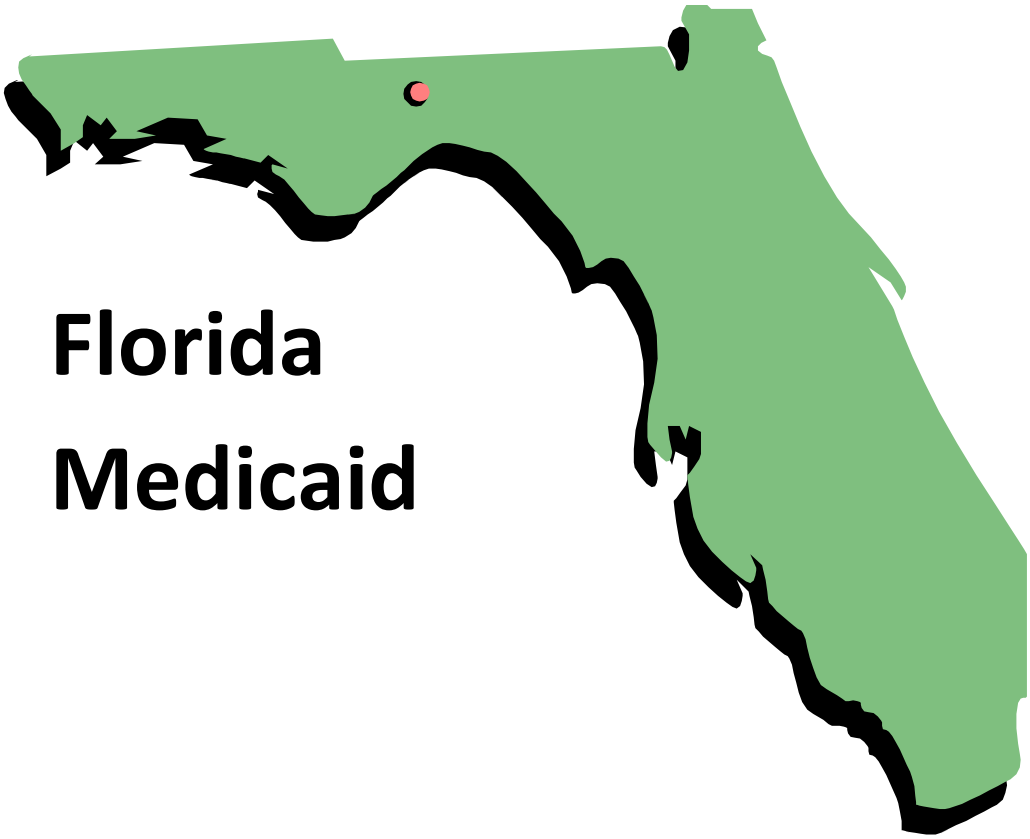

Florida Medicaid

AGED AND DISABLED ADULT WAIVER

SERVICES COVERAGE AND LIMITATIONS HANDBOOK

Agency for Health Care Administration

AHCA
FLORIDA AGENCY FOR HEALTH CARE ADMINISTRATION

UPDATE LOG
AGED AND DISABLED ADULT WAIVER SERVICES COVERAGE AND LIMITATIONS HANDBOOK

How to Use the Update Log

Introduction

The current Medicaid provider handbooks are posted on the Medicaid fiscal agent's Web site at mymedicaid-florida.com. Select Public Information for Providers, then on Provider Support, and then on Provider Handbooks. Changes to a handbook are issued as handbook updates. An update can be a change, addition, or correction to policy. An update may be issued as a revised handbook or a completely new handbook.

It is the provider's responsibility to follow correct policy to obtain Medicaid reimbursement.

Explanation of the Update Log

Providers can use the update log to determine if they have received all the updates to the handbook.

Update describes the change that was made.

Effective Date is the date that the update is effective.

Instructions

When a handbook is updated, the provider will be notified by a postcard or notice. The notification instructs the provider to obtain the updated handbook from the Medicaid fiscal agent's Web site at mymedicaid-florida.com. Select Public Information for Providers, then on Provider Support, and then on Provider Handbooks.

Providers who are unable to obtain an updated handbook from the Web site may request a paper copy from the Medicaid fiscal agent's Provider Support Contact Center at 1-800-289-7799.

UPDATE	EFFECTIVE DATE
New Handbook	March 2004
Replacement Pages	August 2005
Erratum	August 2005
Revised Handbook	May 2009

AGED AND DISABLED ADULT WAIVER SERVICES

COVERAGE AND LIMITATIONS HANDBOOK

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INTRODUCTION TO THE HANDBOOK

Overview

Introduction

This chapter introduces the format used for the Florida Medicaid handbooks and tells the reader how to use the handbooks.

Background

There are three types of Florida Medicaid handbooks:
Provider General Handbook describes the Florida Medicaid Program.

Coverage and Limitations Handbooks explain covered services, their limits, who is eligible to receive them, and the fee schedules.

Reimbursement Handbooks describe how to complete and file claims for reimbursement from Medicaid.

Exceptions: For Prescribed Drugs and Transportation Services, the coverage and limitations handbook and the reimbursement handbook are combined into one.

Legal Authority

The following federal and state laws govern Florida Medicaid:

Title XIX of the Social Security Act,
Title 42 of the Code of Federal Regulations,
Chapter 409, Florida Statutes, and
Chapter 59G, Florida Administrative Code.

The specific Federal Regulations, Florida Statutes, and the Florida Administrative Code, for each Medicaid service are cited for reference in each service-specific coverage and limitations handbook.

In This Chapter

This chapter contains:

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Handbook Use and Format

Purpose

The purpose of the Medicaid handbooks is to furnish the Medicaid provider with the policies and procedures needed to receive reimbursement for covered services provided to eligible Florida Medicaid recipients.
The handbooks provide descriptions and instructions on how and when to complete forms, letters or other documentation.

Provider

The term “provider” is used to describe any entity, facility, person or group who is enrolled in the Medicaid program and renders services to Medicaid recipients and bills Medicaid for services.

Recipient

The term “recipient” is used to describe an individual who is eligible for Medicaid.

General Handbook

General information for providers regarding the Florida Medicaid Program, recipient eligibility, provider enrollment, fraud and abuse policy, and important resources are included in the Florida Medicaid Provider General Handbook.

Coverage and Limitations Handbook

Each coverage and limitations handbook is named for the service it describes. A provider who furnishes more than one type of service will have more than one coverage and limitations handbook.

Reimbursement Handbook

Each reimbursement handbook is named for the claim form that it describes.

Chapter Numbers

The chapter number appears as the first digit before the page number at the bottom of each page.

Page Numbers

Pages are numbered consecutively throughout the handbook. Page numbers follow the chapter number at the bottom of each page.

White Space

The "white space" found throughout a handbook enhances readability and allows space for writing Notes.

Characteristics of the Handbook

Format

The format styles used in the handbooks represent a concise and consistent way of displaying complex, technical material.

Information Block

Information blocks replace the traditional paragraph and may consist of one or more paragraphs about a portion of the subject. Each block is identified or named with a label.

Label

Labels or names are located in the left margin of each information block. They identify the content of the block in order to facilitate scanning and locating information quickly.

Note

Note is used most frequently to refer the user to pertinent material located elsewhere in the handbook.
Note also refers the user to other documents or policies contained in other handbooks.

Topic Roster

Each chapter contains a topic roster on the first page which serves as a table of contents for the chapter, listing the subjects and the page number where the subject can be found.

Handbook Updates

Update Log

The first page of each handbook will contain the update log.
Every update will contain a new updated log page with the most recent update information added to the log.

Each update will be designated by an “Update” and the “Effective Date.”

How Changes Are Updated

The Medicaid handbooks will be updated as needed. Changes may consist of one of the following:

1. Replacement handbook—Major changes will result in the entire handbook being replaced with a new effective date throughout and it will be a clean copy.

2. Revised handbook – Changes will be highlighted in yellow and will be incorporated within the appropriate chapter. These revisions will have an effective date that corresponds to the effective date of the revised handbook.

Effective Date of New Material

The month and year that the new material is effective will appear in the center of each page. The provider can check this date to ensure that the material being used is the most current and up to date.

Identifying New Information

New material will be indicated by yellow highlighting. The following information blocks give examples of how new labels, new information blocks, and new or changed material within an information block will be indicated.

New Label and New Information Block

A new label and a new information block will be identified with yellow highlight to the entire section.

New Material in an Existing Information Block or Paragraph

New or changed material within an existing information block or paragraph will be identified by yellow highlighting to the sentence or paragraph affected by the change.

CHAPTER 1
AGED AND DISABLED ADULT WAIVER SERVICES PROVIDER QUALIFICATIONS AND ENROLLMENT

Overview

Introduction

This chapter describes the Florida Medicaid Aged and Disabled Adult Waiver Program, the purpose of the program, provider qualifications, and provider responsibilities and specifies the authority regulating aged and disabled adult waiver assistance.

Legal Authority

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 441.302.

The Florida Medicaid Aged and Disabled Adult Waiver Program is authorized by Chapter 409.906, Florida Statutes (F.S.) and Chapter 59G-13.030, Florida Administrative Code (F.A.C.).

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Description and Purpose

A/DA

For the purposes of this handbook, A/DA Waiver Program means the Aged and Disabled Adult Waiver Program, and A/DA waiver services means aged and disabled adult waiver services, including services for the cognitively intact, technologically dependent, and medically-complex individuals who have turned 21 years old and "aged out" of the Department of Health, Children's Medical Services Program.

Purpose of this Handbook

This handbook is intended for use by providers that furnish A/DA waiver services to eligible recipients. It must be used in conjunction with the Florida Medicaid Provider Reimbursement Handbook, CMS-1500, which contains specific procedures for submitting claims for payment, and the Florida Medicaid Provider General Handbook, which contains information about the Medicaid program in general.

Note: The handbooks are available on the Medicaid fiscal agent's Web site at mymedicaid-florida.com. Select Public Information for Providers, then on Provider Support, and then on Provider Handbooks. The Florida Medicaid Provider General Handbook is incorporated by reference in 59G-5.020, F.A.C. The Florida Medicaid Provider Reimbursement Handbook, CMS-1500, is incorporated by reference in 59G-4.001, F.A.C.

A/DA Waiver Description

The A/DA waiver is a Medicaid Program that provides home and community-based services to eligible recipients who, but for the provision of these services, would require nursing facility placement.

The A/DA waiver serves recipients who are 18 to 64 years old and determined disabled according to the Social Security Administration and individuals 65 years old and older.

The A/DA waiver also serves cognitively intact, technologically dependent, and medically-complex individuals who have turned 21 years old and "aged out" of the Department of Health, Children's Medical Services Program.

A/DA waiver recipients must demonstrate health conditions and functional limitations that would result in their placement in a nursing facility were it not for the provision of A/DA waiver services.

Purpose of the A/DA Waiver

The purpose of the A/DA Waiver Program is to promote, maintain, and restore the health of eligible elders and adults with disabilities and to minimize the effects of illness and disabilities in order to delay or prevent institutionalization.

A/DA Waiver Responsibilities

Administration Responsibilities

The A/DA Waiver Program is jointly administered by the Agency for Health Care Administration (AHCA), the Department of Elder Affairs (DOEA) and the Department of Children and Families (DCF). AHCA is the "single state agency" designated by the Centers for Medicare and Medicaid Services (CMS) as the lead agency for the administration of the waiver. DOEA and DCF are the operational components of the waiver.

AHCA is responsible for ensuring compliance with federal program requirements, developing Medicaid policy, reimbursing Medicaid providers and operating the cognitively intact, medically complex, technologically dependent young adult population or "Aging Out" section of the waiver.

DOEA is responsible for operating the program for recipients who are 60 years of age or older. DOEA is also responsible for completing the level of care determination on all recipients participating in the waiver.

DCF is responsible for determining all Medicaid recipients' financial eligibility and operating the program for recipients who are ages 18 to 59.

AAAs and Medicaid Waiver Specialists

An Area Agency on Aging (AAA) is located in each DOEA designated Planning and Service Area (PSA). The AAAs employ at least one Medicaid waiver specialist who oversees the A/DA Waiver Program for the PSA.

The Medicaid waiver specialist qualifications and duties are found in the Medicaid waiver specialist contract.

The AAAs shall submit to DOEA for approval all procedures, policy and program instructions to be issued to the case management agencies. DOEA shall submit all major policy and program change instructions to AHCA for review and concurrence prior to issuing to the case management agencies.

The AAAs shall develop and maintain quality assurance and quality improvement initiatives with their case management agencies and service providers to enhance the delivery of services through systemic identification and resolution of recipient issues.

The AAAs shall follow policies and procedures regarding recipient enrollment into the A/DA Waiver Program and "wait list" policies and procedures for those individuals on the "wait list." The "wait list" shall be available for review by AHCA; DCF, Adult Protective Services; and DOEA.

The AAAs shall develop and maintain procedures for service provider recruitment to meet the needs of its A/DA recipients.

The AAAs shall develop monitoring and audit policies and procedures for review of case management agencies and service providers. This shall include review of claims to ensure that contracted rates between the AAA and case management agencies and service providers are equal to or less than those listed in the Aged and Adult Waiver Services Procedure Code and Fee Schedule. Procedures shall be developed for referral of offenders to AHCA for review by Medicaid Program Integrity or provider termination.

Note: To obtain a list of the AAA addresses and telephone numbers, call (850) 414-2000,; log on to: elderaffairs.state.fl.us/ ; or write:

Department of Elder Affairs
Medicaid Waiver Programs
4040 Esplanade Way
Tallahassee, Florida 32399-7000

Note: The Aged and Disabled Adult Waiver Services Procedure Code and Fee Schedule is available on the Medicaid fiscal agent's Web site at mymedicaid-florida.com. Select Public Information for Providers, then on Provider Support, and then on Fee Schedules. It is incorporated by reference in 59G-13.031, F.A.C.

Enrollment in Aging Out

AHCA administers the Aging Out Program of the A/DA waiver, which serves cognitively intact, medically complex, and technologically dependent young adults who age out of the Department of Health, Children's Medical Services program on their 21st birthday.

Note: Contact the AHCA A/DA program analyst at (850) 487-2618 for information about enrollment.

Note: See Chapter 3 for information on the Aging Out Program.

A/DA Waiver Funding

DOEA, AHCA and DCF have line items in their budgets for funding the A/DA waiver. As a Medicaid waiver, the A/DA waiver also receives federal financial participation to supplement general revenue funding. AHCA bills DOEA and DCF for the non-federal cost of reimbursing providers for A/DA waiver services.

DOEA's Spending Authority

DOEA's waiver spending authority responsibilities are to:

- Ensure providers do not transfer A/DA recipients to general revenue-funded programs including Community Care for the Elderly (CCE), Alzheimer's Disease Initiative (ADI), or Local Service Programs (LSP), unless the recipient no longer meets Medicaid waiver financial eligibility or level of care criteria.
- Ensure the AAAs verify that service providers have either a memorandum of agreement, a referral agreement or a contract, which ensures budgetary constraints are understood and followed.

DCF's Spending Authority

DCF's Adult Protective Services Headquarters Program Office manages the budgetary authority for disabled adults ages 18 to 59 served by the A/DA waiver.

DCF district spending allocations are sent to the district program offices as soon as possible at the beginning of each fiscal year (July 1).

DCF's Region program offices verify that service providers have a memorandum of agreement, a referral agreement or a contract that ensures budgetary constraints are understood and followed.

Case Management Provider Qualifications

General Case Management Provider Qualifications

A/DA waiver case management providers must meet the general Medicaid provider qualifications contained in Chapter 2 of the Florida Medicaid Provider General Handbook. In addition, A/DA case management providers must meet the specific provider qualifications listed in this section.

Transition Case Management

Transition Case Management services can be provided to Medicaid eligible individuals who reside in a nursing facility and wish to transition into a less restrictive environment within the community. This service can be used to assess, evaluate, plan, and coordinate the services needed by a potential nursing home transition candidate. Transition case management services can be provided to Medicaid eligible individuals who have resided in a nursing facility for at least 60 consecutive days before their discharge from the nursing facility. The enrolled case management provider may bill for a time period no greater than 180 consecutive days (6

months) prior to discharge, and is not authorized to bill for transition case management services provided until after the individual is discharged from the nursing facility and is actively enrolled in the waiver. After discharge from the nursing facility and enrollment in the waiver, transition case management services end and regular waiver case management services can begin. If an individual is not discharged from the nursing facility, the case management provider will not be authorized to bill for transition case management services.

The provider qualifications and the reimbursement rate for Transition Case Management will remain the same as currently provided by case management services under the waiver.

Case Management Agency Requirements

To provide A/DA waiver case management services, the entity must have one of the following unless case management is provided by DCF staff:

- A referral agreement with an Area Agency on Aging for Department of Elder Affairs (DOEA).
- A referral agreement and contract with the Department of Children and Families (DCF).
- A referral agreement and contract to provide case management through the Community Care of the Elderly (CCE) program authorized by Chapter 430, F.S.
- A referral agreement with another state agency that meets criteria designated by DOEA or DCF and approved by AHCA.

Additional Case Management Agency Requirements

In addition to the above criteria, the case management agency must:

- Have demonstrated capability and experience in developing and implementing comprehensive case management services for adults with complex medical and social needs;
- Have a case management supervisor who holds a minimum of the following:
  - Master's degree in a human service, social science or health field and has a minimum of two years experience in case management, at least one year of which must be related to the elderly and disabled populations;
  - Bachelor's degree in a human service, social science or health field with a minimum of five years experience in case management, at least one year of which must be related to the elderly and disabled populations;: or
  - Professional human service, social science or health related experience may be substituted on a year-for-year basis for the educational requirement, (i.e., a high school diploma or equivalent and nine years of experience in a human service, social science or health field, five years of which must be related to case management, at least one year of which must be related to the elderly and disabled population).
- Employ qualified case managers and assign caseloads that are no more than a ratio of 60 recipients to one case manager;
- Have demonstrated capability and experience in provider network development;
- Have and follow a policy to ensure that its employees, board members, and management avoid any conflict of interest or the appearance of a conflict of interest when using Medicaid funds, when providing services to recipients or making referrals to providers. "Conflict of interest" means receiving or agreeing to receive a direct or indirect benefit or anything of value from a recipient, service provider, vendor, or other person wishing to benefit from this program;

- Have data collection and analysis capabilities that enable the tracking of recipient service utilization, cost and demographic information;
- Develop an organized quality assurance and quality improvement program to enhance delivery of services through systemic identification and resolution of recipient issues;
- Ensure all assessment forms and plans of care are complete and comprehensive including all required signatures whenever appropriate;
- Develop a recording and tracking system log for recipient complaints and resolutions;
- Identify and resolve recipient satisfaction issues; and
- Maintain documentation of the need for all services provided through the waiver.

Case Manager Qualifications

To provide A/DA case management services, a case manager must meet one of the following qualifications:

- Have a bachelor's degree in social work, sociology, psychology or a related social services field and have one year of related professional experience; or
- Have a bachelor's degree in a field other than social science and have a minimum of two years of related professional experience.

Professional human service experience may substitute on a year-for-year basis for the educational requirement.

Waiver Services Provider Qualifications

Introduction

A/DA waiver providers must meet the general Medicaid provider qualifications contained in Chapter 2 of the Florida Medicaid Provider General Handbook. In addition, A/DA waiver providers must meet the specific provider qualifications listed in this section for the services they provide.

Under the A/DA waiver, Medicaid does not reimburse for services furnished by parents, stepparents, spouse, siblings, sons, daughters, household members or any person with custodial or legal responsibility for a Medicaid recipient.

Adult Companion Providers

To provide Medicaid A/DA waiver companion services, providers must be:

- Independent, individual companions;
- Homemaker and companion agencies registered with the Agency for Health Care Administration's Division of Health Quality Assurance (HQA) in accordance with Chapter 400, F.S.;
- Registered nurses licensed in accordance with Chapter 464, F.S.;
- Licensed practical nurses licensed in accordance with Chapter 464, F.S.;
- A home health agency licensed under Chapter 400, Part IV, F.S.;
- A home health agency licensed under Chapter 400, Part IV, F.S. that meets federal conditions of Medicare participation under 42 CFR 484;
- Nurse registries licensed in accordance with Section 400.506, F.S.; or
- Community care provider agencies established in accordance with Chapter 410 or 430, F.S.

Adult Day Health Care Providers

To provide A/DA waiver adult day health care services, providers must be adult day care centers licensed in accordance with Chapter 429, Part III, F.S.

Attendant Care Providers

Attendant care services must be provided by:

- Registered nurses licensed in accordance with Chapter 464, F.S.;
- Licensed practical nurses licensed in accordance with Chapter 464, F.S.;
- A home health agency licensed under Chapter 400, Part IV, F.S.
- A home health agency licensed under Chapter 400, Part IV, F.S. that meets federal conditions of Medicare participation under 42 CFR 484; or
- Nurse registries licensed in accordance with Section 400.506, F.S.

Case Aide Providers

To provide A/DA waiver case aide services, providers must have one of the following unless case aides are provided by DCF staff:

- A referral agreement with an Area Agency on Aging for the Department of Elder Affairs (DOEA).
- A referral agreement and contract with the Department of Children and Families (DCF).
- A referral agreement and contract to provide case management through the Community Care for the Elderly (CCE) program authorized by Chapter 430, F.S.
- A referral agreement and contract to provide case management through the Community Care of the Disabled Adults (CCDA) program authorized by Chapter 410, F. S.
- A referral agreement with another state agency that meets criteria designated by DOEA or DCF and approved by AHCA.

Caregiver Training or Support Services

To provide A/DA waiver caregiver training or support services, providers must be one of the following:

- A home health agency licensed under Chapter 400, Part III, F.S.
- A home health agency licensed under Chapter 400, Part III, F.S. that meets federal conditions of Medicare participation under 42 CFR 484.
- A registered nurse or licensed practical nurse licensed under Chapter 464, F.S.
- A clinical social worker licensed under Chapter 491, F.S.
- A mental health counselor licensed under Chapter 491, F.S.
- A community care provider agency in accordance with Chapter 410 or 430, F.S., or other agency meeting comparable standards.

Chore Providers

To provide A/DA waiver chore services, providers must be:

- Independent vendors with occupational licenses issued by the local governing authority in accordance with Chapter 205, F.S.; or
- A home health agency licensed under Chapter 400, Part III, F.S.
- A home health agency licensed under Chapter 400, Part III, F.S. that meets federal conditions of participation under 42 CFR 484.

Consumable Medical Supply Providers

To provide A/DA waiver consumable medical supplies, providers must be:

- A home health agency licensed under Chapter 400, Part III, F.S.
- A home health agency licensed under Chapter 400, Part III, F.S. that meets federal conditions of Medicare participation under 42 CFR 484.
- Pharmacies licensed in accordance with Chapter 465, F.S.;
- Home medical equipment (HME) providers with occupational licenses issued by the local governing authority in accordance with Chapter 205, F.S. and enrolled as a Medicaid Durable Medical Equipment provider; or
- HME providers licensed in accordance with Chapter 400, Part X, F.S., if the HME provider supplies products that require recipient training and enrolled as a Medicaid Durable Medical Equipment provider.

Counseling Providers

To provide A/DA waiver counseling services, providers must be:

- Psychologists licensed in accordance with Chapter 490, F.S.;
- Mental health counselors licensed in accordance with Chapter 491, F.S.;
- Clinical social workers licensed in accordance with Chapter 491, F.S.;
- A home health agency licensed under Chapter 400, Part III, F.S.
- A home health agency licensed under Chapter 400, Part III, F.S. that meets federal conditions of Medicare participation under 42 CFR 484.
- Marriage and family therapists licensed in accordance with Chapter 491, F.S.; or
- Community mental health centers established by DCF under Chapter 394, F.S. and enrolled as Medicaid Community Behavioral Health providers.

Emergency Alert Response System (EARS)

To provide A/DA waiver emergency alert response system (EARS) services, providers must be:

- Alarm system contractors certified under Chapter 489, F.S.;
- Community care provider agencies exempted from licensure under Chapter 489, F.S.;
- Hospitals licensed in accordance with Chapter 395, F.S.;
- EARS manufacturers and response centers exempted from licensure under Chapter 489, F.S.; or
- Independent EARS vendors exempted from licensure under Chapter 489, F.S. and meeting the definition in Section 489.505 (26), F.S.

Escort Providers

To provide A/DA waiver escort services, providers must be:

- A home health agency licensed under Chapter 400, Part III, F.S.
- A home health agency licensed under Chapter 400, Part III, F.S. that meets federal conditions of Medicare participation under 42 CFR 484; or
- Community care agencies established in accordance with Chapter 410 or 430, F.S.

Financial Risk Reduction Providers

To provide A/DA waiver financial risk reduction services, providers must be:

- Community care agencies established in accordance with Chapter 410 or 430, F.S.;

- A home health agency licensed under Chapter 400, Part III, F.S.
- A home health agency licensed under Chapter 400, Part III, F.S. that meets federal conditions of Medicare participation under 42 CFR 484;
- Banks licensed under Chapter 658 F.S.; or
- Certified public accountants certified under Chapter 473, F.S.

Home-Delivered Meal Providers

To provide A/DA waiver home-delivered meal services, providers must be:

- Food service businesses licensed in accordance with Chapter 509, F.S.; or
- Federal Older Americans Act providers contracted for home delivered meals under Title III, Older Americans Act of 1965.

Home Modifications Providers

To provide A/DA waiver home modifications services, providers must be:

- Contractors licensed by the Department of Business and Professional Regulation (DBPR) in accordance with Chapter 489, F.S. and licensed in accordance with Chapter 205, F.S.;

or

- Independent vendors with an occupational license issued by the local governing authority in accordance with Chapter 205, F.S.

Homemanager and Homemaker Providers

To provide A/DA waiver homemanager and homemaker services, providers must be:

- Independent, individual homemakers;
- Homemaker and companion agencies registered in accordance with Chapter 400, F.S.;
- A home health agency licensed under Chapter 400, Part III, F.S.
- A home health agency licensed under Chapter 400, Part III, F.S. that meets federal conditions of Medicare participation under 42 CFR 484;
- Community care provider agencies established in accordance with Chapters 410 or 430, F.S.; or
- Nurse registries licensed in accordance with Section 400.506, F.S., and providing the service under Sections 400.461-400.518, F.S.

Nutritional Risk Reduction Providers

To provide A/DA waiver nutritional risk reduction services, providers must be dietitians, nutritionists, or nutritional counselors licensed under Chapter 468, Part X, F.S.

Occupational Therapy Providers

To provide A/DA waiver occupational therapy services, providers must be:

- Occupational therapists licensed in accordance with Chapter 468, F.S.; or
- Occupational therapy aides licensed in accordance with Chapter 468, F.S.

Personal Care Providers

To provide A/DA waiver personal care services, providers must be:

- A home health agency licensed under Chapter 400, Part III, F.S.

- A home health agency licensed under Chapter 400, Part III, F.S. that meets federal conditions of Medicare participation under 42 CFR 484.
- Nurse registries licensed in accordance with Section 400.506, F.S.; or
- Community care provider agencies established in accordance with Chapters 410 or 430, F.S.

Pest Control Providers

To provide A/DA waiver pest control services, providers must be pest control businesses licensed by the Department of Agriculture and Consumer Services according to Chapter 482, F.S.

Physical Risk Reduction Providers

To provide A/DA waiver physical risk reduction services, providers must be:

- Physical therapists licensed in accordance with Chapter 486, F.S.;
- Physical therapist aides licensed in accordance with Chapter 486, F.S.;
- A home health agency licensed under Chapter 400, Part III, F.S. with county wide coverage; or
- A home health agency licensed under Chapter 400, Part III, F.S. that meets federal conditions of Medicare participation under 42 CFR 484.

Physical Therapy Providers

To provide A/DA waiver physical therapy services, providers must be:

- Physical therapists licensed in accordance with Chapter 486, F.S.; or
- Physical therapist aides licensed in accordance with Chapter 486, F.S.

Rehabilitation Engineering Evaluation Providers

To provide A/DA waiver rehabilitation engineering evaluations, a provider must:

- Be a Certified Assistive Technology Practitioner credentialed through the Rehabilitation Engineering and Assistive Technology Society of North America; and
- Be familiar with the aged and disabled population served.

