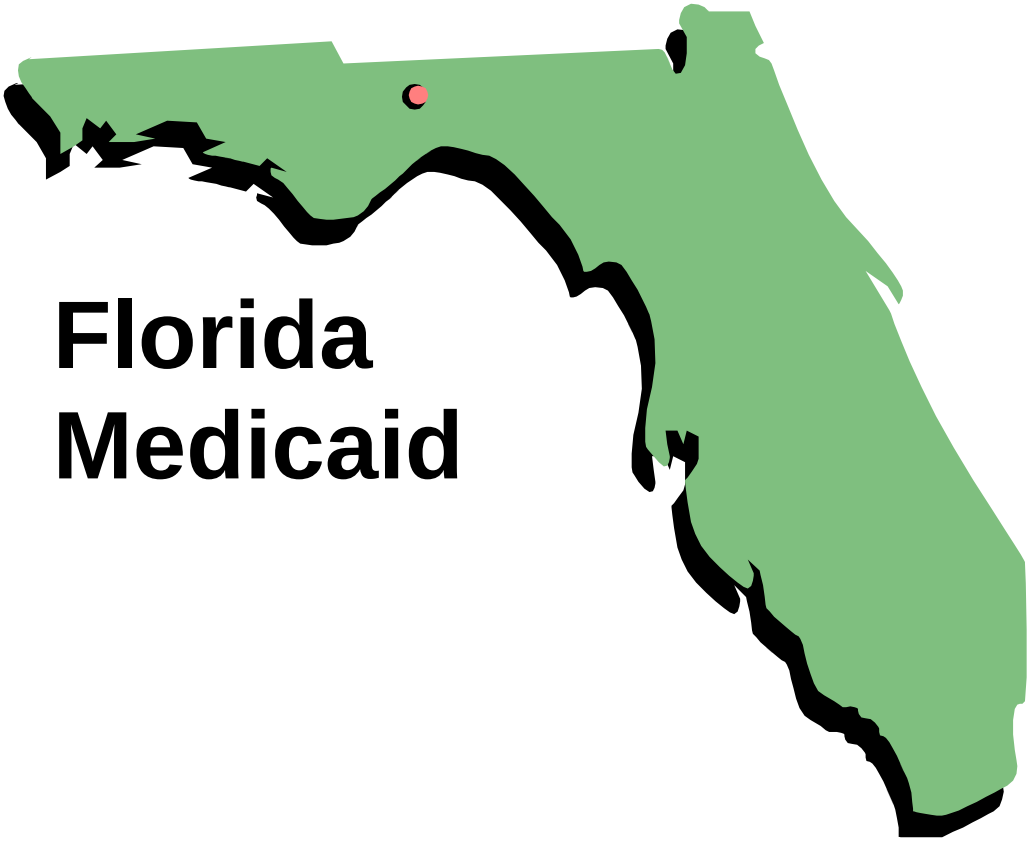

ASSISTED LIVING WAIVER SERVICES COVERAGE AND LIMITATIONS HANDBOOK

Agency for Health Care Administration

March 2011

AHCA
FLORIDA AGENCY FOR HEALTH CARE ADMINISTRATION

UPDATE LOG
ASSISTED LIVING 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 www.mymedicaid-florida.com. Select Public Information for Providers, then Provider Support, and then 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 either replacement pages in an existing handbook or a completely revised handbook.

It is very important that the provider read the updated material and if he maintains a paper copy, file it in the 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 is the month and year that the update was issued.

Effective Date is the date that the update is effective.

Instructions

When a handbook is updated, the provider will be notified by a notice. The notification instructs the provider to obtain the updated handbook from the Medicaid fiscal agent's Web site at www.mymedicaid-florida.com. Select Public Information for Providers, then Provider Support, and then 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 800-289-7799.

UPDATE	EFFECTIVE DATE
New Handbook	March 2011

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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.

Exception: For Prescribed Drugs, 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.
Chapter 59G, Florida Administrative Code.

In This Chapter

This chapter contains:

Handbook Use and Format

Purpose	The purpose of the Medicaid handbooks is to provide 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 provides 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. This general handbook is distributed to all enrolled Medicaid providers and is updated as needed.
Coverage and Limitations Handbook	Each coverage and limitations handbook is named for the service it describes. A provider who provides 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 short and regular way of displaying difficult, technical material.
Information Block	Information blocks replace the traditional paragraph and may consist of one or more paragraphs about a portion of the subject. Blocks are separated by horizontal lines. 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 help scanning and locating information quickly.
Note	Note is used most frequently to refer the user to important 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 list of topics on the first page, which serves as a table of contents for the chapter, listing the subjects and the page number where the subject can be found.

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. The provider can use the update log to determine if all updates to the current handbook have been received. Each update will be designated by an “Update” and the “Effective Date.”
How Changes Are Updated	The Medicaid handbooks will be updated as needed. Changes may be: 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.

Handbook Updates, continued

Effective Date of New Material	The month and year that the new material is effective will appear at the bottom 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 identified 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 and/or paragraph affected by the change.

CHAPTER 1
ASSISTED LIVING WAIVER SERVICES
PROVIDER QUALIFICATIONS AND REQUIREMENTS

Overview

Introduction

This chapter describes the Medicaid Assisted Living (AL) Waiver Services Program, the purpose of the program, and provider qualifications, provider responsibilities and specifies the authority regulating Assisted Living 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 Medicaid AL Waiver Services Program is authorized by Chapter 409, Florida Statutes (F.S.), and Chapter 59G, Florida Administrative Code (F.A.C.).

In This Chapter

This chapter contains:

Description and Purpose

ALWaiver Description

The AL waiver is a Medicaid program that provides extra support and supervision through provision of home and community based services to eligible recipients living in assisted living facilities (ALFs) licensed for extended congregate care (ECC) or limited nursing services (LNS).

The AL waiver serves recipients who are 18 years of age or older. Recipients must be determined disabled according to the Social Security Administration criteria if under 65 years of age.

AL waiver recipients must demonstrate functional deterioration that would result in placement in a nursing facility were it not for the provision of ALwaiver services.

Description and Purpose, continued

Purpose of the AL Waiver	The purpose of the AL waiver program is to promote and maintain the health of eligible recipients and to minimize the effects of illness and disability in order to delay or prevent institutionalization and to enable the individual to live in the home-like setting of an ALF as long as possible. The program provides assisted living services, incontinent supplies, and case management services to eligible recipients living in ALFs
Purpose of this Handbook	This handbook is intended for use by providers that furnish AL 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 Provider Support, and then 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.

AL Waiver Responsibilities

Administrative Responsibilities

The AL 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 and reimbursing Medicaid providers.

DOEA is responsible for the operational administration of the program for recipients who are 60 years of age and older and determining level of care on all recipients participating in the waiver.

As part of the annual review of the operations of the Area Agencies on Aging (AAA's), AHCA and DOEA shall review all procedures issued by the AAA's to case management agencies and ALF service providers to ensure compliance with regulations. All procedures issued which are not in compliance or approved by AHCA and DOEA shall be rescinded in writing with all affected parties notified.

The Department of Children & Families (DCF) is responsible for operating the program for recipients who are ages 18 to 59 years of age and for determining all Medicaid recipients' financial eligibility. DCF also has program oversight of the Optional State Supplementation program.

AL Waiver Responsibilities, continued

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 Assisted Living 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 AL Waiver Program and "wait list" policies and procedures for those individuals aged 60 and older on the "wait list." The DCF is responsible for the "wait list" of individuals aged 18 to 59. The "wait list" shall be available for review by AHCA, DCF and DOEA.

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

The AAAs shall develop monitoring and audit policies and procedures for review of case management agencies and ALF service providers. This shall include review of claims to ensure that contracted rates between the AAA and case management agencies and ALF service providers are equal to or less than those listed in the 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; or log on to: http://www.elderaffairs.state.fl.us; or write:
Department of Elder Affairs
Community Waivers Unit
4040 Esplanade Way
Tallahassee, Florida 32399-7000

Note: The Assisted Living 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 Provider Support, and then Fee Schedules. It is incorporated by reference in 59G-13.031, F.A.C.

ALWaiver Responsibilities, continued

AL Waiver Funding

DOEA, DCF and AHCA have line items in their budgets for funding the ALwaiver. As a Medicaid waiver, the AL waiver program also receives federal financial participation to supplement general revenue funding.

