Companion Services

Description

Companion services consist of non-medical care, supervision and socialization activities provided to an adult on a one-on-one basis or in groups not to exceed three recipients. This service must be provided in direct relation to the achievement of the recipient's goals per his support plan. A companion provider may also assist the recipient with such tasks as self-care needs, meal preparation, laundry and shopping; however, these activities shall not be performed as discrete services. This service does not entail handson medical care. Providers may also perform light housekeeping tasks, incidental to the care and supervision of the recipient. The service provides access to community-based activities that cannot be provided by natural or other unpaid supports, and should be defined as activities most likely to result in increased ability to access community resources without paid support. Companion services may be scheduled on a regular, long-term basis.

Companion services are not merely diversional in nature, but are related to a specific outcome or goal(s) of the recipient. Examples of acceptable companion activities are volunteer activities performed by the recipient as a pre-work activity; going to the library, getting a library card, learning how to use the library and checking out books or videos for personal use; shopping for groceries; or going to an animal shelter to learn about animals, and volunteering or assisting at the animal shelter.

This service is not available to individuals enrolled on the DD Waiver – Tier Four.

Limitations

Providers of companion services are limited to the amount, duration, and scope of the services described on the recipient's support plan and current approved cost plan. A recipient shall receive no more than six hours or 24-quarter hour units of these services per day. A unit is defined as a 15-minute time period or a portion thereof.

A recipient is limited to no more than 30 hours a week of companion services. The unit value is 15 minutes. Companion services are used to provide a meaningful day activity for a recipient. A recipient may not receive a combination of ADT, companion or supported employment services that exceeds 30 hours per week. A recipient may not receive more than a total of 30 hours a week of a paid support, or combination of paid supports designed to be used as a meaningful day activity. The companion rate shall be based on one to three recipients receiving the service during the same time interval. The rate ratio is determined by what is the usual and customary service delivery pattern and does not fluctuate with incidental absences of one or more recipients included in the rate ratio.

Companion services are limited to adults only (21 or older). Recipients may not receive this service in the provider's home. This service cannot be provided concurrently (at the same time) with adult day training, personal care assistance, in-home support services (quarter hour), supported employment and residential habilitation services.

Documentation Requirements

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

1. *Copy of claim(s) submitted for payment;
2. *Copy of service log.

The provider must submit a copy of service log, monthly, to the waiver support coordinator.

If the provider plans to transport the recipient in his private vehicle, at the time of enrollment, the provider must be able to show proof of valid: 1) driver's license, 2) car registration, and 3) insurance. Subsequent to enrollment, the provider is responsible for keeping this documentation up-to-date.

*Indicates reimbursement documentation.

Place of Service

Companion services may be provided in the recipient's own home or family home, or while a recipient who lives in his own home, family home or licensed facility is engaged in a community activity. Companion services provided to a recipient living in a licensed group or foster home must be performed in the community, not the licensed living environment. No service may be provided or received in the provider's home.

Special Considerations

Companion services are provided in accordance with an outcome on the recipient's support plan and are not merely a diversion.

If the provider plans to transport the recipient in his private vehicle, at the time of enrollment, the provider must be able to show proof of valid: 1) driver's license, 2) car registration, and 3) insurance. Subsequent to enrollment, the provider is responsible for keeping this documentation up-to-date.

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

Personal Care Assistance

Description

Personal care assistance is a service that assists a recipient with eating and meal preparation, bathing, dressing, personal hygiene, and other self care activities of daily living. The service also includes activities such as assistance with meal preparation, bed making and vacuuming when these activities are essential to the health, safety and welfare of the recipient and when no one else is available to perform them. This service is provided on a one-on-one basis. Personal care assistance may not be used solely for supervision. Personal care assistance may not be used as a substitute for a meaningful day activity.

This service is not available to individuals enrolled on the DD Waiver – Tier Four.

Limitations

Personal care assistance is limited to the amount, duration and scope of the services described in the recipient's support plan and current approved cost plan. A recipient shall receive no more than 180 hours a month, or 720 quarter hour units of this service per month. A recipient having intensive physical, medical, or adaptive needs meeting the requirements for the intense level of personal care assistance, who needs additional hours over 180 to maintain their health and medical status, may request additional hours of personal care assistance services. The requested additional units must be prior authorized by APD.

