to move into his own apartment.

Provider File. The provider file maintained by the Area is designated as part of the consumer's central record but remains the property of the APD.

Service delivery documentation in the form of service logs, implementation plans, and progress reports or as specified in this Services Directory, that are related to the service and support activities identified in the implementation plan.

Service Log. The service log shall include documentation that includes the consumer's name, Social Security number, consumer's Medicaid ID number, the description of the service, activities, supplies or equipment provided and corresponding procedure code, times and dates service was

rendered, amount billed for each service, provider name and provider Medicaid ID number.

Supported Living Log. Written documentation of the dates, times and summary of the supports provided during contact with the consumer as described in Chapter 65B-11.014, F.A.C.

IV. Service Documentation Requirements

A. Adult Day Training

Reimbursement and monitoring documentation to be maintained by the provider:

1. Copy of claim(s) submitted for payment.
2. Service log.
3. Consumer's implementation plan and supporting data.
4. Staffing documentation such as staffing schedules, payroll records indicating identified support staff and hours worked, and any other supplemental support staffing schedules, which document required staffing ratios.

In addition to the minimum required components of the individual implementation plan described in the definitions section of this Services Directory, the individual implementation plan for adult day training service must contain the following: a description of methods that the provider will use to ensure the consumer makes an informed choice concerning types of work and meaningful day activities (type of activities). This information is to be discussed with consumers and documented at least annually.

1. Monthly summaries for the period being reviewed.
2. An annual report.
3. Results of the annual satisfaction survey.
4. Performance data on the selected service outcomes for this service.

Documentation to be submitted to the Area Support Coordinator by the provider:

1. Copy of service log, monthly.
2. Copy of consumer's implementation plan at the time of first claim submission, and at least annually thereafter at the time of the support plan update and, any time updates and changes are made before they are implemented.
3. Annual report prior to the annual support plan update.

Note: Refer to the definition section for additional information regarding specific documents required.

B. Behavior Analysis Services

Documentation of services must comply with Chapter 65B-4.030(9) and (10), F.A.C. Reimbursement* and monitoring documentation to be maintained by the provider includes:

1. *Copy of claim(s) submitted for payment;
2. *Copy of service log;
3. *Copy of assessment report;
4. *Monthly summary of monitoring including the who, what, when and where of the monitoring events;
5. *Behavior analysis service plan and services provided including graphic display of acquisition and reduction behaviors related to implementation of the service plan;
6. *Annual report; and
7. *If the targeted reduction behaviors meet the requirements identified in Chapter 65B-4.030(9)(10), F.A.C., the LRC review date and recommendations made specific to the plan, a review schedule for the plan must be included.

Documentation to be submitted to the waiver support coordinator by the provider:

1. *Copy of service log, monthly;
2. *Copy of assessment report within 30 days of initially providing services;
3. *A copy of the provider's behavior analysis service plan within 90 days of initially providing services;
4. *Monthly updates of the intervention plan as it is modified;
5. *Graphic displays of acquisition and reduction behaviors related to implementation of the service updated monthly, with baseline data to allow evaluation of progress; and
6. Annual report prior to the annual support plan update.

* Indicates reimbursement documentation.

Refer to the definitions section for additional information.

C. Behavior Assistant Services

Reimbursement* and monitoring documentation to be maintained by the provider:

1. *Copy of claim(s) submitted for payment;
2. *Copy of service log;
3. *Monthly summary notes and graphic display of effects of behavioral service plan;
4. *Copy of the behavior analysis service plan must be in the recipient's file prior to claim submission.
5. *Documentation of approval for services by the LRC chairperson or designee; and
6. *Documentation of monitoring by the responsible person certified in behavior analysis or licensed under Chapters 490 or 491, F.S., of data and implementation of plan. Documentation will include date, time, observations and changes made related to the monitoring event.

Documentation to be submitted to the waiver support coordinator by the provider:

1. Copy of service log, monthly; and
2. Monthly summary note at the time of claims submission.

* Indicates reimbursement documentation.

Refer to the definitions section for additional information.

D. Consumable Medical Supplies

For reimbursement purposes, the provider must submit an invoice listing the supplies purchased.

For monitoring review purposes, the provider must have, at a minimum:

1. A copy of the invoices listing the supplies purchased for the period being reviewed, and
2. The original prescription for the supply (if prescribed).

C. Environmental Accessibility Adaptations

For reimbursement purposes, the provider must submit an invoice listing the adaptations completed on the home. (Prior to processing the invoice for payment, the consumer's waiver support coordinator must document that the services were completed in accordance with the contract or agreement, either by conducting a site visit or by obtaining verbal verification from the consumer/family).

For monitoring review purposes, the provider must have, at a minimum:

1. A copy of the invoices for the period being reviewed; and
2. The original prescription for the environmental adaptation or home accessibility assessment.

D. In-Home Support Services

For reimbursement purposes, the provider must submit:

1. An invoice; and
2. A service log.

For monitoring review purposes, the provider must have, at a minimum:

1. A copy of the service logs; and
2. A copy of the monthly summary notes for the period being reviewed.

E. Personal Emergency Response System

For reimbursement purposes, the equipment installation provider and the emergency monitoring provider must submit invoices specifying the services rendered. For monitoring review purposes, the equipment installation provider and the emergency monitoring provider must have, at a minimum, a copy of the invoices for the period being reviewed. The equipment itself is generally free of charge. The cost of this service involves installation and monitoring.

F. Respite Documentation

For reimbursement purposes, the provider must submit:

1. An invoice; and
2. A service log.

For monitoring review purposes, the provider must have, at a minimum a copy of the service logs, for the period being reviewed.

G. Support Coordination

For reimbursement purposes, the support coordinator must meet certain basic billing requirements. These include progress notes that adequately document the support coordination services rendered. Exceptions granted by the APD to any requirements set forth in the assurance or policy must also be documented. All documentation must be filed in the consumer's central record prior to billing. Prior to requesting a monthly payment for support coordination services for a consumer, the provider shall have the following on file in the consumer's Central Record: the consumer's current support planning information to include the Personal Outcome Measures information and Outcome Notes, and the Individual Cost Guidelines (ICG), a current Waiver Eligibility Work Sheet, a current support plan, and current cost plan.

Full Support Coordination

The support coordinator must conduct at least one face-to-face contact every three (3) months for consumers living in their family home, and two of those contacts per year, will be held in the consumer's residence at six-month intervals. Face-to-face contacts shall relate to or accomplish one or more of the following:

- (a) Assist the consumer to reach outcomes on the support plan, including gathering information to identify outcomes.
- (b) Monitor the health and well being of the consumer.
- (c) Obtain develop or maintain resources needed or requested by the consumer to include natural supports, generic community supports and other types of resources.
- (d) Increase the consumer's involvement in the community.
- (e) Promote advocacy or informed choice for the consumer; or
- (f) Follow-up on the consumer's or family's concerns.

For a consumer living with his or her family, the face-to-face contact with the consumer in the residence is required every six months. The consumer or family may not waive the six-month visit in the home. The need for more frequent face-to-face visits may be determined by the consumer or family. The support coordinator shall document this preference in the support plan.

The support coordinator must conduct at least one other contact or activity per month. These contacts or activities are not merely incidental, but are planned and shall relate to or accomplish those items, previously identified in (a) through (f) above. These contacts or activities may be either with the consumer or with other persons, such as family members, service vendors, community members and so on, and may be conducted face-to-face or by phone. Administrative activities such as typing, filing, mailing, data entry for billing, or leaving messages shall not qualify as contacts or activities.

Letter writing would qualify as another contact if related to services and benefits specific to a consumer's needs. This would exclude form letters to confirm meetings, etc. Additionally, scheduling time to develop the support plan, setting up the face-to-face contact, setting up meetings with other persons, and meeting with one's supervisor or co-workers shall not qualify as contacts or activities.