DOEA's Spending Authority

DOEA's waiver spending authority responsibilities are to:

- Ensure providers do not transfer AL recipients to general revenue-funded programs including Community Care for the Elderly (CCE), 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 AL waiver. DCF's waiver spending authority responsibilities are to:

- Ensure district spending allocations are sent to the district program offices as soon as possible at the beginning of each fiscal year (July1).
- Ensure regional 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

Case Management

Case managers begin the assessment process for applicants for entry into the AL waiver program and provide ongoing case management oversight of the recipient's care in the ALFs.

There can only be one case manager for an ALrecipient. If a recipient age 18 to 59 years of age has a DCF placement worker, the AL case manager must be designated as the sole case manager when the recipient becomes an AL waiver recipient. However, DCF will continue to process Optional State Supplementation (OSS) reviews, placement, and other associated OSS responsibilities.

Case Management Provider Qualifications, continued

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 are the same as currently provided by case management services under the waiver.

General Case Management Provider Qualifications

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

Case Management Agency Requirements

To provide AL waiver case management services, the entity must have one of the following unless case management is provided by DOEA or DCF staff:

- A referral agreement with an Area Agency on Aging for Department of Elder Affairs (DOEA).
- 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 and approved by AHCA.
- A referral agreement with the Department of Children and Families.

Case Management Provider Qualifications, continued

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 Management Provider Qualifications, continued

Case Manager Qualifications

To provide AL 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.

An AL case manager must successfully complete assisted living core training within the first six months of employment.

AL Waiver Facility Provider Qualifications

Introduction

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

AL Waiver Facility Provider Qualifications

- Medicaid AL waiver providers must:
- Be enrolled with the Medicaid fiscal agent as an ALwaiver provider;
- Not be currently suspended from Medicare or Medicaid in any state;
- Be licensed by the Division of Health Quality Assurance (HQA) under Chapter 429, Florida Statutes, for Extended Congregate Care (ECC) or Limited Nursing Services (LNS); and
- Specify a staff member to serve as the facility supervisor authorized to sign service plans if the administrator is not available to perform this function.

Vendor Qualifications

If an ALF purchases services from a vendor, the vendor and staff must meet all mandatory educational, licensing, and certification requirements for the specific area of service furnished.

Provider Enrollment

Enrollment Process

To enroll as an AL 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 1-800-289-7799, 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 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 AL services by signing and dating the enrollment application under the "Approval" section 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 AL 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.

Provider Staffing Responsibilities

The AL facility 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.

Provider Responsibilities

Reporting to Case Manager

AL 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

AL 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 and to the local Area Agency on Aging Medicaid Waiver Specialist;
- 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 Provider Support, and then Provider Handbooks.

Home Health Agencies

Home health agencies contracted by ALF facilities must follow the surety bond policies in accordance with 409.907(7) F.S. and Chapter 2 of the Florida Medicaid Provider General Handbook.

Personal Needs Allowance (PNA)

All recipients of AL waiver services must be allowed to keep from their personal income an amount equal to the personal needs allowance (PNA) under the Optional State Supplementation (OSS) Program (Rule 65A-2.036, F.A.C.). The PNA must be available to the resident by the tenth day of each month. The facility may assist the resident in managing these personal funds, but may not restrict how the resident chooses to spend the PNA funds.

Provider Responsibilities, *continued*

Referral Agreement	Every AL waiver service provider must maintain a current executed referral agreement or memorandum of agreement with the AAA. The executed referral agreement or memorandum of agreement must be on file with the AAA before any AL waiver service is provided. Failure to comply with this AL 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 AL waiver administration in their Planning and Service Areas (PSA's), including: • Receiving waiver enrollment packets for AL 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 and AHCA; • Managing DOEA budget spending authority for DOEA clients; and, • Coordinating with area Medicaid offices, DCF and the Medicaid fiscal agent as needed.

Provider Responsibilities, continued

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.

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 1-800-289-7799, select Option 3.

CHAPTER 2
ASSISTED LIVING WAIVER SERVICES
COVERED SERVICES, LIMITATIONS, AND EXCLUSIONS

Overview

Introduction

This chapter describes the services covered under the Florida Medicaid Assisted Living (AL) Waiver Program. It also describes the requirements for service provision, service limitations, and exclusions.

In This Chapter

This chapter contains:

Service Requirements

Introduction

Medicaid reimburses ALF providers for home and community-based waiver services provided to eligible Medicaid recipients who are enrolled in the ALWaiver Program.

AL 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. Because services are based on the individual needs of each recipient, not every recipient receives every service.

Service Requirements, *continued*

Determination of Medicaid Eligibility

Individuals not already receiving Optional State Supplementation (OSS) or 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 www.myflorida.dcf.state.fl.us/ess 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 (Automated Community Connection to Economic Self-Sufficiency) 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.

AL providers are responsible for verifying appropriate Medicaid eligibility prior to the provision of ALwaiver services.

Note: Information regarding Medicaid eligibility is available on the Internet at: http://www.dcf.state.fl.us/programs/access/.

Service Requirements, *continued*

Who Can Receive Services

Enrollment in the AL 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 legislature.

Recipient "enrollment" means being determined financially and medically eligible for the waiver subject to the availability of respective Department of Elder Affairs (DOEA), Department of Children and Families (DCF) and Agency for Health Care Administration (AHCA) waiver funds.

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 or be 65 years old or older;
- Meet nursing facility Level of Care criteria for Intermediate I or Intermediate II as referenced at 59G-4.180, F.A.C;
- Be deemed appropriate for ALF placement by the facility administrator;
- Must be moving out of a nursing facility or other institutional program, or be an ALF resident needing additional services in order to remain in the ALF, or be living at home and determined at risk of nursing facility placement and have a desire to move into an ALF;
- Have a case manager employed by a waiver enrolled case management agency or by DCF;
- Meet one or more functional criteria as described in the Handbook.

Functional Criteria

Functional criteria for enrollment into the AL waiver include limitations in activities of daily living (ADLs). ADLs are defined as bathing, dressing, grooming, ambulating, eating, toileting, and transferring. To qualify for AL waiver assistance, the recipient must need an average of more than one hour of direct services per day and meet at least one of the following criteria:

- Require assistance with four or more ADLs or three ADLs plus supervision or administration of medication;
- Require total help with one or more ADLs;
- Have a diagnosis of Alzheimer's disease or another type of dementia and require assistance with two or more ADLs;
- Have a diagnosed degenerative or chronic medical condition requiring nursing services that cannot be provided in a standard ALF but are available in an ALF licensed for limited nursing or extended congregate care; or
- Be a Medicaid-eligible recipient who meets ALF criteria, awaiting discharge from a nursing facility placement and who cannot return to a private residence because of a need for supervision, personal care, periodic nursing services, or a combination of the three.

Service Requirements, *continued*

Level of Care Requirements

All applicants for AL 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

A case manager must conduct a comprehensive client assessment. For applicants age 60 and older, the assessment is conducted using a Department of Elder Affairs Assessment Instrument, DOEA Form 701B, (Sept 2008). For applicants 18 to 59 years of age, the assessment is conducted using the Department of Children and Families Adult Services Assessment Instrument CF_AA 3019.

The assessment will evaluate the recipient's health status, functional status, support system and living environment. The case manager must make a face-to-face 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. This form is available from DOEA's Web site at: http://elderaffairs.state.fl.us/english/pubs/pubs/doea701b_sep08.pdf. It is incorporated by reference in 59G-13.030, F.A.C. The Department of Children and Families Assessment Instrument, DCF Form CF-AA 3019, is available from DCF's website: http://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 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 Web site at: http://elderaffairs.state.fl.us/english/cares.php. It is incorporated by reference in 59G-13.030,F.A.C.

Service Requirements, *continued*

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 allow DOEA staff to access medical records. The signed Informed Consent Form must be submitted to CARES 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: http://elderaffairs.state.fl.us/english/cares.php. It is incorporated by reference in 59G-13.030, F.A.C. Note: See Appendix D in this handbook for a copy of the Notification of Level of Care, DOEA-CARES Form 603.
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 relevant 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. All AL waiver recipients must have a signed and dated LOC that includes the LOC's effective date. AL 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 beneficiary's case record. The case manager is required to track LOC reassessment in conjunction with the annual 701B reassessments to ensure that timely evaluations are conducted. 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 significant 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.

Service Requirements, *continued*

Recertification of Eligibility

Recipients enrolled in the AL 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, if needed, is completed, signed and dated by a physician. The case manager shall also complete the DOEA Form 701B.

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.

Freedom of Choice and Informed Choice

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

- Freedom of Choice is the right to choose between receiving services in an institution or receiving services through the AL waiver.
- Informed Choice is the right to choose from all available AL waiver services offered and all enrolled AL 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 AL 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 AHCA-Med Serv Form 3008 completed by the physician.