Respiratory Therapy Providers

To provide A/DA waiver respiratory therapy services, providers must be a respiratory therapist certified under Chapter 468, F.S.

Respite Providers–In-Home and Facility-Based

To provide A/DA waiver in-home respite services, providers must be:

- Home health agencies licensed in accordance with Chapter 400, Part III, F.S., that meet federal conditions of Medicare participation under 42 CFR 484;
- Home health agencies licensed in accordance with Chapter 400, Part III, F.S.;
- Community care provider agencies established in accordance with Chapters 410 or 430, F.S.;
- Nurse registries licensed in accordance with Section 400.506, F.S.; or
- Homemaker or companion agencies that were registered under section 400.509(1), Florida Statutes, on January 1, 1999, and were authorized to provide personal services as a Florida Medicaid Developmental Disabilities Waiver Services provider as of January 1, 1999.

To provide A/DA waiver facility-based respite services, providers must be:

- Adult day care centers licensed in accordance with Chapter 400, Part V, F.S.;
- Assisted living facilities licensed in accordance with Chapter 429, F.S.; or
- Nursing facilities licensed in accordance with Chapter 400, Part II, F.S.

Skilled Nursing Providers

To provide A/DA waiver skilled nursing services, providers must be home health agencies meeting federal conditions of participation under 42 CFR 484 or licensed in accordance with Chapter 400, F.S. and enrolled in the Medicaid Home Health Program.

Specialized Medical Equipment and Supply Providers

To provide A/DA waiver specialized medical equipment and supplies, providers must be:

- Home health agencies licensed in accordance with Chapter 400, Part III, F.S., that meet federal conditions of Medicare participation under 42 CRF 484;
- Home health agencies licensed in accordance with Chapter 400, Part III, F.S.;
- Pharmacies licensed in accordance with Chapter 465, F.S.; or
- HME providers with an occupational license issued in accordance with Chapter 205, F.S. and have an HME license issued in accordance with Chapter 400, Part X, F.S., if the HME provides supplies requiring recipient training.
- Enrolled as a Medicaid Durable Medical Equipment provider.

Speech Therapy Providers

To provide A/DA waiver speech therapy services, providers must be a speech-language pathologist or speech-language pathologist assistant licensed under Chapter 468, F.S.

Provider Enrollment

Enrollment Process

To enroll as an A/DA waiver provider, submit a completed Florida Medicaid Enrollment Application, AHCA Form 2200-003, to the Medicaid waiver specialist at the local Area Agency on Aging (AAA).

Note: Medicaid enrollment application packages are obtained from the Medicaid fiscal agent at 800-289-7799, select Option 4. Enrollment forms are also available on the fiscal agent's Web site at mymedicaid-florida.com. Select Public Information for Providers, and then on Enrollment. The Florida Medicaid Provider Enrollment Application, AHCA Form 2200-003, is incorporated by reference in 59G-5.010, F.A.C.

Medicaid Waiver Specialist Provider Enrollment Responsibilities

The Medicaid waiver specialist located at the AAA is responsible for the following steps to facilitate the provider enrollment process:

- Receiving the enrollment forms;
- Reviewing the enrollment package and requesting additional supporting information or documentation if needed;

- Verifying all required provider and program qualifications are met (e.g., licensure, certifications, etc.);
- Certifying the provider meets the qualification requirements to provide specific A/DA services by signing and dating the enrollment application under the "Approval" section on the bottom of page six of the enrollment application; and,
- Submitting the enrollment package and all original documentation to the Medicaid fiscal agent.

Medicaid Fiscal Agent Responsibilities

The Medicaid fiscal agent notifies the provider of its provider number(s) and effective date of enrollment. The effective date of the Medicaid enrollment for an A/DA waiver provider applicant shall be the date that AHCA or the Medicaid fiscal agent receives the provider application.

Note: See Effective Date of Enrollment in Chapter 2 in the Florida Medicaid Provider General Handbook for additional information.

Multiple Locations

Providers who have practices at more than one location, i.e., satellite offices, must follow the policies for reporting each practice location in accordance with Chapter 2 of the Florida Medicaid Provider General Handbook.

Provider Responsibilities

Provider Staffing Responsibilities

An A/DA provider must furnish sufficient and appropriate staff to meet the needs of waiver recipients.

Staffing requirements must be based on the amount and type of services provided to recipients as authorized in plans of care and in accordance with recipient service needs documented in the needs assessment.

Reporting to Case Manager

A/DA waiver providers are expected to report the following to the recipient's case manager:

- Significant changes in the recipient's normal appearance and functioning;
- Changes affecting the recipient's eligibility for Medicaid or this waiver;
- Recipient plans to discontinue service;
- Recipient plans to move; and
- Recipient hospitalization or death.

Other Responsibilities

A/DA waiver providers must:

- Comply with all licensure and certification requirements applicable to the provider;
- Comply with all provisions of the Medicaid Provider Agreement;
- Promptly report changes in provider name, address, etc. to Medicaid as specified in Chapter 2 of the Florida Medicaid Provider General Handbook;
- Cooperate with monitoring staff of Medicaid or its designated representatives; and

- Comply with the provisions of this handbook, the Florida Medicaid Provider General Handbook, and the Florida Medicaid Provider Reimbursement Handbook, CMS-1500.

Note: The Florida Medicaid provider handbooks are available on the Medicaid fiscal agent's Web site at mymedicaid-florida.com. Select Public Information for Providers, then on Provider Support, and then on Provider Handbooks.

Referral Agreement

Every A/DA waiver service provider must maintain a current executed referral agreement or memorandum of agreement with the AAA or case management agency. The Department of Children & Families' Adult Protective Services offices maintain referral agreements or memorandum of agreement with the A/DA waiver service providers. The executed referral agreement or memorandum of agreement must be on file with the AAA or case management agency before any A/DA waiver service is provided. Failure to comply with this A/DA waiver provider responsibility can result in AHCA recouping any payments made for services provided prior to the executed referral agreement or memorandum of agreement being placed on file.

Medicaid Waiver Specialist Responsibilities

The Medicaid waiver specialists are responsible for A/DA waiver administration in their Planning and Service Areas (PSA's), including:

- Receiving waiver enrollment packets for A/DA waiver providers and verifying that providers meet licensure and certification requirements;
- Training providers, furnishing technical assistance and referring providers for claims technical assistance to the Medicaid fiscal agent field staff;
- Monitoring providers through on-site reviews;
- Preparing written monitoring reports for the provider, DOEA, DCF and AHCA;
- Managing DOEA budget spending authority for DOEA clients; and,
- Coordinating with area Medicaid offices, DCF and the Medicaid fiscal agent as needed.

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 moved from one job to another, without losing health coverage. This federal legislation also requires the health care industry to adopt uniform codes and forms to streamline the processing and use of health data and claims. HIPAA also provides protection for the privacy of people's health care information and gives them greater access to that information.

HIPAA Responsibilities

Florida Medicaid has implemented all of the requirements contained in the federal legislation known as 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. Providers who meet the definition of a covered entity according to HIPAA must comply with HIPAA Electronic Data Interchange (EDI) requirements. This coverage and limitations handbook 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.

Note: For more information regarding HIPAA privacy in Florida Medicaid, see Chapter 2 in the Florida Medicaid Provider General Handbook.

Note: For more information regarding claims processing changes in Florida Medicaid because of HIPAA, see Chapter 1 in the Florida Medicaid Provider Reimbursement Handbook, CMS-1500.

Note: For information regarding changes in EDI requirements for Florida Medicaid because of HIPAA, contact the Medicaid fiscal agent EDI help desk at 866-586-0961 or 800-289-7799, select Option 3.

CHAPTER 2
AGED AND DISABLED ADULT WAIVER SERVICES COVERED SERVICES, LIMITATIONS, AND EXCLUSIONS

Overview

Introduction

This chapter describes the services covered under the Florida Medicaid Aged and Disabled Adult (A/DA) Waiver Program. It also describes the requirements for service provision, service limitations and exclusions.

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Service Requirements

Introduction

Medicaid reimburses providers for home and community-based waiver services provided to eligible Medicaid recipients who have been enrolled in the A/DA Waiver Program.

A/DA waiver services must be rendered by qualified, enrolled providers pursuant to a written plan of care that is developed as a result of a detailed assessment of the recipient's condition and service needs for home and community-based services. Services are based on the individual needs of each recipient; therefore not every recipient receives every service.

Determination of Medicaid Eligibility

Individuals not already receiving Medicaid benefits must be referred to the local Department of Children and Families (DCF) Automated Community Connection to Economic Self-Sufficiency (ACCESS) office or online at state.fl.us/cf_web/ to apply for Medicaid coverage.

An authorized representative may submit the application on behalf of the individual. The individual's case manager may assist an individual in submitting an application for Medicaid benefits.

The applicant must specifically state on the application that it is for "Home and Community-Based Services."

Financial eligibility for home and community-based waiver services is determined by DCF staff using the Institutional Care Program (ICP) assets and income eligibility criteria.

If the DCF ACCESS office made the original financial eligibility determination, that office will notify the recipient annually of the need to renew eligibility. If the recipient is Medicaid-eligible through Supplemental Security Income (SSI), annual financial redetermination by DCF is not required.

A/DA providers are responsible for verifying appropriate Medicaid eligibility prior to the provision of A/DA waiver services.

Note: Information regarding Medicaid eligibility is available on the Internet at dcf.state.fl.us/ess/medicaid.shtml.

Who Can Receive Services

Enrollment in the A/DA Waiver Program is limited to the number of unduplicated recipients stated in the waiver application or amendments, which have been approved by the Centers for Medicare and Medicaid Services, and by the amount of matching state revenue appropriated by the Florida Legislature.

In addition to meeting Medicaid eligibility, participants in the waiver must meet all of the following criteria:

- Be 18 to 64 years old and determined disabled according to the Social Security Administration and individuals 65 years old and older.

- Meet nursing facility Level of Care criteria for Intermediate I or Intermediate II as referenced at 59G-4.180, F.A.C; and
- Be enrolled in the A/DA Waiver Program. Recipient "enrollment" means being determined financially and medically eligible for the waiver subject to the availability of respective Department of Elder Affairs (DOEA), Agency for Health Care Administration (AHCA) and Department of Children and Families (DCF) waiver funds.

Level of Care Requirements

All applicants for A/DA waiver services must be assessed to determine whether they meet the nursing home level of care for Intermediate I or Intermediate II as stated in 59G-4.180, F.A.C. A level of care determination verifies that an individual qualifies for nursing home level of care.

Level of care reviews are performed by the Comprehensive Assessment and Review for Long Term Care Services (CARES) Program in the Department of Elder Affairs.

Comprehensive Client Assessment

The case manager must conduct a comprehensive client assessment using a Department of Elder Affairs Assessment Instrument, DOEA Form 701B, Sept 2008, for applicants 60 years of age and older, or a Department of Children and Families' Adult Services Assessment Instrument, CF-AA Form 3019, PDF 10/2005, for disabled applicants 18 to 59 years of age.

The assessment evaluates the recipient's health status, functional status, support system and living environment. The case manager must make a face-to-face home visit with the recipient to complete the assessment and must give due consideration to the recipient's requests. Permission from the recipient must be obtained by the case manager to communicate with the recipient's formal and informal caregivers.

The comprehensive client assessment must be placed in the recipient's case record as a separately identifiable document. All contacts and visits made in completing the assessment must be documented in the case narrative.

Note: See Appendix A in this handbook for a copy of the Department of Elder Affairs Assessment Instrument, DOEA Form 701B, and Department of Children and Families Assessment Instrument, DCF Form CF-AA 3019. The Department of Elder Affairs Assessment Instrument, DOEA Form 701B, is available from DOEA's website at elderaffairs.state.fl.us/english/pubs/pubs/doea701b_sep08.pdf.
It is incorporated by reference in 58A-1.010, F.A.C. The Department of Children and Families Assessment Instrument, DCF Form CF-AA 3019, is available from DCF's website at dcf.state.fl.us/DCFForms/Search/DCFFormSearch.aspx. It is incorporated by reference in 59G-13.030, F.A.C.

Request for Level of Care

The case manager will submit the assessment and the completed Medical Certification for Nursing Facility/Home and Community Based Services Form (MCNF/HCBS), AHCA-Med Serv Form 3008, May 2009, (formerly the Patient Transfer and Continuity of Care Form) to the local Comprehensive Assessment and Review for Long Term Care Services (CARES) office for determination of level of care (LOC).

Note: See Appendix B in this handbook for a copy of the Medical Certification for Nursing Facility/Home and Community Based Services Form (MCNF/HCBS), AHCA-Med Serv Form 3008.

The form is available on the DOEA website at elderaffairs.state.fl.us/english/cares.php.

Informed Consent Form

The recipient or the recipient's authorized representative must sign the Informed Consent Form, AHCA-Med Serv Form 2040, May 2009, agreeing to the assessment and authorizing DOEA staff to access medical records. The signed Informed Consent Form must be submitted with the assessment instrument and the Medical Certification for Nursing Facility/Home and Community Based Services Form, AHCA-Med Serv Form 3008.

Note: See Appendix C for a copy of the Informed Consent Form, AHCA Med-Serv Form 2040 in English and Spanish. The form is available on the DOEA website at elderaffairs.state.fl.us/english/cares.php.

Level of Care Determination

The Level of Care (LOC) determination is made based on a completed Medical Certification for Nursing Facility/Home and Community Based Services Form, AHCA-Med Serv Form 3008 and the 701B or CF-AA 3019 assessment. All sections of the AHCA-Med Serv Form 3008 form must be completed and the form signed by the attending physician.

The LOC is documented on the Notification of Level of Care, DOEA-CARES Form 603, Revised March 2003. All A/DA waiver recipients must have a signed and dated LOC that includes the LOC's effective date. A/DA waiver service providers will not be reimbursed prior to the LOC effective date.

The LOC must be determined annually by CARES for all recipients and documented in the recipient's case record. The case manager is required to track LOC redeterminations in conjunction with the annual 701B or CF-AA 3019 reassessments to ensure that timely evaluations are conducted. If there are gaps between LOC dates, renewal services will not be rendered.

A revised updated Medical Certification for Nursing Facility/Home and Community Based Services Form (MCNF/HCBS), AHCA-Med Serv Form 3008, must be completed whenever there is a change in the recipient's medical, mental or physical condition.

Note: See Appendix D for a copy of The Notification of Level of Care, DOEA-CARES Form 603. The form is mailed to the provider by the CARES Unit. It is incorporated by reference in 59G-13.030, F.A.C.

Recertification of Eligibility

Recipients enrolled in the A/DA waiver must have their level of care and medical eligibility recertified annually. The recipient's case manager is responsible for ensuring that the Medical Certification for Nursing Facility/Home and Community Based Services Form (MCNF/HCBS), AHCA-Med Serv Form 3008, is completed, signed and dated by a physician. The case manager shall also complete the DOEA Form 701B or the DCF Form CF-AA 3019.

The Medical Certification for Nursing Facility/Home and Community Based Services Form, AHCA-Med Serv Form 3008, is not required for the annual recertification if the level of care is determined within the one-year time frame and a significant change in the recipient's medical condition has not occurred. If the one-year time frame is exceeded or a significant change has occurred, the Medical Certification for Nursing Facility/Home and Community Based Services Form, AHCA-Med Serv Form 3008, is required.

The case manager must send the AHCA-Med Serv Form 3008, Informed Consent Form, AHCA-Med Serv Form 2040, and completed DOEA Form 701B or the DCF Form CF-AA 3019 to the CARES unit for certification of the level of care. If certified by CARES, the CARES unit will send the case manager the CARES Notification of Level of Care form which must be filed in the recipient's case file.

Freedom of Choice and Informed Choice

Freedom of Choice and Informed Choice recipient rights are as follows:

- Freedom of Choice is the right to choose between receiving services in an institution or receiving services through the A/DA waiver.
- Informed Choice is the right to choose from all available A/DA waiver services offered and all enrolled A/DA waiver service providers in their service area.

All applicants assessed to need the institutional level of care have the right to choose between receiving services in an institutional setting or receiving services through the A/DA Waiver Program.

All recipients served through the waiver may select from enrolled, qualified service providers and may change providers at any time. Once a recipient has an approved plan of care, the funds allocated to that plan follow the recipient. Within the funds allocated in the plan of care, the recipient is free to change enrolled, qualified providers as desired to meet the goals and objectives set out in the plan.

Applicant's Copy of Forms

Upon request, all applicants or their authorized representative shall be provided with a copy of any completed assessment instruments, the CARES Notification of Level of Care, and the CF-MED 3008 Form completed by the physician or the DCF Form CF-AA 3019.

Recipient Enrollment into the Waiver

The Medicaid Waiver Specialists and Aging Resource Center (ARC) or Aging and Disability Resource Centers (ADRC) located within the offices of each Area Agency on Aging in the eleven Planning and Service Areas will determine for the 60 years old and older waiver recipients if:

- There is adequate support in the community to ensure the recipient's safety and well being;
- The applicant meets the eligibility criteria for the A/DA waiver; and
- Sufficient funding is available.

Enrollment into the waiver for individuals 18 to 59 years old is determined by the Florida Department of Children and Families, Adult Protective Services Programs' Region Offices. A listing of the District Offices and the telephone numbers are available on this Web site: dcf.state.fl.us/as/.

A/DA Waiting List

The Aging Resource Center or Aging and Disability Resource Center in each Planning and Service Area maintains the A/DA waiver lists in each Planning and Service Area of prospective A/DA recipients who are 60 years old and older that have been screened, appear to be eligible and in need of waiver services, and are waiting for waiver services.

The A/DA waiting list for the 18 to 59 year old disabled adult population of the waiver is maintained at the Florida Department of Children and Families, Adult Protective Services Program Office.

Medical Necessity

Waiver services may be provided only when the service or item is medically necessary. Medically necessary is defined in 59G-1.010 (166) as follows:

"Medically necessary" or "medical necessity" means that the medical or allied care, goods, or services furnished or ordered must:

(a) Meet the following conditions:

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

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

Availability of Other Coverage Sources and Services

Supports and services are developed and delivered in community settings. The supports and services authorized under the A/DA waiver must be used to supplement the supports already provided by family, friends, neighbors, and the community.

When a service must be purchased, services available under the Medicaid state plan must be used before accessing services through the waiver. The waiver cannot supplant or replace a service that is available through the Medicaid state plan. It is a federal requirement to access state plan coverage before the provision of waiver services.

For specific information about Medicaid state plan coverage, refer to the Medicaid Coverage and Limitations Handbook for the particular service. The handbooks are available from the Medicaid fiscal agent's Web site at mymedicaid-florida.com. Select Public Information for Providers, then on Provider Support, and then on Provider Handbooks. They are incorporated by reference in Chapter 59G-4, F.A.C.

Service Delivery Timelines

Recipients enrolled in the waiver will be authorized services that have been determined to be medically necessary, and are available under this waiver, with reasonable promptness. The A/DA Waiver Program will make reasonable efforts to begin provision of services within 90 days of authorization, to the extent that sufficient provider capacity exists.

Case Management Requirements

Description

Every A/DA waiver recipient must have a case manager to assist the recipient in gaining access to needed waiver and Medicaid state plan services and other needed medical, social, educational, and other services regardless of the funding source.

The case manager for the 60 years old or older population must be employed by a Medicaid-enrolled A/DA waiver case management agency. Case management services provided to the 18 to 59 year old disabled adult population may be supplied by the Department of Children and Families district staff or by contract with a Medicaid-enrolled A/DA waiver case management agency.

The case managers are responsible for ongoing assessment of the recipient's needs and level of care, ongoing review of the plan of care, and the recipient's satisfaction with the services provided. Case management services consist of identifying, organizing, documenting, coordinating, monitoring, and modifying services needed by the recipient.

Case management requires extensive knowledge of the existing service network and the skills and the willingness to seek out additional service options that may benefit the recipient.

See Chapter 3 in the handbook for the Aging Out programs' case management qualifications.

Choice of Case Manager

Recipients have a right to select the case management provider or case manager of their choice. In the absence of a selection by the recipient or authorized representative, the case management agency may assign a case manager. The recipient or authorized representative may make a different selection at a later date after the initial selection.

Targeted Case Management

Individuals receiving A/DA home and community-based services cannot also receive Mental Health Targeted Case Management (TCM). TCM is a mental health service that is considered to be duplication when combined with waiver case management.

Case Manager Responsibilities

It is the responsibility of the case manager to perform and document the following activities:

- Create a plan of care based on the recipient's needs;
- Assist the recipient in achieving the goals and objectives set forth in the plan of care;
- Ensure ongoing coordination between the service providers and the recipient as the plan of care is implemented and referrals to available and appropriate resources are made;
- Advocate on behalf of recipients and their caregivers and families through the provision of information and resources necessary to make informed choices;
- Refer recipients to non-Medicaid services when available and appropriate;
- Ensure that recipients are informed they may choose service providers from among all those available;
- Calculate the cost of each service, know the total monthly and annual cost of services for each recipient, and include it in the plan of care;

- Review and update the plan of care every three (3) months to ensure the appropriate services are provided at the level needed by the recipient;
- Maintain an up-to-date recipient case record as required in this handbook;
- Monitor recipient's needs, confirm services receipt, determine satisfaction with services, and document monitoring results and corrective actions taken;
- Ensure that level of care and medical eligibility are redetermined annually by CARES through submission of a completed AHCA-Med Serv 3008 and DOEA Form 701B to the CARES unit for level of care determination;
- Report and document in the recipient's case narrative suspected instances of abuse, neglect, or exploitation to the Florida Abuse Hotline at 1-800- 96ABUSE and provide documentation in the case narrative of all follow up and corrective actions taken;
- Inform recipients regarding grievance procedures and fair hearing rights;
- Assist the recipient with a fair hearing request in the event of a perceived adverse action;
- Attend all required meetings and training scheduled by the Medicaid Waiver Specialists or DOEA Tallahassee Office; and
- Comply with the policies in this handbook.

Visit Requirements

The case manager is required to:

- Maintain, at a minimum, monthly telephone contact with the recipient to verify satisfaction and receipt of services;
- Review the plan of care in a face-to-face visit every three (3) months and if necessary, update the recipient's plan of care; and
- Have an annual face-to-face visit with the recipient to complete the annual assessment and to determine the recipient's functional status, satisfaction with services, changes in service needs and develop a new plan of care.

The case manager must clearly document in the case narrative the above scheduled visits to the recipient. The case manager may combine the quarterly visits with the monthly contact requirement.

Limitations

A case manager's caseload cannot exceed either 60 individuals or a number specified by the Florida Legislature, whichever is less.

The DOEA Tallahassee Office must approve any changes in the maximum caseload numbers.

Note: See Appendix A for the Aged and Disabled Adult Services Waiver Procedure Codes and Fee Schedule for the maximum units of service and the maximum reimbursement per unit. The Fee Schedule is available on the Medicaid fiscal agent's Web site at mymedicaid-florida.com. Select Public Information for Providers, then on Provider Support, and then on Fee Schedules. It is incorporated by reference in 59G-13.031, F.A.C.

Covered Services

Medicaid will reimburse for the following documented case management activities:

- Assisting A/DA waiver applicants with waiver enrollment and the Medicaid eligibility application process;

- Assisting A/DA waiver enrolled recipients with the annual redetermination for Medicaid eligibility;
- Conducting recipients' comprehensive assessment and update assessments for service needs;
- Developing and reviewing A/DA plans of care;
- Arranging for service delivery;
- Monitoring waiver service provision and quality of services;
- Recording case management activities in the recipient's case record;
- Telephone and face-to-face recipient contacts;
- The three (3) month and twelve (12) month reviews and updates to the recipient's plan of care;
- Recording case narratives associated with billable activities; and
- Case closure and termination. In the event that the recipient dies, the last billing date is the date of death.

Recipient Case Records

The case manager must keep a detailed case record. This record is required to ensure that information regarding the recipient's condition and service provision is contained in a single location to promote continuity and quality of care. It is the basis for quality assurance monitoring.

The recipient's case record documents all activities and interactions with the recipient and any other provider(s) involved in the support and care of the recipient. The record must include the following information:

- Recipient demographic data including emergency contact information, guardian contact data, if applicable, permission forms, and copies of assessments, evaluations, and medical and medication information;
- Legal data such as guardianship papers, court orders and release forms;
- Copies of eligibility documentations, including level of care determinations by CARES;
- Needs assessments, including all physician referrals;
- Plans of care including accurate cost projections;
- Documentation of interaction and contacts (including telephone contacts) with recipient, family members, service providers or others related to services;
- Documentation of issues relevant to the recipient remaining in the community with supports and services consistent with his or her capacities and abilities. This includes monitoring achievement of goals and objectives as set forth in the plan of care;
- Copies of any Agreement of Expectations, AHCA-Med Serv Form 033, executed between the recipient and provider;
- A Cooperative Agreement for a Hospice and Medicaid Waiver Enrolled Recipient, AHCA Form 5000-30, October 2003, if applicable;
- Problems with service providers must be addressed in the narrative with a planned course of action noted. Documentation of progress made towards resolution of such problems must be clear and concise; and
- All narratives in case records must be signed and dated by the case manager.

Note: See Chapter 2 of the Medicaid Provider General Handbook for additional information regarding service documentation requirements.

Note: See Appendix E for a copy of the Agreement of Expectations, AHCA-Med Serv Form 033, May 2009. The form is available by photocopying it from the handbook. It is incorporated by reference in 59G-13.030, F.A.C.

Note: See Appendix F for a copy of the Cooperative Agreement for a Hospice and Medicaid Waiver Enrolled Recipient, AHCA Form 5000-30. It is available on the Medicaid fiscal agent's Web site at mymedicaid-florida.com. Select Provider Support, and then on Medicaid Forms. It is incorporated by reference in 59G-4.140, F.A.C.

Case Narrative Requirements

Case narrative entries must include details so that a reviewer will be able to understand the circumstances and evaluate the case manager's effectiveness in meeting the recipient's needs and addressing concerns as they arise.

All case management activities must be recorded in the case narrative.

The narrative must be clearly written and document comprehensively what the case manager has done to meet the needs identified in the plan of care.

There should be documentation of the activities of others on behalf of the recipient.

For monthly telephone contact, the narrative must reflect the case manager's monitoring of client changes and the receipt and satisfaction with services.

For all face-to-face visits, the narrative must record the case manager's observations of the recipient's behavior, physical appearance and environment. The case manager must note the recipient's self-reported medical, mental, physical and emotional status.

Case managers must develop and maintain case narratives for every recipient receiving A/DA waiver services to ensure the recording of a recipient's condition and service provision is contained in a single location to promote continuity and quality of care. It is the basis for quality assurance monitoring and documenting the provision of Medicaid services. The narrative must be kept in the recipient's case record in chronological order for audit, monitoring and quality assurance purposes and each entry must be signed and dated by the case manager on the date the entry was made.

To ensure the confidentiality of recipient information, case records must be maintained by the case management agency at a secure central location.

Recording Time

Case management service is reimbursed on a fee for service basis and entries must document the amount of time spent performing case management activities. Travel and time spent documenting activities in the case record must be included in the calculation of the total time spent for each date of service.

The total time spent for each date of service must be converted to units (15 minute increments) for case management reimbursement.

Electronic Records

Case narratives may be in electronic format. The narrative must be kept in the recipient's case record in chronological order for audit, monitoring and quality assurance purposes. If electronic format is used, back up files must be kept.

Permanent Record Documentation

All case record documentation must be legible and written or typed in blue or black ink. No erasures or "whiteout" is permitted. In case of error, the entry must be lined through, initialed, and dated by the writer. Each entry must be initialed and dated by the case manager.

Plan of Care

Description

A plan of care is a written document that authorizes the recipient's service needs as determined by the assessment instrument and the Medical Certification for Nursing Facility/Home and Community Based Services Form AHCA-Med Serv Form 3008. The plan must specify the services and supports to be provided regardless of the funding source. Development of the plan of care is a critical part of service delivery and must be done in cooperation with the recipient and may include family members or others providing direct care or support to the recipient.

The plan of care must specify:

- All the services and supports to be provided regardless of the funding source;
- The service provider;
- The number of units of each service to be provided; and
- The duration of the service.