Limited Support Coordination

The support coordinator must conduct two (2) face-to-face visits per year (including at least one home visit) and two (2) other billable activities as

outlined in the Family and Supported Living Waiver Handbook or Services Directory. The face-to-face contact conducted in the support plan development period may count as one face-to-face contact. The second face-to-face contact shall occur toward the middle of the support plan year.

Face-to-face contacts shall relate to or accomplish one or more of the following:

- (a) Assist the consumer to reach outcomes on the support plan, including gathering information to identify outcomes.
- (b) Monitor the health and well-being of the consumer.
- (c) Obtain develop and/or maintain resources needed or requested by the consumer to include natural supports, generic community supports and other types of resources.
- (d) Increase the consumer's involvement in the community.
- (e) Promote advocacy or informed choice for the consumer.
- (f) Follow-up on the consumer's or family's concerns.

The support coordinator will conduct at least two other contacts or activities per year. These contacts or activities are not merely incidental, but are planned and shall relate to or accomplish those items, previously identified in (a) through (f) above. These contacts or activities may be either with the consumer or with other persons, such as family members, service vendors, or community members and may be conducted face-to-face or by phone. Administrative activities such as typing, filing, mailing, data entry for billing, or leaving messages shall not qualify as contacts or activities.

The initial support plan package (Individual Cost Guidelines (ICG), Support Plan, Cost Plan and Personal Outcome Measures (POMs) will be billed during the three months surrounding the development of the support planning documents at the full rate of \$148.39 per month. During these three months all services will remain the same as those in full support coordination.

Limited support coordination will then be billed at \$45 per month for the remainder of that cost plan year, i.e. for a total of nine (9) months. Activities will continue to be recorded and tracked in progress notes up to the 9-hour maximum, which may be accumulated over the remaining nine months. Activities should be tracked using quarter hour increments.

For consumers receiving supported living coaching services, it is the support coordinator's responsibility to schedule and participate in a quarterly meeting with the consumer and the supported living coach. The purpose of this meeting is to review supported living needs with the

consumer and the coach to determine if services are being provided at a satisfactory level and to assure that housing, health, safety, and financial support is adequate. The support coordinator shall document the results of each meeting in the progress notes. This quarterly meeting with the consumer and the supported living coach may satisfy the face-to-face meeting requirement provided the meeting takes place in the consumer's home.

Cost Plans

All consumers on the FSL Waiver must have a Cost Plan prepared and updated annually. Each consumer's annual Cost Plan budget may not exceed the total annual dollar cap in FSL Waiver services. The cost of full support coordination must be included in the cost plan budget. All consumers receive full support coordination unless the consumer receives supported living coaching services. If supported living coaching is provided consumers receive limited support coordination, however, full support coordination must be included in the cost plan budget in case full services are needed during the year.

The Cost Plan may also reflect Supported Living Stipends and Supported Living startup funds from General Revenue. Area offices have authority to review all initial Cost Plans and make determinations regarding exceeding individual service dollar caps based on medical necessity. The FSL Waiver Cost Plan Worksheet must be completed to provide documentation (Attachment E). Subsequent revisions to Cost Plans that exceed individual service dollar caps, based on medical necessity, must be reviewed and approved by the Central Program Office or contracted entity designated by the APD for prior service authorization reviews.

Monitoring

For monitoring review purposes, the provider must have on file for the period being reviewed:

- A copy of all of the consumers' support plans and approved cost plans in their Central Record.
- Documentation in the Central Record that the basic billing requirements were met for the months in which the provider was reimbursed for services.
- Progress notes that adequately detail support coordination provided to the consumer and his or her family or guardian.
- Documentation in the Central Record that a face-to-face visit with the consumer in supported living, quarterly meetings with the consumer and their supported living coach.

- Copies of the annual reports and individual implementation plans submitted by other providers as required and appropriate to each service.
- Current and correct demographic information for each consumer.
- Results of the annual satisfaction survey.
- Performance information on the selected outcomes projected in this document.

In addition, the support coordinator is expected to document in all consumer Central Records all other support coordination services, activities or contacts that assisted consumers to meet support plan outcomes or personal goals, become more integrated into communities and address each consumer or family's concerns. Progress notes should adequately and clearly document all support coordination services provided to a consumer.

H. Supported Employment

Reimbursement and monitoring documentation to be maintained by the provider:

1. Copy of claim(s) submitted for payment.
2. Service Log.
3. Monthly summary.
4. Documentation in the form of a letter from Vocational Rehabilitation (VR) Services or a case note detailing contact with a named VR representative, the date, summary of conversation, etc., indicating a lack of available VR funding for supported employment.
5. Implementation and employment plan must be completed at the time of first claim submission and annually thereafter at the time of support plan update and at any time updates and changes are made before they are implemented.
6. Annual report.

In addition to the minimum required components of the individual implementation plan described in the definition section of this Services Directory, the individual implementation plan for supported employment service must also contain the following:

- Documentation that the provider has furnished information and support to the consumer enabling the consumer to make an informed choice about the type of work preferred, job changes or career advancement opportunities will be provided to the Waiver Support Coordinator for the central file.
- For consumers receiving services in the individual model there must be documented bi-weekly contacts either on the job site or

in another setting to monitor the needs and provide supports for retraining, adequacy of workplace supports and relationships, and job satisfaction or desires for job change.

Documentation to be submitted to the Waiver Support Coordinator by the provider:

1. Copy of service log, monthly.
2. Implementation and employment plan at the time of first claim submission and annually thereafter.
3. Performance data on the selected service outcomes projected in this document.

I. Supported Living Coaching

Reimbursement and monitoring documentation to be maintained by the provider:

1. Copy of claim(s) submitted for payment.
2. Service log or time intervention log, which shall be supported by progress notes including documentation of activities, supports and contacts with the consumer, other providers and agencies with dates and times, and a summary of support provided during the contact, any follow up needed and progress toward achieving support plan goals. This service log and progress notes shall be placed in the consumer's record prior to claim submission.
3. Individual implementation plan, or in the case of transition, a transition plan, must be completed at the time of the first claim submission and annually thereafter at the time of the support plan update and at any time updates and changes are made before they are implemented. In addition to the minimum required components of the individual implementation plan described in the definitions section of this Services Directory, the individual implementation plan for supported living coaching service must also contain the following:
 - The frequency of the supported living service.
 - How home, health and community safety needs will be addressed and the supports needed to meet these needs.
 - The method for accessing the provider 24-hours per-day, 7-days per-week for emergency assistance.
4. A description of how natural and generic supports will be used to assist in supporting the consumer; and a financial profile that includes strategies for assisting the person in money management when requested by the consumer or guardian and

the amount approved for the supported living subsidy. The financial profile is critical in determining whether or not the housing selected by the consumer is within his financial means and will identify the need for monthly subsidy that must be approved by the Area. An annual written report, summarizing the consumer's progress toward achieving the goal(s) from the support plan. The annual report shall include objective, fact-based, information reflecting the results of training and supports provided to the consumer over the course of the year as well as subjective information (opinions) and recommendations. The annual report shall be submitted to the consumer or guardian and the support coordinator 30 days prior to the end of the support plan year.

5. An annual satisfaction survey as described in Section 65B-11.008, F.A.C. At least annually, consumers receiving supported living coaching services will be asked to complete a survey that addresses satisfaction with supported living services. While it is the provider's responsibility to assure the consumer has the opportunity to complete the survey, staff providing direct supported living services to the consumer may not assist in the survey activity for that consumer. The results of the survey will be maintained in the consumer's record and a copy forwarded to the Area for review.
6. The consumer's waiver support coordinator is responsible for arranging, scheduling and documenting a quarterly meeting in which the consumer and the provider of services review the current supported living services. The purpose of this visit is to update the housing survey to assure that the home continues to meet basic health and safety standards and to determine if supported living coaching services are being carried out as identified on the support plan. The supported living coach and the Area are to review the consumer's bank statements and other financial records at the time of the quarterly visit. This review will be documented in the progress notes contained in the provider's service log unless the supported living provider is excluded from the meeting at the request of the consumer.
7. An initial housing survey containing quarterly updates of the consumer's health and safety status. The housing survey will be updated quarterly and made available to the Area at or prior to the quarterly meeting. Documentation of the meeting and subsequent recommendations will be made in the consumer's record.