Personal care assistance services shall be billed at the standard rate level for the service based on the published rate system. The standard rate is paid when a recipient requires minimal support through instructional prompts, cues, and supervision to properly complete the basic personal support areas of eating, bathing, toileting, grooming, and personal hygiene. Standard and moderate level needs for the service cannot exceed 180 hours or 720 quarter hour units of the service per month. A rate other than the standard rate level for this service shall only be authorized when it has been determined through use of the APD-approved assessment and the support planning process that a recipient requires an enhanced level of supports.

The need for an enhanced rate and the approved rate level shall be identified in the recipient's support and cost plan and on the authorization for service submitted to the provider by the recipient's support coordinator. Recipients with the following needs may require enhanced services:

- Recipients who have a moderate level of support identified in the current abilities section of the APD-approved assessment may receive the rate level identified as moderate for the service. The moderate rate is paid when a recipient routinely requires prompts, supervision and physical assistance, to include lifting and transferring, to complete the basic personal care areas of eating, bathing, toileting, grooming, and

personal hygiene. Moderate needs for the service cannot exceed 180 hours or 720 quarter hour units of the service per month.

- Recipients who have an intense level of support identified in the current abilities section of the APD-approved assessment may receive the rate level identified as intense for the service. The intensive rate is paid when a recipient requires total physical assistance, to include lifting and transferring, in at least three of the basic personal care areas identified above due to physical, medical or adaptive limitations. Additional hours a month over the 180 hour limit may be requested for intensive physical, medical or adaptive needs when the hours are essential to maintain the recipient's health and medical status. Any recipient who requires PCA services between 10:00 p.m. and 6:00 a.m. shall provide documentation from a physician stating that PCA services are medically necessary during this time. The support plan shall also explain the duties that a PCA provider will perform between the hours of 10:00 p.m. and 6:00 a.m.

This service cannot be provided concurrently (at the same time) with companion services or ADT services. Recipients who receive in-home support services are not eligible to receive personal care assistance.

Note: Refer to the Florida Medicaid Home Health Services Coverage and Limitations Handbook for additional information on Medicaid State Plan coverage. The handbook is available on the Medicaid fiscal agent's Web site at www.mymedicaid-florida.com . Select Public Information for Providers, then on Provider Support, and then on Provider Handbooks. The handbook is incorporated by reference in 59G-4.130, F.A.C.

Documentation Requirements

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

1. *Copy of claim(s) submitted for payment; and
2. *Copy of service log.

The provider must submit a copy of service log, monthly, to the waiver support coordinator.

If the provider plans to transport the recipient in his private vehicle, at the time of enrollment, the provider must be able to show proof of valid: 1) driver's license, 2) car registration, and 3) insurance. Subsequent to enrollment, the provider is responsible for keeping this documentation up-to-date.

*Indicates reimbursement documentation.

Place of Service

Personal care assistance shall be provided in the recipient's own home or family home or while the recipient who lives in one of those arrangements is engaged in a community activity. No service may be provided or received in the provider's home, a hospital, an ICF/DD or other institutional environment.

Special Considerations

Personal care assistance for persons under the age of 21 may be provided through Medicaid Home Health State Plan Program services. Recipients who live in their own home or adults that live in a family home may require personal care assistance to assist them with meeting their own personal care needs.

For recipients living in their own home, consider the physical limitations or abilities to meet daily personal care assistance needs.
Recipients living in foster or group homes are not eligible to receive this service, except:

- During an overnight visit with family or friends away from the foster or group home to facilitate the visit; or
- When a group home resident recovering from surgery does not require the care of a nurse, and the group home operator is unable to provide the personal attention required to insure the recipient's personal care needs are being met. Under these circumstances, it would be considered reasonable to provide this service to a group home resident only on a time-limited basis. Once the recipient has recovered, the service must be discontinued.

A relative is defined as someone other than a legally responsible family member, who is required to provide care for the recipient such as a parent of a minor child or a family member who is also a plenary guardian of an adult. With regard to relatives providing this service, controls must be in place to make sure that the payment is made to the relative as a provider only in return for specific services rendered; and there is adequate justification as to why the relative is the provider of care. An example of a viable reason may be lack of providers in a rural area.

Personal care assistance is monitored through the statewide quality assurance program for waiver services and the recipient's or family's contact with the waiver support coordinator. The recipient or family member should contact the waiver support coordinator when concerns arise or if needs change. The waiver support coordinator must request changes to the care plan to increase or decrease services based on a significant change in the recipient's condition or circumstance and must submit the changes to the APD Area Office for approval.

Reimbursement for nursing oversight of services provided by home health agencies and nurse registries is not a separate reimbursable service. The cost must be included in the personal care service.