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 those who are 60 years old and older, if:

- The applicant meets the eligibility criteria for the ALwaiver; and
- Sufficient funding is available.

Service Requirements, *continued*

Recipient Enrollment into the Waiver, continued

Enrollment into the waiver for individuals 18 to 59 years old is determined by the Florida Department of Children and Families (DCF). The DCF Adult Protective Services Headquarters Program Office will determine when sufficient funding is available to enroll new recipients. Local Adult Protective Services staff or case management agencies will determine if the applicant meets eligibility criteria for the AL waiver program. Enrollment into the waiver is contingent upon the Legislature providing DCF with funding for the waiver.

AL Waiting List

The 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 maintain the AL waiver lists of prospective AL recipients who are 60 years and older that have been screened, appear to be eligible and in need of waiver services, and are waiting for waiver services.

The AL waiting list for adults with disabilities ages 18 to 59 is maintained at the DCF's Adult Protective Services Headquarters 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)(a)(c), Florida Administrative Code (F.A.C.). as follows:

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

(b) 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 defined by the Medicaid program and not be experimental or investigational;
4. Be reflective of the level of service that can safely be furnished, 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 beneficiary, the beneficiary's caretaker, or the provider.

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

Service Requirements, continued

Availability of Other Coverage Sources and Services

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.

However, this does not affect the services provided by the ALF to recipients under the AL's "assisted living services." These services are part of the waiver program, reimbursed to the facility and not accessed through state plan.

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 www.mymedicaid-florida.com. Select Public Information for Providers, then Provider Support, and then 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 available under this waiver, with reasonable promptness. The AL 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 AL 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 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.

Choice of Case Manager

Recipients have a right to select the case management provider 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.

Case Management Requirements, continued

Targeted Case Management

Individuals receiving home and community-based services cannot receive Mental Health Targeted Case Management (TCM) at the same time. 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;
- Provide the information and resources necessary for recipients and their families and caregivers 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;
- Upon request, assist the recipient with a fair hearing request;
- Attend all required meetings and training scheduled by the Medicaid Waiver Specialists or DOEA Tallahassee Office; and
- Comply with the policies in this handbook.

Case Management Requirements, continued

Visit Requirements

The case manager is required to:

- Maintain, at a minimum, face to face 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 to develop a new plan of care.

Limitations

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.

A case manager's caseload cannot exceed a maximum of either 60 individuals or a number specified by the Florida Legislature.

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

Note: See the Assisted Living Waiver Procedure Codes and Fee Schedule for the maximum reimbursement for case management. The Fee Schedule is available on the Medicaid fiscal agent's Web site at www.mymedicaid-florida.com. Select Public Information for Providers, then Provider Support, and then 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 AL waiver applicants with waiver enrollment and the Medicaid eligibility application process;
- Assisting AL waiver enrolled recipients with the annual redetermination for Medicaid eligibility;
- Conducting recipients' comprehensive assessment and update assessments for service needs;
- Developing and reviewing AL 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 quarterly and annual 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.

Case Management Documentation

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 and representative designation, if applicable, and permission forms, copies of assessments, evaluations, and medical and medication information;
- Legal documents 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;
- 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 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 www.mymedicaid-florida.com. Select Provider Support, and then Medicaid Forms. It is incorporated by reference in 59G-13.030, F.A.C.

Case Management Documentation, continued

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 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 AL 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 at a flat monthly rate that includes performing the case management activity and the actual time spent documenting activities in the case record.
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 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 frequency 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 DCF Assessment Instrument CF-AA 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 AL waiver services that are coordinated and monitored by a case manager.

In order for the AL provider to bill for ACS, the plan of care must show a need for ACS services as determined by a health assessment completed by a physician or other licensed practitioner of the healing arts. ACS must be coordinated and monitored by the AL case manager to ensure there is no duplication of services between the waiver plan of care and the facility's plan of care for ACS services provided to the recipient.

Note: For further information on ACS see the Assistive Care Services Coverage and Limitations Handbook available from the Medicaid fiscal agent's Web site at www.mymedicaid-florida.com. Select Public Information for Providers, then Provider Support, and then Provider Handbooks. It is incorporated by reference in 59G-4.025, F.A.C.

Plan of Care, *continued*

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 be in compliance with Rule 58A-1.010, F.A.C. and contain the following elements:

- Client name and Medicaid identification number;
- Case management agency name and Medicaid provider identification number;
- Client's assessed service needs;
- Types, frequency and duration of planned DOEA and non-DOEA services;
- The provider and associated costs of each planned service;
- Initiation, revision and termination dates of the care plan;
- An acknowledgement that the client or client's representative is involved in the development of the care; Client or representative and case manager signatures and date of signatures; and
- The facility administrator or designee's signature on the plan of care to acknowledge the services needed by the waiver recipient.

Plan of Care, *continued*

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 of the client's services. The plan of care should also include a client's individual goals for wellness.and 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. 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.

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 authorization for the AL waiver provider to provide waiver services. Service authorizations must not vary in amount, frequency or duration from the services specified in the current plan of care. The case manager must provide the ALF with the plan of care in advance of service provision. Without this authorization, the provider cannot be assured reimbursement. 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.

Plan of Care, continued

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.

The plan of care is considered authorized when it is signed and dated by the case manager.

Plan of Care Implementation, Review and Annual Assessment

Plan of Care Implementation and Review

The case manager implements the approved plan by:

- Identifying services to be provided by the facility;
- Monitoring the recipient's service needs on an ongoing basis to ensure that needs are being met;
- Performing monthly 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 representative 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. The necessity for plan of care reviews conducted more frequently than the quarterly review must be noted 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 is in agreement when changes are made to the plan of care.

Plan of Care Implementation, Review and Annual Assessment, continued

Assistive Care Services

Assistive Care Services (ACS) is a Medicaid state plan service available to eligible recipients receiving Optional State Supplementation (OSS) payments while enrolled in the AL waiver. These services are not covered services under the AL waiver, but must be included in the waiver plan of care.

The ACS components are health support, assistance with activities of daily living, assistance with instrumental activities of daily living, and medication assistance.

OSS recipients who are eligible for both ACS and AL waiver services must have a service plan in which services that are considered ACS are shown and identified separately from AL waiver services. The same entries are made for each ACS service component as for each AL waiver service.

Note: See the Assistive Care Services Coverage and Limitations Handbook for additional information on Assistive Care Services.

Increasing and Decreasing Service Authorizations

AL waiver recipients or their designated representatives may request additional services when the recipient's needs change or there is a change in the recipient's mental or physical condition.

When the AL recipient's condition or needs change, the recipient or the designated representative must contact the recipient's AL 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.

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.

Annual Assessment

AL 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.

Plan of Care Implementation, Review and Annual Assessment, *continued*

Termination of Services

Termination of waiver services 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 assisted living facility;
- The recipient chooses to terminate participation in the waiver program;
- 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 56G-4.180, F.A.C.; or,
- The recipient dies.

Waiver services must not be reimbursed while the recipient is hospitalized or in a nursing facility. The temporary suspension of AL 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 days in advance of terminating the service. If the beneficiary disagrees with the action being taken, the beneficiary 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 or Suspension of Services

When a recipient's participation in the AL waiver is terminated or suspended, the case manager must immediately:

- Notify the assisted living facility that the AL waiver services that are being provided to the recipient are cancelled;
- Notify the DCF ACCESS Office; and,
- Notify the recipient of the right to due process, if appropriate.

Plan of Care Implementation, Review and Annual Assessment, continued

Case Manager Responsibilities Regarding Termination or Suspension of Services, continued

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 the recipient's actions continue to be abusive and cannot be resolved by the assisted living facility's administration or staff, 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 or authorized representative must be given a ten day written notification of the proposed termination and right to a fair hearing.

Service Documentation Requirements and Provider Responsibilities

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 frequency of service deemed necessary in the plan of care..

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 AL waiver services or service components rendered to waiver recipients:

- If the ALF subcontracts services, provide the name of provider or provider agency rendering each service through the ALF to the recipient;
- Type of service provided;
- Amount of service provided;
- Date of service; and
- Place of service.

Case management documentation must clearly describe the activities associated with maintaining the recipient in the ALF setting. The documentation must show that services are consistent with the plan of care and are being delivered according to the plan. The plans of care and all the assessments must be in the recipient's case file at the ALF and available to DOEA, DCF and AHCA staff for the purposes of monitoring and surveying.

Service Documentation Requirements and Provider Responsibilities, continued

Facility Provider Responsibilities

ALFs are required by licensure to provide sufficient staff and a variety of services to all individuals residing in assisted living facilities.

The facility staffing for waiver recipients 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 recipient's assessment.