8. Up-to-date information regarding the demographic, health, medical and emergency information, and a complete copy of the current support plan, if approved by the consumer or guardian, for each consumer served.
9. Performance data on the selected service outcomes projected in this document.

Documentation to be submitted to the waiver support coordinator by the provider:

1. Copy of service log or time intervention log, monthly.
2. Copy of individual implementation plan or transition plan (must be completed at the time of first claim submission and annually thereafter at the time of the support plan update, and at any time updates and changes are needed and before they are implemented.
3. Annual report prior to annual support plan update.

All consumers on the FSL Waiver must have a Cost Plan prepared and updated annually. Each consumer's annual Cost Plan budget may not exceed the total annual dollar cap in FSL Waiver services. The cost of full support coordination must be included in the cost plan budget. All consumers receive full support coordination unless the consumer receives supported living coaching services. If supported living coaching is provided consumers receive limited support coordination, however, full support coordination must be included in the cost plan budget in the event full services are needed during the year.

The Cost Plan may also reflect Supported Living Stipends and Supported Living startup funds from General Revenue. Area offices have authority to review all initial Cost Plans and make determinations regarding exceeding individual service dollar caps based on medical necessity. The FSL Waiver Cost Plan Worksheet must be completed to provide documentation (Attachment E). Subsequent revisions to Cost Plans that exceed individual service dollar caps, based on medical necessity, must be reviewed and approved by the Central Program Office or contracted entity designated by the APD for prior service authorization reviews.

J. Transportation

1. Reimbursement and monitoring documentation to be maintained by the provider.
 - a. Copy of claim(s) submitted for payment.
 - b. Trip logs.
2. Documentation to be submitted to the waiver support coordinator by the provider.
 - a. Copy of trip logs, monthly
3. Areas must maintain a database for each enrolled provider to include.
 - a. The names of the consumers being transported by that provider.
 - b. The beginning and ending date of each consumer's service.
 - c. The destination and distance of each consumer's authorized trip.
 - d. The cost per vehicle mile.
 - e. The amount authorized to be billed monthly for each consumer.

This information may be obtained from the consumer's service authorizations and verified by trip logs and quarterly operating or service reports submitted by providers. Fixed-route, fixed-schedule bus systems shall, at the time of enrollment, provide the Area office with proof of their status as the local Public Transit Authority.

Limited transportation providers shall, at the time of enrollment, provide the Area office with proof of current Florida driver's license, vehicle registration, possess a vehicle that is in safe operating condition and maintain at least minimum vehicle liability insurance coverage as required by Florida law (PIP). Attachment B



Attachment A MEDICAID WAIVER SERVICES AGREEMENT

GENERAL TERMS AND CONDITIONS

This Agreement is entered into between the Florida Agency for Persons with Disabilities, hereinafter referred to as “APD”, and _____, hereinafter referred to as the “Provider”. The Provider agrees to provide _____ under the Family and Supported Living Waiver Program to eligible recipients.

I. AGREEMENT DOCUMENTS

A. The Medicaid Waiver Services Agreement consists of the General Terms and Conditions and the following documents:

Core Assurances as described in the current Family and Supported Living Waiver Services Directory are incorporated into this agreement by reference.

Rate Structure documents are incorporated into this Agreement by reference (current documents are available on the Developmental Disabilities Program web site)

The Family and Supported Living Services Directory, listing requirements for specific services, is incorporated into this Agreement, by reference.

B. Prior to providing any services the provider must, in order to be compensated by the Family and Supported Waiver Program, execute a Medicaid Provider Agreement with the Agency for Health Care Administration (Agency), and be issued a Medicaid provider number by the Agency. The provider must at all times maintain a current and valid Medicaid Provider Agreement with the Agency. The provider must comply with the terms and conditions of the Medicaid Provider Agreement.

II. THE PROVIDER AGREES:

To comply with all of the terms and conditions contained within the Agreement documents attached and those contained in the Family and Supported Living Waiver Services Directory for specific services rendered by the provider.

A. APD Monitoring, Audits, Inspections, and Investigations

1. To permit persons duly authorized by the Agency for Persons with Disabilities (APD), Agency or representatives of either, to monitor, audit, investigate and inspect any recipient records, payroll and expenditure records (including electronic storage media) papers, documents, facilities, goods and services of the provider which are relevant to this contract, and to interview any recipients receiving services and employees of the provider to assure the APD of the satisfactory performance of the terms and conditions of this contract.
2. Following such evaluation, the APD or its authorized representative will furnish to the provider a written report of its findings and request for development, by the provider, of a Quality Improvement Plan (QIP) for needed corrections. The provider hereby agrees to correct all noted deficiencies identified by the APD, Agency or their authorized representatives within the specified period of time identified within the report documentation. Failure to correct noted deficiencies within stated time frames may result in termination of this agreement.
3. Upon demand, at no additional cost to the Agency, APD, or their authorized representatives, the provider will facilitate the duplication and transfer of any records or documents (including electronic storage media), during the required retention period of five years after termination of the Agreement, or if an audit has been initiated and audit findings have not been resolved at the end of five years, the

records shall be retained until resolution of the audit findings or any litigation which may be based on the terms of this Agreement, at no additional cost to the APD.

4. To comply and cooperate immediately with APD requests for information, records, reports, and documents deemed necessary to establish methods to review the rate setting process to ensure that provider rates are based on accurate information and reflect the existing operational requirements of each service. Any individual who knowingly misrepresents the information required in rate setting commits a felony of the third degree, punishable as provided in Chapters 775.082-083, 775.044, F.S.
5. To comply and cooperate immediately with any inspections by the APD Developmental Disabilities Program, reviews, investigations or audits deemed necessary by the Office of the Inspector General (Section 20.055, F.S.).
6. To include the aforementioned audit, inspections, investigations and record keeping requirements in all subcontracts and assignments.

B. Indemnification

1. To be liable for and indemnify, defend, and hold the APD, Agency and all of their officers, agents, and employees harmless from all claims, suits, judgments, or damages, including attorneys' fees and costs, arising out of any act, actions, neglect, or omissions by the provider, its agents, or employees during the performance or operation of this contract or any subsequent modifications thereof, whether direct or indirect, and whether to any person or tangible or intangible property.
2. That its inability to evaluate its liability or its evaluation of liability shall not excuse the provider's duty to defend and to indemnify within seven days after notice by the APD by certified mail. After the highest appeal taken is exhausted, only an adjudication or judgment specifically finding the provider not liable shall excuse performance of this provision. The provider shall pay all costs and fees, including attorneys' fees related to these obligations and their enforcement by the APD. The APD's failure to notify the provider of a claim shall not release the provider of these duties. The provider shall not be liable for negligence, which is solely that of the APD.

C. Insurance

To obtain and maintain at all times liability insurance coverage, as required by state or federal law or by this Agreement.

D. Return of Funds

To be responsible for the timely correction of all billing or reimbursement errors resulting in an overpayment, including reimbursement for services not properly authorized or documented. Reimbursement will be made pursuant to the Florida Medicaid Provider Reimbursement Handbook Non-Institutional 081. Federal regulations, 42 CFR 433.312, require refund of overpayments within 60 days of discovery. The Agency will be the final authority regarding the timeliness of the reimbursement process.

III. TERMINATION

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

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

IV. GOVERNING LAW

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

V. AGREEMENT DURATION

This Agreement shall be effective _____ or the date on which it has been signed by both parties, whichever is later, and shall terminate on _____ which is no later than three years from the effective date, or 30 days after a final rule is promulgated, whichever is sooner. A final rule is the adoption of a Family and Supported Living Waiver Services Florida Medicaid Coverage and Limitations handbook, or its equivalent.