The plan of care is based on the Department of Elder Affairs Assessment Instrument, DOEA Form 701-B, or the Department of Children and Families Assessment Instrument CF-AA Form 3019, and the Medical Certification for Nursing Facility/Home and Community Based Services Form (MCNF/HCBS), AHCA-Med Serv Form 3008. The information gathered through these instruments is used by the case manager to establish the recipient's plan of care and to identify both waiver and non-waiver services required to maintain the recipient in the community and reduce functional limitations in order to avoid nursing facility placement.

The case manager or recipient must ensure all required areas of the Medical Certification for Nursing Facility/Home and Community Based Services Form (MCNF/HCBS), AHCA Med-Serv Form 3008, are complete, including all required signatures, for all comprehensive assessments and annual assessments.

The plan of care must document the need for A/DA waiver services that are coordinated and monitored by a case manager.

Purpose

The purpose of the plan of care is to:

- Enable the case manager and the recipient to establish goals based on the completed AHCA Med-Serv Form 3008 and the assessment;
- Identify problems that present barriers to attaining the goals; and

- Develop and document outcomes and patterns of service delivery that will help resolve identified problems so that stated goals can be achieved.

Plan of Care Document

The plan of care document must contain the following elements: 1) Client name and Medicaid identification number; 2) Case management agency name and Medicaid provider identification number; 3) Client's assessed service needs; 4) Types, units, frequency and duration of planned waiver and non-waiver services; 5) The provider and associated costs of each planned service; 6) Initiation, revision and termination dates of the care plan; 7) An acknowledgement that the client or client's representative is involved in the development of the care; and 8) Client or representative and case manager signatures and date of signatures.

Plan of Care Development

The case manager develops the plan of care specific to the recipient's needs that are identified in the assessment and the AHCA Med-Serv Form 3008 instruments. The recipient, or legal guardian, guardian advocate, caregiver, or authorized representative must be consulted in the development of the plan.

The plan of care must specify all authorized services and is the basis for service authorizations. Services authorized must be the most cost beneficial for accomplishing the recipient's plan of care objectives. The ultimate goal of the plan must be to enable recipients to live a dignified life in the least restrictive setting appropriate to their needs.

When service needs are identified, the recipient must be given information about the available providers so that an informed choice of providers can be made. The entire care planning process must be documented in the case record.

The plan of care must include the date it is developed. The duration and scope of service must be specified for each service authorized. It is recommended that services only be initially authorized for up to six months in order to determine the continued need for the frequency authorized. After the initial six months, the plan of care can be authorized for up to 12 months.

Service authorizations must reflect care plan specified services. When developing service authorizations, case managers must take care to authorize service parameters and times of service mutually agreeable to the recipient and the service provider. Services or service amounts not specified in the service authorization are not considered approved or authorized. Reimbursement for services furnished, but not specified in the service authorization, are subject to recoupment. Services provided outside the time frames specified in the service authorization are also subject to recoupment.

Note: See Chapter 5 of the Medicaid Provider General Handbook for information on fraud and abuse.

Service Providers' Authorization for Services

The plan of care is the basis for waiver service provider's service authorization. Service authorizations must not vary in amount, frequency or duration from the services specified in the current plan of care. The case manager must send the recipient's service authorization to the service provider in advance of service provision. Without this service authorization, the provider cannot be assured reimbursement. Services must be provided timely and within the specified dates. If a provider exceeds the limits specified on the plan of care, Medicaid is not responsible for reimbursing the excess.

Prior to providing services, Medicaid providers shall verify the recipient is Medicaid waiver eligible.

Service authorization is contingent upon the enrolled recipient remaining eligible for Medicaid during the month of service. If a recipient loses Medicaid eligibility, the service authorization is null and void. Should this happen, the provider must contact the case manager or the Medicaid Waiver Specialist at the Area Agency on Aging.

Recipient's Copy

The case manager must provide a copy of the plan or a new copy if any revisions are made to the plan upon request by the recipient or authorized representative.

Recipient's Approval and Signature

Prior to signing the plan of care, the case manager must inform the recipient or the authorized representative that the signature indicates agreement with the plan as well as the statement on the bottom of the plan of care form regarding the right to a fair hearing and informed choice.

The recipient or the authorized representative must sign the plan of care to indicate agreement with the plan. If the recipient is unable to sign his or her name due to a disability, and there is no authorized representative, the recipient must indicate his or her agreement verbally and this agreement must be documented in the case narrative and on the plan itself with a notation indicating, "recipient is unable to sign due to disability." If the recipient is unable to write his or her name a mark may be made and witnessed. After the mark, the witness will write "His or Her mark" and then sign that they witnessed the recipient's mark.

Plan of Care Implementation, Review and Annual Assessment

Plan of Care Implementation and Review

The case manager implements the approved plan by:

- Identifying providers for each service;
- Monitoring the recipient's service needs on an ongoing basis to ensure that needs are being met;
- Performing monthly telephone contact with the recipient and following the requirements for recipient visits, as stated in this handbook, to determine ongoing service needs as well as satisfaction with current service provision; and
- Reviewing the plan of care with the recipient or caregiver face-to-face every three (3) months to determine if the recipient's needs continue to be met. The plan of care may need to be reviewed more frequently depending on changes in the recipient's condition or living situation. The necessity for reviews conducted more frequently than the three-month review must be justified in the narrative.

The case manager must monitor the plan of care for continuity of services and ensure that changes in the recipient's status warrant service increases, service reductions, or other changes in the plan of care.

The case manager must make a narrative notation that the recipient or the legal guardian, guardian advocate, caregiver, or authorized representative are in agreement when changes are made to the plan of care.

Increasing and Decreasing Service Authorizations

A/DA waiver recipients or their designated representatives may request additional service units when the recipient's needs change or there is a change in the recipient's mental or physical condition.

When the A/DA recipient's condition or needs change, the recipient or designated representative must contact the recipient's A/DA case manager. The case manager must assess the situation to verify the changed conditions or increased needs. If the case manager determines the recipient's changed condition or needs endanger the recipient's health and safety, the case manager must revise the plan of care and service authorization.

For the revised plan of care to be effective, a narrative notation must be made by the case manager that the recipient, or the legal guardian, guardian advocate, caregiver, or authorized representative is in agreement with the increase in services.

For changes or increases in services for the disabled adult population of the waiver to be effective the case manager must submit a completed Request for Service Increase Form, CF-AA 1116, pdf. May 2004, for processing through the DCF, Adult Protective Services Region Program Office.

If a change in the recipient's condition results in a decrease in services, the recipient must be given a ten-day written notification of the proposed decrease and notification of the right to a fair hearing before the change in services takes effect.

Note: Please refer to Appeal Rights and Fair Hearing Process in this chapter for additional information.

Note: See Appendix G for a copy of the Request for Service Increase Form, CF-AA 1116. The form is available from DCF's website at dcf.state.fl.us/DCFForms/Search/DCFFormSearch.aspx. It is incorporated byreference in 59G-13.030, F.A.C.

Annual Assessment

A/DA waiver recipients must receive a complete assessment at least annually. If changes in the recipient's condition warrant a complete update assessment, an assessment should be done based on circumstances and need.

Annual assessment results will be used to develop a new plan of care. Assessments must be maintained in the recipient's case record. All contacts and visits made in completing the reassessment must be noted in the case narrative.

Termination of Enrollment

Termination of waiver enrollment can occur when it is determined that:

- The service is no longer necessary to try to prevent institutionalization and to allow the recipient to remain safely in the community;
- The recipient chooses to terminate participation in the waiver program;

- The recipient refuses to comply with an Agreement of Expectations, AHCA- Med-Serv Form 033;
- The recipient moves out of state;
- The recipient becomes financially ineligible for Medicaid;
- The recipient is non-compliant or repeatedly refuses to follow a written plan of care or to cooperate with waiver case managers;
- The recipient no longer meets the defined level of care criteria for Intermediate I or Intermediate II as stated in 59G-4.180, F.A.C.; or
- The recipient dies.

Waiver services may not be reimbursed while the recipient is hospitalized or in a nursing facility. The temporary suspension of A/DA waiver services does not automatically terminate a recipient's participation in the waiver. Each circumstance must be weighed by the case manager who will determine, based upon the health, safety, and welfare of the recipient, if the temporary suspension will become a permanent termination of waiver services.

The case manager must discuss all decisions to terminate services with the recipient and the service provider prior to the action. If the decision is made to terminate a service, written notice must be sent to the recipient at least ten (10) days in advance of terminating the service. If the recipient disagrees with the action being taken, the recipient has the right to appeal the adverse action.

Note: See the section on Appeal Rights and Fair Hearings for additional information on fair hearings.

Case Manager Responsibilities Regarding Termination

When a recipient's participation in the A/DA waiver is terminated, the case manager must immediately:

- Notify all service providers to cancel A/DA waiver services that are being provided to the recipient;
- Notify the DCF Region Office;
- Enter the termination in the DOEA CIRTS system; and
- Notify the recipient of the right to due process, if appropriate.

Agreement of Expectations

Where the recipient does not cooperate with the approved plan of care or is abusive toward service providers, the case manager can terminate services. When either of these situations is present, the case manager will contact the recipient about the situation or behavior and possible consequences if the situation or behavior continues. These contacts must be documented in the case narrative.

If discussion of the situation or behavior does not result in positive change, the case manager can initiate an Agreement of Expectations (AHCA-Med Serv Form 033) with the recipient. The Agreement will document agreed-to expectations of behavior between the recipient and the service provider(s) and will be signed by the recipient, the case manager and the case manager supervisor. If the executed Agreement of Expectations does not result in improvement, the case manager may take action to terminate the recipient from the waiver program.

Documentation of the situation or behavior and corrective steps taken must appear in the case narrative. The recipient must be given a ten day written notification of the proposed termination and right to a fair hearing.

Note: See Appendix E for a copy of the Agreement of Expectations form.

Service Documentation Requirements

Introduction

Medicaid will only reimburse for waiver services 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 and receipt of the service. Services are authorized indicating maximum units of service deemed necessary in the plan of care and the service authorization. If the maximum number of units is not necessary to complete tasks, the provider should bill accordingly and not bill for activities in excess of what is needed.

General Service Documentation Requirements

When a Medicaid waiver service is rendered, the provider must document the service provision and file the documentation prior to requesting reimbursement. Appropriate documentation is required in order to receive payment. All service documentation must be dated and signed by the service provider.

Providers must document the following specific elements for all A/DA waiver services or service components rendered to waiver recipients:

- Name of provider, provider agency and specific individual rendering each service;
- Type and amount of service provided;
- Date and place of service; and
- Signature of recipient or recipient's authorized representative verifying receipt of all services on the same day of service provision. An exception occurs when the postal service or a commercial delivery service delivers consumable medical supplies; in those cases no signature will be required.

Documentation of a recipient's inability to sign must be noted in the case record.

For the purpose of monitoring and reviewing of service claims, the provider must retain documentation on file for a minimum of five years.

Note: See Chapter 2 of the Florida Medicaid Provider General Handbook for additional information regarding service documentation requirements.

Service Log

The provider must keep a service log that includes documentation of the recipient's name, recipient'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 (in units if applicable) billed for each service, provider's name, and Medicaid provider number.

Covered Services

Introduction

A/DA waiver services must be rendered by qualified, Medicaid-enrolled, waiver providers based on the recipient's needs that are documented in an approved plan of care. The plan of care specifies services to be provided and the cost of these services.

All A/DA waiver recipients must receive case management and at least one other waiver service.

Medicaid will only reimburse approved waiver services that are specifically identified in the approved plan of care by service type, frequency and duration.

Under the A/DA waiver, Medicaid does not reimburse for services furnished by parents, stepparents, spouse, siblings, sons, daughters, household members or any person with custodial or legal responsibility for a Medicaid recipient.

The A/DA waiver provider is responsible for first accessing Medicaid state plan services before billing the waiver program. For example, for Consumable Medical Supplies, the A/DA waiver provider is responsible for first accessing Medicaid state plan services through the Medicaid Durable Medical Equipment and Medical Supply Services Program before billing the waiver program.

If a dually-eligible (Medicare and Medicaid) waiver recipient receives any of the services described on the following pages from a home health agency, the provider must be licensed and Medicaid and Medicare certified. As applicable, Medicare and regular Medicaid state plan programs (non-home and community-based waiver programs) must be billed before billing the waiver program.

A/DA Services

Listed below are the services, in addition to case management, that may be provided for a recipient who is participating in the A/DA waiver and who needs the services to reach an outcome described on the plan of care.

- Adult Companion Services
- Adult Day Health Care Services
- Attendant Care Services
- Caregiver Training and Support – Individual or Group
- Case Aide
- Case Management
- Chore Services
- Chore Services–Enhanced
- Consumable Medical Supplies and Consumable Medical Supplies–Enhanced
- Counseling Services
- Emergency Alert Response System–Installation and Maintenance
- Escort Services
- Financial Assessment and Maintenance Risk Reduction Services
- Home Delivered Meals
- Home Modification Services
- Home Manager and Homemaker Services
- Nutritional Risk Reduction Services
- Occupational Therapy Services

- Personal Care Services
- Pest Control Services–Initial Visit and Maintenance
- Physical Risk Reduction Services
- Physical Therapy Services
- Rehabilitation Engineering Evaluation Services
- Respiratory Therapy Services–Evaluation and Treatment
- Respite Services–In-Home and Facility-Based
- Skilled Nursing Services
- Specialized Medical Equipment and Supplies
- Speech-Language Pathology Therapy Services

A description follows for each service, which includes a service description, associated procedures, service delivery requirements, and service limitations.

Adult Companion Services

Description

Adult Companion Services are non-medical care, supervision and socialization provided to a functionally impaired adult. Companions may assist or supervise the recipient with such tasks as meal preparation, laundry and shopping. Providers may also perform light housekeeping tasks that are incidental to the care and supervision of the individual.

Case Manager Responsibilities

The case manager must:

- Authorize these services only in accordance with a therapeutic goal in the plan of care. The services cannot be purely diversional in nature.
- State in the plan of care the activities the Companion Services provider must perform.

Service Limitations

The following service limitations apply to adult companion services:

- Adult Companion Services are limited to the amount, duration and scope of services described in the recipient's plan of care and approved budget for cost of service as authorized by the case manager.
- The services may be provided at the recipient's residence or anywhere in the community where supervision and care is necessary.
- Adult Companions may not drive the recipient in their car or the recipient's car but may accompany the recipient on public transportation, by taxi or on Medicaid transportation.
- Companion Services may not be provided or received in the Companion Services provider's home.
- The services may not be provided by a family member. Medicaid does not reimburse for services furnished by parents, stepparents, spouse, siblings, sons, daughters, household members or any person with custodial or legal responsibility for a Medicaid recipient.
- See the Aged and Disabled Adult Services Waiver Procedure Codes and Fee Schedule, for the maximum units of service and the maximum reimbursement per unit.

Note: The Fee Schedule is available on the Medicaid fiscal agent's Web site at mymedicaid-florida.com. Select Public Information for Providers, then on Provider Support, and then on Fee Schedules. It is incorporated by reference in 59G-13.031, F.A.C.

Service Exclusions

Companion Services do not include hands-on personal care or nursing care.

Adult Day Health Care Services

Description

Adult Day Health Care services are furnished four or more hours per day on a regularly scheduled basis, for one or more days per week, in an outpatient setting. The services encompass both health and social services needed to ensure the optimal functioning of the individual. Three meals per day may be provided as part of these services. Physical, occupational and speech therapies, if indicated in the recipient's plan of care, will be furnished as component parts of this service. Transportation between the recipient's place of residence and the Adult Day Health care center will be provided as a component part of these services and the cost of this transportation is included in the rate paid to providers of Adult Day Health Care services.

Case Manager Responsibilities

The case manager must:

- Verify that recipients who are authorized to receive up to four hours or more of Adult Day Health Care per session are offered meals and snacks accordingly.
- Verify that authorized physical, occupational, and speech-language pathology therapies are being performed as needed by properly qualified and licensed therapy providers.

Service Limitations

The following service limitations apply to Adult Day Health Care services:

- Adult Day Health Care services are limited to the amount, duration and scope of services described in the recipient's plan of care as authorized by the case manager.
- The services must be provided in a licensed adult day care center.
- The services must be provided for four or more hours per day on a regularly scheduled basis for at least one day per week.
- Authorization of ten hours per day requires extensive written justification.
- See the Aged and Disabled Adult Services Waiver Procedure Codes and Fee Schedule, for the maximum units of service and the maximum reimbursement per unit.

Note: The Fee Schedule is available on the Medicaid fiscal agent's Web site at mymedicaid-florida.com. Select Public Information for Providers, then on Provider Support, and then on Fee Schedules. It is incorporated by reference in 59G-13.031, F.A.C.

Service Exclusions

During the recipient's attendance at the center, payment will not be made for Adult Day Health Care services when other Medicaid services are provided. When other Medicaid services are

provided, Adult Day Health Care services can be billed for that portion of the attendance period not covered by other Medicaid services.

As physical, occupational and speech therapies are included under the Adult Day Health Care services reimbursement rate, Medicaid cannot be billed for these services during the recipient's attendance at the center.

Attendant Care Services

Description

Attendant Care services are both supportive and health-related hands-on care services specific to the needs of the individual. Attendant Care services are those that substitute for the absence, loss, diminution, or impairment of a physical or cognitive function.

Attendant Care services may include skilled nursing care or personal care to the extent permitted by state law. Housekeeping activities incidental to the performance of care may also be furnished as part of this activity. This service can be authorized when the recipient's mental or physical condition requires assistance with medically related needs.

Case Manager Responsibilities

The case manager must:

- Consult with a registered nurse (RN), licensed to practice in the state of Florida, before authorizing Attendant Care services.
- Include documentation of the RN consultation in the case narrative.
- Ensure that the RN provides the required supervision of the services; the frequency and intensity of which is specified in the recipient's plan of care.

Service Limitations

The following service limitations apply to Attendant Care services:

- Attendant care services are limited to the amount, duration and scope of services described in the recipient's plan of care as authorized by the case manager.
- Attendant Care services must be provided in the recipient's home.
- The services may not be used at the same time as Personal Care or Adult Companion Services.
- See the Aged and Disabled Adult Services Waiver Procedure Codes and Fee Schedule, for the maximum units of service and the maximum reimbursement per unit.

Note: The Fee Schedule is available on the Medicaid fiscal agent's Web site at mymedicaid-florida.com. Select Public Information for Providers, then on Provider Support, and then on Fee Schedules. It is incorporated by reference in 59G-13.031, F.A.C.

Case Aide

Description

Case Aide services are provided to waiver recipients by a case aide under the direction of case managers. Case Aide services include assistance with implementing plans of care, oversight and supervision of provider training activities and paraprofessional tasks intended to maximize productivity of case managers.

Case Manager Responsibilities

The case manager must not authorize case aide services for the purpose of formulating care plans and assessments.

Caregiver Training and Support Services–Individual and Group

Description

Caregiver Training and Support services are for the families of waiver recipients. "Family" is defined as the persons who live with or provide care to a waiver recipient and may include a parent, spouse, children, relatives, foster family, or in-laws. It does not include individuals employed to care for the recipient.

Caregiver Training and Support can include instruction about treatment regimens and use of specified equipment in the plan of care and update training as necessary to safely maintain the waiver recipient in the home. The training may be provided on an individual basis or in a group setting.

Case Manager Responsibilities

The case manager must:

- Specify all Caregiver Training and Support in the plan of care and note whether the Caregiver Training and Support service will be provided in individual or group settings.
- Document all family training sessions in the case notes.
- Monitor the recipient and caregiver's satisfaction with this service.

Service Limitations–Individual

The following service limitations apply to individual Caregiver Training and Support services:

- Caregiver Training and Support services are limited to the amount, duration and scope of services described in the recipient's plan of care as authorized by the case manager.
- The services can be provided at the recipient's home, health professional's office or other location.
- See the Aged and Disabled Adult Services Waiver Procedure Codes and Fee Schedule, for the maximum units of service and the maximum reimbursement per unit.

Note: The Fee Schedule is available on the Medicaid fiscal agent's Web site at mymedicaid-florida.com. Select Public Information for Providers, then on Provider Support, and then on Fee Schedules. It is incorporated by reference in 59G-13.031, F.A.C.

Service Limitations–Group

The following service limitations apply to group Caregiver Training and Support services:

- The services may be provided at any location.
- The maximum size of the group sessions is 20 participants.
- See the Aged and Disabled Adult Services Waiver Procedure Codes and Fee Schedule, for the maximum units of service and the maximum reimbursement per unit.

Chore Services

Description

Chore services are those needed to maintain the recipient in a home that is clean and sanitary and provides a safe environment. Chore services include heavy household chores such as washing floors, windows and walls, tacking down rugs and tiles, and moving heavy items of furniture in order to provide safe access and egress.

Case Manager Responsibilities

The case manager must:

- Authorize this service only in cases where neither the recipient nor anyone else in the household is capable of performing or financially able to obtain the service, and where no other relative, caregiver, landlord, community or volunteer agency, or third party payer is capable of or responsible for this service.
- In the case of rental property, examine the landlord's responsibilities in the lease agreement prior to any authorization of service.

Service Limitations

The following service limitations apply to Chore services:

- Chore services are limited to the amount, duration and scope of services described in the recipient's plan of care as authorized by the case manager.
- Chore services performed on the exterior of the recipient's dwelling are limited to those promoting safe access and egress to the dwelling. Examples are mowing the lawn and trimming shrubs.
- See the Aged and Disabled Adult Services Waiver Procedure Codes and Fee Schedule, for the maximum units of service and the maximum reimbursement per unit.

Note: The Fee Schedule is available on the Medicaid fiscal agent's Web site at mymedicaid-florida.com. Select Public Information for Providers, then on Provider Support, and then on Fee Schedules. It is incorporated by reference in 59G-13.031, F.A.C.

Chore Services–Enhanced

Description

Enhanced Chore services are provided in order to return the recipient's home and property to a clean, sanitary and safe environment. This service is to provide heavy-duty cleaning such as

removal of debris, cleaning roofs and gutters, correcting code violations, cleaning carpet, as well as renting dumpsters, carpet cleaning machines and protective clothing for the provider.

Case Manager Responsibilities

A case manager must:

- Only authorize this service in cases where neither the recipient nor anyone else in the household is capable of performing or financially able to obtain this service.
- Authorize this service when no other relative or caregiver, landlord, community or volunteer agency or third party is capable of performing or responsible for this service.
- In the case of rental property, examine the landlord's responsibilities in the lease agreement prior to any authorization of service.

Service Requirements

Enhanced Chore services performed on the exterior of the recipient's dwelling are limited to promoting safe access and egress to the dwelling. Shrub trimming and removal of trees and tree limbs that are a danger to the recipient are examples of Enhanced Chore services.

Service Limitations

The following service limitations apply to Enhanced Chore services:

- Enhanced Chore services are limited to the amount, duration and scope of services described in the recipient's plan of care as authorized by the case manager.
- The services must be provided at the recipient's residence. A team of no more than three people may be used.
- See the Aged and Disabled Adult Services Waiver Procedure Codes and Fee Schedule, for the maximum units of service and the maximum reimbursement per unit.

Note: The Fee Schedule is available on the Medicaid fiscal agent's Web site at mymedicaid-florida.com. Select Public Information for Providers, then on Provider Support, and then on Fee Schedules. It is incorporated by reference in 59G-13.031, F.A.C.

Consumable Medical Supplies and Consumable Medical Supplies–Enhanced

Description

Consumable Medical Supplies are disposable supplies used by the recipient that are essential to care for the recipient's needs. Such supplies enable a recipient to either perform activities of daily living or stabilize and monitor a health condition.

Scope of Service

Consumable Medical Supplies and Enhanced Consumable Medical Supplies provided under the A/DA Waiver Program are in addition to the supplies available under the Medicaid state plan Durable Medical Equipment and Medical Supplies Program in scope and quantity. Please refer to the Florida Medicaid Durable Medical Equipment and Medical Supplies Coverage and Limitations Handbook for information on the supplies covered by the program.

A/DA waiver funds may not be utilized for consumable medical supplies available under the Florida Medicaid Durable Medical Equipment and Medical Supply Services Program, unless the supplies that are available under the program are unable to meet the physician-ordered

specifications. The provider must file a copy of the completed Prior Authorization form PAO1 07/2008, denying or approving the request, in the case record for each requested DME service.

Consumable Medical Supplies must be authorized by the case manager in consultation with a medical professional (physician or RN), but do not require a physician's prescription.

Note: The Florida Medicaid Durable Medical Equipment and Medical Supplies Coverage and Limitations Handbook is available on the Medicaid fiscal agent's Web site at mymedicaid-florida.com. Select Public Information for Providers, then on Provider Support, and then on Provider Handbooks. It is incorporated by reference in 59G-4.070, F.A.C.

Note: The Prior Authorization form PAO1 07/2008 is available on the Medicaid fiscal agent's Web site at mymedicaid-florida.com. Select Public Information for Providers, then on Provider Support, and then on Forms. It is incorporated by reference in 59G-4.001, F.A.C.

Incontinence Supplies

Medically-necessary incontinence supplies not provided by the state plan or in excess of the state plan limits may be reimbursed through the ADA Waiver Program. Disposable briefs and diapers must meet the Quality Standards for Briefs and Diapers.

Case Manager Responsibilities

The case manager must:

- Ensure that the Consumable Medical Supplies are of direct medical or remedial benefit to the recipient.
- Ensure that the item(s) is not available under the Florida Medicaid Durable Medical Equipment and Medical Supply Services Program or through any other source before authorizing this service.
- Note that the supplies and the needed amount of each item are specifically authorized in the plan of care.
- Ensure that if there are multiple vendors enrolled to provide consumable medical supplies, the recipient must be encouraged to select from among the eligible vendors based upon the availability of the item needed, quality, and best price.
- Carefully review the utilization of consumable medical supplies to ensure that a large surplus does not accumulate in the recipient's residence.

Service Limitations—Consumable Medical Supplies

The following service limitations apply to Consumable Medical Supplies:

- Consumable Medical Supply services are limited to the amount, duration and scope of services described in the recipient's plan of care as authorized by the case manager.
- The services are to be provided in a recipient's residence or health care professional's office.
- Recipients or their family members cannot be reimbursed for Consumable Medical Supplies purchased on their own.
- If a dually-eligible (Medicare and Medicaid) waiver recipient receives this service from a home health agency, the provider must be licensed and certified. Medicare must be billed before billing Medicaid.
- See the Aged and Disabled Adult Services Waiver Procedure Codes and Fee Schedule for the maximum reimbursement for Consumable Medical Supplies

Service Limitations–Consumable Medical Supplies-Enhanced

The following service limitations apply to Enhanced Consumable Medical Supplies:

- Enhanced Consumable Medical Supply services are limited to the amount, duration and scope of services described in the recipient's plan of care as authorized by the case manager.
- The services are to be provided in a resident's residence or health care professional's office.
- Recipients or their family members cannot be reimbursed for Enhanced Consumable Medical Supplies purchased on their own.
- If a dually-eligible Medicare and Medicaid waiver recipient receives this service from a home health agency, the provider must be licensed and certified. Medicare must be billed before billing Medicaid.
- See the Aged and Disabled Adult Services Waiver Procedure Codes and Fee Schedule, for the maximum reimbursement for Enhanced Consumable Medical Supplies.

Service Exclusions

A/DA waiver funds may not be utilized for Consumable Medical Supplies available under the Florida Medicaid Durable Medical Equipment and Medical Supply Services Program, unless the supplies that are available under the Medicaid Durable Medical Equipment and Medical Supply Services Program are unable to meet the physician-ordered specifications. A copy of the completed Prior Authorization Form PAO1 07/2008, denying or approving the request, must be in the case record for each requested DME service.

Counseling Services

Description

Counseling services are the treatment of the recipient's emotional and psychosocial condition by a licensed mental health practitioner to address the symptoms arising from the stresses of the aging process and the functional limitations of that process or disability. This service includes the development of appropriate personal support networks, exploration of possible alternative behavior patterns, therapeutic social skills, and identification of optimal interpersonal functioning.

Scope of Services

Counseling services provided under the A/DA Waiver Services Program must supplement mental health services available under the Medicaid Community Behavioral Health Program. The Medicaid Community Behavioral Health Program is a Medicaid state plan program available to all Medicaid recipients. See the Florida Medicaid Community Behavioral Health Services Coverage and Limitations Handbook for additional information on the program's services.