Personal care assistance providers are not reimbursed separately for transportation and travel cost. These costs are included in the rate.

Respite Care

Description

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

Limitations

Respite care service providers are not reimbursed separately for transportation and travel cost. These costs are integral components of respite care services and are included in the basic fee.

Respite care services are limited to the amount, duration, and scope of the service described on the recipient's support plan and current approved cost plan. The amount of respite services are determined individually and limited to no more than thirty days per year, (720 hours) per recipient.

Documentation Requirements

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

1. *Copy of claim(s) submitted for payment; and
2. *Service log.

The provider must submit a copy of service log, monthly, to the waiver support coordinator.

If the provider plans to transport the recipient in his private vehicle, at the time of enrollment the provider must be able to show proof of: 1) a valid driver's license; 2) car registration, and 3) insurance. Subsequent to enrollment, the provider is responsible for keeping this documentation up-to-date.

*Indicates reimbursement documentation.

Place of Service

This service may be provided in the recipient's own home, family home or foster home. The recipient may also go to a licensed group, foster home, or assisted living facility to receive the service. Overnight respite care can be provided only in the recipient's own home, family home, licensed foster home, group home or ALF. This service cannot be provided in the provider's home.

Special Considerations

Recipients living in licensed group homes are not eligible to receive respite care services.

Relatives who live outside the recipient's home and are enrolled as Medicaid waiver providers may provide respite care services and be reimbursed for the services. The relative must meet the same qualifications as other providers of the same service. With regard to relatives

providing this service, safeguards must be taken to ensure that the payment is made to the relative as a provider, only in return for specific services rendered, and there is adequate justification as to why the relative is the provider of care. An example of a valid reason may be a general lack of enrolled providers due to the rural setting.

Most recipients who require respite care services do not need the services of a registered or licensed practical nurse. Nurses should only be employed to perform this service when the recipient has a complex medical condition. If a nurse provides this service, a prescription will be necessary.

Providers of respite services must use the published stepped quarter hour rate for the service or the daily rate if respite services are provided for ten or more hours a day. The provider must bill for only those hours of direct contact with the recipient(s). The respite rate shall be determined based on from one to three recipients in the home receiving the service. Respite services provided in a licensed residential facility will be billed at the ratio of 1:1 in the stepped rate for the service.

Support Coordination

Description

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

Once a recipient's support plan is developed and the cost plan is approved by the APD, the waiver support coordinator assists the recipient to meet his support plan outcomes or personal goals by linking the recipient with natural and generic supports and services available through family, friends and community resources. When natural or generic supports are unavailable or are in the process of development, the waiver support coordinator assists the recipient in locating services available through local, state or federal sources, including Medicaid, the DD waiver and APD, as authorized.

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

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

Transitional Support Coordination

Transitional support coordination consists of activities that assist the recipient in transitioning from a nursing facility (NF), Developmental Disabilities Institution (DDI), or an intermediate care facility for the developmentally disabled (ICF/DD). These activities include working with the recipient to arrange for the provision of community-based services and supports upon discharge, including those available under this waiver and other services and supports, regardless of funding source, necessary to ensure the health and welfare of the recipient.

Waiver support coordinators are responsible for working with the institutional provider and staff and coordinating their activities with the facility's discharge planning process. The waiver support coordinator will develop an initial support plan based on current assessments including the facility's summary of the recipient's developmental, behavioral, social, health and nutritional status and discharge plan designed to assist the recipient in adjusting to their new living environment. The support plan will identify the community supports and services required to meet these identified needs. Waiver support coordinators can bill for up to 90 days

(three months) for services rendered prior to the recipient's discharge. These services can be billed only after the recipient is discharged.

The waiver support coordinator will maintain, at a minimum, weekly contact with the recipient for the first 30 days following discharge to ensure that community supports and services are meeting the recipient's needs. The waiver support coordinator will update the support plan at the end of the 30-day period, identifying progress made with the transition to community-based living and changes in supports and services. At the end of each month following discharge, if the waiver support coordinator has provided all necessary services, including the weekly face-to-face visits for the first 30 days following discharge, they may bill for up to 90 days at the enhanced waiver support coordination rate.

Limited Support Coordination

Limited support coordination services are less intensive case management services available upon request by an adult receiving services or the adult's guardian. Adults receiving limited support coordination may request to change to full support coordination due to an increased need for assistance, but must remain in full support coordination for the remainder of the cost plan year.