VI. INDEPENDENT STATUS

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

VII. OFFICIAL REPRESENTATIVES (Names, Addresses, and Telephone Numbers):

1. The name and telephone number of the provider's contact person and street address where financial and administrative records are maintained is:

Name:

Telephone Number:

Address:

2. The name, address, and telephone number of the representative of the provider responsible for administration of the service(s) under this Agreement is:

Name:

Telephone Number:

Address:

3. The name, address, and telephone number of the APD's contact person for this Agreement is:

Name:

Telephone Number:

Address:

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

VIII. INTEGRATED AGREEMENT

Only these General Terms and Conditions, the Core Assurances, attachment as referenced, the Medicaid Provider Agreement and the Family and Supported Living Waiver Services Directory, which is incorporated into this Agreement by reference, contain all the terms and conditions agreed upon by the parties.

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

The provider, by signing below, attests that the provider has received and read the entire Agreement inclusive of its attachments, and document as referenced, listed in Section 1, A., the service-specific requirements for enrolled providers, contained in the Family and Supported Living Waiver Services Directory, and understands each section and paragraph.

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

PROVIDER:

SIGNED

BY:

NAME:

TITLE:

DATE:

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

SIGNED

BY:

NAME:

TITLE:

DATE:

Attachment B

Core Assurances for Providers of Developmental Disabilities Medicaid Home and Community-Based Services Waiver Program

Chapter 393, Florida Statutes, charges the Agency for Persons with Disabilities (APD) with providing services, particularly community-based services, to ensure the well being and improve the quality of life of recipient's with developmental disabilities. Section 393.066, Florida Statutes, specifically directs the APD to purchase these services through contracts with private businesses, not-for-profit corporations, units of local government and other organizations capable of providing the services in a cost-beneficial manner. The APD, as the operating agency, and the Agency for Health Care Administration (Agency/AHCA) the single state Medicaid agency, has agreed to jointly purchase necessary services for recipients with developmental disabilities through the Family and Supported Living Home and Community-Based Services Waiver. This waiver is a federally approved Medicaid waiver services program, authorized by Title XIX of the Social Security Act. Section 20.19, Florida Statutes. The APD and AHCA are required to establish contractual performance standards for all contracted recipient services and service provision quality in the delivery of contracted Medicaid waiver services. The APD expressly requires that the contractual performance standards assure financial integrity.

These Core Assurances and the specific service requirements published in the Family and Supported Living Waiver Services Florida Medicaid Coverage and Limitations handbook incorporated into this Agreement by reference provides the terms and conditions by which the provider of waiver services to recipient's with developmental disabilities served by the APD agree to be bound. Breach of the terms and conditions set forth in these Assurances shall be considered indicative of the provider's failure to comply with the terms and conditions set forth in this document and the Developmental Services Medicaid Waiver Services Agreement.

Programmatic Definition of Terms

Agency/AHCA means the Agency for Health Care Administration.

Agency or Group Provider means a business, or organization enrolled to provide a waiver service(s), which has one, or more staff employed to carry out the enrolled service(s). All employees of an agency or group provider must meet the qualifications and requirements specified in this Agreement and those specified for enrolled service(s). The provider shall maintain a personnel file documenting qualifications of all employees and their background screening results.

Central Record or Provider File of a Recipient means a file (or a series of continuation files) kept by the provider. The provider file maintained by the support coordinator is designated as the recipient's *Central Record*. These files contain the following documentation that must be recorded, stored and made available for monitoring and review: (1) recipient's demographic data including emergency contact information, parental or guardian contact data, permission forms, results of assessments and evaluations, and medical and medication information; (2) legal data such as guardianship papers, court orders and release forms; (3) service delivery information including the current support plan, cost plan or written authorization of services, and implementation plans; and, (4) service delivery documentation in the form of progress reports or as specified in the Family and Supported Living Waiver Services Coverage and Limitations Handbook, that are related to the service and support activities identified in the recipient's implementation plan.

Community Integrated Settings means those local, non-segregated, settings for recipients with developmental disabilities, which possess the following characteristics: (1) generic local community resources utilized by other people without disabilities; and (2) settings which promote direct personal interaction with others, with or without developmental disabilities.

Core Assurances means this document that specifies administrative and programmatic requirements for the Family and Supported Living Home and Community-Based Services Waiver and Developmental Disability Program waiver(s) providers.

Cost-beneficial means economical in terms of the goods or services received and the money spent.

Cost Plan is the form used to list all services requested by the recipient on the support plan, regardless of funding source, and the anticipated cost of each waiver service. The District Office must approve the cost plan prior to service provision. Each time a recipient's support plan is amended to increase or add services the cost plan must be amended and approved in order for the service to be initiated. A support plan and cost plan must be updated annually for each recipient to reflect current needs and situations. APD approved cost plan forms are available from the District Office.

Cost Plan Year means the 365 or 366 days that correspond to the span of time, covered by the recipient's support plan.

APD means the Agency for Persons with Disabilities (APD), which includes the Developmental Disabilities Program Office (Central Office), located in Tallahassee, and the Developmental Disabilities District or Regional Office (District), located throughout the state.

District or Region means a service district or region of the Florida Agency for Persons with Disabilities.

The current **APD approved assessment**, entitled Individual Cost Guidelines (ICG), is a tool designed to determine the recipients' resource allocations of waiver(s) funds for recipients receiving supports from the State of Florida Agency for Persons with Disabilities' Developmental Disabilities Program (DDP). The ICG is a validated tool that provides a rational basis for the allocation of the waiver funds to individuals with developmental disabilities. Waiver(s) funds refer to funds allocated through the Developmental Services HCBS waiver, the Family and Supported Living Waiver, and the Consumer-Directed Care Plus waiver (CDC+). The instructions for the completion of this assessment is provided by the APD and is completed at least every three years or as determined necessary by the recipient and the District due to changing needs of the recipients.

Implementation Plan is an individualized document, developed by the provider with direction from the recipient that specifies how the recipient will be assisted by the provider(s) to achieve or maintain specific support plan goal(s). This plan also includes any training objective(s) to be met by the recipient. At a minimum, the plan will include the actions and tasks (strategies) to be employed by the provider, to achieve the recipient's identified goal(s) and/or objectives. The system of data assessment used for measuring the progress of programs and services is also included in the plan. Refer to the Family and Supported Living Waiver Services Coverage and Limitations Handbook for Implementation Plan adding more detailed requirements regarding specific services.

Recipient(s) is any person receiving services through the Family and Supported Living Home and Community-Based Services Waiver.

Medicaid Home and Community-Based Services Waiver Programs means federally approved Medicaid programs, authorized by Title XIX of the Social Security Act, for the Family and Supported Living Home and Community-Based Services Waiver (SL/HCBS). Chapter 393, F.S., specifies Medicaid funded services for an enrolled recipient.

Medicaid Provider Agreement is the contractual agreement between the provider and the Agency for Health Care Administration, which establishes the provider's eligibility to render services under the Medicaid program.

Medicaid Waiver Services Agreement is the contractual agreement between the Family and Supported Living Program and providers of waiver services that consists of the Medicaid Waiver Services

Agreement (form CF-DS 3064), and the Core Assurances for providers of Medicaid Home and Community-Based Waiver Services Programs. Specific service requirements, as defined in the Family and Supported Living Waiver Services Coverage and Limitations handbook, including rate methodology information, are incorporated into the Agreement by reference. All providers must complete and submit this agreement to the APD for its approval, before providing services to recipient's enrolled in the Family and Supported Living Home and Community-Based Services Waiver.

Medical Necessity or Medically Necessary means a set of conditions established by the Agency for Health Care Administration (AHCA) in section 59G-1.010(166)(a) and (c), F.A.C., and Chapter 393, F.S., for determining the need for and appropriateness of Medicaid funded services for an enrolled recipient.

Monitoring is a review by the APD, the Agency for Health Care Administration, or an authorized agent of either, of the provider's administrative and programmatic service delivery systems.