Note: The Florida Medicaid Community Behavioral Health Services Coverage and Limitations Handbook is available on the Medicaid fiscal agent's Web site at mymedicaid-florida.com. Select Public Information for Providers, then on Provider Support, and then on Provider Handbooks. It is incorporated by reference in 59G-4.050, F.A.C.

Services Limitations

The following service limitations apply to Counseling services:

- Counseling services are limited to the amount, duration and scope of services described in the recipient's plan of care as authorized by the case manager.
- This service may be provided at the recipient's home or the provider's office.
- See the Aged and Disabled Adult Services Waiver Procedure Codes and Fee Schedule, for the maximum units of service and the maximum reimbursement per unit.

Note: The Fee Schedule is available on the Medicaid fiscal agent's Web site at mymedicaid-florida.com. Select Public Information for Providers, then on Provider Support, and then on Fee Schedules. It is incorporated by reference in 59G-13.031, F.A.C.

Treatment Plan Requirements

Counseling services require the provider to develop a treatment plan for sessions with a goal of resolution of the presenting problem(s).

Emergency Alert Response System–Installation and Maintenance

Description

The Emergency Alert Response System (EARS) service is an electronic device that enables certain individuals at high risk of institutionalization to secure help in an emergency. The recipient may also wear a portable "help" button to allow for mobility. The system is connected to the person's phone and programmed to signal a response center once a "help" button is activated.

Case Manager Responsibilities

The case manager must:

- Document the need for the EARS system in the plan of care.
- Verify whether EARS equipment is more cost-effective to rent, lease, or purchase. If the EARS equipment is more economical to purchase, the case manager should verify that the equipment is not obsolete before purchasing and provides a warranty agreement for at least one year.

Service Requirements

The following service requirements apply to EARS:

- The EARS response center and equipment must operate 24 hours per day and comply with the requirements of Chapter 489, F. S. The response center equipment must consist of at least a primary receiver, a back-up receiver, a back-up power supply and a telephone line monitor.
- The EARS response center equipment must be able to:
  - Operate primary and back-up receivers independently and interchangeably;
  - Receive and process signals with only one of the receivers on line;
  - Record receipt of signals or messages; and
  - Operate on a back-up power source for at least 24 hours.
- EARS equipment provided consists of a home communicator (HC) and can also include a button and timer. The HC is kept in the recipient's home and is connected to the telephone line. The device must be able to receive a signal from the recipient's optional button or timer and have audible and visual indicators for visually and hearing impaired. The optional button can be carried in the recipient's hand or attached to a cord worn

around the neck. The button must be activated by pushing the button to signal the HC. The HC will dial the emergency number and activate audible, visual or voice communicators.

- The optional timer must be capable of being set to automatically activate a signal after a specified period of inactivity in the home. The HC must be able to receive the timer's signal and either activates the audible, visual or voice indicators or communicators. The HC must have a reset feature that would allow the timer to be reset. When the recipient is away from home, the timer's controls must allow the device to be turned off. The communicator must have a back-up power source that would operate the device for at least 24 hours in the event of a power failure. The communicator must have a self-diagnostic program that is performed automatically every 24 hours.

Service Limitations–Installation

The following service limitations apply to EARS installations:

- EARS installation services are limited to the amount, duration and scope of services described in the recipient's plan of care as authorized by the case manager.
- The EARS system is limited to those recipients who live alone, or who are alone for significant parts of the day, and have no regular caregiver for extended periods of time, and who would otherwise require extensive routine supervision.
- The services must be provided at the recipient's residence.
- See the Aged and Disabled Adult Services Waiver Procedure Codes and Fee Schedule, for the maximum number of installations and the maximum reimbursement per installation.

Note: The Fee Schedule is available on the Medicaid fiscal agent's Web site at mymedicaid-florida.com. Select Public Information for Providers, then on Provider Support, and then on Fee Schedules. It is incorporated by reference in 59G-13.031, F.A.C.

Service Limitations–Maintenance

The following service limitations apply to EARS maintenance:

- EARS maintenance services are limited to the amount, duration and scope of services described in the recipient's plan of care as authorized by the case manager.
- The services must be provided at the recipient's residence.
- See the Aged and Disabled Adult Services Waiver Procedure Codes and Fee Schedule, for the maximum reimbursement for EARS maintenance.

Response Center Staff Requirements

EARS response center personnel must receive pre-service training on location in all operational aspects of the equipment, subscriber installation, equipment testing, and program implementation. The provider must maintain documentation of the pre-service training of each EARS service employee. Yearly in-service training to update and refresh response center personnel must be completed and records of the training must be maintained on each response center employee.

Escort Services

Description

Escort services provide trained individuals to accompany and assist recipients to and from service providers. Escorts may provide language interpretations for recipients who have hearing or speech impairments and may also be used to translate foreign languages on behalf of the recipient.

Case Manager Responsibilities

The case manager must verify that escorts are trained to provide necessary assistance to recipients during trips. This verification includes not only assistance with hearing, speech or foreign language deficiencies, but also assistance with any activities of daily living (ADLs) deficits.

Service Limitations

The following service limitations apply to Escort services:

- Escort services are limited to the amount, duration and scope of services described in recipient's plan of care as authorized by the case manager.
- This service can be provided at all locations.
- See the Aged and Disabled Adult Services Waiver Procedure Codes and Fee Schedule, for the maximum units of service and the maximum reimbursement per unit. Although this service can be authorized for up to eight hours per day, such an authorization would be unusual and requires extensive documentation of the justification.

Escort Transportation Restrictions

This service does not permit the escort to drive any vehicle for the purpose of transporting a recipient.

If the escort is not covered by the Medicaid Non-Emergency Transportation Services Program, the reimbursement for this service will include the costs of Medicaid transportation for the escort.

Financial Assessment and Maintenance Risk Reduction Services

Description

Financial Risk Reduction Services provide assessment of problem financial areas as well as coaching and guidance for budgeting and paying bills. These services may include the establishment of checking accounts and direct deposits. These services reduce the risk of financial exploitation of the recipient.

Case Manager Responsibilities

The case manager must:

- Clearly state in the plan of care what services are to be performed.
- Provide oversight to ensure the service provider is making appropriate payments for the recipient and note any other activities authorized under this service.

Service Limitations–Assessment

The following service limitations apply to Financial Assessment and Risk Reduction services:

- Financial Assessment and Risk Reduction services are limited to the amount, duration and scope of services described in the recipient's plan of care as authorized by the case manager.
- The services must be provided in either the recipient's residence or the provider's office.
- See the Aged and Disabled Adult Services Waiver Procedure Codes and Fee Schedule, for the maximum units of service and the maximum reimbursement per unit.

Note: The Fee Schedule is available on the Medicaid fiscal agent's Web site at mymedicaid-florida.com. Select Public Information for Providers, then on Provider Support, and then on Fee Schedules. It is incorporated by reference in 59G-13.031, F.A.C.

Service Limitations–Maintenance

The following service limitations apply to Financial Assessment and Risk Reduction services:

- Financial Maintenance and Risk Reduction services are limited to the amount, duration and scope of services described in the recipient's plan of care as authorized by the case manager.
- The services must be provided in either the recipient's residence or the provider's office.
- See the Aged and Disabled Adult Services Waiver Procedure Codes and Fee Schedule, for the maximum units of service and the maximum reimbursement per unit.

Provider Responsibilities

Service providers must maintain separate files for each waiver recipient served. Service documentation must include all records relating to bills paid by the provider, copies of all bank statements, and copies of any deposits made by the provider.

Home Delivered Meals

Description

Home Delivered Meal services are meals delivered to the recipient's residence. In order to receive this service, recipients must be identified by the case manager as having difficulty in shopping or preparing appropriate, nutritious meals. Recipients will be given a choice of meals from a menu provided in advance.

All meals will provide each participating older individual a minimum of 33 1/3% of the current Dietary Reference Intake (DRI). For further information please see this website: aoa.dhhs.gov/prof/aoaprog/nutrition/nutrition.asp. The meals must comply with the current Dietary Guidelines for Americans and meet the nutritional needs of a (moderately active) 70+ female (Please see the USDA My Pyramid Food Intake Pattern: mypyramid.gov/index.html) and reflect the predominant state wide demographic.

Home delivered meals do not constitute a full and complete nutritional regimen.
The "choice from a menu in advance" requirement means the recipient must have at least two choices from the menu. One choice may be a "cold" meal such as a sandwich with fruit and raw vegetables.

Case Manager Responsibilities

The case manager must:

- Verify and document that the recipient has difficulty in shopping for groceries or preparing meals and has no caregiver capable of providing this service.
- Ensure that the Home Delivered Meals provider gives the recipient a choice of meals from a menu provided in advance. Meals listed on the advance meal menus must satisfy at least one-third of the Dietary Reference Intake (DRI) nutritional requirements.
- Verify the Home Delivered Meals are appropriate for the recipient and the recipient is satisfied with the meals.

Service Limitations

The following service limitations apply to Home Delivered Meals:

- Home Delivered Meal services are limited to the amount, duration and scope of services described in the recipient's plan of care as authorized by the case manager.
- Each meal offered on the advance meal menus must be evaluated and certified by a licensed registered dietician, through the local delivery agency, as satisfying at least one-third of the DRI requirements.
- The services must be provided at the recipient's residence and documentation of receipt of service is required.
- See the Aged and Disabled Adult Services Waiver Procedure Codes and Fee Schedule, for the maximum number of meals per day and maximum reimbursement.

Note: The Fee Schedule is available on the Medicaid fiscal agent's Web site at mymedicaid-florida.com. Select Public Information for Providers, then on Provider Support, and then on Fee Schedules. It is incorporated by reference in 59G-13.031, F.A.C.

Service Exclusions

Home Delivered Meals do not constitute a full and complete nutritional program (three meals per day = 100% DRI).

Service Restrictions

The following service restrictions apply to home delivered meals:

- Home Delivered Meals can be hot, cold, frozen, dried, canned or a combination of these options. More than one meal may be delivered provided proper storage and heating facilities are available in the recipient's residence. The recipient must be able to prepare and consume the additional meals himself or with available assistance.
- The Home Delivered Meals provider is responsible for overseeing that potentially hazardous foods must be held and transported in a method that ensures hot food temperatures are 1400 Fahrenheit or higher and cold food temperatures are 410 Fahrenheit or lower.

Home Modification Services

Description

Home Modification services provide physical adaptations to the recipient's residence. These services must be required in the recipient's plan of care to ensure the health, welfare and safety of the recipient, or enable the recipient to function more independently at home. Without these services, the recipient would require additional in-home services or institutionalization.

Such adaptations may include the installation of ramps and grab-bars, widening of doorways, modification of bathroom facilities, or installation of specialized electric and plumbing systems to accommodate the medical equipment and supplies which are necessary for the recipient's welfare.

Beyond this scope, major accessibility adaptations may require the assessment of a rehabilitation engineer. This home accessibility assessment must include evaluation of the current home and describe the most cost-beneficial manner to provide accessibility of the home for the recipient on the waiver.

Case Manager Responsibilities

The case manager must:

- Ensure that the requested modifications are noted in the recipient's plan of care.
- Ensure that all modifications are being made to the recipient's residence and do not require a home accessibility assessment by a rehabilitation engineer.
- Interview the recipient and determine that he is not planning to move either to another residence or institutional setting within the next three months.
- Ensure that in the event of either the recipient's death or change of residence that all work will stop immediately.

Medicaid Waiver Specialist Responsibilities

The Medicaid Waiver Specialist must verify that adaptations are performed by a qualified independent, general, residential, or building contractor licensed under Chapter 205 or Chapter 489, Florida Statutes, in accordance with all state and local building codes.

Service Limitations

The following service limitations apply to Home Modification services:

- Home Modification services are limited to the amount, duration and scope of services described in the recipient's plan of care as authorized by the case manager.
- Modifications made to a rental property that is a recipient's residence require written permission from the landlord prior to beginning the modification.
- See the Aged and Disabled Adult Services Waiver Procedure Codes and Fee Schedule, for the maximum number of Home Modification jobs per year and the maximum reimbursement per job.

Note: The Fee Schedule is available on the Medicaid fiscal agent's Web site at mymedicaid-florida.com. Select Public Information for Providers, then on Provider Support, and then on Fee Schedules. It is incorporated by reference in 59G-13.031, F.A.C.

Service Exclusions

The following service exclusions apply to Home Modification services:

- Adaptations or improvements to the home, which are of general utility, and are not of direct medical or remedial benefit to the individual, such as carpeting, roof repair and central air conditioning, are excluded from this service.
- Adaptations that add to the total square footage of the residence are excluded from this service.

Homemanager and Homemaker Services

Description

Homemanager and Homemaker services consist of general household activities (meal preparation and routine household care) provided by a trained homemaker, when the individual who is regularly responsible for these activities is temporarily absent or unable to manage the home and care for him or herself or others in the home.

Case Manager Responsibilities

The case manager must:

- Give specific instructions to the provider regarding tasks to be completed as part of the service authorization.
- Verify that the specific instructions are being followed and that the recipient is satisfied with the service.

Scope of Service

Homemaker services include the following:

- Meal planning and preparation.
- Housekeeping—when the waiver recipient occupies only a portion of the residence, the homemaker must maintain this area only.
- Laundry—only the waiver recipient's laundry is the responsibility of the homemaker.
- Clothing Repair—repair is restricted to the waiver recipient's clothing.
- Minor home repair such as changing light bulbs or tightening screws on a loose rail.
- Shopping assistance—this assistance is limited to the waiver recipient's needs.
- Reporting changes in the recipient's condition to the case manager.
- Following emergency procedures, when needed.
- Other related duties as specified in the care plan.

Service Limitations

The following service limitations apply to Homemaker services:

- Homemaker services are limited to the amount, duration and scope of services described in the recipient's plan of care as authorized by the case manager.
- The services must be provided at the recipient's residence.
- See the Aged and Disabled Adult Services Waiver Procedure Codes and Fee Schedule, for the maximum units of service and the maximum reimbursement per unit.

Note: The Fee Schedule is available on the Medicaid fiscal agent's Web site at mymedicaid-florida.com. Select Public Information for Providers, then on Provider Support, and then on Fee Schedules. It is incorporated by reference in 59G-13.031, F.A.C.

Nutritional Risk Reduction Services

Description

Nutritional Risk Reduction services provide assessment and guidance to the recipient or caregiver in the planning and preparation of nutritionally appropriate meals for the purpose of promoting better health through improved nutritional status.

Case Manager Responsibilities

The case manager must monitor the recipient's nutritional and health status to verify improvement in the planning and preparation of nutritious meals as a result of the assessment and guidance provided.

Service Limitations

The following service limitations apply to Nutritional Risk Reduction services:

- Nutritional Risk Reduction services are limited to the amount, duration and scope of services described in the recipient's plan of care as authorized by the case manager.
- The services can be provided at the recipient's home, health professional's office or other location.
- If the recipient's condition requiring the initial authorization of this service has not been resolved or at least improved within six months, authorization of this service beyond the initial six months requires extensive documentation.
- See the Aged and Disabled Adult Services Waiver Procedure Codes and Fee Schedule, for the maximum units of service and the maximum reimbursement per unit.

Note: The Fee Schedule is available on the Medicaid fiscal agent's Web site at mymedicaid-florida.com. Select Public Information for Providers, then on Provider Support, and then on Fee Schedules. It is incorporated by reference in 59G-13.031, F.A.C.

Occupational Therapy Services

Description

Occupational Therapy services addresses the functional needs of the individual related to self-help skills; adaptive behavior; and sensory, motor and postural development.

Occupational Therapy services include evaluation and treatment to prevent or correct physical and cognitive deficits or to minimize the disabling effect of these deficits. Examples are perceptual motor activities, exercises to enhance functional performance, kinetic movement activities, guidance in the use of adaptive equipment and other techniques related to improving motor development.

The Occupational Therapist must be currently licensed under Chapter 468, Florida Statutes.

Scope of Services

Occupational Therapy services provided under the A/DA Waiver Program are in addition to those available under the Medicaid state plan Therapy Services Program. The services must differ in amount, scope and quantity from the Florida Medicaid Therapy Services Program. Please refer to the Florida Medicaid Therapy Services Coverage and Limitations Handbook for information on services covered by the program.

Note: The Florida Medicaid Therapy Services Coverage and Limitations Handbook is available on the Medicaid fiscal agent's Web site at mymedicaid-florida.com. Select Public Information for Providers, then on Provider Support, and then on Provider Handbooks. It is incorporated by reference in 59G-4.320, F.A.C.

Case Manager Responsibilities

The case manager must:

- Ensure that the physician's prescription is obtained before services begin and that the prescription contains the following information: the recipient's diagnosis; the specific type of evaluation requested or the specific type of service; and the duration and frequency required for treatment. Include this documentation in the recipient's case record.
- Consult with the therapist at least monthly to ensure the recipient's continued need for this service.

Service Limitations

The following service limitations apply to Occupational Therapy services:

- Occupational Therapy services are limited to the amount, duration and scope of services described in the recipient's plan of care as authorized by the case manager.
- The services may be provided at the recipient's home, the provider's office, or other location.
- If a dually-eligible (Medicare and Medicaid) waiver recipient receives this service from a home health agency, the provider must be licensed and certified. Medicare must be billed before billing Medicaid. For a provider to bill Medicare they must meet the Federal Conditions of Participation.
- See the Aged and Disabled Adult Services Waiver Procedure Codes and Fee Schedule, for the maximum units of service and the maximum reimbursement per unit.

Note: The Fee Schedule is available on the Medicaid fiscal agent's Web site at mymedicaid-florida.com. Select Public Information for Providers, then on Provider Support, and then on Fee Schedules.

Personal Care Services

Description

Personal Care services provide assistance with eating, bathing, dressing, personal hygiene, and other activities of daily living. These services include assistance with meal preparation. When specified in the plan of care, this service can also include such housekeeping chores as bed making, dusting and vacuuming, which are incidental to the care furnished, or essential to the

recipient's health and welfare. These services under the A/DA Waiver Program differ in service definition and provider type from the services offered under the Florida Medicaid Home Health Program.

Case Manager Responsibilities

The case manager must note in the plan of care the amount, duration and scope of services provided by the service provider.

Medicaid Waiver Specialist Responsibilities

The Medicaid Waiver Specialist must ensure that the personal care workers are supervised by a registered nurse, licensed to practice nursing in Florida, who will conduct a supervisory home visit every 60 days to observe the personal care worker.

Service Limitations

The following service limitations apply to Personal Care services:

- Personal Care services are limited to the amount, duration and scope of services described in the recipient's plan of care as authorized by the case manager.
- The services may be provided at the recipient's home or other locations.
- Family members will not be paid for furnishing Personal Care services to the recipient. Medicaid does not reimburse for services furnished by parents, stepparents, spouse, siblings, sons, daughters, household members or any person with custodial or legal responsibility for a Medicaid recipient.
- The services may be authorized when the recipient's mental or physical condition is such that the individual requires assistance with activities of daily living (ADLs) or instrumental activities of daily living (IADLs).
- See the Aged and Disabled Adult Services Waiver Procedure Codes and Fee Schedule, for the maximum units of service and the maximum reimbursement per unit.

Note: The Fee Schedule is available on the Medicaid fiscal agent's Web site at mymedicaid-florida.com. Select Public Information for Providers, then on Provider Support, and then on Fee Schedules.

Scope of Service

Personal Care services include the following:

- Providing assistance to the recipient to complete personal hygiene (bathing, grooming, mouth care, etc.).
- Assisting with bladder and bowel requirements that include assisting the recipient to and from the bathroom or with bedpan routines.
- Assisting the recipient in following through with physician's orders as prescribed in the plan of care. The provider shall not administer any medication, but may bring medicine to the recipient and remind the recipient to take the medicine at a specified time.
- Assisting with food, nutrition, and diet activities, including preparing meals, when required and other incidental services (i.e. housekeeping chores) essential to the health and welfare of the waiver recipient.
- Performing household services (changing bed linen or arranging furniture), when such services are essential to the recipient's health and comfort.

Personal Care Provider Requirements

Personal Care providers must have emergency procedures in the event of a crisis during the course of care.

Personal Care providers cannot change sterile dressings, irrigate body cavities, administer medications, or perform any other activities reserved for nurses under Chapter 464, F.S. (Nurse Practice Act).

RN Supervision Requirements

Personal Care providers must be supervised by a licensed Florida registered nurse, who performs a supervisory home visit at least every 60 days to observe the provision of services.

Pest Control Services–Initial Visit and Maintenance

Description

Pest Control services aid in maintaining an environment free of insects, rodents and other potential disease carriers to enhance safety, sanitation, and cleanliness of the recipient's residence.

Case Manger Responsibilities

The case manager must:

- Verify and document that the recipient is not planning to move to another residence, enter an assisted living facility, or nursing home within one month.
- Contact the recipient prior to authorizing this service and determine if the recipient has any health conditions that need to be considered by the pest control provider.

Service Limitations–Initial Visit

The following service limitations apply to Pest Control Initial service visit:

- Pest Control services are limited to the amount, duration and scope of services described in the recipient's plan of care as authorized by the case manager.
- The services must be provided at the recipient's residence.
- See the Aged and Disabled Adult Services Waiver Procedure Codes and Fee Schedule, for the maximum reimbursement for the initial visit. The maximum allowable authorization is one initial visit per recipient. The case manager must use judgment in making a decision for a second initial visit and document in the recipient's case narrative the reasoning behind the decision.

Note: The Fee Schedule is available on the Medicaid fiscal agent's Web site at mymedicaid-florida.com. Select Public Information for Providers, then on Provider Support, and then on Fee Schedules. It is incorporated by reference in 59G-13.031, F.A.C.

Service Limitations–Maintenance

The following service limitations apply to Pest Control Maintenance services:

- Pest Control services are limited to the amount, duration and scope of services described in the recipient's plan of care as authorized by the case manager.

- The services must be provided at the recipient's residence.
- Pest Control services will not be authorized if other parties such as landlords are responsible for providing this service.
- See the Aged and Disabled Adult Services Waiver Procedure Codes and Fee Schedule, for the maximum allowable visits for pest control maintenance services and the maximum reimbursement per visit. The maximum allowable authorization is one visit per month per client.

Physical Risk Reduction Services

Description

Physical Risk Reduction services provide assessment and provision of hands-on care and technical guidance to recipients and caregivers regarding specific exercises to increase physical strength capacity, dexterity, and endurance to perform activities of daily living.

Case Manager Responsibilities

The case manager must consult with a medical professional (physician or RN) to determine the potential benefit of these services before authorizing risk reduction for the recipient.

Service Limitations

The following service limitations apply to Physical Risk Reduction services:

- Physical Risk Reduction services are limited to the amount, duration and scope of services described in the recipient's plan of care as authorized by the case manager.
- This service may be provided at the recipient's home, the health professional's office or other location.
- See the Aged and Disabled Adult Services Waiver Procedure Codes and Fee Schedule, for the maximum units of service and the maximum reimbursement per unit.

Note: The Fee Schedule is available on the Medicaid fiscal agent's Web site at mymedicaid-florida.com. Select Public Information for Providers, then on Provider Support, and then on Fee Schedules. It is incorporated by reference in 59G-13.031, F.A.C.

Service Restriction

If the situation or condition justifying the initial authorization of this service has not been resolved or at least improved within six months, authorization of this service beyond the initial six months requires extensive justification.

Physical Therapy Services

Description

Physical Therapy is a specifically prescribed program to develop, improve or restore neuro-muscular or sensory-motor function, relieve pain, or control postural deviations to attain maximum performance.

Physical Therapy services include evaluation and treatment of range-of-motion, muscle strength, functional abilities and the use of adaptive and therapeutic equipment. Examples are

rehabilitation through exercise, massage, the use of equipment and habilitation through therapeutic activities.

The Physical Therapist must be currently licensed under Chapter 486, Florida Statutes.

Scope of Services

Physical Therapy services provided under the A/DA Waiver Program are in addition to those available under the Florida Medicaid Therapy Services Program. The services must differ in amount, scope and quantity from the Florida Medicaid Therapy Services Program. Please refer to the Florida Medicaid Therapy Services Coverage and Limitations Handbook for information on services covered by the program.

Note: The Florida Medicaid Therapy Services Coverage and Limitations Handbook is available on the Medicaid fiscal agent's Web site at mymedicaid-florida.com. Select Provider Support, and then on Handbooks. It is incorporated by reference in 59G-4.320, F.A.C.

Case Manager Responsibilities

The case manager must:

- Consult with a medical professional (physician or RN) about the recipient's physical condition prior to authorizing this service.
- Ensure that the physician's prescription is obtained before services begin and that the prescription contains the following information: the recipient's diagnosis; the specific type of evaluation requested or the specific type of service; and the duration and frequency required for treatment. This documentation must be included in the recipient's case record.
- Consult with the therapist at least monthly to ensure the recipient's continued need for this service.

Service Limitations

The following service limitations apply to Physical Therapy services:

- Physical Therapy services are limited to the amount, duration and scope of services described in the recipient's plan of care as authorized by the case manager.
- The services may be provided at the recipient's home, the provider's office or other location.
- If a dually-eligible (Medicare and Medicaid) waiver recipient receives this service from a home health agency, the provider must be licensed and certified. Medicare must be billed before billing Medicaid. For the provider to bill Medicare they must meet the Federal Conditions of Participation.
- See the Aged and Disabled Adult Services Waiver Procedure Codes and Fee Schedule, for the maximum units of service and the maximum reimbursement per unit. Although this service may be authorized for up to four hours per day, such an authorization would be unusual and requires extensive documentation.

Note: The Fee Schedule is available on the Medicaid fiscal agent's Web site at mymedicaid-florida.com. Select Public Information for Providers, then on Provider Support, and then on Fee Schedules. It is incorporated by reference in 59G-13.031, F.A.C.

Rehabilitation Engineering Evaluation Services

Description

Rehabilitation Engineering Evaluation services include assessment of the systematic application of technologies, or engineering methodologies, needed to address the barriers confronted by aged and disabled adults living in community-based settings.

Areas to be assessed include education, rehabilitation, transportation, independent living and socialization. The service also includes assistance in obtaining or maintaining assistive technology devices, as well as training and technical assistance needed by individuals and caregivers regarding the operation or application of such devices which are necessary to ensure the health and welfare of the recipient, or which enable him to remain independent in the community.

The services are intended for recipients who require further evaluation than that usually required by a recipient prior to receipt of assistive technologies service.

Major home accessibility adaptations may require the assessment of a rehabilitation engineer. This home accessibility assessment shall include evaluation of the current home and describe the most cost-beneficial method to make the home accessible for the waiver recipient.

Case Manager Responsibilities

The case manager must:

- Consult with a medical professional (physician or RN) to determine the potential benefit before authorizing these services and to document this consultation within the case record.
- Determine that the assistive technologies or equipment are necessary to prevent institutionalization or risk of institutionalization and will enable the recipient to live in the least restrictive setting appropriate to his needs.

Service Limitations

The following service limitations apply to Rehabilitation Engineering Evaluation services:

- Rehabilitation Engineering Evaluation services are limited to the amount, duration and scope of the evaluation described in the plan of care and approved cost plan.
- The number of occurrences permitted will coincide with the limit set for the assistive technologies, adaptive equipment services or Home Modification services requiring assessment by a rehabilitation engineer.
- See the Aged and Disabled Adult Services Waiver Procedure Codes and Fee Schedule, for the maximum reimbursement for rehabilitation engineering evaluation services.

Note: The Fee Schedule is available on the Medicaid fiscal agent's Web site at mymedicaid-florida.com. Select Public Information for Providers, then on Provider Support, and then on Fee Schedules. It is incorporated by reference in 59G-13.031, F.A.C.

Respiratory Therapy Services-Evaluation and Treatment

Description

Respiratory Therapy is treatment of conditions that interfere with respiratory functions or other deficiencies of the cardiopulmonary system.

Respiratory Therapy services include evaluation and treatment related to pulmonary dysfunction. Examples are ventilatory support, therapeutic and diagnostic use of medical gases, respiratory rehabilitation, management of life support systems and bronchopulmonary drainage, breathing exercises, and chest physiotherapy.

The Respiratory Therapist must be currently licensed under Chapter 486, Florida Statutes.

Scope of Services

Respiratory Therapy services provided under the A/DA Waiver Services Program are in addition to those available under the Florida Medicaid Therapy Services Program.