ALFs must provide 24-hour on-site staff to meet scheduled or unpredicted needs and to provide supervision for safety and security. AL waiver providers must also:

- Provide each recipient with a private room or apartment or a semi-private room or apartment shared with a roommate of the recipient's choice and consent;
- Develop a service plan for each AL waiver recipient;
- Provide all waiver services indicated in the service plan;
- Specify a staff member to serve as the facility supervisor authorized to sign service plans if the administrator does not perform this function;
- Provide all ALwaiver recipients with a personal needs allowance (PNA) in an amount equal to that set by Chapter 65A-2.036, F.A.C.;
- Comply with all provisions of the Medicaid Provider Agreement; and
- Cooperate with the AHCA surveyor staff and the DOEA or DCF monitoring staff and their designated representatives.

AL Waiver and Covered Services

Introduction

AL 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 assisted living facility provides the recipient with the approved services and bills for the reimbursement rate allowed under the AL waiver. The plan of care specifies services to be provided and the cost of these services

All AL waiver recipients must receive:

- Case management; and
- Assisted living services.

The receipt of incontinence supplies is based on need.

Note: See the Assisted Living Waiver Procedure Codes and Fee Schedule for the service-specific procedure codes and fees. The Fee Schedule is available on the Medicaid fiscal agent's Web site at www.mymedicaid-florida.com. Select Public Information for Providers, then Provider Support, and then Fee Schedules. It is incorporated by reference in 59G-13.031, F.A.C.

AL Waiver and Covered Services, continued

Case Management	Case management is a service that provides the ALwaiver recipient with a case manager who will identify, organize, coordinate, and monitor the services needed by the recipient. The case manager also assists the recipient to access needed services.
Assisted Living	Assisted living is a service that includes an array of components provided by or through the ALF in which the recipient resides. These components will be provided only when the recipient is not capable of performing them and where no relative, caretaker, community volunteer or agency, or third party payor is capable or responsible for their provision. Each recipient must have a resident contract with the ALF that specifies the resident's room and board costs and the services to be provided by the facility. Prior to including a service component into a recipient's plan of care, the case manager must examine the recipient's resident contract to determine if any needed service component is already covered by the facility's basic charges and would be considered duplicative. Duplicative service components must not be included or authorized in the plan of care.

AL Waiver and Covered Services, *continued*

Assisted Living Service Components

The following components are included in the assisted living service:

- Attendant call system;
- Attendant care;
- Behavior management;
- Chore services;
- Companion services;
- Homemaker services;
- Intermittent nursing;
- Medication administration;
- Occupational therapy;
- Personal care;
- Physical therapy;
- Specialized medical equipment and supplies;
- Speech therapy; and
- Therapeutic social and recreational services.

The criteria for provision of each component are explained as follows.

Attendant Call System Component

The attendant call system is an emergency response system for recipients who are at high risk of falling, becoming disoriented or experiencing some disorder that puts them in physical, mental, or emotional jeopardy requiring immediate assistance. The recipient either wears an electronic device (e.g., a medallion or a bracelet) or is in proximity to a button that enables the resident to summon emergency help from an ALF attendant. This component also includes alerting the attendant if the recipient wanders from the facility.

Attendant Care Component

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.

Behavior Management Component

Behavior management consists of specialized approaches to manage the behavior of recipients with dementia. These approaches are remedial measures aimed at preventing or improving disruptive behaviors. They may include supervision of recipients with behavior problems due to dementia and educational activities for training staff to respond to a recipients' behavior.

AL Waiver and Covered Services, continued

Chore Services Component	The chore component consists of services needed to maintain the home-like setting as a clean, sanitary, and safe environment. This component includes heavy household chores such as washing floors, windows and walls, tacking down loose rugs and tiles, and moving heavy items of furniture in order to provide safe access and egress.
Companion Service Component	The companion service component is provided to functionally impaired recipients and consists of non-medical care, supervision, and socialization. Companions may assist the recipient with activities such as meal preparation, laundry, and shopping, but do not perform these activities as a separate service. The provision of companion service does not entail hands-on medical care. Companions may perform light housekeeping tasks incidental to the care and supervision of the recipient. This component is provided in accordance with a therapeutic goal in the plan of care and is not intended to be provided as a leisure or entertainment activity.
Homemaker Component	The homemaker component consists of general household activities (meal preparation and routine household care) provided by staff or a trained homemaker.
Intermittent Nursing Component	Intermittent nursing consists of services provided by a licensed nurse on an as-needed basis to ensure therapeutic regimens such as changing dressings, administering medications, assessing the recipient's state of health, and other activities within the scope of the nursing practice. Medicaid does not reimburse for continuous nursing services provided to AL waiver recipients.

AL Waiver and Covered Services, *continued*

Medication Administration Component

Medication administration, supervision and assistance may be provided to AL waiver recipients as long as qualified staff is available to render the service component.

Medication supervision and administration can only be provided by licensed nurses. ALF staff should be aware of DOEA's requirement that assistance with self-administered medications can be provided either by a licensed nurse or, with a documented request and informed consent, an unlicensed staff member. The unlicensed staff member must be trained to assist residents with self-administered medications, in accordance with Chapter 58A-5.0191(5), Florida Administrative Code, and must demonstrate the ability to accurately read and interpret a prescription label.

Pursuant to 429.256, Florida Statutes, assistance with self-administration of medications includes taking the medication from where it is stored and delivering to the resident; removing a prescribed amount of medication from the container and placing it in the resident's hand or another container; helping the resident by lifting the container to their mouth; applying topical medications; and keeping a record of when a resident receives assistance with self-administration of the medications.

Occupational Therapy Component

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. Please refer to the Florida Medicaid Therapy Services Coverage and Limitations Handbook for information on services covered by this program.

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

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

AL Waiver and Covered Services, continued

Case Manager Responsibilities

The case manager must:

- Ensure that the physician's prescription is obtained by the facility 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 is receiving benefits from, and wishes to continue, the service.

Personal Care Component

Personal Care services provide assistance with eating, bathing, dressing, personal hygiene, and other activities of daily living. This component may provide assistance with the preparation of meals. 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, provided by the assisted living facility under the AL Waiver Program, differ in service definition and provider type from the services offered under the Florida Medicaid Home Health Program.

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).

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).

Physical Therapy Component

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. Please refer to the Florida Medicaid Therapy Services Coverage and Limitations Handbook for information on services covered by this program.

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

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 Handbooks. It is incorporated by reference in 59G-4.320, F.A.C.

ALWaiver and Covered Services, *continued*

Case Manager Responsibilities

The case manager must:

- Ensure that the physician's prescription is obtained by the facility 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 is receiving benefits from, and wishes to continue, the service.

Specialized Medical Equipment and Supplies Component

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.

Items reimbursed with waiver funds shall be in addition to any medical equipment and supplies furnished under the Medicaid Durable Medical Equipment and Medical Supply Services program and will exclude those items which are not of direct medical or remedial benefit to the individual. A physician's prescription is required for Specialized Medical Equipment and Supplies under the waiver. 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
The case manager's responsibility in providing and approving this service includes the following:

- 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 beneficiary'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 regular Florida Medicaid Durable Medical Equipment and Medical Supply Services program 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.

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 www.mymedicaid-florida.com. Select Public Information for Providers, then Provider Support, and then Provider Handbooks. It is incorporated by reference in 59G-4.070, F.A.C.

AL Waiver and Covered Services, *continued*

Speech-Language Pathology Component	Speech-Language Pathology services involve the evaluation and treatment of speech-language disorders. It is provided when medical diagnosis indicates a need for treatment of speech and language disorders that result in a communication disability. This component is limited to the evaluation and treatment of speech disorders, such as aphasia, which result from stroke and cerebral trauma, dementia, or other degenerative neurologic diseases affecting oral motor functions. Please refer to the Florida Medicaid Therapy Services Coverage and Limitations Handbook for information on services covered by the program. Speech-Language Pathology therapy services must be provided by licensed speech-language pathologists or a certified speech-language pathology assistant under the supervision of a licensed speech-language pathologist. The Speech-Language Pathology Therapist must be currently licensed under Chapter 468, Florida Statutes. Note: The Florida Medicaid Therapy Services Coverage and Limitations Handbook is available on the Medicaid fiscal agent's Web site at www.mymedicaid-florida.com. Select Public Information for Providers, then Provider Support, and then Provider Handbooks. It is incorporated by reference in 59G-4.320, F.A.C.
Therapeutic Social and Recreational Services Component	The therapeutic social and recreational services component allows the ALF to provide activities to improve the mobility, motor skills, or alertness of AL waiver recipients. These activities may also serve to divert the attention and enhance the quality of life of waiver recipients with dementia.
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 AL waiver program. Disposable briefs and diapers must meet the Quality Standards for Briefs and Diapers.