Non-Reimbursed Transportation means any transportation that is provided as a component to one or more primary waiver service(s) for recipients on the waiver. This transportation service is not reimbursed separately from the primary waiver service.

Person-Centered is an approach, developed from the recipient's perspective rather than that of the program or resource used to provide the services and supports necessary to meet the recipient's needs.

Personal Outcome means the major expectation(s) that a recipient has during his or her life. The recipient's expectations for the services and supports he or she receive are defined by these outcomes, which may also be referred to as their personal goals.

Personal Outcome Process is the process used, with the recipient, to assess how to obtain the outcomes he or she considers most important in his or her life. This process includes getting to know the recipient and the significant people in his or her life, determining the presence or absence of personal outcomes, and the supports necessary to achieve the outcomes desired. The process may also involve record review, on-site visits to service providers and additional interviews with the provider's staff. All providers are expected to assist in the outcome process. With the use of the Personal Outcome Measures tool and the information gathered during the personal outcome process, the District is responsible for compiling and reporting information and planning for needed supports and services.

Provider means an individual, group or agency vendor that is also an approved Medicaid waiver provider that has entered into a contractual agreement with the APD that is eligible to provide one or more of the SL/HCBS waiver services listed in the Family and Supported Living Waiver Services Coverage and Limitations Handbook.

Provider Self-Assessment is an evaluation completed by the provider reviewing its organizational capabilities for meeting the recipient's outcomes or goals and the service requirements identified in the Medicaid Waiver Services Agreement, the Family and Supported Living Waiver Services Coverage and Limitations Handbook. This self-assessment also reviews the provider's policies and procedures by identifying the extent to which they are consistent with their daily practices and the objectives stated in the Medicaid Waiver Service Agreement.

Quality Improvement Plan means a plan of proposed, corrective actions developed by the provider that address the improvements needed for services cited below standard by the APD or their authorized agent. Those providers deemed non-compliant with these Assurances and requirements found in the Family and Supported Living Waiver Services Coverage and Limitations Handbook will submit written Quality Improvement Plans (QIPs), as required in their written monitoring report. The provider may also develop a Quality Improvement Plan, addressing needed program improvements identified through a self-assessment.

Reportable Events are any of the following events, which must be reported to the District.

- a. Altercation. A physical confrontation occurring between a recipient and employee or two or more recipient's at the time services are being rendered, or when a recipient is in the physical custody of the APD, which results in one or more recipient's or employees receiving medical treatment by a licensed health care professional.
- b. Recipient Death. A person whose life terminates due to or allegedly due to an accident, act of abuse, neglect or other incident occurring while in the presence of an employee, in an Agency for Persons with Disabilities' operated or contracted facility or service center; while in the physical custody of the APD; or when a death review is required, Child Death Review Procedures.
- c. Recipient Injury or Illness. A medical condition of a recipient requiring medical treatment by a licensed health care professional sustained or allegedly sustained due to an accident, act of abuse, neglect or other incident occurring while in the presence of an employee, in a an Agency for Persons with Disabilities' or contracted facility or service center, or who is in the physical custody of the APD.
- d. Elopement. The unauthorized absence beyond eight hours, or other time frames as defined by a specific program operating procedure or manual, of a child or adult who is in the physical custody of the APD.
- e. Escape. The unauthorized absence as defined by statute, APD operating procedure or manual, of a recipient committed to or securely detained in an Agency for Persons with Disabilities' mental health or developmental services forensic facility covered by Chapters 393, 394 or 916, F.S.
- f. Other Incident. An unusual occurrence or circumstance initiated by something other than natural causes or out of the ordinary such as a tornado, kidnapping, riot or hostage situation, which jeopardizes the health, safety and welfare of recipient's who are in the physical custody of the APD.
- g. Sexual Battery. An allegation of sexual battery by a recipient on a recipient, employee on a recipient, or recipient on an employee as evidenced by medical evidence or law enforcement involvement.
- h. Suicide Attempt. An act which clearly reflects the physical attempt by a recipient to cause his or her own death while in the physical custody of the APD or an APD contracted or certified provider, and which results in bodily injury requiring medical treatment by a licensed health care professional.

These reporting procedures do not replace the abuse, neglect and exploitation reporting system. Regardless of their status as an event in recipient risk prevention, allegations of abuse, neglect or exploitation must always be reported immediately to the Florida Abuse Hotline and appropriate district human rights advocacy committees as required by law.

Zero Tolerance

- a. Penalties for Sexual Abuse: Confirmed cases of sexual abuse by service providers will result in immediate termination of the waiver enrollment status of the individual who committed the abuse as well as the imposition of legal penalties. If it is determined that administrators, owners, or operators of a provider agency are considered to be culpable for the abuse through negligence or failure to report the incident(s), their waiver enrollment status will be terminated. Criminal and administrative penalties will be pursued.

- b. **Mandatory Reporting Requirements:** A person with knowledge of, or having reasonable cause to suspect that a child is being sexually abused by a parent, legal custodian, caregiver, or other person responsible for the child's welfare, as defined in Section 39.201, F.S., is required to report such knowledge or suspicion to the Department of Children and Families' Central Abuse Hotline at 1-800-96-ABUSE (1-800-962-2873). Pursuant to Section 415.1034, F.S., any service provider with knowledge of, or having reasonable cause to suspect that a vulnerable adult has been or is being abused, neglected or exploited shall immediately report such knowledge or suspicion to the Department of Children and Families' Central Abuse Hotline at 1-800-96-ABUSE (1-800-962-2873). Failure to report known or suspected cases of sexual abuse represents an offense that will be cause for termination of waiver enrollment status. Criminal and administrative penalties will be pursued.
- c. **Client-on-Client Sexual Abuse:** Known or suspected sexual abuse between two individuals with developmental disabilities must also be reported immediately to the Department of Children and Families' Central Abuse Hotline at 1-800-96-ABUSE (1-800-962-2873), so that an investigation will occur in order to determine whether or not the sexual abuse was the result of inadequate supervision or neglect on the part of a service provider or caregiver. The incident must also be reported immediately to the District/Region Developmental Disabilities Program Office to ensure the continued health and safety of the individuals involved.

Retail Outlet means any provider that derives fifty percent or more of its revenue from the sale of goods to the general public and is not engaged in any business that is specifically targeting recipient's receiving waiver services. Retail Outlets are certified only for the purpose of delivering commodities.

Solo Provider is an eligible provider who personally renders waiver services directly to recipients and does not employ others to render waiver services.

Support Plan is an individualized plan of supports and services designed to meet the needs of an enrolled recipient. This plan is based upon the preferences, interests, talents, attributes and needs of a recipient. The recipient or parent, legal guardian advocate, as appropriate, shall be consulted in the development of the plan and shall receive a copy of the plan and any revisions made to the plan. Each plan shall include the most appropriate, least restrictive, and most cost-beneficial environment for accomplishment of the objectives and a specification of all services authorized. The plan shall include provisions for the most appropriate level of care for the recipient. The ultimate goal of each plan, whenever possible, shall be to enable the recipient to live a dignified life in the least restrictive setting, appropriate to the recipient's needs. The support plan must be completed according to the instructions provided by the APD.

Valued Social Roles means those activities that are recognized by the general public, defining the recipient in the context of their relationships with others. Typical valued social roles include but are not limited to: co-worker, employee, neighbor, volunteer, student, friend, family member, athlete, theatergoer, church member, taxpayer, citizen, etc.

THE ASSURANCES

The provider assures compliance with the following stipulations:

1.0 COMPLIANCE WITH LAWS AND REGULATIONS

A. Compliance with State Law and Regulations

1. The provider will comply with state statutes and rules of the operating agency, which is the Agency for Persons with Disabilities including Chapters 393 and 409, F.S., Chapters 65B-4, 65B-8, 65B-11, and 59G-8 F.A.C., and with all procedures pertaining to the implementation of the waiver, including all rates and fee schedules developed under such laws, rules, and regulations.
2. The provider will uphold the rights and privileges of recipient's with developmental disabilities, as specified in Chapter 393.13, F.S., "The Bill of Rights of Persons Who are Developmentally Disabled."