The services must differ in amount, scope and quantity from the Florida Medicaid Therapy Services Program. Please refer to the Florida Medicaid Therapy Services Coverage and Limitations Handbook for information on services covered by the program.

Note: The Florida Medicaid Therapy Services Coverage and Limitations Handbook is available on the Medicaid fiscal agent's Web site at mymedicaid-florida.com. Select Provider Support, and then on Handbooks. It is incorporated by reference in 59G-4.320, F.A.C.

Case Manager Responsibilities

The case manger must:

- Ensure that the physician's prescription is obtained before services begin and that the prescription contains the following information: the recipient's diagnosis; the specific type of evaluation requested or the specific type of service; and the duration and frequency required for treatment. This documentation must be included in the recipient's case record.
- The case manager must state in the plan of care the amount, duration and scope of services to be provided by the service provider.
- Consult with the therapist at least monthly to ensure the recipient's continued need for this service.

Service Limitations–Evaluations

Respiratory Therapy Evaluations are limited to:

- One initial evaluation per recipient, per service provider.
- One re-evaluation every six months per recipient, per provider.
- See the Aged and Disabled Adult Services Waiver Procedure Codes and Fee Schedule, for the maximum reimbursement for respiratory therapy evaluation services.

Note: The Fee Schedule is available on the Medicaid fiscal agent's Web site at mymedicaid-florida.com. Select Public Information for Providers, then on Provider Support, and then on Fee Schedules. It is incorporated by reference in 59G-13.031, F.A.C.

Service Limitations–Treatments

The following service limitations apply to Respiratory Therapy treatments:

- A Respiratory Therapy treatment must have a minimum duration of 15 minutes of face-to-face contact between the recipient and the therapist.
- The recipient's physician must prescribe therapy treatment.
- If a dually-eligible (Medicare and Medicaid) waiver recipient receives this service from a home health agency, the provider must be licensed and certified. Medicare must be billed before billing Medicaid. For the provider to bill Medicare they must meet the Federal Conditions of Participation.
- Respiratory Therapy treatments are limited to one per day.
- Treatment must be provided in the residence or professional office.
- See the Aged and Disabled Adult Services Waiver Procedure Codes and Fee Schedule, for the maximum units of service and the maximum reimbursement per unit.

Note: The Fee Schedule is available on the Medicaid fiscal agent's Web site at mymedicaid-florida.com. Select Public Information for Providers, then on Provider Support, and then on Fee Schedules. It is incorporated by reference in 59G-13.031, F.A.C.

Respite Care Services–In Home and Facility Based

Description

Respite Care services are provided to individuals unable to care for themselves and are furnished on a short-term basis because of the absence or need for relief of those persons normally providing care.

Case Manager Responsibilities

The case manager must:

- State in the plan of care what activities the respite provider is expected to perform. Specifically, if light housekeeping and assistance with personal care are required, the plan of care and service authorization must detail these services.
- Not authorize Respite services if the recipient's caregiver must work and the recipient requires constant supervision and cannot be left alone in the absence of the caregiver. The case manager must consider other appropriate services such as Adult Day Care or Adult Companion services in the case of a working caregiver.

Service Limitations-General

The following general service limitations apply to Respite care services:

- Respite services are limited to the amount, duration and scope of services described in the recipient's plan of care as authorized by the case manager.
- Respite services as described in this section shall only be provided on the basis of need to relieve the primary caregiver.
- Respite services may be provided in the recipient's residence, a Medicaid certified nursing facility, a licensed adult day care facility, or an assisted living facility.
- See the Aged and Disabled Adult Services Waiver Procedure Codes and Fee Schedule, for the maximum units of service and the maximum reimbursement per unit.

Note: The Fee Schedule is available on the Medicaid fiscal agent's Web site at mymedicaid-florida.com. Select Public Information for Providers, then on Provider Support, and then on Fee Schedules. It is incorporated by reference in 59G-13.031, F.A.C.

Service Limitations—In-Home

Respite In-Home services must be provided at the recipient's residence.

Service Limitations—Facility-Based

Facility-Based Respite services must be provided in either a Medicaid-certified nursing facility, a licensed adult day care facility, or a licensed assisted living facility.

Skilled Nursing Services

Description

Skilled Nursing services are those within the scope of Florida's Nurse Practice Act, which are listed in the recipient's plan of care and are provided on an intermittent basis to recipients who either do not require continuous nursing supervision or whose need is predictable. Services are provided by a registered professional nurse, or licensed practical or vocational nurse under the supervision of a registered nurse, licensed to practice in the state of Florida. Skilled Nursing services may be provided in the provider's office or the recipient's home.

Examples of Skilled Nursing services under the waiver include medication management, dressing changes, ostomy and catheter care, and treatment of decubitus ulcers or any service listed in the recipient's plan of care requiring skilled nursing.

Scope of Services

Case managers are expected to ensure that needed Skilled Nursing services are not otherwise available under the Florida Medicaid state plan. Nursing services provided under the A/DA Waiver Program are in addition to those available under the Medicaid Home Health Services Program in amount, scope and quantity. Please refer to the Florida Medicaid Home Health Services Coverage and Limitations Handbook for information on services covered by the program.

Note: The Florida Medicaid Home Health Services Coverage and Limitations Handbook is available on the Medicaid fiscal agent's Web site at mymedicaid-florida.com. Select Public Information for Providers, then on Provider Support, and then on Provider Handbooks. It is incorporated by reference in 59G-4.320, F.A.C.

Case Manager Responsibilities

The case manager must:

- Ensure that the skilled nursing visit is ordered, through prescription, by the attending physician.
- Ensure that the need for skilled nursing is documented in the case record.
- Consult with the skilled nurse at least monthly to ensure the recipient's continued need for this service.

Service Limitations

The following service limitations apply to Skilled Nursing services:

- Skilled Nursing services are limited to the amount, duration and scope of services described in the recipient's plan of care as authorized by the case manager.
- Skilled Nursing may be provided at the recipient's residence or provider's office.
- Nurses providing skilled nursing services under the procedure code for Skilled Nursing—BSN must have a Bachelor of Science degree in nursing.
- If a dually-eligible (Medicare and Medicaid) waiver recipient receives this service from a home health agency, the provider must be licensed and certified. Medicare must be billed before billing Medicaid. For the provider to bill Medicare they must meet the Federal Conditions of Participation.
- See the Aged and Disabled Adult Services Waiver Procedure Codes and Fee Schedule, for the maximum units of service and the maximum reimbursement per unit.

Note: The Fee Schedule is available on the Medicaid fiscal agent's Web site at mymedicaid-florida.com. Select Public Information for Providers, then on Provider Support, and then on Fee Schedules. It is incorporated by reference in 59G-13.031, F.A.C.

Specialized Medical Equipment and Supplies

Description

Specialized Medical Equipment and Supplies services include adaptive devices, controls, or appliances, specified in the recipient's plan of care, which enable recipients to increase their ability to perform activities of daily living. This service also includes repair of such items as well as replacement parts.

Scope of Service

Specialized Medical Equipment and Supplies provided under the A/DA Waiver Program are in addition to the supplies available under the Medicaid Durable Medical Equipment and Medical Supplies Program. Services must differ in scope and quantity from the Medicaid Durable Medical Equipment and Medical Supplies Program. Please refer to the Florida Medicaid Durable Medical Equipment and Medical Supplies Coverage and Limitations Handbook for information on the equipment covered by the program.

A/DA waiver funds may not be utilized for durable medical equipment available under the Florida Medicaid Durable Medical Equipment and Medical Supply Services Program, unless the equipment that is available under the program are unable to meet the physician-ordered specifications. The case manager must file a copy of the completed Prior Authorization form PAO1 07/2008, denying or approving the request, in the case record for each requested DME service.

Note: The Florida Medicaid Durable Medical Equipment and Medical Supplies Coverage and Limitations Handbook is available on the Medicaid fiscal agent's Web site at mymedicaid-florida.com. Select Public Information for Providers, then on Provider Support, and then on Provider Handbooks. It is incorporated by reference in 59G-4.070, F.A.C.

Note: The Prior Authorization form PAO1 07/2008 is available on the Medicaid fiscal agent's Web site at mymedicaid-florida.com. Select Public Information for Providers, then on Provider Support, and then on Forms. It is incorporated by reference in 59G-4.001, F.A.C.

Case Manager Responsibilities

The case manager must:

- Consult with a medical professional (physician or RN) and obtain a physician's prescription before authorizing items under this service and include this documentation in the recipient's case record.
- A copy of the physician's prescription must be attached to the provider's service authorization.
- Ensure that an item is not available under the Florida Medicaid Durable Medical Equipment and Medical Supply Services Program (state plan) or through any other source before authorizing this service.
- Prior to authorizing the purchase, rental or lease of an item, obtain at least three price quotations, if three service providers are available. The price quotation information must be placed in the case narrative.
- Obtain the warranty information from the equipment provider and maintain the information in the recipient's case record. All items must meet applicable standards of manufacture, design and installation.

Service Limitations

The following service limitations apply to Specialized Medical Equipment and Supplies:

- Specialized Medical Equipment and Supply services are limited to the amount, duration and scope of services described in the recipient's plan of care as authorized by the case manager.
- The services must be provided in the recipient's residence.
- See the Aged and Disabled Adult Services Waiver Procedure Codes and Fee Schedule, for the maximum limits on purchases and the maximum reimbursement per purchase.

Note: The Fee Schedule is available on the Medicaid fiscal agent's Web site at mymedicaid-florida.com. Select Public Information for Providers, then on Provider Support, and then on Fee Schedules. It is incorporated by reference in 59G-13.031, F.A.C.

Service Exclusions

A/DA waiver funds may not be utilized for Specialized Medical Equipment and Supplies available under the Florida Medicaid Durable Medical Equipment and Medical Supply Services program, unless the supplies that are available under the regular Medicaid program are unable to meet the physician-ordered specifications. A copy of the completed Prior Authorization form PAO1 07/2008, denying or approving the request, must be in the case record for each requested DME service.

Speech-Language Pathology Services

Description

Speech-Language Pathology services involve the evaluation and treatment of speech-language disorders.

Services include the evaluation and treatment of disorders of verbal and written language, articulation, voice, fluency, phonology, mastication, deglutition, cognition, communication (including the pragmatics of verbal communication), auditory processing, visual processing, memory, comprehension and interactive communication as well as the use of instrumentation, techniques, and strategies to remediate and enhance the recipient's communication needs, when appropriate. Services also include the evaluation and treatment of oral pharyngeal and laryngeal sensorimotor competencies.

Examples are techniques and instrumentation to evaluate the recipient's condition, remedial procedures to maximize the recipient's oral motor functions, and communication via augmentative and alternative communication (AAC) systems.

The Speech-Language Pathology therapist must be currently licensed under Chapter 468, Florida Statutes.

Scope of Services

Speech-Language Pathology services provided under the A/DA Waiver Services Program are in addition to those available under the Medicaid Therapy Services Program. The services must differ in amount, scope and quantity from the Medicaid Therapy Services Program. Please refer to the Florida Medicaid Therapy Services Coverage and Limitations Handbook for information on services covered by the program.

Note: The Florida Medicaid Therapy Services Coverage and Limitations Handbook is available on the Medicaid fiscal agent's Web site at mymedicaid-florida.com. Select Public Information for Providers, then on Provider Support, and then on Provider Handbooks. It is incorporated by reference in 59G-4.320, F.A.C.

Case Manager Responsibilities

The case manager must:

- Ensure that the physician's prescription is obtained before services begin and that the prescription contains the following information: the recipient's diagnosis; the specific type of evaluation requested or the specific type of service; and the duration and frequency required for treatment. This documentation must be included in the recipient's case record.
- Document in the plan of care the amount, duration and scope of services to be provided by the service provider.
- Consult with the therapist at least monthly to ensure the recipient's continued need for this service.

Service Limitations

The following service limitations apply to Speech-Language Pathology services:

- Speech-Language Pathology services are limited to the amount, duration and scope of services described in the recipient's plan of care as authorized by the case manager.
- The recipient's physician must prescribe therapy treatment.
- This service can be provided at any location.
- If a dually-eligible (Medicare and Medicaid) waiver recipient receives this service from a home health agency, the provider must be licensed and certified. Medicare must be

billed before billing Medicaid. For the provider to bill Medicare they must meet the Federal Conditions of Participation.

- Although this service can be authorized for up to four hours per day, such an authorization would be unusual and requires extensive documentation of the justification.
- See the Aged and Disabled Adult Services Waiver Procedure Codes and Fee Schedule, for the maximum units of service and the maximum reimbursement per unit.

Note: The Florida Medicaid Therapy Services Coverage and Limitations Handbook is available on the Medicaid fiscal agent's Web site at mymedicaid-florida.com. Select Public Information for Providers, then on Provider Support, and then on Provider Handbooks. It is incorporated by reference in 59G-4.320, F.A.C.

Hospice Election for A/DA Waiver Recipients

Introduction

Hospice care may be provided to a recipient who is enrolled in one of the Medicaid home and community-based services (HCBS) waivers identified on the Attachment to the Cooperative Agreement for a Hospice and Medicaid Waiver Enrolled Recipient, AHCA Form 5000-30A, October 2003.

Note: See Appendix F for a copy of the Attachment to the Cooperative Agreement for a Hospice and Medicaid Waiver Enrolled Recipient, AHCA Form 5000-30A. The form may be photocopied from the handbook. It is incorporated by reference in 59G-4.140, F.A.C.

Recipient Eligibility

A/DA waiver recipients who elect hospice do not require a referral to DCF to determine eligibility for the hospice program.

Coordination of Hospice and A/DA Waiver Services

Hospice services are provided for the recipient and family needs related to the terminal illness for which the recipient elected hospice. At the time the recipient chooses hospice, the waiver case manager will coordinate services with the hospice care coordinator or case manager. The hospice care coordinator or case manager must provide to the waiver case manager the Notice of Hospice Election Waiver, AHCA Form 5000-29, October 2003.

Waiver services may be provided for any pre-existing conditions not related to the hospice diagnosis, other conditions unrelated to the hospice diagnosis and services not provided by hospice. The waiver case manager and the hospice care coordinator or case manager will enter into a cooperative agreement using a Cooperative Agreement for a Hospice and Medicaid Waiver Enrolled Recipient, AHCA Form 5000-30, October 2003.

Medicaid does not reimburse duplicative hospice and waiver services provided to the same recipient.

Note: See Appendix F for a copy of the Notice of Hospice Election Waiver, AHCA Form 5000-29, and the Cooperative Agreement for a Hospice and Medicaid Waiver Enrolled Recipient, AHCA Form 5000-30. The forms may be photocopied from the handbook. They are incorporated by reference in 59G-4.140, F.A.C.

Case Manager Responsibilities

The case manager must coordinate services with the hospice care coordinator or case manager and document those services on the Cooperative Agreement for a Hospice and Medicaid Waiver Enrolled Recipient, AHCA Form 5000-30, the recipient's plan of care and in a case narrative notation.

Appeal Rights and Fair Hearing Process

Grievance Procedure

A/DA waiver recipients age 60 and older can file a grievance concerning any action taken by DOEA or the DOEA service provider network. Recipients may contact their case managers for assistance with their grievance. Upon recipient request, case managers must assist the recipient or the recipient's designated representative with preparation of the grievance. Participation in the DOEA grievance process does not affect a recipient's right to a fair hearing.

The Department of Children and Families, who administers the disabled component of the A/DA waiver (disabled recipients between the ages of 18 and 59) has no formal grievance procedure. Waiver recipients in this category may proceed directly to a fair hearing, described below.

Right to a Fair Hearing

In accordance with Chapter 42, Part 431.221(d) of the Code of Federal Regulations, a recipient has certain appeal rights. A recipient has the right to appeal any action taken by AHCA, DOEA, DCF or service providers that adversely affects the receipt of services. Advance notice of termination of services or program participation must inform the A/DA recipient of the right to a fair hearing.

A/DA waiver recipients must be given ten (10) calendar days advance written notice of change in or termination of services or program participation. The advance notice must inform the waiver recipient of the right to a fair hearing.

Where to Apply for a Hearing

Hearing requests must be sent to:

Department of Children and Families
Office of Hearing Appeals
1317 Winewood Boulevard, Building 5, Room 203
Tallahassee, Florida 32399-0700

The telephone number is (850) 488-1429.

How to Request a Hearing

The A/DA waiver applicant, recipient, or authorized representative must request a hearing within 90 days of the receipt of the written notification of the adverse decision. Upon recipient request, A/DA waiver case managers must assist recipients with the fair hearing process.

Continuation of Benefits

If the A/DA waiver applicant, recipient, or authorized representative requests a fair hearing within 10 calendar days of the receipt of the notice of case action or denial of service, waiver services must continue at the level prior to the adverse action.

If an A/DA waiver applicant or recipient requests a fair hearing and services are reinstated to the prior level, the applicant or recipient might be requested to repay that portion of the benefits that the hearing decision determines to be invalid. The applicant or recipient must be given written notice of this responsibility.

A copy of the written notice must be placed in the recipient's case file.

Reinstated Benefits

Reinstated or continued benefits must not be reduced or terminated prior to the final hearing decision unless an additional cause for adverse action occurs while the hearing decision is pending, and the recipient fails to request a hearing after a subsequent notice of adverse action.

The A/DA waiver case manager must inform the recipient or authorized representative in writing if benefits are reduced or terminated prior to the hearing decision.

A copy of the written notice must be placed in the recipient's case file.

Notification of Fair Hearing Decisions

The hearing officer must send the applicant, recipient, or the authorized representative a copy of the Final Order. In addition to describing the final decision of the hearing, the Final Order explains that:

- The applicant, recipient, or authorized representative can request a judicial review of the decision; and
- The applicant, recipient, or authorized representative must pay the cost of any judicial review.

Time Limit on Hearing Decision

Federal law requires that the final hearing decision be made and communicated to all involved parties within 90 calendar days of the hearing request.

Necessary Actions to be Taken When Appeal is Granted

Recipient benefit restoration or increases resulting from the final hearing decision must begin within 10 calendar days of the date the local office is notified.

Benefit changes are effective based on the date specified by the hearing officer.

CHAPTER 3
AGING OUT PROGRAM

Overview

Introduction

This chapter describes the Aging Out Program under the Aged and Disabled Adult Waiver, the purpose of the program, the policy and procedure for enrollment, provider qualifications and responsibilities, and recipient disenrollment.

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Description and Purpose

Aging Out Program Description

The Aging Out Program under the Aged and Disabled Adult (A/DA) waiver provides services to specific individuals who have been receiving medical services in the home through the Department of Health, Children's Medical Services (CMS). When these individuals reach 21 years of age, CMS can no longer provide these services, and the individual "ages out" of CMS.

Based on a recommendation and referral from CMS, individuals who meet all eligibility requirements may be enrolled in the Aging Out Program under the Aged and Disabled Adult waiver.

Aging Out recipients must meet nursing facility level of care and be capable of receiving services in the home, based on the Comprehensive Assessment and Review for Long-Term Care Services (CARES) Assessment.

Note: See Chapter 2, Service Requirements, Level of Care Determination.

Purpose

Enrollment in the Aging Out Program is intended to ensure the smooth, uninterrupted provision of services necessary for the recipient to maintain the highest practical level of physical, emotional, and psychosocial well being while remaining in the home and community.

Eligibility

The individual must meet all the following criteria for enrollment in the Aging Out Program:

- **Referrals** for the Aging Out program must be made by Children's Medical Services' Case Coordinator to the Agency for Health Care Administration approximately six months before the recipient turns 21;
- **Age 21 and older**;
- **Cognitively Intact**: defined as oriented to time and place and able to display independence in daily decision making, able to make decisions regarding health care, comprehension and problem solving ability;
- **Medically Complex**: individuals with chronic debilitating diseases or conditions of one or more physiological or organ systems that make the individual dependent upon medical, nursing or health supervision or intervention; and
- **Technology Dependent**: individuals requiring medical apparatus and procedures to sustain life.

Covered Services Provided to the Aging Out Recipient

Recipients enrolled in the Aging Out Program under the A/DA waiver are eligible to receive all services provided under the A/DA waiver after first accessing all available Medicaid state plan services and services available through community resources.

Note: Please refer to Chapter 2, Covered Services, for a list of available A/DA waiver services.

Enrollment Policy and Procedures

Enrollment

Enrollment in the Aging Out Program is limited to eligible individuals. These individuals are referred to the Agency for Health Care Administration (AHCA), Aged and Disabled Adult (A/DA) waiver program analyst by Children's Medical Services (CMS) approximately six (6) months before the individual turns 21 years of age.

The program analyst will review the child's current CMS Care Coordination Assessment and other applicable materials in order to determine eligibility for the Aging Out Program. If the recipient meets the eligibility requirements, the program analyst will notify the recipient or the recipient's family in writing and, if available, provide a list of enrolled A/DA waiver's Aging Out Program enhanced case management agencies in the recipient's area. When the recipient has chosen a case management agency, the recipient or case management agency will notify the A/DA waiver program analyst. If a case management agency is not available, the program analyst will provide oversight of the recipient's services.

The case manager from the chosen agency will contact the CMS office that referred the recipient and arrange for a home visit with the recipient, accompanied by the CMS Care Coordinator and, if needed, a nurse from the area Medicaid office. The CMS Care Coordinator will provide historical background to the case manager of the recipient's services under CMS.

The purpose of this visit is to assess the services, equipment and consumable medical supplies currently provided to the recipient and to determine whether the current level best meets the service needs of the recipient. This assessment, along with the Comprehensive Assessment & Review for Long Term Care Services (CARES) assessment provides the basis for developing the plan of care.

An individual must be enrolled into the A/DA waiver to participate in the Aging Out Program. The case manager will provide the necessary documentation to the local Comprehensive

Assessment & Review for Long Term Care Services (CARES) office for an assessment of the recipient's level of care.

If necessary, the case manager will assist the recipient or family in obtaining a Medicaid eligibility determination through the Department of Children and Families (DCF).

Note: See Chapter 2, Service Requirements, Level of Care Determination

Provider Qualifications and Responsibilities

Area Medicaid Office Nurses

If needed, the area Medicaid office nurse will accompany the case manager to the first on-site assessment review of the recipient's service needs and provide medical input for required and necessary services. The area Medicaid office nurse will act as a medical consultant to the case manager and accompany the case manager on subsequent on-site assessments if it is necessary to resolve medical issues.

General Case Management Provider Qualifications

Aging Out case managers will provide services under Case Management Aging Out-Enhanced under the A/DA waiver. All case management providers must meet the general Medicaid provider qualifications contained in Chapter 2 of the Florida Medicaid Provider General Handbook. In addition, Aging Out case management providers must meet the specific provider qualifications listed in this section.

Note: The Florida Medicaid Provider General Handbook is available on the Medicaid fiscal agent's Web site at mymedicaid-florida.com. Select Public Information for Providers, then on Provider Support, and then on Provider Handbooks. It is incorporated by reference in 59G-5.020, F.A.C

Case Management Agency Qualifications

See Chapter 1, Case Management Provider Qualifications.

Case Manager Qualifications

In addition to being employed by a qualified case management or home health agency, each individual case manager providing services under the Aging Out Program must meet the following minimum requirements:

- Bachelor's degree in nursing,
- Masters degree in social work, public health or other health related profession and two years of experience working with individuals with complex medical needs, or
- A four-year college degree and three years of professional experience working with medically-complex individuals.

Case Manager Requirement

If available, every Aging Out Program recipient must have a case manager who is employed by a Medicaid-enrolled A/DA waiver case management or home health agency. A list of qualified Case Management-Enhanced agencies is available from the A/DA waiver program analyst and the local area Medicaid office in the recipient's area. Whenever possible, the recipient will be given a choice of case management agencies from which to choose.

All case managers will work directly with and report issues or problems in the program to the AHCA, A/DA waiver program analyst.

Case Management Responsibilities and Documentation Requirements

The case manager for the Aging Out recipient is responsible for performing and documenting the following activities once the A/DA waiver program analyst determines that there is funding available to serve the candidate:

- Develops and implements a plan of care using the Aged and Disabled Adult Waiver Aging Out Plan of Care, AHCA-Med Serv Form 047 (see Appendix H), for the recipient based upon the assessment and needs documented in the case record;
- Coordinates the CARES assessment for the issuance of the Notification of Level of Care, DOEA-CARES form 603 (see Appendix D), and the re-issuance of this document yearly;
- Identifies qualified, enrolled providers for the needed services and issues a specific authorization for needed services;
- If there is no A/DA waiver-enrolled provider available to provide a needed service for a recipient, seek out and identify potential providers, screen the provider's qualifications and refer the provider to the Area Agency on Aging for the Medicaid waiver enrollment process;
- Informs the recipient of fair hearing rights;
- Monitors services received by the recipient on a monthly basis to ensure that services are rendered as authorized and delineated in the plan of care;
- Contacts the recipient by telephone once a month or visits face-to-face if requested by the recipient or family;
- Monitor recipient's needs, services receipt, satisfaction with services and changes in service needs as needed;
- Reviews the plan of care provided by the home health agency every six months with the recipient to ensure the continuing need for and appropriateness of services and prepares an Aging Out plan of care for the recipient's signature;
- Provide a written authorization of services to the home health agency for a six month period;
- Reviews the consumable medical supplies, if applicable, by invoice of items currently supplied by the provider and provides a written authorization of services to the medical supplier for a six month period;
- Contacts the service provider when there is any indication that services are not being rendered as authorized; investigate and take action as needed to ensure adequate and appropriate service provision;
- Maintains a current list of service providers for all available services;
- Accompanies the A/DA waiver program analyst to on-site monitoring reviews and assists the program analyst with desk reviews of recipient files and maintains monitoring reports and corrective actions taken;
- Reports suspected instances of abuse, neglect, or exploitation to the Florida Abuse Hotline, 800-96-ABUSE (22873) and notifies the A/DA program analyst;
- Ensures that Medicaid state plan services are utilized first before authorizing services under the waiver;
- Coordinates waiver services with all other services provided to the recipient;
- Ensures all assessment, informed consent and plan of care forms are complete including all required signatures;
- Refers the recipient to non-Medicaid services as available and appropriate;

- Documents all interaction with the recipient in the case record and maintains an up-to-date case record as required in this handbook to include the plan of care, case notes, current CARES assessment, level of care, letters of authorization, all correspondence sent and received on behalf of the program recipient, current recipient and family information, and monitoring reviews;
- Maintains all case records in a secure location within the case management or home health agency; and
- Notifies the A/DA waiver program analyst of all disenrollments from the program to ensure accurate reporting of enrollment in the Florida Medicaid Management Information System.

Note: See Appendix H for a copy of the Aged and Disabled Adult Waiver Aging Out Plan of Care, AHCA-Med Serv Form 047, May 2009. The form is available by photocopying it from Appendix H. It is incorporated by reference in 59G-13.030, F.A.C.

Note: See Appendix D for a copy of The Notification of Level of Care, DOEA-CARES Form 603. The form is mailed to the provider by the CARES Unit. It is incorporated by reference in 59G-13.030, F.A.C.

Recipient Disenrollment

Disenrollment

Aging Out recipients may be disenrolled from the program at any time if it is determined by the case manager, the Medicaid area office nurse or the A/DA waiver program analyst that the recipient's health, safety and welfare is at risk and that remaining in the home in the waiver program is no longer medically appropriate or in the best interests of the recipient.

Due to the medical complexity of the Aging Out recipient, services may not be terminated until an alternative plan or program is in place. If a determination is made to disenroll the recipient, the recipient must receive written notification of the effective date of their disenrollment within ten calendar days. The effective date for disenrollment will be 30 days from the day in which disenrollment was effected by the case manager or A/DA waiver program analyst.

Voluntary Disenrollments

At the time of enrollment, the case manager or A/DA waiver program analyst will notify the recipient that she or he has the right to disenroll at any time. The recipient's right to voluntarily disenroll shall not in any way be restricted. All voluntary disenrollments must be fully documented in the recipient case record and the recipient informed of his or her right to a fair hearing.

Disenrollment

With proper written documentation, the following reasons require disenrollment of recipients:

- Ineligibility for the Aged and Disabled Adult waiver, Aging Out Program;
- The yearly CARES assessment finds that the enrolled recipient can no longer be provided services safely in the home and community;
- The case manager, Medicaid area office nurse or A/DA waiver program analyst determines that the recipient can no longer be provided services safely in the home and community;

- Recipient moves out of the state of Florida;
- Placement in a skilled nursing facility or other institution;
- Refusal or inability to comply with the plan of care, which would endanger the recipient's safety, health and welfare; and
- Death of the recipient.