Assistive Care Services and the Waiver

Assistive Care Services and the Waiver

Assistive care services are a Medicaid state plan service that AL waiver providers may provide to their waiver recipients receiving Optional State Supplementation (OSS). Assistive care services are not an AL waiver service. The OSS is a cash assistance program for low-income individuals. Its purpose is to supplement a person's income to help pay for room and board costs of an assisted living facility, mental health residential treatment facility or adult family care home.

Note: For reimbursement information for ACS see Chapter 3 of the handbook.

All applicable requirements, procedures and policies regarding the provision of Assistive Care Services (ACS) may be found in the Assistive Care Services Coverage and Limitations Handbook and must be followed by the ALF providing ACS to Optional State Supplementation (OSS) recipients.

A recipient of ACS must require an integrated set of services on a 24-hour basis and must have a health assessment by a physician or other licensed practitioner of the healing arts (Physician Assistant, Advanced Registered Nurse Practitioner, Registered Nurse) acting within the scope of their practice under state law establishing the medical necessity of at least two of the four service components and the need for at least one specific ACS each day.

The following components can be provided under the assistive care service plan:

- Health support;
- Assistance with activities of daily living (ADLs);
- Assistance with instrumental activities of daily living (IADLs); and
- Assistance with self-administration of medication.

Each of the service components are described below.

Health Support Component

Health support is defined as requiring the provider to:

- Observe the recipient's whereabouts and well-being on a daily basis;
- Remind the recipient of any important tasks on a daily basis; and
- Record and report any significant changes in the recipient's appearance, behavior, or state of health to the recipient's health care provider, designated representative, or case manager.

Assistance with Activities of Daily Living (ADLs) Component

Assistance with activities of daily living (ADLs) is defined as providing assistance with one or more of the following activities: individual assistance with ambulating, transferring, bathing, dressing, eating, grooming, and toileting. At least one service must be required daily.

Assistive Care Services and the Waiver, continued

Assistance with Instrumental Activities of Daily Living (IADLs) Component	Assistance with instrumental activities of daily living (IADLs) is defined as providing intensive assistance with one or more of the following activities: individual assistance with shopping for personal items, making telephone calls, and managing money.
Assistance with Self-Administration of Medication Component	Assistance with self-administration of medication is defined as assistance with, or supervision of, self-administration of medication at least daily in accordance with licensure requirements applicable to the facility type. Note: See the definition and requirements for assistance with self-administration of medication under the previous heading: Medication Administration Component.

Placement and Discharge

Introduction	Residency in an AL-enrolled ALF is a requirement of eligibility for receipt of AL services. If a recipient has met all the criteria for receipt of AL services except placement into an AL-enrolled ALF or is in one ALF and will be moving to another, according to the circumstances, denial of waiver services or termination from the AL waiver may be necessary. Any time this occurs, the affected recipient will be advised of his appeal rights.
Nursing Facility Placement	If a recipient who is receiving AL services becomes too debilitated to remain in the ALF, the ALF in coordination with the case manager will contact CARES for an assessment and recommendation for appropriate nursing facility placement. Any time a nursing facility placement is necessary for an AL waiver recipient who receives Optional State Supplementation (OSS) payments, the placement must be coordinated with the DCF ACCESS Office.
Move to Another ALF	If a recipient requests to move or is moved: • From one AL-enrolled facility to another AL-enrolled facility, the case manager will assist in coordinating the placement and the recipient will remain eligible to receive AL services in the new ALF; or • From one AL-enrolled ALF to an ALF that is not an AL-enrolled waiver provider, the case manager will terminate the recipient from the AL waiver and services will be discontinued. Any time a change in facilities is necessary for a recipient who receives Optional State Supplementation (OSS) payments, the change must be coordinated with the DCF ACCESS Office.

Placement and Discharge, continued

ALF Discharge Requirements	If an ALF administrator initiates discharge of an AL recipient from the ALF, the discharge must be done in accordance with the facility's written policies and the recipient or recipient's designated representative or guardian must be given appropriate notice in accordance with Chapter 58A-5, Florida Administrative Code.

Hospice Election for AL 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 E 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 and 59G-13.030, F.A.C.
Recipient Eligibility	AL waiver recipients who elect hospice do not require a referral to the DCF ACCESS Office to determine eligibility for the hospice program.
Coordination of Hospice and AL 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 must notify the hospice care coordinator or case manager. The hospice care coordinator or case manager will provide to the waiver case manager the Notice of Hospice Election Waiver, AHCA Form 5000-29. 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 E 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 and 59G-13.030, F.A.C.

Hospice Election for AL Waiver Recipients, continued

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	AL waiver recipients 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.
Right to a Fair Hearing	In accordance with Chapter 42, Section 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 AL recipient of the right to a fair hearing. AL 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 & 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 AL 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, AL waiver case managers must assist recipients with the fair hearing process.

Appeal Rights and Fair Hearing Process, continued

Continuation of Benefits	If the AL 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 AL 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 AL 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
ASSISTED LIVING WAIVER SERVICES PROCEDURE CODES AND FEES

Overview

Introduction

This chapter provides and describes the procedure codes, maximum units of service and approved fees for the Assisted Living (AL) waiver.

In This Chapter

This chapter contains:

Reimbursement Information

Introduction

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 the descriptions are copywritten by the American Medical Association. All rights reserved.

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 www.mymedicaid-florida.com. Select Public Information for Providers, then Provider Support, and then Provider Handbooks.

Reimbursement Information, continued

Introduction, continued

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 AL waiver services are paid on a capitated basis. Under a capitated payment, the provider is paid a set fee for each service performed and billed.

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 copywritten 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

General Information

Case managers must coordinate access to services through all available funding sources prior to accessing waiver services. Services cannot be provided under a 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. Waiver

No service may be provided under a 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.

Reimbursement Information, continued

Services and the Hierarchy of Reimbursement, continued

If a 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 home health agency for Medicare reimbursable services provided to a dual-eligible recipient.

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

Case managers may authorize 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

AL waiver providers may bill for three waiver services and one state plan service (Assistive Care Services) provided in their facilities. Each procedure code listed on the Assisted Living Waiver Procedure Code and 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;
- The maximum fee that Medicaid will reimburse for the service.
-

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

Maximum Fees

Medicaid reimburses AL waiver assisted living and case management services at the maximum fee. Incontinence supplies are reimbursed according to use but at no more than the maximum allowed fee.

Reimbursement Information, continued

Case Management Reimbursement	Case management activities in the AL waiver are paid on a fixed monthly rate. Reimbursement will be made if case management activities were provided for a recipient for any portion of the month.
Billing for Case Management	AL case management services are billed once a month. The date of service (DOS) is always the last day of the month for which reimbursement is requested. However, if the recipient is admitted to a hospital or a nursing facility, the DOS must be the day before the recipient's admission in order for case management to be reimbursed. Reimbursement will be made if case management activities were provided for a recipient for any portion of the month.
Transition Case Management Reimbursement	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. Case management providers may not bill for both transition case management and waiver case management in the same month.
Incontinence Supplies Service	Medically-necessary incontinence supplies not provided by Medicaid state plan or in excess of the state plan limits may be reimbursed through the AL waiver program. Disposable briefs and diapers must meet the Quality Standards for Briefs and Diapers. This service is billed once a month using the last day of the month for which reimbursement is being requested. The total billing should represent the amount of the number of incontinence supplies used by the waiver consumer. Individual waiver incontinence supplies must be maintained in a separate location and AL providers must keep accurate monthly records of supplies used by individual waiver consumers. However, if the recipient is admitted to a hospital or a nursing facility, the date of service (DOS) must be the day before the recipient's admission in order for incontinence supplies to be reimbursed.

Reimbursement Information, continued

Reimbursement for Assisted Living Service and Assistive Care Services Components	The assisted living service components are reimbursed at a single per diem rate according to the number of days the recipient is present and receiving services in the facility while enrolled in the AL waiver. Only the facility may bill for providing the AL waiver client for the assisted living service components. The single per diem rate is considered payment in full. Assistive care service components for eligible Optional State Supplementation (OSS) recipients are also reimbursed by the number of days (i.e., units) the recipient resides in the facility. The total numbers of units are billed once a month using the last day of the month for which reimbursement is requested as the date of service (DOS). The billing method should be consistent, preferably once per month. However, if the recipient is admitted to a hospital or a nursing facility, the last DOS must be the day before the recipient's admission. Reimbursement will not be made for any continuous 24-hour period that the recipient is temporarily absent from the facility. Note: See the Assistive Care Services Coverage and Limitations Handbook for additional information on assistive care services. It is available on the Medicaid fiscal agent's Web site at www.mymedicaid-florida.com.
Total Reimbursement	The total monthly reimbursement for each AL wavier recipient (excluding incontinence supplies) is the daily rate times the number of days in the month.