B. Compliance with Federal Laws and Regulation

1. The provider will comply with Title VI of the Civil Rights Act of 1964, as amended, 42 U.S.C. 2000d et seq., prohibiting discrimination on the basis of race, color or national origin in programs and activities that receive or benefit from federal financial assistance.
2. The provider will comply with Section 504 of the Rehabilitation Act of 1973, as amended, 29 U.S.C. 2000e, et seq., in regard to employees or applicants for employment.
3. The provider will comply with the Age Discrimination Act of 1975, as amended, 42 U.S.C. 6101 et seq., which prohibits discrimination on the basis of age, in programs or activities that receive or benefit from federal financial assistance.
4. The provider will comply with the Omnibus Budget Reconciliation Act of 1981, PL 97-35, prohibiting discrimination on the basis of sex or religion in programs and activities that receive or benefit from federal financial assistance.
5. The provider will comply with the Americans with Disabilities Act of 1990, PL 101-336, prohibiting discrimination, based on disability, in employment, public accommodations, transportation, state and local government services and telecommunications.
6. The provider will comply with Title 42, Code of Federal Regulations (CFR) 431.51, which states that each recipient served by the provider will be provided freedom of choice within the scope of available funding levels. Freedom of choice includes, but is not limited to:
 - (a) Opportunities for the recipient to select non-waiver funded supports available to the general community from among those activities or experiences that meet the recipient's needs and preferences;
 - (b) Opportunities for the recipient to select providers of Medicaid State Plan services from among those providers enrolled in the Medicaid waiver program, and that also meet the recipient's needs and expectations;
 - (c) Opportunities for the recipient to select providers of waiver services from those eligible to provide waiver services and enrolled in the Medicaid program, meeting the recipient's needs and expectations;

- (d) Opportunities for the recipient to change providers of supports and services;
- (e) Opportunities for the recipient to work with a provider to identify mutually agreeable times and settings for the provision of supports or services; and
- (f) The opportunity for the recipient to end his or her participation in the waiver.

2.0 PROGRAM REQUIREMENTS

- A. The provider will not disclose or use any information concerning a recipient who is receiving services under the waiver, without the written consent of the recipient or the recipient's legal guardian, in accordance with Chapter 393.13 F.S. and federal regulations.
- B. In accordance with Chapter 415.1034, F.S., the provider or any employee of the provider who knows, or has reasonable cause to suspect, that a recipient receiving services from Developmental Disabilities is being or has been abused, neglected or exploited, will immediately report such knowledge or suspicion to the central abuse registry and tracking system of the Department of Children and Families, using the statewide toll-free telephone number (1-800-96ABUSE). TTY users call 1-800-453-5145.
- C. The provider understands and agrees that the APD is responsible for the expenditure of all funds appropriated to the APD by the Florida Legislature for recipient's receiving services from Developmental Disabilities and Family and Supported Living Home and Community-Based Services Waiver Programs. The APD is ultimately responsible for determining the **appropriateness or medical necessity** of services purchased, in accordance with 59G 1.010 F.A.C., Chapter 393, F.S., and the amount of Developmental Disabilities funds available to purchase services and goods.
- D. The provider agrees, within the mission and scope of the service(s) offered, to safeguard the health, safety and well being of all recipients' receiving services from the provider.
- E. The provider agrees, within the mission and scope of the service(s) offered, to assist people in their achievement of personal outcomes in the areas of personal goals, choice, social inclusion, relationships, rights, dignity and respect, health, environment, security and satisfaction.
- F. The provider agrees to participate in and support the personal outcome process for each recipient. The provider will also use the recommendations from the Person-Centered Review report that is part of the statewide quality assurance system to:(1) implement person-centered supports and services, (2) enhance service delivery in a manner that supports the achievement of personal outcomes, and (3) make improvements in the provider's service delivery system.
- G. The provider agrees, with the recipient's permission, to participate in the discussion of the recipient's record, the recipient's progress, the extent to which the recipient's needs are being met or any need for modifications to their support plan, implementation plan, or other documents, as applicable. This discussion could involve the APD or its authorized representatives, other service providers, the recipient, the guardian, family and friends.
- H. The provider agrees, with the recipient's permission, to provide information about the recipient to assist in the development of the support plan, and to attend the support planning meeting when invited by the recipient, family member or guardian.
- I. The provider agrees, to provide the recipient with opportunities for relevant training, achieve his or her personal goals, and to expand his or her life experiences within the community, through the provision of person-centered supports and services. These services and supports will be provided within the scope, intensity and duration specified on the recipient's support plan and approved cost plan.

- J. It is the responsibility of the Family and Supported Living Home and Community-Based Services Waiver program providers and employees of waiver providers who furnish non-reimbursed transportation services to recipient's as part of one or more primary waiver service(s) and who are not reimbursed for such transportation to meet the following requirements. The provider must be able to show, at time of enrollment, proof of valid driver's license, car registration and insurance. Subsequent to enrollment, the provider is responsible for keeping this documentation up-to-date.
- K. The provider understands and agrees to provide and bill for those services that have been authorized and approved by the District on the recipient's cost plan. The provider agrees not to bill for services until rendered, as authorized.
- L. The provider shall attend training sessions specific to the type of services provided, monthly support coordination district meetings and quarterly provider meetings as scheduled by the District.

2.1 Required Training

The provider and its employees will ensure they receive the specific training required to successfully serve each recipient including the following topics:

1. Emphasis on individual choice and rights;
2. The responsibilities of and procedures for maintaining the health, safety, and well being of recipient's served;
3. Recognition of abuse and neglect and required reporting procedures, to include domestic violence and sexual assault;
4. Development and implementation of the required documentation for each waiver service.
5. The Medicaid Waiver Services Agreement and its Attachment. The Family and Supported Living Waiver Services Florida Medicaid Coverage and Limitations handbook and its Appendices, and the use of personal outcomes to establish a person-centered approach to service delivery.
6. Other training specific and appropriate to the needs of the recipient's served by the provider and required for specific services listed in the Developmental Services Waiver Services Coverage and Limitations Handbook, for which the provider is enrolled and eligible to provide.
7. All direct service providers are required to complete training in the APD's Direct Care Core Competencies Training, or an equivalent curriculum approved by the APD within 120 days from the effective date of this rule. Said training may be completed using the APD's web-based instruction, self-paced instruction or classroom-led instruction.

The provider shall maintain on file for review, adequate and complete documentation to verify their participation, and the participation of their employees, in the required training sessions. This documentation shall, at a minimum, include the training topic(s), length of training session, date and location of training, name and signature of trainer, name and signature of person(s) in attendance.

2.2 APD Notification

The provider will share responsibility and assist the APD and others in the notification and resolution of the following issues and concerns for, or on behalf of, each recipient served by the provider:

- A. Notifying the District and other providers of issues concerning:
 1. The recipient's continued eligibility for waiver services. Any provider that becomes aware of a recipient's loss of Medicaid benefits shall immediately contact the recipient's support coordinator.
 2. The possibility of losing Medicaid eligibility. Any provider that becomes aware of a recipient's pending loss of Medicaid benefits shall immediately contact the recipient's District.
 3. Plans to move out of the District or state; and
 4. Plans to discontinue receiving services from the provider, waiver or the APD.
- B. Immediate notification to the District of an emergency or of an unusual occurrence or circumstance. Said notification of an unusual occurrence or circumstance includes, but is not limited to:
 1. Hospitalization of the recipient;
 2. Involvement of law enforcement agencies;
 3. Concerns about abuse, neglect, or exploitation and reporting of abuse, and reportable events; and
 4. Death of a recipient.