The A/DA waiver program analyst will review the recipient case before disenrollment occurs. All disenrollments must be fully documented in the recipient case record. Recipients must be informed of their right to a fair hearing in all cases of disenrollment from the Aged and Disabled Adult Waiver, Aging Out Program.

Note: See Chapter 2, Appeal Rights and Fair Hearing Process, for information regarding the policy and procedures for the fair hearing process.

Disenrollment Reporting and Verification

The case manager must send a list of all disenrollments to the A/DA waiver program analyst. The case manager will specify reason(s) for recipient disenrollments in accordance with the procedures and specifications in this handbook.

The reason(s) for disenrollment will be reviewed by the A/DA waiver program analyst before final disposition. Through review and by approval of the A/DA waiver program analyst, AHCA may reinstate enrollment in the subsequent month for any enrollee whose reason for disenrollment is not consistent with established guidelines.

Except for the following reasons, all Medicaid recipients must be afforded the right to file for a fair hearing:

- Disenrollments due to moving out of the state;
- Disenrollments due to loss of Aged and Disabled Adult Waiver Aging Out Program eligibility;
- Disenrollments due to death; and
- Disenrollments due to institutional placement.

Discharge Planning

The case manager or A/DA waiver program analyst will assist the recipient and family in preparing discharge plans for recipients being disenrolled or transitioning to institutional placement and document the plans in the recipient's case record, which must contain the following minimum information:

- Recipient’s name;
- Recipient Medicaid ID number;
- Other arrangements made or discharge status (e.g., skilled nursing facility);
- Reason for disenrollment with brief explanation;
- Recipient or recipient’s representative signature, documentation of verbal request or other indicator of recipients' request to disenroll;
- Date; and
- Acknowledgment signature by case manager.

CHAPTER 4
AGED AND DISABLED ADULT WAIVER SERVICES PROCEDURE CODES AND FEE SCHEDULE

Overview

Introduction

This chapter provides and describes the procedure codes, maximum units of service and approved fees for the Aged and Disabled Adult Services (A/DA) waiver.

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Reimbursement Information

Introduction

For complete reimbursement information, all providers should refer to the Florida Medicaid Provider General Handbook and the Florida Medicaid Provider Reimbursement Handbook, CMS-1500. The Florida Medicaid Provider General Handbook is incorporated by reference in 59G-5.020, Florida Administrative Code (F.A.C.). The Florida Medicaid Provider Reimbursement Handbook, CMS-1500, is incorporated by reference in 59G-4.001, F.A.C. The handbooks are available on the Medicaid fiscal agent's website at mymedicaid-florida.com. Select Public Information for Providers, then on Provider Support, and then on Provider Handbooks.

Medicaid reimburses home and community-based waiver procedure codes based on the Centers for Medicare and Medicaid Services (CMS) Healthcare Common Procedure Coding System (HCPCS) that have been approved by the CMS.

The procedure codes listed in this handbook are HCPCS codes. The codes are part of the standard code set described in the Physician's Current Procedure Terminology (CPT) book. Please refer to the CPT book for complete descriptions of the standard codes. CPT codes and descriptions are copy written by the American Medical Association. All rights reserved.

The A/DA waiver services are paid on a fee-for-service basis. Fee-for-service is a method of payment where the provider is paid a fee for each procedure performed and billed.

Pay-to-provider is a term used in the Medicaid program to refer to the enrolled Medicaid provider who receives payment from Medicaid for covered services provided to eligible recipients. The pay-to-provider can be the provider who has provided treatment to a Medicaid recipient or the provider group to which the treating provider belongs.

Procedure Codes

Medicaid reimburses home and community-based waiver procedure codes based on the Healthcare Common Procedure Coding System (HCPCS) codes, Level I and Level II.

Level 1 procedure codes (CPT) are a systematic listing and coding of procedures and services performed by providers. Each procedure or service is identified by a five digit numeric code. The codes are part of the standard code set described in the Physician's Current Procedure Terminology (CPT) book. Please refer to the CPT book for complete descriptions of the standard codes. CPT codes and descriptions are copy written by the American Medical Association. All rights reserved.

Level 2 procedure codes are national codes used to describe medical services and supplies. They are distinguished from Level 1 codes by beginning with a single letter (A through V) followed by four numeric digits. The codes are part of the standard code set described in HCPCS Level II Expert code book. Please refer to the HCPCS Level II Expert code book for complete descriptions of the standard codes. The HCPCS Level II Expert code book is copyrighted by Ingenix, Inc. All rights reserved.

Services and the Hierarchy of Reimbursement

Case managers must coordinate access to services through all available funding sources prior to accessing A/DA waiver services. Services cannot be provided under the A/DA waiver if they are available from another funding source. It is the responsibility of the waiver services provider, with the assistance of the waiver case manager, to determine whether the same type of service offered through the waiver is also available through other funding sources, including Medicaid state plan.

Other funding sources must be accessed in this order:

1. Third Party Payer
2. Medicare
3. Medicaid State Plan programs
4. A/DA waiver

No service may be provided under the A/DA waiver if it is already provided by another Medicaid program unless the type or the amount of service necessary would not be covered under the other Medicaid program.

If an A/DA recipient is dually-eligible under Medicare and Medicaid, the case manager must authorize those providers that are enrolled as Medicare and Medicaid providers so that any services that are covered by Medicare can be billed to Medicare first before billing to Medicaid. For example, Medicaid cannot reimburse a non-Medicare enrolled home health agency for Medicare reimbursable services provided to a dual-eligible beneficiary.

Other Medicaid program services must be accessed when possible before using A/DA waiver services. For example, the Medicaid Durable Medical Equipment and Medical Supplies Program services must be accessed before using A/DA waiver consumable medical supplies or specialized medical equipment.

Case managers may authorize A/DA waiver services when the service is not provided by or has reached the limit of another funding source such as private insurance, Medicare, or other Medicaid programs.

Items and services inappropriately billed through the waiver prior to accessing Medicaid state plan services will be considered as overpayments and subject to recoupment.

CMS-1500 Claim Form

Effective July 1, 2008, home and community-based services waiver providers must complete and submit CMS-1500 claim forms or the electronic equivalent to receive reimbursement from Medicaid.

Note: See Chapter 1 in the Florida Medicaid Provider Reimbursement Handbook, CMS-1500, for specific procedures for submitting claims for payment.

Fee Schedule

Each procedure code listed on the Aged and Disabled Adult Services Waiver fee schedule corresponds to a service described in Chapter 2 of this handbook.

The Procedure Codes and Fee Schedule lists:

- Codes associated with the service;
- A brief description of the service;
- The maximum fee that Medicaid will reimburse for the procedure; and,
- The maximum number of reimbursable units.

Note: The Aged and Disabled Adult Services Waiver Procedure Codes and Fee Schedule is available on the Medicaid fiscal agent's Web site at mymedicaid-florida.com. Select Public Information for Providers, then on Provider Support, and then on Fee Schedules. It is incorporated by reference in 59G-13.031, F.A.C.

Maximum Fees

Medicaid reimburses A/DA waiver services at the maximum fee or the provider's usual and customary fee, whichever is lower.

Units of Service

Unless otherwise noted on the Aged and Disabled Adult Services Waiver Procedure Codes and Fee Schedule, A/DA waiver services are reimbursed in time increments. Each time increment is called a unit of service. Each unit is defined as a 15-minute time period or portion thereof.

The number of service units billed must be consistent with the number of service units authorized by the A/DA waiver case manager.

To receive reimbursement, A/DA waiver providers must total units of service provided to the waiver recipient for each date of service and submit one claim for the appropriate number of units of service for each date of service.

Case Management

To receive reimbursement for case managers, the A/DA waiver case management agency must total the amount of time an individual case manager provides case management services to a waiver recipient on each date of service and submit one claim for the appropriate number of units of service for the date of service. Both times and the number of units for each date of service must be noted in the narrative.

A/DA Waiver Program Monitoring and Claims

The A/DA Waiver Program is monitored as follows:

- Each month a statistically significant number of case files and paid claims are randomly selected from each Planning and Service Area (PSA) for review by the Medicaid Waiver Specialists to monitor compliance with A/DA waiver policies.
- Case files that do not comply with A/DA waiver policies are subject to corrective action plans.
- Paid claims that are not in compliance with waiver service policies are subject to recoupment and corrective action plans.
- DOEA or AHCA will impose additional sanctions for repeated noncompliance.

Note: See Chapter 5 in the Florida Medicaid Provider General Handbook for additional information on recoupment and fraud.

Procedure Code Modifiers

Definition of Modifier

A/DA waiver services providers must use the modifiers with the procedure codes listed on the Aged and Disabled Adult Services Waiver Procedures Codes and Fee Schedule when billing for the specific services in the procedure code descriptions. The modifiers listed on the fee schedule can only be used with the procedure codes listed. Use of modifiers with any other procedure codes will cause the claim to deny or pay incorrectly.

Note: See Chapter 1 in the Florida Medicaid Provider Reimbursement HandbookCMS-1500, for additional information on entering modifiers on the claim form

APPENDIX A

COMPREHENSIVE ASSESSMENT INSTRUMENTS

DEPARTMENT OF ELDER AFFAIRS ASSESSMENT INSTRUMENT, DOEA FORM 701B AND DEPARTMENT OF CHILDREN AND FAMILIES ASSESSMENT INSTRUMENT, CF-AA FORM 3019

DEPARTMENT OF ELDER AFFAIRS STATE OF FLORIDA

PRIORITY SCORE:

Department of Elder Affairs Assessment Instrument

Rule 58A-1.010, F.A.C.

RISK SCORE:

OWNER ID _____ OWNER ASSESSOR ID _____

PROVIDER ID _____ PROVIDER ASSESSOR ID _____

ASSESSOR NAME _____ SIGNATURE _____

##: Items required in CIRTS P: Priority Score Items (O): Items required for OAA (C): Items required for CARES

(O) (C) A. Demographic Information

##1. Name: _____
First Middle Initial Last

##2. Social Security Number: - -

3. Medicaid Number: _____

3a. Consumer Type: ☐ Caregiver (C) ☐ Elder Recipient (E)

3b. Are you the caregiver of a grandchild or child, under 19 or disabled? ☐ Yes (Y) ☐ No (N)

##4. Physical Address: _____
Street

_____ _____ _____ _____
City State ZIP County

4a. Mailing Address (if different) _____
Street

_____ _____ _____ _____
City State ZIP County

4b. Phone Number: ( ) _____

##4c. Is this Public Housing? ☐ Yes (Y) ☐ No (N)

##4d. Assessment Date _____
M M D D Y Y Y Y

##4e. Assessment Site ☐ Home (CH) ☐ Hospital (H) ☐ Nurs. Home (NH) ☐ Day Care (DC) ☐ ALF (ALF) ☐ Other (O)

##4f. Assessment Type ☐ OAA (O) ☐ OA3E (O3E) ☐ Update (U) ☐ signif. change ☐ Initial (I) Asmt. ☐ Waiting List Full Asmt. (WL) ☐ CARES (C) non-community ☐ Annual (A)

##5. Date of Birth _____
M M D D Y Y Y Y

##6. Sex ☐ Female (F) ☐ Male (M)

##7. Race ☐ White (W) ☐ Black (B) ☐ Native Am. (N) ☐ Asian/Pacific (A) ☐ Other (O)

##8. Ethnicity ☐ Hispanic (H) ☐ Other (O)

##9. Primary language _____

##10. Marital Status ☐ Married (M) ☐ Single (S) ☐ Separated (P) ☐ Widowed (W) ☐ Divorced (D) ☐ Partner (O)

##11. Referral Source ☐ CARES (C) ☐ APS (A) ☐ Lead Agency (L) ☐ Hospital (H) ☐ Upstreaming/CARES (U) ☐ Other (O) ☐ Self (S) ☐ Aging Out - DCF CCDA ☐ Aging Out - DCF HCDA

If consumer at Imminent Risk of NH placement, check : ☐ Imminent Risk (IM)

If Transitioning out of a Nursing Home, check : ☐ Transition from NH (TRNH)

##If APS, check level of risk: ☐ High (H) ☐ Medium (M) ☐ Low (L)

##11a. Referral Date _____
M M D D Y Y Y Y

##12. Is there a Primary Caregiver? P ☐ Yes (Y) ☐ No (N)

##13. Living Situation P ☐ With Caregiver (WC) ☐ With Other (WO) ☐ Alone (AL)

##14. Need outside assistance to evacuate? ☐ Yes (Y) ☐ No(N)

##15. Registered with County Special Needs Registry? ☐ Yes (Y) ☐ No(N)

##16a. Individual Monthly Income _____ ☐ Refused (OAA only)

##16b. Couple Monthly Income _____ ☐ Refused (OAA only)

##16c. Receiving Food Stamps? ☐ Yes (Y) ☐ No (N)

##17a. Estimated Total Individual Assets ☐ Refused (OAA only)
☐ $0 - $2,000 (M) ☐ $2,001 - $5,000 (N) ☐ over $5,000 (P)

##17b. Estimated Total Couple Assets ☐ Refused (OAA only)
☐ $0 - $3,000 (M) ☐ $3,001 - $6,000 (N) ☐ over $6,000 (P)

DEPARTMENT OF ELDER AFFAIRS STATE OF FLORIDA

B. CONSUMER CONDITIONS

1. Mental Health/Behavior/Cognition

(O) ##Who is answering questions? ☐ Consumer ☐ Other

(O) ##a. How would you describe your satisfaction with life in general?

☐ Excellent (1) ☐ Good (2) ☐ Fair (3) ☐ Poor (4)

(O) ##b. Compared to a year ago, how is your attitude on life?

☐ Much Better (1) ☐ Better (2) ☐ About same (3) ☐ Worse (4)

##c. **ASSESSOR:** Are behavioral problems present?

☐ Yes (Y) ☐ No (N)

(O) ##d. **ASSESSOR:** Does behavior indicate a need for supervision?

☐ Yes (Y) ☐ No (N)

CHECK ALL THAT APPLY:

YES (Y) or NO (N)

(O)
- ☐ Wanders for no apparent reason
- ☐ Demonstrates significant memory problems
- ☐ Appears to be depressed
- ☐ Appears to be lonely or dangerously isolated
- ☐ Has thoughts of suicide
- ☐ Exhibits abusive, aggressive or disruptive behavior
- ☐ Presents other problems

ENTER Y = CORRECT N = INCORRECT

(O) ##e. What is today's date?

Month ____ ☐

Day ____ ☐

Day/Week ____ ☐

Year ____ ☐

Where are we?

Home Address or Facility Name: ____ ☐

City ____ ☐

State ____ ☐

County ____ ☐

(O) (C) ##f. Count Backwards from 20 to 1

20, 19, 18, 17, 16, 15, 14, 13, 12, 11, 10, 9, 8, 7, 6, 5, 4, 3, 2, 1

Mark total number of errors (Max = 10)

0	1	2	3	4	5	6	7	8	9	10

##g. **ASSESSOR:** Are cognitive problems present?

☐ Yes (Y) ☐ No (N)

##h. Currently receiving mental health services? ☐ Yes (Y) ☐ No (N)

##i. **ASSESSOR:** Need for mental health referral?

☐ Yes (Y) ☐ No (N)

C. CONSUMER RESOURCES

##a. **ASSESSOR:** Formal and/or informal resources provide services as needed to address the mental health/cognitive needs of the consumer.

☐ Always Available (1) ☐ Sometimes Available (2) ☐ Rarely Available (3) ☐ Unavailable (4) ☐ Not Needed (5)

SUMMARY

##b. **ASSESSOR:** Consumer oriented to time?

☐ Always (1) ☐ Sometimes (2) ☐ Rarely (3) ☐ Never (4)

##c. **ASSESSOR:** Consumer oriented to place?

☐ Always (1) ☐ Sometimes (2) ☐ Rarely (3) ☐ Never (4)

DEPARTMENT OF ELDER AFFAIRS STATE OF FLORIDA

B. CONSUMER CONDITIONS

(O)##2. Physical Health

##a. How would you rate your overall health at the present time? P

☐ Excellent (1) ☐ Good (2) ☐ Fair (3) ☐ Poor (4)

##b. Compared to a year ago, how would you rate your health? P

☐ Much Better (1) ☐ Better (2) ☐ About same (3) ☐ Worse (4)

##c. How much do your physical problems stand in the way of your doing the things you want to do? P

☐ Not at all (1) ☐ Occasionally (2) ☐ Often (3) ☐ All the time (4)

(O) (C)##3. Functional
How much help do you need with the following Activities of Daily Living (ADL's)? P

(Codes: 0=No Help, 1=No help but relies on Assistive Device, 2=Supervision, 3=Some Help, 4=Total Help, can't do at all)

☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	##a. Bathe
☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	##b. Dress
☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	##c. Eat
☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	##d. Use Bathroom
☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	##e. Transfer
☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	##f. Walking/Mobility

(O) (C)##4. How much help do you need with the following Instrumental Activities of Daily Living (IADL's)? P

(Codes: 0=No Help, 1=No help but relies on Assistive Device, 2=Supervision, 3=Some Help, 4=Total Help, can't do at all)

☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	##a. Do heavy chores
☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	##b. Do light housekeeping
☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	##c. Use phone
☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	##d. Manage money
☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	##e. Prepare meals
☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	##f. Do shopping
☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	##g. Take medication
☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	##h. Use transportation

C. CONSUMER RESOURCES

(O)##2.

##a. Is medical care readily available? P

☐ Always (4) ☐ Sometimes (3) ☐ Rarely (2) ☐ Never (1)

##b. Is transportation to medical care readily available? P

☐ Always (4) ☐ Sometimes (3) ☐ Rarely (2) ☐ Never (1)

##c. Do your finances/insurance permit access to healthcare and medications? P

☐ Always (4) ☐ Sometimes (3) ☐ Rarely (2) ☐ Never (1)

(O)##3.
How often do you have adequate assistance with the following ADL's? P

(Codes: 3=Always, 2=Sometimes, 1=Rarely 0=Never, 0=No help needed)

☐ 3	☐ 2	☐ 1	☐ 0	##a. Bathe
☐ 3	☐ 2	☐ 1	☐ 0	##b. Dress
☐ 3	☐ 2	☐ 1	☐ 0	##c. Eat
☐ 3	☐ 2	☐ 1	☐ 0	##d. Use Bathroom
☐ 3	☐ 2	☐ 1	☐ 0	##e. Transfer
☐ 3	☐ 2	☐ 1	☐ 0	##f. Walking/Mobility

##NEED FOR ASSISTIVE DEVICES? ☐ Yes ☐ No
If yes, explain:

(O)4##How often do you have adequate assistance with the following IADL's? P

(Codes: 3=Always, 2=Sometimes, 1=Rarely 0=Never, 0=No help needed)

☐ 3	☐ 2	☐ 1	☐ 0	##a. Do heavy chores
☐ 3	☐ 2	☐ 1	☐ 0	##b. Do light housekeeping
☐ 3	☐ 2	☐ 1	☐ 0	##c. Use phone
☐ 3	☐ 2	☐ 1	☐ 0	##d. Manage money
☐ 3	☐ 2	☐ 1	☐ 0	##e. Prepare meals
☐ 3	☐ 2	☐ 1	☐ 0	##f. Do shopping
☐ 3	☐ 2	☐ 1	☐ 0	##g. Take medication
☐ 3	☐ 2	☐ 1	☐ 0	##h. Use transportation

##NEED FOR ASSISTIVE DEVICES? ☐ Yes ☐ No
If yes, explain:

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NUTRITION SCORE:

(O) ##D. Nutrition Status

YES (Y) or NO (N)

(C) ☐ ##1. Have you lost or gained 10 pounds or more in the last 6 months without trying?
Yes (2) No (0) *If yes, Gain:* _____ *Loss:* _____

(C) ☐ ##2. Do you take 3 or more kinds of medicine a day? (Include over-the-counter AND prescription medicines)
Yes (1) No (0)

☐ ##3. Do you have 2 or more drinks of beer, wine, or liquor almost every day?
Yes (2) No (0)

☐ ##4. Do you have an illness or condition that made you change the food you eat?
Yes (2) No (0) *Are you on any special diets for medical reasons? If on special diet(s), check all that apply:*

☐ *Low sodium/salt* ☐ *Low fat/cholesterol* ☐ *Low Sugar* ☐ *Calorie supplement*
☐ *Other (specify)* _____

☐ ##5. Do you eat at least two meals a day? *How is your appetite? Would you say that your appetite is:*
Yes (0) No (3) ☐ *Good* ☐ *Fair* ☐ *Poor*

☐ ##6. Do you eat some fruits and vegetables every day?
Yes (0) No (1) *Briefly describe what you usually eat and drink during a typical day (including food on weekends):*

_____
_____
_____

☐ ##7. Do you have some milk products every day?
Yes (0) No (1)

☐ ##8. Do you have any problems with your teeth, mouth, or throat that make it hard for you to chew or swallow?
Yes (2) No (0) ☐ *Tooth or mouth problems* ☐ *Taste problems* ☐ *Can't eat certain foods* ☐ *Swallowing problems*
☐ *Food allergies* ☐ *Nausea* *Other (Describe)* _____

☐ ##9. Do you eat alone most of the time?
Yes (1) No (0)

☐ ##10a. Are you usually able to shop for yourself?
Yes (0) No (0.5)

☐ ##10b. Are you usually able to cook for yourself?
Yes (0) No (0.5)

☐ ##11. Are you usually able to eat without help?
Yes (0) No (1)

☐ ##12. Do you have enough money to buy the food you need?
Yes (0) No (4)

TOBACCO USE

##1. Do you smoke or use tobacco products? ☐ Yes (Y) ☐ No (N)

##2. Have you ever smoked or used tobacco? ☐ Yes (Y) ☐ No (N)
If yes, for how long? _____

##3. Do you live with others who smoke? ☐ Yes (Y) ☐ No (N)

ASSESSOR:
DOES THERE APPEAR TO BE A NEED FOR FOOD STAMPS? ☐ Yes (Y) ☐ No (N)

CURRENT HEIGHT: _____

CURRENT WEIGHT: _____

SUMMARY

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(O) (C) E1. Health Conditions *YES (Y) or NO (N)*

- ☐ ##1. Arthritis (type) _____
- ☐ ##2. Bed sore(s) (Decubitus) Location _____
- ☐ ##3. Cancer ☐ Lung ☐ Skin ☐ Oral ☐ Other
- ☐ ##4. Dementia(Alz, OBS, etc.)
- ☐ ##5. Diabetes (IDDM/NIDDM)
- ☐ ##6. Emphysema/COPD
- ☐ ##7. Heart Problems (CHF, MI, etc.)
- ☐ ##8. Incontinence (Bladder/Bowel)
- ☐ ##9. Liver Problems (Cirrhosis, Hepatitis)
- ☐ ##10. Pneumonia
- ☐ ##11. Stroke (CVA, etc.)
- ☐ ##12. Osteoporosis
- ☐ ##13. Parkinson's Disease
- ☐ ##14. Other (from list below) _____

Others: *Yes(Y) or No (N)* Enter most problematic in #14 above

- ☐ Allergies (type) _____
- ☐ Amputation (site) _____
- ☐ Asthma (type) _____
- ☐ Bladder/Kidney Problems (UTI, etc.)
- ☐ Blood Pressure - High Low
- ☐ Broken Bones/Fractures Location _____
- ☐ Dehydration
- ☐ Dizziness
- ☐ Falls in past year
- ☐ Gallbladder Problems
- ☐ Hearing Problems
- ☐ Ostomy care (type) _____
- ☐ Pacemaker
- ☐ Paralysis (site) _____
- ☐ Seizure disorder
- ☐ Sleep Problems
- ☐ Thyroid Problems (Graves, Myxedema, etc.)
- ☐ Ulcers (type/site) _____
- ☐ Vision Problems (Cataracts, Glaucoma)
- ☐ Other _____

(O) (C) E2. Special Services

Yes or No, if yes, indicate frequency

- ☐ ##Physical Therapy _____
- ☐ ##Occupational Therapy _____
- ☐ ##Respiratory Therapy _____
- ☐ ##Other, from list on right _____

Others: *YES (Y) or NO (N)*

- ☐ Bowel/bladder rehab
- ☐ Bowel impaction therapy
- ☐ Catheter care (type) _____
- ☐ Dialysis
- ☐ Insulin therapy
- ☐ Lesion irrigation
- ☐ Oxygen therapy
- ☐ Oxygen treatment
- ☐ Skilled Nursing
- ☐ Speech therapy
- ☐ Suctioning
- ☐ Tube Feeding
- ☐ Wound care
- ☐ Other _____

F. Medications

(including refrigerated meds, non-prescription drugs, over the counter, herbal remedies, etc.)

Medication	Dosage	Administration Method	Frequency	Physician

1. **ASSESSOR:** Does consumer seem to be compliant with medications? ☐ Yes ☐ No ☐ Unsure

2. **ASSESSOR:** What interferes with medication compliance?
☐ Alcohol Interaction ☐ Drug Interaction ☐ Can't Afford ☐ Confused ☐ N/A
☐ Other: _____

3. Has consumer been hospitalized in the last 6 months?
☐ No ☐ Yes
If yes, why? _____

3a. Has consumer visited the Emergency Room in the past 6 months?
☐ No ☐ Yes
If yes, why? _____

4. Indicate consumer's status:

a. Vision (w/glasses if used) ☐ Good ☐ Fair ☐ Poor ☐ Blind

b. Hearing (w/ aid if used) ☐ Good ☐ Fair ☐ Poor ☐ Deaf

c. Speech ☐ Good ☐ Fair ☐ Poor ☐ Gestures Signs ☐ Unable

d. Walking (w/ device if used) ☐ Good ☐ Fair ☐ Poor ☐ Chairbound ☐ Bedbound

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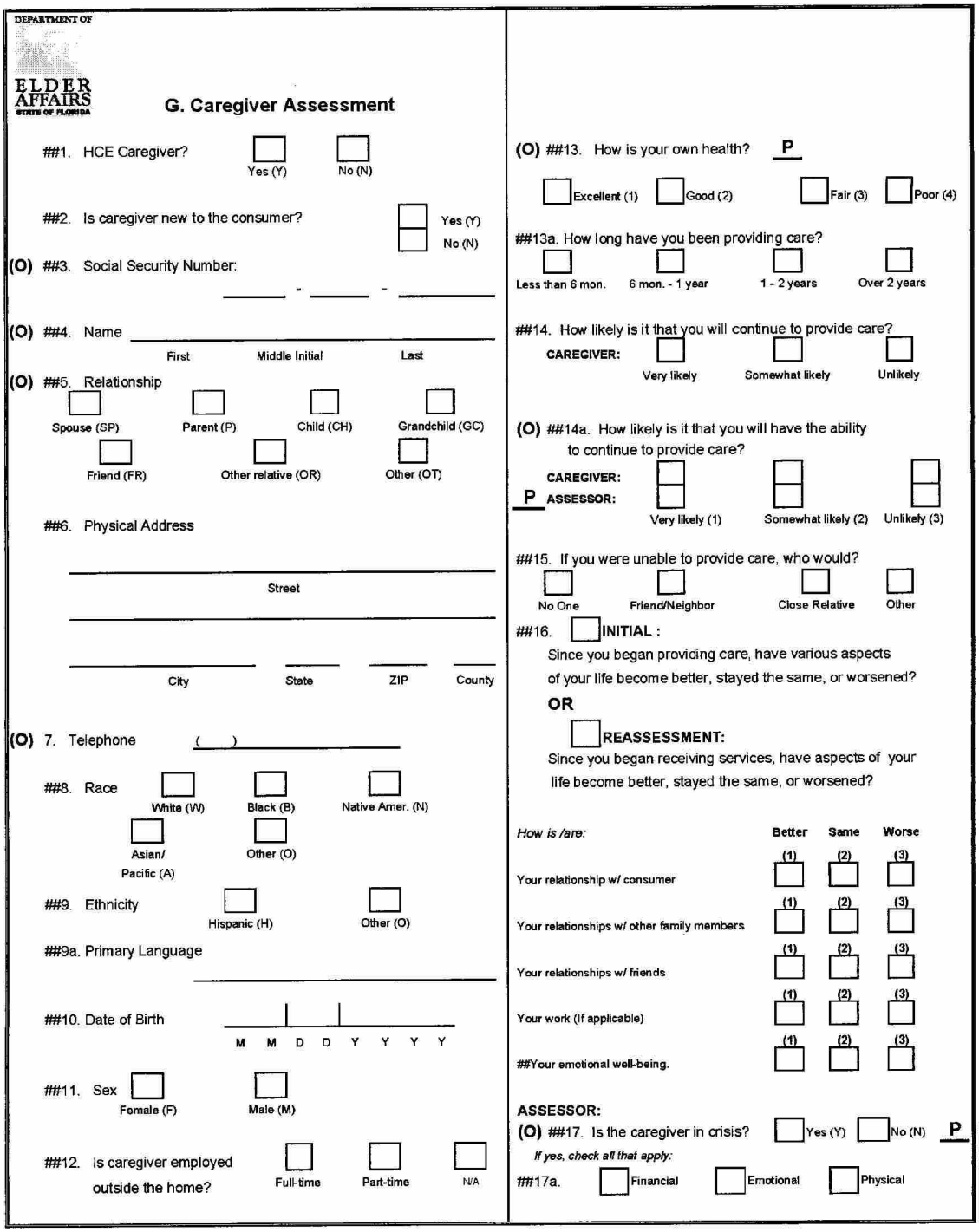

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G. Caregiver Assessment

##1. HCE Caregiver? ☐ Yes (Y) ☐ No (N)

##2. Is caregiver new to the consumer? ☐ Yes (Y) ☐ No (N)

(O) ##3. Social Security Number: ___ - ___ - ___

(O) ##4. Name _____ (First / Middle Initial / Last)

(O) ##5. Relationship
☐ Spouse (SP) ☐ Parent (P) ☐ Child (CH) ☐ Grandchild (GC)
☐ Friend (FR) ☐ Other relative (OR) ☐ Other (OT)

##6. Physical Address
_____ (Street)
_____
_____ (City) ____ (State) ____ (ZIP) ____ (County)

(O) 7. Telephone ( ) _____

##8. Race ☐ White (W) ☐ Black (B) ☐ Native Amer. (N) ☐ Asian/ Pacific (A) ☐ Other (O)

##9. Ethnicity ☐ Hispanic (H) ☐ Other (O)

##9a. Primary Language _____

##10. Date of Birth ___ ___ ___ ___ (M M D D Y Y Y Y)

##11. Sex ☐ Female (F) ☐ Male (M)

##12. Is caregiver employed outside the home? ☐ Full-time ☐ Part-time ☐ N/A

(O) ##13. How is your own health? P
☐ Excellent (1) ☐ Good (2) ☐ Fair (3) ☐ Poor (4)

##13a. How long have you been providing care?
☐ Less than 6 mon. ☐ 6 mon. - 1 year ☐ 1 - 2 years ☐ Over 2 years

##14. How likely is it that you will continue to provide care?
CAREGIVER: ☐ Very likely ☐ Somewhat likely ☐ Unlikely

(O) ##14a. How likely is it that you will have the ability to continue to provide care?
CAREGIVER: / P ASSESSOR: ☐ Very likely (1) ☐ Somewhat likely (2) ☐ Unlikely (3)

##15. If you were unable to provide care, who would?
☐ No One ☐ Friend/Neighbor ☐ Close Relative ☐ Other

##16. ☐ INITIAL :
Since you began providing care, have various aspects of your life become better, stayed the same, or worsened?