Reimbursement Information, continued

Daily Billing for Assisted Living Waiver and State Plan Service Components

The ALE Worksheet is no longer used to calculate daily service reimbursement under the waiver program. The facility will be reimbursed for providing the waiver assisted living services at $32.20 per day, per waiver recipient. This does not affect the personal responsibility for room and board or the OSS recipient's payment to the facility for room and board. These payments are between the ALF and the recipient.

AL waiver recipients must be present in the ALF for some period each day that is billed for assisted living services. However, no billing is permitted for partial days of service.

When the AL resident is transferring between two AL assisted living facilities, the discharging facility may not bill for the day of discharge and the admitting facility may bill for the day of admission.

When the AL recipient is transferring to a hospital or nursing home or leaving for a temporary absence, the AL facility cannot bill for the date the recipient leaves the AL facility.

When the AL resident is returning to the AL facility from a hospital, nursing home stay, or other temporary absence, the AL facility can bill for the date of return.

Recipient Responsibility for Room and Board

The room and board monthly amount is part of the private contract or agreement between the ALF and the recipient. The waiver is prohibited from paying room and board in an ALF. The financial responsibility for room and board is agreed to between the recipient and the facility and it is the facility's responsibility to collect this payment. It has no effect on the daily reimbursement rate for assisted living services ($32.20 per day) or any other services under the waiver.

However, each waiver recipient is to receive a personal needs allowance of $54.00 per month for personal expenditures out of the monthly room and board fee. The personal needs allowance should be received by the recipient within the first ten days of the month. The facility may not determine how the personal needs allowance is used by the recipient.

Reimbursement Information, continued

Contributions

The AL waiver provider may not take contributions from family or other parties as a requirement to serve a recipient under the AL waiver. AL providers must agree to accept the AL applicant based upon the individual's financial ability to cover the ALF room and board costs from the applicant's personal financial resources. The ALF may not solicit contributions from family or third parties to cover these expenses.

Upon initial enrollment and subsequent annual level of care redeterminations of AL participants, AL case managers must verify that family members or other third parties have not been required to make contributions in order for the AL provider to serve the waiver applicant or recipient.

Family or third parties may make voluntary contributions to an AL provider. However, regular monthly, quarterly, or yearly contributions will cause the AL waiver program case managers to closely monitor any AL waiver enrollments in that ALF.

ALE Waiver Program Monitoring and Claims

The AL 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 DOEA's Monitoring and Quality Assurance Unit to monitor compliance with AL waiver policies.
- The Monitoring and Quality Assurance Unit visits specific ALFs and talks with AL waiver recipients to ensure the recipients are receiving needed services and are satisfied with the ALF.
- Case files that do not comply with AL 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

AL waiver service providers must use the modifiers with the procedure codes listed on the Assisted Living Waiver Procedure 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 the Florida Medicaid Provider Reimbursement Handbook, CMS-1500, for additional information on entering modifiers on the claim form

APPENDIX A

DEPARTMENT OF ELDER AFFAIRS ASSESSMENT INSTRUMENT, DOEA FORM 701B

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)

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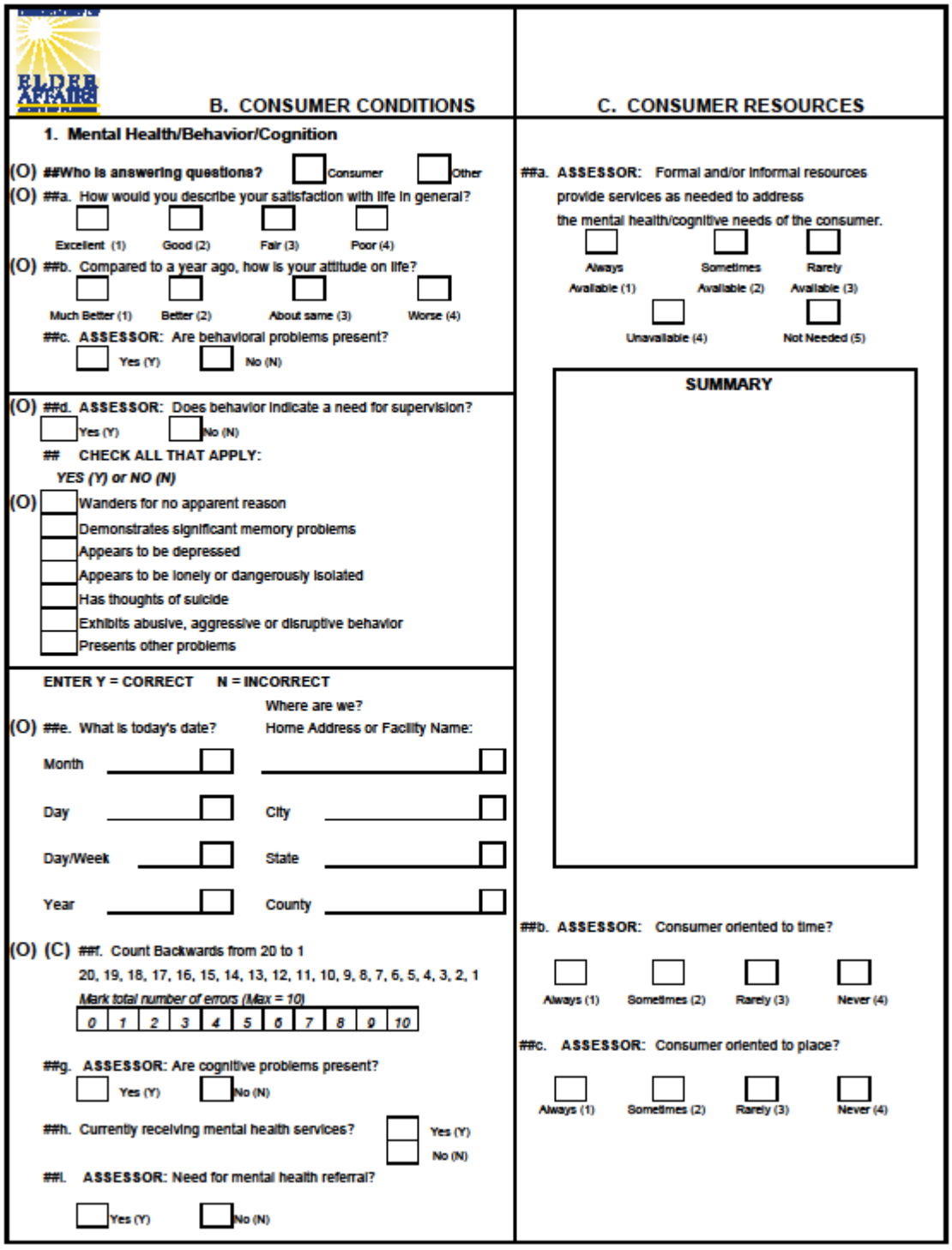

B. CONSUMER CONDITIONS

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)