3.0 ADMINISTRATIVE POLICIES, PROCEDURES, AND PRACTICES

Pursuant to Section 393.062, Florida Statutes, the APD is charged with ensuring the most cost-beneficial and effective community-based services for recipients with developmental disabilities. In order to accomplish this objective the APD requires that each provider type and those providing the services listed below develop written policies and procedures for the provision of services to recipients under the Medicaid waiver:

- All agency or group providers;
- Solo Practitioners providing the following services: Adult Day Training, Supported Employment, and Supported Living coaching.

- A. The provider's practices shall be consistent with its written policies and procedures. Revisions to the provider's policies and procedures shall be made in a timely manner if modifications in provider practices deviate from the policies as written.
- B. The provider's policies shall address, at a minimum, the following:
 1. Procedures on the use of the Personal Outcome Process, and how individual outcome information will be incorporated into service delivery planning;

2. Procedures governing how a person-centered approach to services will be provided in order to meet the needs of the recipient's served and to achieve the personal goals on the support plan;
 3. Policies and procedures that will promote the health and safety of every recipient who receives services from the provider;
 4. Policies and procedures, which detail the safe administration and handling of medication in order to assure the health and safety of recipient's served, if it is the policy of the provider that the provider or the provider's staff should not administer or assist in administration of medication, this should be clearly stated;
 5. Policies and procedures to ensure the smooth transition of the recipient between providers and other supports and services;
 6. Policies and procedures that address the provider's staff training plan and that specify how pre-service and in-service activities will be carried out including HIV/AIDS training pursuant to Chapter 381.0035 F.S., CPR and all other mandated training;
 7. The provider's grievance procedures, as outlined in section 3.10 of this document; and
 8. The provider's procedures for conducting provider self-assessments.
- C. Each agency or group provider will maintain a current table of organization, including board of directors (when applicable), directors, supervisors, support staff, and all other employees.

3.1 Self-Assessment

Each agency or group provider, or Solo or Individual Provider furnishing specific services referenced in 3.0 above shall perform an annual self-assessment to determine the effectiveness of services being offered and the provider's compliance with requirements identified in this Agreement and the Developmental Services Waiver Services Florida Medicaid Coverage and Limitations handbook. This annual assessment will assist the provider to determine, within the realm and scope of the service(s) that is provided, the extent to which the provider is developing and maintaining person-centered processes that will assist recipient's in the achievement of personal outcomes, particularly in the areas of personal goals, choice, social inclusion, relationships, rights, dignity and respect, health, environment, security and satisfaction. At a minimum, the provider's Self-Assessment survey will include a combination of: a) records review; b) interviews to determine the extent to which provider actions support the achievement of personal goals identified by recipient's receiving services; and c) annual recipient satisfaction surveys. The provider, as part of the Self Assessment process develops a Quality Improvement Plan, addressing the areas in need of improvement.

3.2 Screening Requirement

Each provider **will maintain on file** and make available upon request, documentation that:

- A. Level Two background screening requirements are met for all direct service providers who are unrelated to their recipient's, in accordance with Chapter 393.0655, F.S.
- B. State and national criminal and history background checks are performed for any officer, director, billing agent, managing employee and any affiliated person, partner, or shareholder having ownership interest of 5 percent or greater in the agency, in accordance with section 409.907, F.S.

- C. All employees meet qualifications as specified in this document and the Family and Supported Living Waiver Services Coverage and Limitations handbook, including copies of licenses, certificates, high school and/or college diplomas and certified college transcripts as required.

3.3 Changes in Provider Status

- A. The provider understands and agrees that the APD and recipient's served will be notified of any change, sale or transfer of ownership. Recipient's receiving services will be given an opportunity to receive services from the new owner, purchaser, or transferee, or to select another provider.
- B. The provider understands and agrees that the APD shall be notified, prior to any change in provider status from a solo or individual provider to an agency or group provider. Such change shall be subject to APD review and approval.
- C. The provider understands and agrees that if they voluntarily terminate services, experiencing a break in service of ninety (90) days or more, and desire to return to the waiver in any capacity, that they will be considered a new applicant and shall comply with all the requirements of a new applicant.

3.4 Records Retention

- A. The provider will establish and maintain for review records pertinent to this Agreement that sufficiently and properly reflect all services provided and revenues and expenditures of funds provided by the APD and Medicaid under this Agreement. All records pertinent to this Agreement, including information stored in electronic media, shall be retained for a period of at least five (5) years after the completion date of the Agreement. If a state or federal audit has been initiated and audit findings have not been resolved at the end of five (5) years, the records shall be retained until resolution of the audit findings or any litigation, which may be based on the terms of this Agreement. Records shall be established and maintained in accordance with generally accepted accounting procedures and practices.
- B. The provider agrees that if all or part of the business is sold or transferred, the provider will maintain and make available to the APD and the Agency, those Medicaid-related records required to be kept unless the provider enters into an agreement with a third party to do so and furnishes the APD with a copy of such agreement. Any such agreement will require the holder or custodian of the records to comply with the terms set forth in this document for retention and access to said records.

3.5 Financial Requirements

- A. The provider agrees to notify the APD in writing prior to any filing for bankruptcy protection.
- B. Appropriate to the type and scope of services rendered, the provider agrees to maintain a separate checking account for any personal funds of any and all recipient's in the care of, or receiving services from the provider. If a single trust account is maintained for all recipient's personal funds, a separate accounting must be maintained for each recipient's funds, which reconciles monthly to the account's total as noted on the bank statement and is retained by the provider for review by the APD or Agency. The provider further understands and agrees that at no time should any recipient's personal funds be co-mingled with any other funds, including those of the provider or any of its employees. The provider shall maintain on file a written consent to manage personal funds, signed by the recipient or their legal guardian. The provider shall maintain on file receipts for individual purchases of \$25.00 or more.

- C. Neither the provider nor its employees, in their official capacity, will receive any financial benefit as a result of being named the beneficiary of a life insurance policy covering a recipient served by the provider.
- D. Neither the provider nor its employees, in their official capacity, will benefit financially by borrowing or otherwise using the personal funds of a recipient served by the provider.

3.6 Marketing Practices

The provider will market its services in a professional and ethical manner.

- A. The provider shall not, nor shall employees of the provider, possess or use for the purpose of solicitation, lists or other information from any source that identifies recipient's receiving services from the APD.
- B. The provider shall not, nor shall employees of the provider, solicit recipients directly or through an agent, through the use of fraud, intimidation, undue influence, or any form of overreaching or vexatious conduct, including offering discounts or special offers that include prizes, free services, or other incentives.
- C. The provider shall not, nor shall employees of the provider, unduly influence a recipient to request a support or service, select a support or service vendor or participate in an activity, regardless of whether or not the recipient request, selection or participation results in any benefit to the provider.

3.7 Goods and Services Provided

- A. The provider will conduct or be responsible for the following duties, for or on the behalf of each recipient served by the provider. The provider will:
 - 1. Document all service provision clearly and legibly in accordance with the Family and Supported Living Waiver Services Coverage and Limitations Handbook in a manner that will describe the limits of service, units of service, payment of service, location of service, and any other special consideration that will clearly document the rationale for the provision of the service;
 - 2. File all required documentation in the recipient's record prior to submitting a claim for services rendered;
 - 3. Maintain documentation in accordance with procedures specified in these Agreement documents, including the specific service requirements identified in the Family and Supported Living Waiver Services Coverage and Limitations Handbook, for each participant being served, as well as for each waiver service being provided. The APD, Agency or their authorized representative retains the right to review a recipient's record(s) at any time.
 - 4. Bill for only those services for which an approved service authorization has been received. Services shall be billed only at the approved rate, frequency and duration. Copies of service authorizations shall be kept on file by the provider and shall be made available to APD, Agency or their authorized representative for monitoring purposes.
- B. The provider understands and agrees that the APD and Agency has the final authority on all matters pertaining to paid services or goods purchased with funds appropriated to the APD for recipient's who receive services through the waiver.