OR

☐ REASSESSMENT:
Since you began receiving services, have aspects of your life become better, stayed the same, or worsened?

How is /are:	Better (1)	Same (2)	Worse (3)
Your relationship w/ consumer	☐	☐	☐
Your relationships w/ other family members	☐	☐	☐
Your relationships w/ friends	☐	☐	☐
Your work (If applicable)	☐	☐	☐
##Your emotional well-being.	☐	☐	☐

ASSESSOR:
(O) ##17. Is the caregiver in crisis? ☐ Yes (Y) ☐ No (N) P
If yes, check all that apply:
##17a. ☐ Financial ☐ Emotional ☐ Physical

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H. Social Resources

1. Does consumer live alone? ☐ Yes (6) ☐ No (0) If no, with whom? _____

##1a. Does consumer care for grandchildren on a permanent basis? ☐ Yes ☐ No

##2. If needed, could you stay with someone, or they stay with you? ☐ Yes (Complete below) (0) ☐ No (6)

Name: _____ Relationship to consumer: _____

Address: _____ Phone: _____

##3. Do you have someone you can talk to when you have a problem (other than caregiver)? ☐ Yes (0) ☐ No (4)

Name: _____ Relationship to consumer: _____

##4. About how many times do you talk to friends, relatives, telephone reassurance volunteers or others on the telephone in a week, either they call you or you call them?

☐ Once a day or more (0) ☐ 2-6 times a week (2) ☐ Once a week (2) ☐ Not at all (4) ☐ No phone (4)

##5. How many times during a week do you spend time with someone who does not live with you - you go see them, they come to visit, or you do things together? ☐ Once a day or more (0) ☐ 2-6 times a week (2) ☐ Once a week (2) ☐ Not at all (4)

6. Are you able to participate in activities such as day care, senior center, church or other interests that you enjoy? ☐ Yes ☐ No If no, why not? _____

7. Do you own a pet? ☐ Yes ☐ No If yes, specify _____

Can you feed your pet? ☐ Yes ☐ No Clean up after your pet? ☐ Yes ☐ No Exercise your pet? ☐ Yes ☐ No

8. If consumer is the caregiver/guardian of a grandchild or child, under 19 years old or disabled, (section A. #3a. & 3b.) complete information on the child:

Child's name: _____ Child's date of birth: ___ - ___ - _____

Child's relationship to the consumer: _____ Is child disabled? _____ (Yes or No)

SUMMARY

##I. Environmental Assessment (Enter Risk below in CIRTS)

Case Manager: Please indicate the specific area(s) where there are potential safety or accessibility problems for the client.

☐ Building in need of repairs	☐ Refrigerator not working	☐ Grab bars/handrails needed
☐ Furniture in need of repairs	☐ Telephone not working	☐ Bathtub/shower unsafe
☐ Inadequate/insufficient plumbing	☐ No telephone	☐ Commode unsafe
☐ No/insufficient heat	☐ Flooring/rugs loose	☐ Electrical hazards
☐ No/insufficient hot water	☐ Lighting inadequate	☐ Insect or other pests present
☐ No air conditioning	☐ Stairs/railings unsafe	☐ Unsanitary conditions or odors
☐ Stove not working	☐ Ramp needed/unavailable	☐ Other - specify in comments

COMMENTS:

☐ **No Risk:** The physical environment is generally well equipped and supportive. This includes building, neighborhood and necessary furnishings.

☐ **Low Risk:** The physical environment has few negative aspects. The few negative aspects are minor or within acceptable living standards and are not hazardous to the consumer's well-being.

☐ **Moderate Risk:** The physical environment is negative. Many aspects are substandard or hazardous. The consumer may not be able to remain in the current dwelling.

☐ **High Risk:** The physical environment is strongly negative or hazardous. The consumer should change dwellings or is very likely to need to change dwellings unless immediate corrective action is taken to address the negative or hazardous aspects.

DEPARTMENT OF ELDER AFFAIRS STATE OF FLORIDA

ASSESSMENT SUMMARY

PROBLEMS	LIABILITIES/ CHALLENGES/BARRIERS	RESOURCES/ASSETS	GAPS WHICH NEED TO BE MET IN CARE PLAN
B. CONSUMER CONDITIONS			
D. NUTRITION			
E. HEALTH			
F. MEDICATIONS			
G. CAREGIVER			
H. SOCIAL RESOURCES			
I. ENVIRONMENTAL			

DOEA FORM 701B, September 2008 8

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Florida Department of Children and Families

ADULT SERVICES CLIENT ASSESSMENT

Client Name:_____ **Client ID:**_____

Information Source / Relationship to Client:_____ / _____

I. HEALTH ASSESSMENT

SUBJECTIVE EVALUATION OF HEALTH: Overall, do you consider your health as excellent, good, fair, poor or serious?

_____ Excellent (0) _____ Good (5) _____ Fair (10) _____ Poor (15) _____ Serious (20)

SUBJECTIVE EVALUATION OF HEALTH SCORE [ ]

HEALTH PROBLEMS

1. Do you have any health problems, and how do they affect you? For instance, has your doctor told you that you have any of the following health problems or symptoms?

This form has BEEN REPAIRED, and you can now save a completed document. And pages 6, 7 and 8 can be filled in on-line. If you have any problems with this form, please notify Lee Riggs at (850)487-1952 or SunCom 277-1952.

Health Condition	Present	Interferes with Living	Condition Not Under Treatme
Allergies (Type) (Drug/skin/etc.)	___	___	___
Amputation	___	___	___
Anemia (Type)	___	___	___
Arthritis (Type)	___	___	___
Asthma (Type)	___	___	___
Bladder/Kidney Problems (UTI, etc)	___	___	___
Broken Bones (Type; Site)	___	___	___
Cancer (Type)	___	___	___
Cerebral Palsy	___	___	___
Decubitus	___	___	___
Dehydration	___	___	___
Dementia (Type) (Alz., OBS, etc)	___	___	___
Dialysis (Type)	___	___	___
Diabetes (Type)	___	___	___
Dizziness	___	___	___
Emphysema (COPD, etc)	___	___	___
Head Trauma	___	___	___
Hearing Problems	___	___	___
Heart Problems (CHF, MI, etc)	___	___	___
High Blood Pressure (Type)	___	___	___
Liver Problems (Cirrhosis/Hepatitis)	___	___	___
Lupus	___	___	___
Multiple Sclerosis	___	___	___
Muscular Dystrophy	___	___	___
Osteoporosis	___	___	___
Paralysis (Site)	___	___	___
Parkinson's Disease	___	___	___
Pneumonia	___	___	___
Potassium/Sodium Imbalance	___	___	___
Seizure Disorders (Epilepsy, etc)	___	___	___
Shingles (Herpes Zoster)	___	___	___
Sleep Problems	___	___	___
Spina Bifida	___	___	___
Spinal Injury	___	___	___
Stroke (CVA, etc)	___	___	___
Tuberculosis	___	___	___
Ulcers	___	___	___
Vision Problems (Type)	___	___	___
Thyroid Problems (Graves, etc)	___	___	___
Other:_____	___	___	___
Other:_____	___	___	___

Describe concerns regarding health problems:

HEALTH ASSESSMENT SCORE [ ]

0 = No Health Conditions, 5 = Minor Health Conditions, 10 = Moderate Health Conditions
15 = Substantial Health Conditions, 20 = Serious Heal

Incorporated by reference in 59G-13.030, F.A.C., CF-AA 3019, PDF 10/2005

I. HEALTH ASSESSMENT

MEDICAL TREATMENTS AND THERAPIES (Place a ✓ mark next to any of the following medical treatments received by the client)

☐	Aseptic dressing	☐	Insulin therapy	☐	Physical therapy
☐	Bedsores treatment	☐	Lesion irrigation	☐	Occupational therapy
☐	Bowel/bladder rehab	☐	Ostomy care (type:)	☐	Speech therapy
☐	Catheter care (type:)	☐	Oxygen	☐	Respiratory therapy
☐	Dialysis (type:)	☐	Respiratory treatment	☐	Radiation
☐	IV fluids	☐	Suctioning	☐	Chemotherapy
☐	IV medicines	☐	Tube feeding	☐	Other (specify below)

NOTE ANY SPECIAL EQUIPMENT OR PROVIDERS USED OR NEEDED BY THE CLIENT:

MEDICATIONS (List current prescription and non-prescription medications)

Name of Medication	Dosage	Frequency	Physician	Name of Medication	Dosage	Frequency	Physician

What pharmacy does client use?

Describe concerns regarding medication use:

NUTRITION

(Enter scores below)

1. How is your appetite? Would you say that your appetite is good, fair or poor?
   ____ Good (0) ____ Fair (2) ____ Poor (6)

2. Current weight and height? Weight:_____ Height:_____

3. Have you gained or lost significant (10% change) amount of weight in the last 6 months? ____ Yes (4) ____ No (0)
   Describe gain or loss: _____ Gain _____ Loss
   Note: If significant gain or loss of weight was recommended by a physician, a "Yes" response receives no score.
   Was significant gain or loss recommended by a physician?

4. Do you have difficulty eating? Why?

	Yes	No		Yes	No
Tooth or mouth problems?	____ (4)	____ (0)	Taste problems?	____ (0)	____ (0)
Swallowing Problems?	____ (4)	____ (0)	Problems eating certain foods?	____ (0)	____ (0)
Nausea/Vomiting?	____ (4)	____ (0)	Any food allergies?	____ (0)	____ (0)

   Any other problems with eating (describe below)? ____ Yes (0) ____ No (0)

5. Are you on any special diets for medical reasons? ____ none (0) ____ 1 diet (4) ____ 2 or more diets (6)
   ____ Low sodium (salt) ____ Low fat/cholesterol ____ Low sugar ____ Calorie supplement ____ Other (describe below)

6. Describe concerns regarding nutrition problems:

NUTRITION SCORE ☐

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II. FUNCTIONAL ASSESSMENT

III. CLIENT SUPPORT ASSESSMENT Page 3

FUNCTIONAL ASSESSMENT Do you need someone to assist you with: **Activities of Daily Living (ADLs)**	Total Assistance	Some Help/Supervision	No Help
1. Dressing. Includes getting out clothes and putting them on and fastening them, and putting on shoes.	0	2	3
2. Grooming. Includes combing hair, washing face, shaving, and brushing teeth.	0	2	3
3. Bathing. Includes running the water, taking the bath or shower and washing all parts of the body, including hair.	0	2	3
4. Eating. Includes eating, drinking from a cup and cutting foods.	0	2	3
5. Transferring. Includes getting in and out of a bed or chair.	0	2	3
6. Walking/Mobility. Includes walking. Independence in walking refers to the ability to walk short distances at home. (Does not include climbing stairs.)	0	2	3
7. Climbing Stairs. Ability to climb stairs.	0	2	3
8. Toileting. Includes ability to manage use of toilet.	0	2	3
9. Bladder/Bowel Control ____ Never have accidents (0) ____ Occasionally have accidents (2) ____ Often have accidents (3) ____ Always have accidents (4) (enter score)			
10. Does client wear special briefs for incontinence? ____ Yes ____ No (If no, skip next question)			
11. How well do you manage changing them?	0	2	3

CLIENT SUPPORT What help are you receiving? (detail who, what, how often) What equipment would aid in the performance of these activities?	Is Amount of Help Adequate?
1.	☐ Yes ☐ No
2.	☐ Yes ☐ No
3.	☐ Yes ☐ No
4.	☐ Yes ☐ No
5.	☐ Yes ☐ No
6.	☐ Yes ☐ No
7.	☐ Yes ☐ No
8.	☐ Yes ☐ No
9.	☐ Yes ☐ No
10.	
11.	☐ Yes ☐ No

ADL SCORE (sum of circled 2's, 3's & Bladder Control Score) ____

ADL IMPAIRMENT COUNT (# of 2's & 3's circled) ____

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II. FUNCTIONAL ASSESSMENT

III. CLIENT SUPPORT ASSESSMENT Page 4

FUNCTIONAL ASSESSMENT Do you need someone to assist you with: **Instrumental Activities of Daily Living (IADLs)**	No Help	Some Help/Supervision	Total Assistance
12. Answering the Telephone. Includes the use of an amplifier or special equipment.	0	2	3
13. Making Telephone Calls. Includes ability to call another party on the telephone.	0	2	3
14. Shopping. Includes shopping for food and other things, but does not include transportation.	0	2	3
15. Transportation Ability. Includes using local transportation or driving to places beyond walking distance.	0	2	3
16. Preparing Meals. Includes preparing meals for yourself including sandwiches, cooked meals and TV dinners.	0	2	3
17. Laundry. Includes doing laundry; putting clothes in the washer or dryer, starting and stopping the machine, and drying clothes.	0	2	3
18. Light Housekeeping. Includes dusting, vacuuming, sweeping, etc., but does not include laundry.	0	2	3
19. Heavy Chores. Includes yard work, windows, moving furniture, but does not include laundry.	0	2	3
20. Taking Medication. Includes ability to take own medication.	0	2	3
21. Handling Money. Includes managing own money, such as paying bills, and/or balancing checkbook.	0	2	3

CLIENT SUPPORT What help are you receiving? (detail who, what, how often) What equipment would aid in the performance of these activities?	Is Amount of Help Adequate?
12.	☐ Yes ☐ No
13.	☐ Yes ☐ No
14.	☐ Yes ☐ No
15.	☐ Yes ☐ No
16.	☐ Yes ☐ No
17.	☐ Yes ☐ No
18.	☐ Yes ☐ No
19.	☐ Yes ☐ No
20.	☐ Yes ☐ No
21.	☐ Yes ☐ No

IADL SCORE (Sum of circled 2's & 3's in IADL section) ☐

IADL IMPAIRMENT COUNT (# of 2's & 3's circled) ☐

CLIENT SUPPORT SCORE (includes Client Support Items 1 - 21) ☐

0 = No need, 5 = Low need, 10 = Moderate need, 15 = Substantial need, 20 = Serious need

CLIENT SUPPORT COUNT(# N's) (includes Client Support Items 1 - 21) ☐

Comments / Functional and Client Support Assessment Sections:

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IV. ENVIRONMENTAL ASSESSMENT

SUBJECTIVE EVALUATION OF ENVIRONMENT

1. Are you concerned about your safety in your home or neighborhood? ____ Yes ____ No (If yes, explain)

POTENTIAL SAFETY/ACCESSIBILITY PROBLEMS

1. (Check all of the following areas that apply)

Area		Comments
Structural damage/dangerous floors	____	
Barriers to access	____	
Electrical hazards	____	
Fire hazards	____	
Unsanitary conditions/odors	____	
Insects or other pests	____	
Poor lighting	____	
Insufficient hot water/water	____	
Insufficient heat/air conditioning	____	
Inaccessible shopping	____	
Inaccessible transportation	____	
Inaccessible telephone	____	
Unsafe neighborhood	____	
Inability to evacuate in emergency	____	
Other (describe)	____	

ENVIRONMENTAL COUNT(# of √'s) ☐ **ENVIRONMENT SCORE** ☐

0 = No need, 5 = Low need, 10 = Moderate need
15 = Substantial need, 20 = Serious need

V. INDICATION OF OTHER PROBLEMS

Is there any indication of cognitive functioning problems? ____ Yes ____ No **(If yes, complete Page 6)**

Is there any indication of mental health/substance abuse problems? ____ Yes ____ No **(If yes, complete Page 7)**

Is caregiver assessment warranted? ____ Yes ____ No **(If yes, complete Page 8)**
(Check yes for HCDA, and others as warranted)

Go To Page 6 Go Back To Page One

CLIENT ASSESSMENT SCORING MATRIX

DOMAIN	LEVEL 1		LEVEL 2		LEVEL 3		LEVEL 4		LEVEL 5		
	Range	Score	Range	Score	Range	Score	Range	Score	Range	Score	Count
Subjective Evaluation of Health	0		5		10		15		20		
Health Assessment	0		5		10		15		20		
Nutrition	≤4		6-10		12-16		18-22		24-28		
Functional - ADLs	≤5		6-11		12-17		18-24		25-31		
Functional - IADLs	≤5		6-11		12-17		18-24		25-30		
Client Support	0		5		10		15		20		
Environment	0		5		10		15		20		
Total Ranges (L1 - L5)	≤14		15-52		53-90		91-130		131-169		
TOTAL CLIENT SCORE: (Does not include Count)											

Signature of Assessor ____ Program/Unit ____ Date ____

Signature of Assessor ____ Program/Unit ____ Date ____

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VI. COGNITIVE ASSESSMENT

Go To Page 7 Go Back To Page One

(Complete only if indication(s) of cognitive functioning problems)

COMMUNICATION ABILITY

1. Rate the client's speaking and communication ability based on performance in the interview:

Speaking	Communication
____ Speaks clearly with others of the same language	____ Transmits/receives information
____ Some defect in speech--usually gets message across	____ Limited ability
____ Unable to speak clearly/does not speak	____ Nearly or totally unable

2. Assessor's rationale and concerns regarding indication(s) of cognitive impairment:

(The following mental status exam may be used to document assessor's concerns.)

MENTAL STATUS QUESTIONNAIRE (MSQ) Orientation-Memory-Concentration Test (Katzman et al., 1983)

Now I'm going to read you a list of questions. These are questions that are often asked in interviews like this and we are asking them the same way to everyone. Some may be easy and some may be difficult. Let's start with the current year.

Items	Maximum Errors	Score	Weight	Weighted Score
What year is it now?	1	____	x 4 =	____
What month is it now?	1	____	x 3 =	____

(Tell the client you are giving them a man's name and address to memorize.)

Memory phrase: John Brown, 42 Market Street, Chicago

(Elicit 3 correct repetitions from the client, phrase by phrase or word by word, if necessary, before continuing.)

Without looking at a clock, about what time is it? (Within 1 hour)	1	____	x 3 =	____														
Count backwards from 20 to 1. (Check missed/out of order numbers in boxes.)	2	____	x 2 =	____														
20	19	18	17	16	15	14	13	12	11	10	9	8	7	6	5	4	3	2	1

Say the months in reverse order. Hint: For ease in scoring, start with the month of December.
(Check missed/out of order months in boxes.) ..... 2 ____ x 2 = ____

Dec.	Nov.	Oct.	Sept.	Aug.	July	June	May	Apr.	Mar.	Feb.	Jan.

Go Back To Page One

Ask the client to repeat the memory phrase. Prompt the client if necessary: "It was John Brown..."
(Write the client's response on the line below to score.) ..... 5 ____ x 2 = ____

	John	Brown,	42	Market Street,	Chicago
Error Points:	(1)	(1)	(1)	(1)	(1)

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weighted risk score: (0-4 = Low) (5-9 = Moderate) (10-28 High)

Total Weighted Error Score: ____

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VII. MENTAL HEALTH/SUBSTANCE ABUSE ASSESSMENT

Go To Page 8 Go Back To Page One

(Complete only if indication(s) of mental health/substance abuse problems)

Are you currently or have you previously received mental health services or counseling? ____ Yes ____ No

What is your mental health diagnosis? _____

Name of provider: _____ Describe services:

EMOTIONAL WELL BEING: Now I have some questions about how you have been feeling during the past month.

	Yes	No
Are you satisfied with life?	____	____
Have you been depressed or very unhappy?	____	____
Have you been very anxious or nervous?	____	____
Have you had difficulty sleeping?	____	____
Have you seen or heard things that other people didn't see or hear?	____	____
Have you become physically aggressive, or made threats to harm anyone?	____	____
Have you had a serious thought about harming or killing yourself?	____	____
Is anyone plotting against you?	____	____

MEMORY ASSESSMENT: I'd like to ask you some questions about your memory and ability to find things. In the past month have you:

	Yes	No
Had problems with your memory?	____	____
Frequently lost items such as your purse/wallet or glasses?	____	____
Failed to recognize family members or friends?	____	____
Lost your way around the house; can't find the bedroom or bathroom?	____	____
Forgotten to turn the stove off?	____	____
Wandered away from home for no apparent reason?	____	____

ALCOHOL/SUBSTANCE USE

Do you drink alcoholic beverages including beer and wine? ____ Yes ____ No (If no, skip next question.)

On average, counting beer, wine, and other alcoholic beverages, how much do you drink? (Describe frequency.)

Do you have a history of substance abuse? ____ Yes (Describe) ____ No

Do you smoke or use tobacco? ____ Yes ____ No (If no, skip next question.)

On average, how much do you smoke per day? (Describe frequency.)

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Assessor's rationale and concerns regarding indication(s) of mental health issues/substance abuse:

VIII. CAREGIVER ASSESSMENT

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(Complete for all HCDA clients and for other client's if there is an indication of caregiver issues.)
(Address to caregiver only)

1. Name:_____ Relationship:_____

2. How long have you given care to (Name of client)? _____ Years _____ Months

3. How often do you give care to (Name of client)? Would you say you give care:
   ____ Every day ____ At least once a week
   ____ Several times a week ____ Less than once a week
   ____ Don't know

4. Are you employed full-time, part-time, or not working at all?
   ____ Full-time ____ Part-time ____ Not working

5. If you were suddenly unable to provide care, who would take your place?
   ____ No one ____ Other (specify):_____

6. How is your own health? Would you say it is excellent, good, fair or poor?
   ____ Excellent ____ Good ____ Fair ____ Poor

7. Considering the care you provide for (Name of client), I would like to ask you if various aspects of your life have become better, the same, or worse. Let's start with...

	Better	Same	Worse	Don't Know
Relationship with (Name of client)	____	____	____	____
Relationship with other family members	____	____	____	____
Relationship with friends	____	____	____	____
Your health	____	____	____	____
Your work (if applicable)	____	____	____	____
Your emotional well-being	____	____	____	____

8. Is there anything else we need to know that makes it difficult for you to manage care? ____ Yes (explain) ____ No

9. Do you (caregiver) need training or services? ____ Yes (describe) ____ No

10. Assessor's concerns regarding caregiver's ability to provide care:

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APPENDIX B

MEDICAL CERTIFICATION FOR NURSING FACILITY/HOME AND COMMUNITY BASED SERVICES FORM, AHCA-Med Serv Form 3008

DRAFT

FLORIDA MEDICAID **MEDICAL CERTIFICATION FOR NURSING FACILITY/HOME- AND COMMUNITY-BASED SERVICES FORM (MCNF/HCBS)**

(Replaces Patient Transfer and Continuity of Care Form)

(A) FACILITY INFORMATION

Facility From _____ Admission Date ____/____/____ Discharge Date ____/____/____

Facility To _____

(B) DEMOGRAPHIC INFORMATION

Individual's DOB ____/____/____ Sex _____ Race _____

Individual's Last Name _____ First Name _____

Individual's Address _____

Nearest Relative/Health Care Surrogate _____

PHYSICIAN INFORMATION

Name _____

Will you care for individual in NF? ☐ Yes ☐ No

If no, referred to _____

Principal Diagnosis _____

Secondary Diagnosis _____

Discharge Diagnosis _____

(Problem List may be attached)

Surgery Performed & _____ ____/____

Allergy/Drug Sensitivity _____

MEDICATION AND TREATMENT ORDERS (copies may be attached)

_____

_____

_____

_____

_____

_____

(C) PREADMISSION SCREENING FOR MENTAL ILLNESS/MENTAL RETARD

1. Is dementia the primary diagnosis? ☐ Yes ☐ No
2. Is there an indication of, or diagnosis of mental retardation (MR), or has the individual received MR services within the last 2 years? ☐ Yes ☐ No
3. Is there an indication of, or diagnosis of serious mental illness (MI), such as (check all that apply):
   - ☐ Schizophrenia
   - ☐ Mood disorder
   - ☐ Somatoform disorder
   - ☐ Paranoia
   - ☐ Panic or severe anxiety disorder
   - ☐ Personality disorder
   - ☐ Other psychotic or mental disorder leading to chronic disability
4. Has the individual received MI services within the past two years? ☐ Yes ☐ No
5. Is the individual a danger to self or others? *(If yes, please attach)* ☐ Yes ☐ No
6. Is the individual on any medication for the treatment of a serious illness or psychiatric diagnosis? ☐ Yes ☐ No
7. If yes, is the MI or psychiatric diagnosis controlled with medicatio ☐ Yes ☐ No
8. Is the individual being admitted from a hospital after receiving ac ☐ Yes ☐ No inpatient care?
9. Does the individual require nursing facility services for the condi ☐ Yes ☐ No he/she received care in the hospital?
10. Has the physician certified the individual is likely to require less ☐ Yes ☐ No of nursing facility services?