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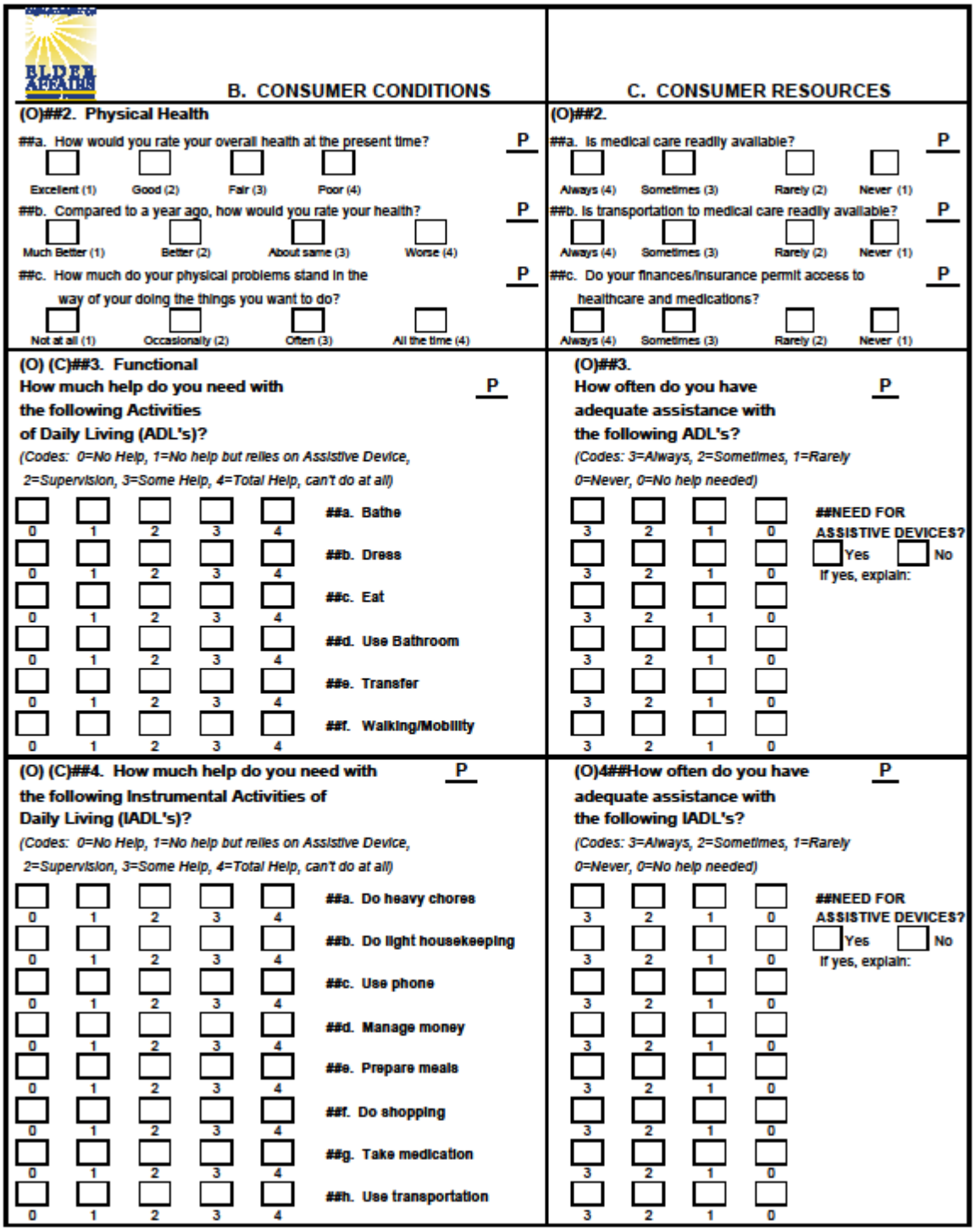

B. CONSUMER CONDITIONS

(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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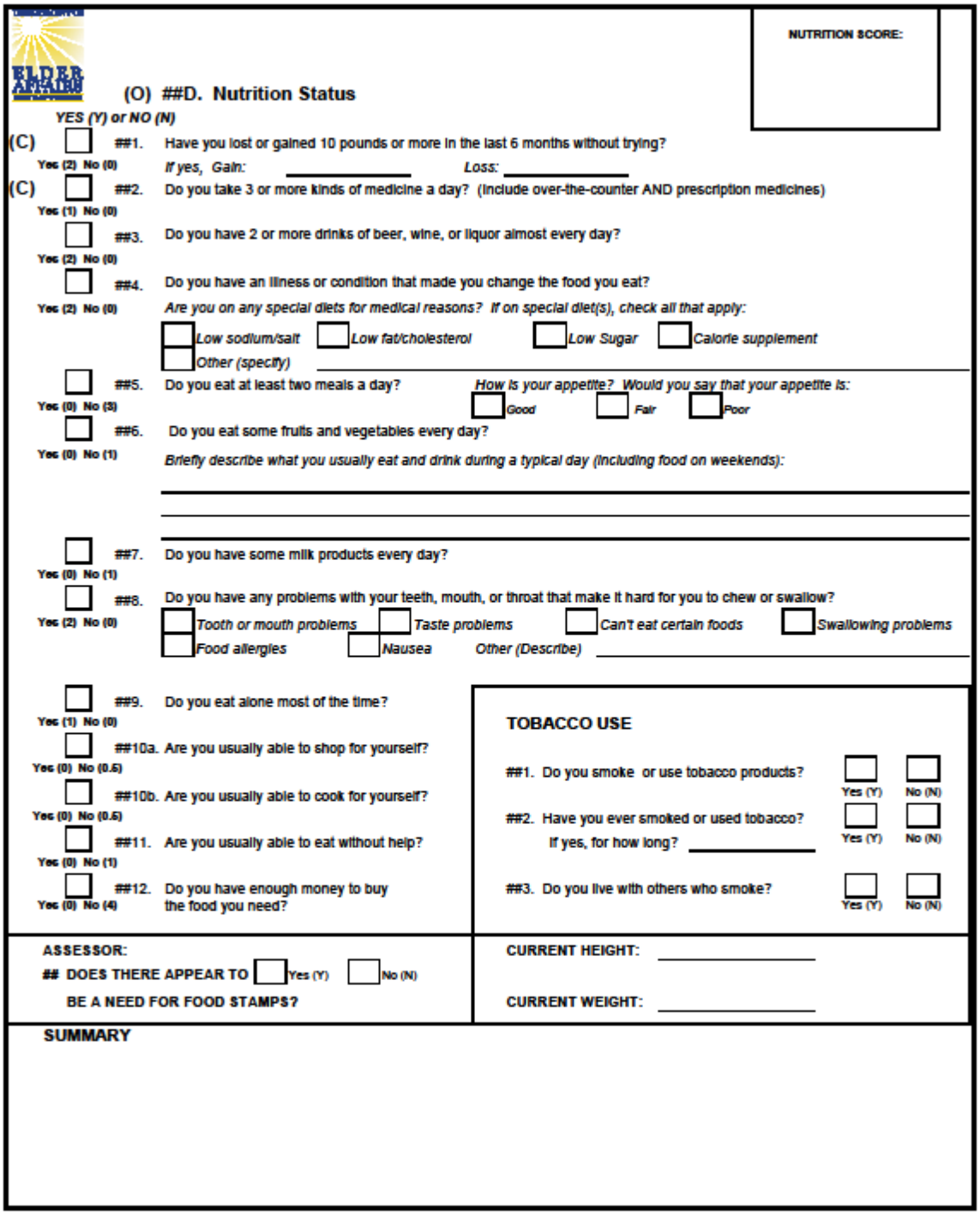

NUTRITION SCORE:

(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 ☐ Yes (Y) ☐ No (N)
BE A NEED FOR FOOD STAMPS?

CURRENT HEIGHT: _____

CURRENT WEIGHT: _____

SUMMARY

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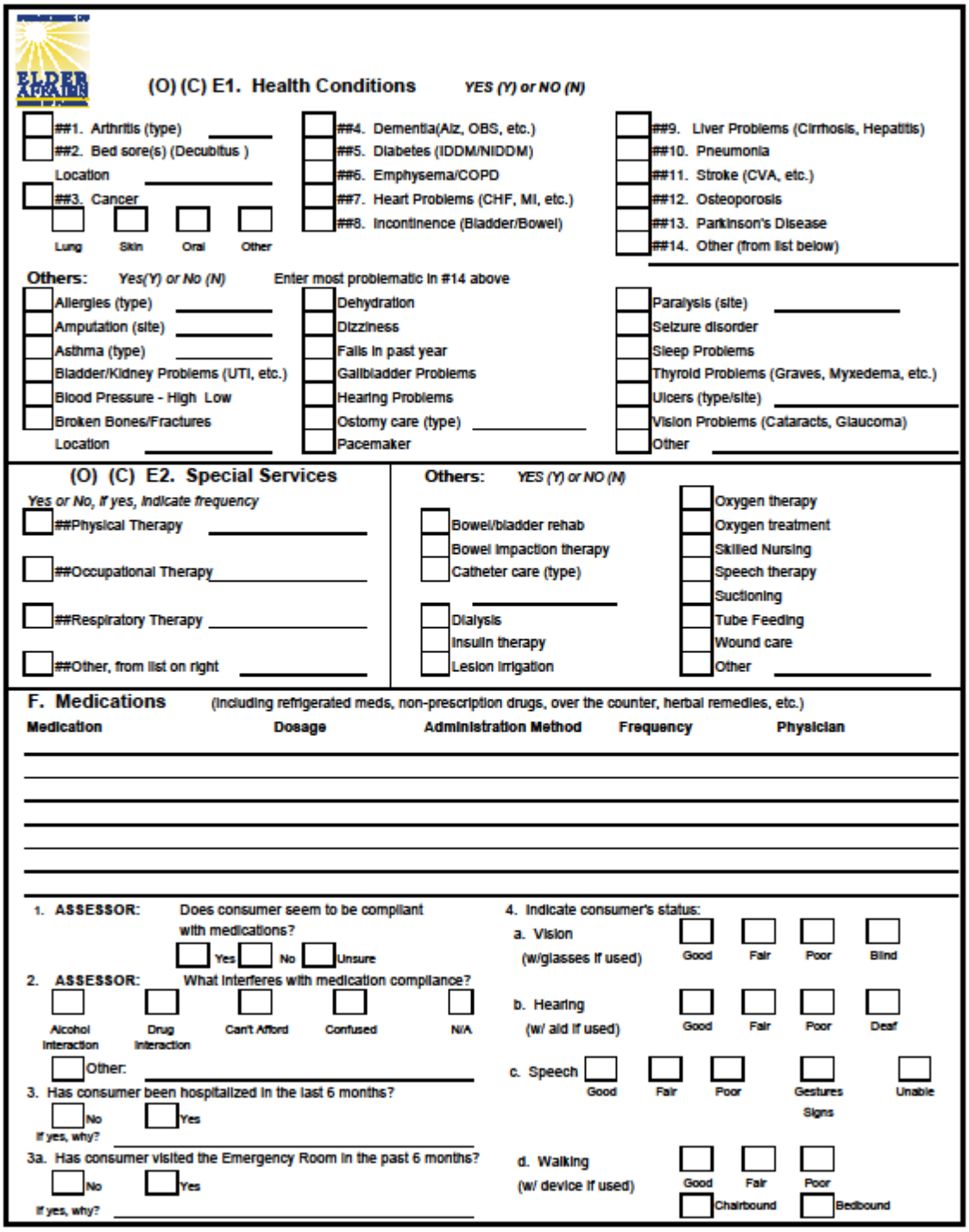