3.8 Payment Provisions

- A. The provider understands and agrees that all claims for duly authorized and rendered services will be submitted directly through the Medicaid FMMIS system. Claims submitted for payment and the corresponding support documentation must be correct and legible.
- B. The provider understands and agrees that the Medicaid fiscal agent or the Office of the Comptroller will not pay a different Medicaid waiver payment rate for the same level of service for the same provider-type and will only pay for those services authorized and directly related to the recipient's goals as identified in his current support plan and that are authorized on the recipient's current and approved cost plan.
- C. The provider understands and agrees that payment from the Medicaid fiscal agent is made to a provider that is determined eligible by a District Office and has executed a Medicaid Waiver Services Agreement. The provider further understands that payment is contingent upon its enrollment in Medicaid as a waiver provider of Family and Supported Living Home and Community-Based Services Waiver services.
- D. The provider understands that Medicaid payment will be payment in full for the services provided. The provider understands that it may not bill the recipient or family for any service that is authorized for reimbursement by Medicaid.
- E. The provider understands and agrees that payment from the Medicaid fiscal agent will be made only after services are rendered.
- F. Payment shall not be made for services not rendered.
- G. The provider understands and agrees that the APD is under no obligation to fund or fill vacancies created, under any circumstance.
- H. The provider understands and agrees that submission of a claim for a service that is not authorized on the service authorization form is grounds for termination of the Medicaid provider agreement.

3.9 Recoupment of Funds

- A. The provider understands and agrees that the APD or Agency will recoup funds paid to the provider for any reimbursed service for which the provider cannot produce the required documentation that fully supports the service as being rendered.
- B. The provider understands that payment for services that are not authorized, appropriately documented, or not billed appropriately through the FMMIS system, or are billed in excess of the maximum units authorized, will result in recoupment of funds by the APD or Agency.

3.10 Grievance Procedures

The provider understands and agrees to establish and maintain written grievance procedures that will be used to resolve conflicts that may arise between the recipient, family, and/or guardian and the provider. These procedures do not preclude appropriate requests for a hearing, nor do they preempt the recipient, family, and guardian's right to request a change in services and/or provider.

- A. These procedures will specify:
 - 1. That grievance procedures will be reviewed and signed by the recipient, family and/or guardian within 30 days of beginning services and annually thereafter;

2. Those grievance procedures will be communicated in clear, understandable language to the recipient, his or her family or guardian. Responses to grievances will be provided verbally and in writing at the recipient's level of comprehension and in the language understood by the recipient;
3. That a log of all grievances filed by recipients, families or guardians will be maintained for review and will include the following information:
 - (a) The name of the person making the complaint and their relationship to the recipient receiving services;
 - (b) The date the complaint is received;
 - (c) A clear description of the complaint. (Oral complaints will be documented in writing.) All complaints should be retained in the recipient's file and a copy retained with the grievance log; and
 - (d) The date of and the final disposition of each logged complaint.
4. The established procedures should provide for prompt resolution of any conflict.

Attachment C

Contact Directory

**Area Offices
Agency for Health Care Administration
Medicaid**

For information or assistance regarding other Medicaid/Waiver Handbooks

Area 1
Suncom

(850) 595-5700
695-5700

Serving: Escambia, Okaloosa,
Santa Rosa, and Walton counties

Area 2A
Suncom

(850) 872-7690
777-7690

Serving: Bay, Franklin, Gulf, Holmes,
Jackson, and Washington counties

Area 2B
Suncom

(850) 921-8474
291-8474

Serving: Calhoun, Gadsden, Jefferson,
Leon, Liberty, Madison, Taylor, and
Wakulla counties

Area 3A
Suncom

(386) 418-5350
NONE

Serving: Alachua, Bradford, Columbia,
Dixie, Gilchrist, Hamilton, Lafayette,
Levy, Putnam, Union, and Suwannee
counties

Area 3B
Suncom

(352) 732-1349
667-1349

Serving: Citrus, Hernando, Lake,
Marion, and Sumter counties

Area 4
Suncom

(904) 353-2100
826-2100

Serving: Baker, Clay, Duval, Nassau, St.
Johns, Flagler, and Volusia counties

**Area Offices
Agency for Health Care Administration
Medicaid**

For information or assistance regarding other Medicaid/Waiver Handbooks

<u>Area 5</u> <i>Suncom</i>	(727) 552-1191 513-2659	<u>Serving:</u> Pasco and Pinellas counties
<u>Area 6</u> <i>Suncom</i>	(813) 871-7600 512-8290	<u>Serving:</u> Hardee, Highlands, Hillsborough, Manatee, and Polk counties
<u>Area 7</u> <i>Suncom</i>	(407) 317-7851 344-7851	<u>Serving:</u> Brevard, Orange, Osceola, and Seminole counties
<u>Area 8</u> <i>Suncom</i>	(941) 338-2620 748-2620	<u>Serving:</u> Charlotte, Collier, DeSota, Glades, Hendry, Sarasota, and Lee Counties
<u>Area 9</u> <i>Suncom</i>	(561) 881-5080 264-5080	<u>Serving:</u> Indian River, Martin, Okeechobee, Palm Beach, and St. Lucie counties
<u>Area 10</u> <i>Suncom</i>	(954) 202-3200 423-3200	<u>Serving:</u> Broward county
<u>Area 11</u> <i>Suncom</i>	(305) 499-2000 429-2000	<u>Serving:</u> Dade and Monroe counties

Attachment D

Contact Directory

**Area Offices
Agency for Persons with Disabilities
Developmental Disabilities Program**

For information or assistance, ask for the staff person assigned to the Developmental Services Home and Community-Based Services Waiver.

<u>Area 1</u> <i>Suncom</i>	(850) 595-8344 695-8344	<u>Area 10</u> <i>Suncom</i>	(954) 467-4218 453-4218
<u>Area 2</u> <i>Suncom</i>	(850) 487-1992 277-1992	<u>Area 11</u> <i>Suncom</i>	(305) 377-5029 452-5029
<u>Area 3</u> <i>Suncom</i>	(352) 955-5793 625-5793	<u>Area 12</u> <i>Suncom</i>	(386) 238-4718 380-4026
<u>Area 4</u> <i>Suncom</i>	(904) 992-2440 876-2440	<u>Area 13</u> <i>Suncom</i>	(352) 330-2162 895-2177
<u>Area 7</u> <i>Suncom</i>	(407) 245-0440 344-0440	<u>Area 14</u> <i>Suncom</i>	(863) 619-4100 561-4100
<u>Area 8</u> <i>Suncom</i>	(239) 338-1572 722-1572	<u>Area 15</u> <i>Suncom</i>	(772) 468-4080 240-4080
<u>Area 9</u> <i>Suncom</i>	(561) 837-5564 252-5564	<u>Area 23</u> <i>Suncom</i>	(813) 558-5540 514-5540

Attachment E Family and Supported Living Waiver Cost Plan Worksheet

Date: _____

Consumer: _____

District Contact: _____ District Number: _____

Services available with annual Waiver dollar caps:

Adult Day Training -----	\$1,000.00
Behavior Analysis Services (including Behavior Assessment and Behavior Assistant) -----	\$4,500.00
Consumable Medical Supplies -----	\$800.00
Environmental Accessibility Adaptations -----	\$2,000.00
In-home Supports -----	\$5,000.00
Personal Emergency Response System -----	\$300.00
Respite Care -----	\$1,000.00
Support Coordination -----	\$1,780.68
Supported Employment -----	\$2,500.00
Supported Living Coaching -----	\$3,500.00
Transportation -----	\$1,000.00

Service requested	Budget *
Support Coordination	\$ 1,780.68
	\$ _____
	\$ _____
	\$ _____
	\$ _____
	\$ _____
Total Annual Budget not to exceed \$14,282.00	\$ _____

General Revenue Funds Requested: _____
Supported Living Startup Funds \$ _____

Supported Living Stipend: \$ _____ monthly x 12 = \$ _____

* If request exceeds individual Waiver dollar cap, justification of medical necessity is required. Detail below and/or submit additional documentation.