(D) ADDITIONAL ORDERS (Orders may be attached)

_____

_____

_____

_____

_____

(E) HISTORY & PHYSICAL AND LABS

1. PHYSICAL EXAM (History & Physical may be attached)

Head Ears Eyes Nose & Throat (HEENT) _____

_____

Neck _____

Cardiopulmonary _____

_____

Abdomen _____

GU _____

Rectal _____

Extremities _____

Neurological _____

Other _____

_____

Free from communicable diseases ☐ Yes ☐ No

2. LABORATORY FINDINGS (Reports may be attached)

TB Test ☐ Yes ☐ No Date ____/____/____

Results _____

Chest X-Ray ☐ Yes ☐ No Date ____/____/____

Results _____

(F) IMMUNIZATIONS GIVEN

- ☐ Pneumococcal Vaccine Date ____/____/____
- ☐ Influenza Vaccine Date ____/____/____
- ☐ Tetanus and Diphtheria Vaccine Date ____/____/____
- ☐ Herpes Zoster Vaccine Date ____/____/____

(G) PHYSICAL THERAPY (Attach Orders)

☐ New Referral ☐ Continuation of Therapy

FREQUENCY OF THERAPY _____

INSTRUCTIONS _____

- ☐ Stretching
- ☐ Passive Range of Motion (ROM)
- ☐ Active assistive
- ☐ Active
- ☐ Progressive resistive
- ☐ Coordinating Activities
- ☐ Non-weight bearing
- ☐ Partial weight bearing
- ☐ Full weight bearing
- ☐ Progress bed to wheelchair
- ☐ Recovery to full function
- ☐ Wheelchair independent
- ☐ Complete ambulation

Sensation Impaired: ☐ Yes ☐ No

Restrict Activity: ☐ Yes ☐ No

PRECAUTIONS

- ☐ Cardiac
- ☐ Other _____

ADDITIONAL THERAPIES (Attach Orders)

- ☐ Occupational Therapy
- ☐ Speech Therapy
- ☐ Respiratory Therapy
- ☐ Other _____

(H) TREATMENT AND EQUIPMENT NEEDS (Attach Orders)

- ☐ Catheter Care
- ☐ Changing Feeding Tube
- ☐ Dressing Changes
- ☐ Ostomy Care
- ☐ Wound Care
- ☐ Suctioning
- ☐ Trach Care
- ☐ Diabetic Care
- ☐ Monitor Blood Sugar/Frequency _____
- ☐ Administer Insulin
- ☐ Tube Feeding
- ☐ Oxygen *(Select from below)*
  - ☐ PRN
  - ☐ Continuous @L/min _____

Instructions

(I) SPECIAL DIET ORDERS (Orders may be attached)

_____

_____

(J) TYPE OF CARE RECOMMENDED

☐ Skilled Nursing Extended Care Facility (ECF), Duration _____ Rehab Potential (check one) ☐ Good ☐ Fair ☐ Poor

☐ Intermediate Care: Duration _____ Admission Date to Nursing Facility ____/____ Effective Date of Medical Condition ____/____/____

☐ I certify that this individual requires ECF Nursing Facility Care for the condition for which he/she received care during hospitalization.

☐ I certify that this individual is in need of Medicaid Waiver Services in lieu of Institutional placement.

Print Physician's Name _____

Address _____

Phone Number _____ **Fax** _____

Email Contact Address _____

_____ ____/____/____

Physician's Signature **Date**

FOR ONLINE APPLICANT USE ONLY

IF APPLYING FOR MEDICAID, PLEASE INCLUDE POE

AHCA-Med Serv Form 3008, May 2009 --(Replaces Patient Transfer and Continuity of Care Form 3008 July 2006 - CF Med 3008)

FLORIDA MEDICAID

NURSING/SOCIAL WORK ASSESSMENT
[Page 2 may be completed by a Nurse or Social Worker]

INDIVIDUAL'S NAME _____ DOB _____

ADLs ARE AT TIME OF NF ADMISSION

(K) VISION (w/glasses if used)	☐ 1. Good ☐ 2. Fair ☐ 3. Poor ☐ 4. Blind	**AMBULATION**	☐ 1. No assistance ☐ 2. With assistive device ☐ 3. With supervision ☐ 4. Requires assistance* ☐ 5. Total help ☐ 6. Bed bound
HEARING (w/aid if used)	☐ 1. Good ☐ 2. Fair ☐ 3. Poor ☐ 4. Deaf	**ENDURANCE**	☐ 1. Tolerates distance (250 feet sustained activity) ☐ 2. Needs intermittent rest ☐ 3. Rarely tolerates short acitivities ☐ 4. No tolerance
SPEECH	☐ 1. Good ☐ 2. Fair ☐ 3. Poor ☐ 4. Gestures or signs ☐ 5. Unable to speak	**TRANSFER**	☐ 1. No assistance ☐ 2. With assistive device ☐ 3. With supervision ☐ 4. Requires assistance* ☐ 5. Bed bound
COMMUNI-CATION	☐ 1. Transmits messages/receives information ☐ 2. Limited ability ☐ 3. Nearly or totally unable	**WHEELCHAIR USE**	☐ 1. No assistance ☐ 2. Assistance with difficult maneuvering ☐ 3. Wheels a few feet ☐ 4. Unable ☐ N/A
MENTAL AND BEHAVIOR STATUS	☐ 1. Alert ☐ 2. Confused ☐ 3. Disoriented ☐ 4. Comatose ☐ 5. Aggressive ☐ 6. Disruptive ☐ 7. Apathetic ☐ 8. Wanders ☐ 9. Safety restraints needed ☐ 10. Well motivated	**TOILETING**	☐ 1. No assistance ☐ 2. With assistive devices ☐ 3. With supervision ☐ 4. Requires assistance ☐ 5. Total assistance ☐ A- Bathroom ☐ B - Bedside commode ☐ C- Bedpan
SKIN CONDITION	☐ 1. Intact ☐ 2. Dry/Fatigue ☐ 3. Irritations (rash) ☐ 4. Open Wound ☐ 5. Decubitus Site:_____ Stage:_____ Size:_____	**BLADDER CONTROL**	☐ 1. Continent ☐ 2. Occasional incontinence - once/week or less ☐ 3. Frequent incontinence - up to once a day ☐ 4. Total incontinence ☐ 5. Catheter - indwelling
DRESSING	☐ 1. No assistance ☐ 2. Supervision ☐ 3. Requires assistance* ☐ 4. Has to be dressed	**BOWEL CONTROL**	☐ 1. Continent ☐ 2. Occasional incontinence-once/week or less ☐ 3. Frequent incontinence - up to once a day ☐ 4. Total incontinence ☐ 5. Ostomy
BATHING	☐ 1. No assistance ☐ 2. Supervision ☐ 3. Requires assistance* ☐ 4. Is bathed ☐ A- Tub ☐ B - Shower ☐ C- Sponge Bath	**FEEDING**	☐ 1. No assistance ☐ 2. Tray set up only ☐ 3. Requires assistance ☐ 4. Is fed ☐ 5. Aspirates
TEACHING NEEDS	☐ 1. Diabetic ☐ 2. Cardiac ☐ 3. Ostomy ☐ 4. Other (specify):	**DIET**	☐ 1. Full ☐ 2. Mechanical Soft ☐ 3. Pureed ☐ 4. Other (specify):

***(HANDS ON NEEDED)**

Comments: _____

SIGNATURE AND TITLE _____ **DATE** ____/____/____

(L) SOCIAL WORK ASSESSMENT

Prior Living Arrangement _____

Long Range Plan/Agency Referrals _____

Adjustments to Illness or Disability _____

Comments _____

SIGNATURE AND TITLE _____ **DATE** ____/____/____

DCF ACCESS Confirmation #: _____

DCF ACCESS Confirmation #: _____

Instructions for Completing the AHCA-Med ServForm 3008

This form is a dual-purpose form for physicians to certify Nursing Facility Care or Home- and Community-Based Services (Medicaid Waiver Services)

I. In an effort to assist you in the completion of the MedServ-3008 form, the following definitions are being provided.

A. **Skilled Nursing (ECF):** ECF means extended care facility. The definition of skilled nursing can be found in 59G.-4.290(3)(b), Florida Administrative Code. [To access this information on the Internet use the following link: https://www.flrules.org/gateway/readFile.asp?sid=0&tid=1849225&type=1&file=59G-4.290.doc]

Skilled Nursing must be:

- Ordered by and remain under the supervision of a physician;
- Sufficiently medically complex to require supervision, assessment, planning, or intervention by a registered nurse;
- Required to be performed by, or under the direct supervision of, a registered nurse or other health care professionals for safe and effective performance;
- Required on a daily basis;
- Reasonable and necessary to the treatment of a specific documented illness or injury; and
- Consistent with the nature and severity of the individual's condition or the disease state or stage.

B. **Intermediate Care:** The definition of intermediate care can be found in 59G-4.180(3)(b), Florida Administrative Code. [To access this information on the Internet use the following link: https://www.flrules.org/gateway/readFile.asp?sid=0&tid=1847673&type=1&file=59g-4.180.doc]

Intermediate Care must be:

- Ordered by and remain under the supervision of a physician;
- Medically necessary and provided to an applicant or recipient whose health status and medical needs are of sufficient seriousness as to require nursing management, periodic assessment, planning or intervention by licensed nursing or other health professionals;
- Required to be performed under the supervision of licensed nursing or other health professionals;
- Necessary to achieve the medically desired results and to ensure the comfort and safety of the applicant or recipient;
- Required on a daily or intermittent basis;
- Reasonable and necessary to the treatment of a specific documented medical disorder, disease or impairment; and
- Consistent with the nature and severity of the individual's condition or the disease state or stage

II. To further assist you in the completion of the MedServ-3008 form, the following **instructions** are provided: (Additional information is located on the Comprehensive Assessment and Review for Long Term Care Services (CARES) Web site: http://elderaffairs.state.fl.us/english/cares.php

Section A: Facility Information

List where the individual is transferring to and from, along with admission and discharge dates, if appropriate.

Section B: Demographic Information

- Enter individual's demographic information
- List physician's name
- Answer the question regarding the care of the individual in the nursing facility and who the individual will be referred to if you will not be caring for individual
- List the principal diagnosis for which the individual has been hospitalized/admitted
- List all other diagnosis for which the individual has for secondary diagnosis, as well as discharge diagnosis
- Attach Problem List
- Include any surgeries performed, including date of surgery
- List all allergies and drug sensitivities
- If the individual is to be discharged with medication(s) and/or treatment(s), specify them by name, including dosage and method of administration. If you need additional space, you may attach additional pages, but please indicate that you have done so.

Section C: Preadmission Screening

This section contains items numbered one through ten, which meet the mental illness/mental retardation screening required by Omnibus Budget Reconciliation Act (OBRA) '87. Answer each item by checking the appropriate box for Yes or No to indicate the individual's mental illness/mental retardation (MI/MR) status (additional documentation may be attached).

Section D: Additional Orders (Orders may be attached)

Section E: History & Physical and Labs

1. **Physical Exam: (History & Physical may be attached)**

- Review all body systems of the individual and list specific findings
- Briefly describe the individual's medical history
- Describe the individual's mental and physical functional limitations
- Use additional order space (D) for additional findings if needed

2. **Laboratory Findings: (Reports may be attached)**

- Check if TB Test has been completed or not; provide date of testing and results
- List date of chest x-ray and results
- Use additional order space (D) for other lab orders or results

Section F: Immunizations Given

- List dates of last Pneumococcal vaccine, Influenza vaccine, Tetanus and Diphtheria vaccine and Herpes Zoster vaccine.

Section G: Physical Therapy (Attach Orders)

- Check if this is a new referral or continuation of therapy
- List frequency of treatment
- Provide instructions for other physical therapy needs (Use additional order (D) if needed)
- Check therapy ordered and precautions if any for individual

Section G: Additional Therapies (Attach Orders)

- List type of therapy ordered and precautions if any for the individual
- Use additional order space (D) for additional therapies not listed
- List instructions for therapy identified

Section H: Treatment and Equipment Needs (Attach Orders)

- Check type of treatment and equipment needs for individual
- Use additional order space (D) for other treatment or equipment needs not listed

Section I: Special Diet Orders (Orders may be attached)

- List individual's dietary restrictions and requirements

Section J: Type of Care Recommended

- Indicate the type of care (skilled nursing ECF or intermediate) recommended for the individual and the duration
- Indicate the individual's rehabilitation potential (good, fair, or poor)
- List admission date to nursing facility
- Indicate certification of individual requiring ECF Nursing Facility Care for the condition for which the individual received care during hospitalization
- Indicate certification of individual in need of Medicaid Waiver Service in lieu of institutional care placement
- List effective date for certification
- Print name, address, and phone number of physician
- MD/DO must sign and date form as mandated by federal law

Section K: The Nursing/Social Work Assessment Form

- Activities of Daily Living (ADLs) are at the time of admission into the nursing facility
- (*) Indicates "Hands on is needed" for this ADL
- Check appropriate box on the Nursing Assessment to indicate the level of assessment of the individual at time of admission
- Add additional nursing assessment information in the Comment Section
- Sign and date form

Section L: The Nursing/Social Work Assessment Form

- Social Work Assessment is to be completed at the time of nursing facility admission
- Sign and date form

The Nursing/Social Work Assessment Form (page 2 of the MedServ-3008 form) is to be completed for individuals in hospitals and nursing facilities seeking level of care for nursing facility placement.

- Page 2 is not required for individuals in the community seeking nursing facility placement
- Page 2 may be completed and signed by a nurse or social worker

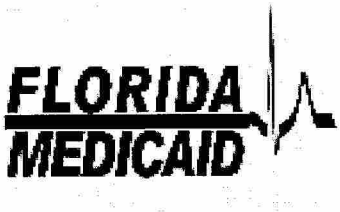
Please note: This form is also located for your convenience at the following link: http://elderaffairs.state.fl.us/english/cares.php

From this link you may download the form, complete as appropriate for each individual, save the .pdf file as needed before printing, signing and returning to CARES.

APPENDIX C

INFORMED CONSENT FORM, AHCA-Med Serv Form

DRAFT



STATE OF FLORIDA

AGENCY FOR HEALTH CARE ADMINISTRATION (AHCA)
DEPARTMENT OF ELDER AFFAIRS (DOEA)

INFORMED CONSENT FORM

CLIENT'S NAME: _____

DATE OF BIRTH: _____

An assessment is required for all persons applying for or receiving assistance for long-term care. This includes the Institutional Care Program (ICP) and Home and Community-Based Services (HCBS) waiver programs.

In order to evaluate my needs, I am giving my consent to the following:

- **I agree to an assessment to identify my need for long-term care, and to determine if my needs can be met in the community instead of a nursing facility.**
- **I authorize DOEA staff to access my medical records. I understand and agree that DOEA may need to talk to my doctor and other health professionals. I also understand that they may need to interview my family members, close friends and social services professionals about my situation.**

_____
Individual or Representative

_____
Relationship (if representative signs)

_____
Date

AHCA-Med Serv 2040, May 2009

FLORIDA MEDICAID

DEPARTAMENTO DE LAS PERSONAS MAYORES

ESTADO DE LA FLORIDA
AGENCIA DE ADMINISTRACIÓN PARA EL CUIDADO DE LA SALUD (AHCA)
DEPARTAMENTO DE LAS PERSONAS MAYORES (DOEA)

CONSENTIMIENTO Y DECLARACIÓN
DE QUE HA ENTENDIDO LO QUE FIRMA

NOMBRE DEL CLIENTE:_____

FECHA DE NACIMIENTO:_____

Es necesario que las personas que estén solicitando o recibiendo ayuda de cuidado a largo plazo pasen por una evaluación. Se incluyen los programas de exoneración (waiver) del Programa de Cuidado Institucional *(ICP,* del inglés *Institutional Care Program)* y los Servicios Domésticos y Comunitarios *(CSB,* del inglés *Home and Community Based Services).*

A fin de evaluar mis necesidades, consiento...

- ... a que se evalúe mi necesidad de cuidado a largo plazo, y se determine si en lugar de internarme en un asilo, mis necesidades pueden satisfacerse dentro de la comunidad, y
- Autorizo al DOEA (Departamento de las Personas Mayores) a tener acceso a mis expedientes médicos. Entiendo y estoy de acuerdo que dichos departamentos pudieran necesitar hablar con mi médico y otros profesionales médicos. También entiendo que pudieran tener que entrevistar a familiares, amigos íntimos y profesionales de servicios sociales sobre mi estado.

_____
Persona o representante

_____
Relación (si firmase un representante)

_____
Fecha

AHCA-Med Serv 2040, May 2009.

APPENDIX D

NOTIFICATION OF LEVEL OF CARE, DOEA-CARES FORM 603

DRAFT

ELDER AFFAIRS

Notification of Level of Care

1. From CARES PSA/Worker: _____ To District: _____ C&F Unit/Other: _____

   Case Mgr: _____ Case Mgt Agency: _____

2. Client Name: _____ DOB: _____ SSN: _____

   Current Location: _____

3. **Level of Care:**

   ☐ Skilled ☐ Intermediate I ☐ Withhold LOC

   ☐ Risk of Hospital ☐ Intermediate II ☐ Does Not Meet LOC

4. **Meets Program Requirements For:**

   ☐ PAC ☐ Aged & Disabled Adults ☐ Assisted Living

   ☐ Channeling ☐ Elder Care ☐ Cystic Fibrosis

   ☐ Model Waiver ☐ Brain and Spinal Cord Injury ☐ LTCCDPP

   ☐ PACE ☐ Does Not Meet Waiver Criteria ☐ Other Program Specify: _____

5. **Placement Recommendation:**

   ☐ Community ☐ Nursing Facility ☐ Temporary Nursing Facility

   ☐ Swing Bed ☐ State Mental Health Hospital ☐ Other Placement Specify: _____

   ☐ Hospital Based Nursing Bed for Rehab Care

6. **OBRA Screen:** ☐ MI Level I ☐ MR Level I ☐ MI Level II ☐ MR Level II

7. **LOC Effective Date:** _____

8. **Comments:** _____

   _____

   _____

   _____

   _____

9. **Approval Signature:** _____ **Date:** _____

DOEA-CARES form 603 (Revised, March 2003), Incorporated by reference in 59G-13.030, F.A.C.

APPENDIX E

AGREEMENT OF EXPECTATIONS
AHCA-MED SERV FORM 033

DRAFT

AGREEMENT OF EXPECTATIONS

This Agreement of Expectations is developed in order for all those involved in providing care to _____ can reach an understanding of the services to be provided in the Plan of Care and to establish an agreement on the expected acceptable behavior toward those service providers involved in providing care.

This Agreement will provide a written record on the agreed upon provisions listed below in order that the approved plan of care will be followed and the service providers will be able to provide services without the fear of inappropriate behavior. It is agreed that the recipient and his or her representative, if applicable, should be involved in his or her care and take personal responsibility for his or her behavior toward the service provider. If the recipient continues to be noncompliant with the approved plan of care or if the recipient continues to subject service employees to inappropriate behavior, the Medicaid Aged and Disabled Adult Services Waiver Program's ability to continue providing services may be in jeopardy.

If the Agreement does not result in improvement, the case manager may take action to terminate the recipient from the waiver program with a ten day advance written notice of the proposed termination and the right to a Fair Hearing.

The parties agree to the provisions below:

1. Provider agrees to:

2. Recipient agrees to:

Agreement of Expectations, continued

If either party fails to meet these expectations, the case manager will be contacted immediately. The agreement becomes effective on the date the recipient, service provider(s), case manager and the case manager's supervisor signs below. Each party must be given a copy of the agreement.

_____ _____

Recipient Signature Date

_____ _____

Service Provider Date

_____ _____

Case Manager Date

_____ _____

Case Manager's Supervisor Date

AHCA-Med Serv Form 033, May 2009

APPENDIX F

HOSPICE FORMS

NOTICE OF HOSPICE ELECTION WAIVER, AHCA FORM 5000-29

COOPERATIVE AGREEMENT FOR A HOSPICE AND MEDICAID WAIVER ENROLLED RECIPIENT, AHCA FORM 5000-30

ATTACHMENT TO COOPERATIVE AGREEMENT FOR A HOSPICE AND MEDICAID WAIVER ENROLLED RECIPIENT, AHCA FORM 5000-30A

FLORIDA MEDICAID

NOTICE OF HOSPICE ELECTION WAIVER

TO:	**Waiver Case Manager/Support Coordinator**	**FROM:**	**Hospice Care Coordinator/Case Manager**
	_____		_____
	_____		_____
Phone:	_____	**Phone:**	_____

This is to advise that the recipient identified below has elected to receive hospice care benefits under:

☐ Medicare ☐ Medicaid

Name: _____ Election Date: _____

Medicaid ID#: _____ DOB: _____

Guardian: _____

Address: _____

Phone No.: _____

Attached is information identifying the recipient's terminal illness diagnosis and the hospice services which will be provided to manage the terminal illness and related conditions.

Hospice services shall start on _____ (Date). If you are not in accord with the hospice service start date, contact _____ (Name) at _____ (Phone Number) immediately.

Distribution of Copies:
1. Waiver
2. Physician
3. Hospice

AHCA 5000-29, October 2003 (59G-4.140, F.A.C.)

COOPERATIVE AGREEMENT FOR A HOSPICE AND MEDICAID WAIVER ENROLLED RECIPIENT

Recipient's Name: _____ Recipient's Medicaid #: _____

	Services to be Provided
Hospice Name: _____ Hospice Care Coordinator/Case Manager: _____ Terminal Illness Diagnosis: _____ Hospice Effective Date:	
Waiver Type: _____ Waiver Case Manager/Support Coordinator: _____ Waiver Diagnoses:	

☐ Reviewed by Hospice Care Coordinator/Case Manager _____ Signature _____ Date

☐ Reviewed by Waiver Case Manager/Support Coordinator _____ Signature _____ Date

☐ Reviewed by Recipient or Recipient's Representative _____ Signature _____ Date

Attachment to
COOPERATIVE AGREEMENT FOR A
HOSPICE AND MEDICAID WAIVER ENROLLED RECIPIENT

HOSPICE
Physician Services, **Nursing Services,** Medical Social Services and **Supportive Counseling Services, Home Health Aide, Homemaker Services, Therapy Services (Physical, Occupational, Speech, Respiratory)** Laboratory and X-ray Services, **DME and Medical Supply Services,** Pharmacy Services, **Nutritional Counseling, Respite** (institutional), Spiritual Care, Bereavement Services, Volunteer Services

WAIVERS	
Assisted Living	**TBI/SCI**
Attendant Call System, Attendant Care, **Behavior Management**, Chore, Companion Services, **Homemaker, Intermittent Nursing**, Medication Administration/Management, **Incontinence Supplies, Occupational Therapy**, Personal Care, **Physical Therapy, Specialized Medical Equipment and Supplies, Speech Therapy**, Therapeutic Social and Recreational Programming	**Assistive Technologies and Adaptive Equipment**, Rehabilitation Engineering Evaluation, **Personal Adjustment Counseling**, Behavior Programming, Life Skills Training, Community Support Coordination, **Attendant Care, Companion Services**, Environmental Modification, **Personal Care**
Channeling	**Aged and Disabled Adult**
Adult Companion Services, Adult Day Health Care, Family Training, Chore, **In-Home Counseling**, Environmental Accessibility Adaptations, Financial Educational and Protective Services, Special Home Delivered Meals, **Home Health Aide, Special Drug and Nutritional Assessment Services, Personal Care**, Personal Emergency Response (PERS), **Respite, Skilled Nursing, Special Medical Equipment, Special Medical Supplies, Therapy Services (Occupational, Physical, and Speech)**	Adult Companion Services, Adult Day Health Care, Attendant Care, Family Training, Chore, **Consumable Medical Supplies, Counseling**, Environmental Accessibility Adaptations, Escort, Financial Risk Reduction, Home Delivered Meals, **Homemaker, Nutritional Risk Reduction, Personal Care**, Personal Emergency Response (PERS), Pest Control, Physical Risk Reduction, **Respite, Skilled Nursing, Specialized Medical Equipment and Supplies**, Case Aide, Health Support, **Therapy Services (Occupational, Physical, Speech, and Respiratory)**
Model Waiver	**Supported Living Waiver**
Respite Care, Environmental Accessibility Adaptations, Assistive Technology and Service Evaluation	**Supported Living Coaching, In-Home Support, Adult Day Training, Supported Employment and Transportation**
Developmental Services	
Respite Care, Therapy Assessment/Services (Physical, Occupational, Speech, Respiratory), Skilled Nursing (LPN), Special Medical Home Care, **Residential Nursing Services, Dietitian Services, Personal Care**, Residential Habilitation, **Specialized Medical Equipment and Supplies**, Environmental Modifications, Non-Residential Support Services, In-Home Support Services, Transportation, Behavioral Assessment, Therapy and Assistant Services, Adult Day Training, Chore Services, Companion Services, **Homemaker**, Adult Dental Services, Massage Assessment and Therapy, **Support Coordination**, Specialized Mental Health Assessment and Therapy, Personal Emergency Response Systems, Child Day Training and Supported Employment	

NOTE: Highlighted services identify areas with greatest potential of duplication in service provision. The Cooperative Agreement must clearly differentiate non-duplication of services.

AHCA 5000-30A, October 2003 (59G-4.140, F.A.C.)

APPENDIX G

REQUEST FOR APPROVAL OF PLAN OF CARE SERVICES INCREASE, CF-AA 1116

DRAFT

FLORIDA DEPARTMENT OF CHILDREN & FAMILIES

Request for Approval of Care Plan Services Increase

Part I: Recipient Information

Name: Last name, first name, middle name or initial	Date of birth:
Social security number:	Medicaid/Medicare Medical assistance number:
Current Address: County:	Address where services will be received: County:
Status (Transfer/Existing): If individual is a transfer, indicate originating district/agency: If individual is an existing consumer with your agency, indicate current monthly authorized units of service by service type(s):	Describe reason for service funding increase. An Adult Services client reassessment was completed on _____ by _____ and respective revised care plan revisions made on _____ by _____, to reflect that this Recipient is justifiably in need of increased Service(s) based on (check all situations which apply): ☐ Failing Support System ☐ Decrease in Functional Capacity ☐ Rapidly Deteriorating Health
Medicaid waiver eligibility date: _____	

Provider Information

Agency name:	Agency contact person:
Agency address:	Phone: _____ Fax: _____ E-mail address:

Part II: Summary of Recipient's Presenting Situation. (Refer to form instructions for details about the type of information required here. Use the space below or include attachment.)

Part III: Proposed New Service Request. (Please indicate the new care plan services being requested and the corresponding, anticipated service start dates.)

Service	Anticipated start date	Service	Anticipated start date

Incorporated by reference in 59G-13.030, F.A.C., CF-AA 1116, PDF 05/2004

APPENDIX H

AGED/DISABLED ADULT WAIVER AGING OUT PLAN OF CARE, AHCA-Med Serv Form 047

DRAFT

FLORIDA MEDICAID

AGED/DISABLED ADULT WAIVER AGING OUT PLAN OF CARE

PAGE ____ OF ____ RECIPIENT: _____ MEDICAID NUMBER: _____ CASE MANAGER & AGENCY:	CARE PLAN DATE:	DESIRED OUTCOMES: AGED/DISABLED ADULT WAIVER PROVIDER:	ESTIMATED MEDICAID WAIVER MONTHLY CARE PLAN COST:
HEALTH CONDITIONS: (a) (b) (c) (d)	CARE PLAN REVIEW:	ANTICIPATED SERVICE IMPACT ON HEALTH CONDITIONS:	ESTIMATED MEDICAID WAIVER ANNUALIZED CARE PLAN COST:

#	Date	Problems	Service/Activity Waiver/Nonwaiver	Frequency & Duration Needed: Began (B) Ended (E)	Provider (Waiver/Nonwaiver):	Date Service: Began (B) Ended (E) Problem: Resolved (RS) Revised (RV)	Unit Cost	Monthly Cost

I have participated in developing this care plan through discussions regarding my assessed needs, and the services and service providers available to help meet those needs. I prefer to handle my service needs with the assistance of a Case Manager. While I may select the assistance of a case manager, I also understand that the amount of assistance I receive is dependent upon my ability and preference. I understand I am entitled to a grievance review if my services are reduced, changed, or terminated. For Medicaid Waiver services, I accept the services from my choice of enrolled providers, instead of nursing home placement. I understand under Medicaid Waiver, in addition to a grievance review, I am further entitled to a fair hearing. I authorize the provider to release information concerning the services I receive under all programs to the Agency for Health Care Administration.

RECIPIENT/DESIGNATED REPRESENTATIVE:	DATE:	CASE MANAGER:	DATE:

AHCA-Med Serv Form 047, May 2009, Incorporated by reference in 59G-13.030, F.A.C.