ELDER AFFAIRS

(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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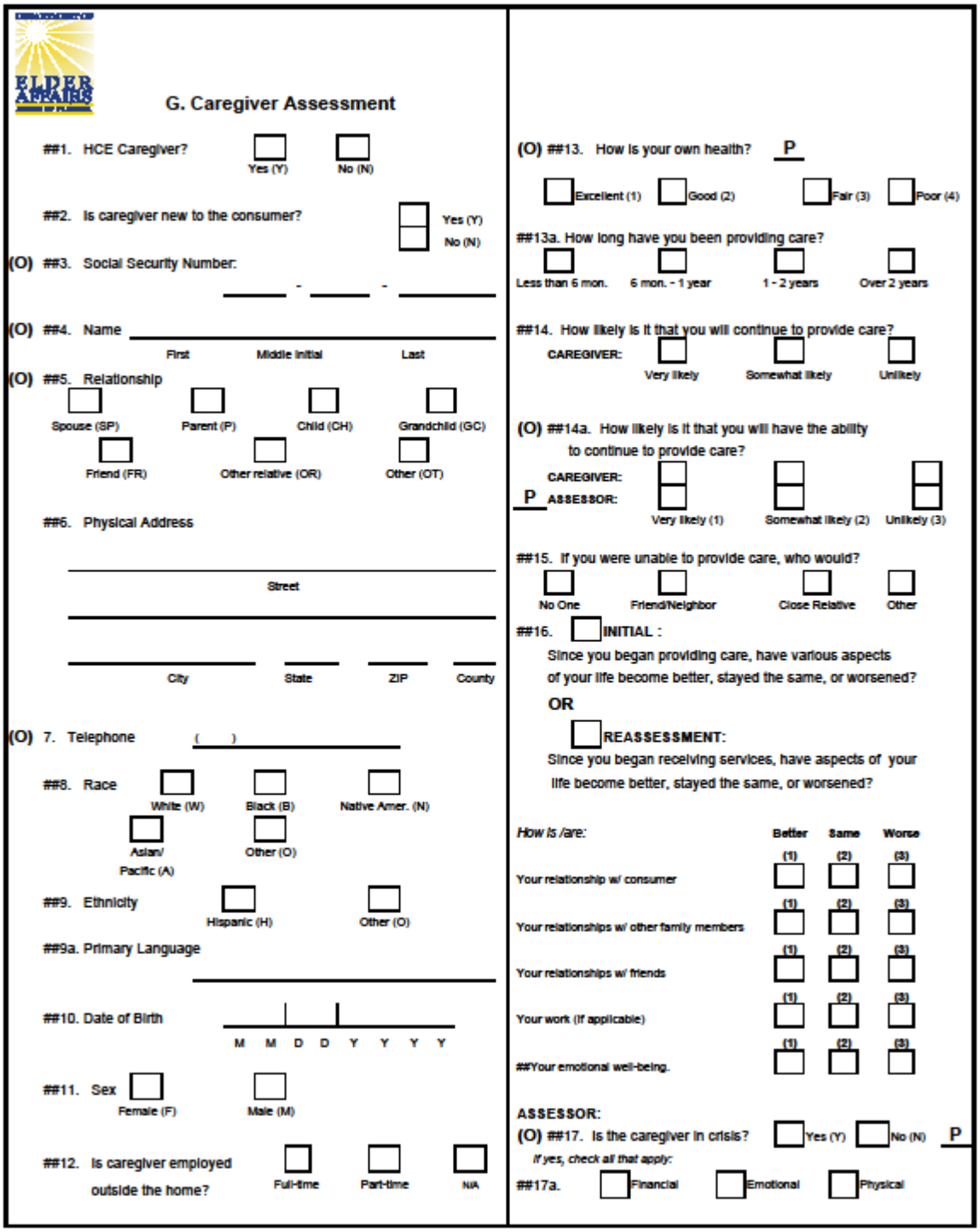

G. Caregiver Assessment

##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.

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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			

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APPENDIX B

DEPARTMENT OF CHILDREN AND FAMILIES
ADULT SERVICES CLIENT ASSESSMENT, FORM CF-AA 3019

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?

Health Condition	Present	Interferes with Living	Condition Not Under Treatment
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.

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 ☐

CF-AA 3019, PDF 10/2005

II. FUNCTIONAL ASSESSMENT

III. CLIENT SUPPORT ASSESSMENT Page 3

FUNCTIONAL ASSESSMENT Do you need someone to assist you with: Activities of Daily Living (ADLs)	No Help	Some Help/Supervision	Total Assistance
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) ____

CF-AA 3019, PDF 10/2005

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,

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

Comments / Functional and Client Support Assessment Sections:

CF-AA 3019, PDF 10/2005

IV. ENVIRONMENTAL ASSESSMENT

Page 5

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)

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	≤3		6-11		12-17		18-24		25-31		
Functional - IADLs	≤3		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

CF-AA 3019, PDF 10/2005

VI. COGNITIVE ASSESSMENT

(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.							
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)

weighted risk score: (0-4 = Low) (5-9 = Moderate) (10-28 High)

Total Weighted Error Score: _____

CF-AA 3019, PDF 10/2005

VII. MENTAL HEALTH/SUBSTANCE ABUSE ASSESSMENT

(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.)

Assessor's rationale and concerns regarding indication(s) of mental health issues/substance abuse:

CF-AA 3019, PDF 10/2005

VIII. CAREGIVER ASSESSMENT

(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:

CF-AA 3019, PDF 10/2005

APPENDIX C

MEDICAL CERTIFICATION FOR NURSING FACILITY HOME AND COMMUNITY BASED SERVICES FORM, AHCA MED SERV FORM 3008

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** _____/_____/_____

(B) DEMOGRAPHIC INFORMATION

Individual's DOB _____/_____/_____ Sex _____ Race _____

Individual's Last Name First Name

Individual's Address

Nearest Relative/Health Care Surrogate P

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)

Date _____/_____

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
   - ☐ 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 inpatient care? Yes ☐ No
9. Does the individual require nursing facility services for the condit he/she received care in the hospital? Yes ☐ No
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 DOE

AHCA-Med Serv Form 3008, May 2009 --(Replaces Patient Transfer and Continuity of Care Form 3008 July 2006 - CF Med 3008)

APPENDIX D

INFORMED CONSENT FORM, AHCA-MED SERV FORM 2040

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, Incorporated by reference in 59G-4.200, F.A.C.

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, Incorporated by reference in 59G-4.200, F.A.C.

APPENDIX E

NOTIFICATION OF LEVEL OF CARE, DOEA-CARES FORM 603

DEPARTMENT OF ELDER AFFAIRS STATE OF FLORIDA

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 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 _____ **. If you are not in accord with the hospice service start date, contact**

Date

_____

Name

at _____ **immediately.**

Phone Number

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** _____

AHCA 5000-30, October 2003 (59G-4.140, F.A.C.)

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.)