Children under the age of 18 who live in the family home shall use only limited support coordination. Limited support coordination for children living in their family home may be approved at the full support coordination level by the APD Area Office for a time limit not to exceed 60 days per cost plan year should a family emergency warrant increased support from this service. The Area Office will maintain documentation of the approval and the nature of the emergency on file. The emergency approval and explanation of the need should be clearly documented in the case notes for the recipient by the waiver support coordinator.

Limited support coordination services are billed at a reduced rate and have reduced contact requirements. The limited support coordinator must conduct two (2) face-to-face visits per year (including at least one home visit) and one (1) other billable activity a month as outlined in the Documentation Requirements section of the handbook for this service.

The face-to-face contacts conducted in the support plan development period may count as one face-to-face contact. The second face-to-face contact shall occur toward the middle of the support plan year. The support coordinator shall:

1. Perform required assessments and develop the annual support and cost plan. The cost plan shall be submitted for prior service authorization.
2. Document in case notes and other records all activities completed on behalf of the recipient.
3. Arrange initial providers and complete service authorizations as needed.
4. Continue to ensure that Medicaid eligibility is maintained by providing all assistance necessary to maintain Medicaid benefits.

5. Enter into an agreement specifying the activities the recipient expects the support coordinator to conduct as part of the limited support coordination on his or her behalf and those that the recipients and family will assume.

Limited Support Coordinators will not:

1. Be responsible for ongoing monthly face-to-face contact and other required monthly contacts, except as identified above.
2. Oversee the delivery of supports and services.

Limitations

The provider must accept all recipients who select the provider for waiver support coordination services and not reject any recipient referred to them or who selects them from within the geographic boundaries previously approved by the APD Area. The APD may grant exceptions to this requirement in writing.

The caseload for waiver support coordination is established by the Legislature. Effective January 1, 2008 the caseload for this service is 43 full time recipients. Each waiver support coordinator shall maintain a caseload of no more than 43 full time recipients, or as specified in statute, even when that total includes recipients who are not participants in the waiver or are not recipients of the Developmental Disabilities Program. Support coordination services are rendered in a ratio that does not exceed one certified full-time equivalent (FTE) waiver support coordinator position to every 43 full time recipients. "Full Time Equivalent" means a person who is providing support coordination services for 43 full time recipients. A recipient who receives limited support coordination is considered a half-time recipient on a caseload. Waiver support coordinators who provide limited support coordination may have a caseload of more than 43 individuals, not to exceed 43 full time recipients. Supervisors of waiver support coordinators within group providers shall limit their caseloads to less than 43 full time recipients and must ensure that adequate supervision is also provided for support coordination employees. When a provider is planning to expand services, providers may temporarily exceed the above ratios for a period not to exceed 60 consecutive days.

The support coordination provider must notify the APD Area Office in writing of any vacancies or leave of absences granted with a list of recipients affected by this vacancy, within five days of each occurrence. Vacancies due to the termination or resignation of a waiver support coordinator that result in caseloads temporarily exceeding the maximum of 43 full time recipients may be for a period of no more than 60 consecutive days, per vacancy. The 60 consecutive days begin with the date the vacancy actually occurs. Failure of the provider to notify the APD Area Office of the vacancy within the required timeframe will result in recoupment of funds received by the provider.

Vacancies due to a waiver support coordinator submitting a written request to the APD Area Office for leave based on the intent of the Family and Medical Leave Act that result in caseloads temporarily exceeding the maximum of 43 full time recipients are allowed for a period of no more than 60 working days, per vacancy.

If the support coordination provider cannot fill a reported vacant position within the time allotted, the APD Area Office must be notified prior to the 60th consecutive or 60th working day, whichever is applicable to the situation. Upon receipt of this notification, the APD Area Office will provide 14 calendar days notice to the affected recipients and agency of the need to select a different waiver support coordination provider. This notification will enable the APD Area Office to inform the affected recipients of the impending change in their support coordination provider. This notification will allow sufficient time for the recipient to choose an available provider from within or outside the current agency and the provider to complete needed paperwork and take any other necessary actions. It will also allow the recipient time to adjust to the anticipated changes. Vacancies resulting in caseloads exceeding the maximum of 43 full time recipients for more than the above stated number of days may subject the provider to recoupment of funds and the recipients served to transition to another enrolled support coordination provider, chosen by the recipient. All caseload transfers will be accomplished by the APD Area Office working with the provider to identify those recipients affected by the vacancy and who will cause the temporary support coordinator to exceed the maximum caseload of 43 full time recipients.

Expansion of services includes increasing the number of recipients served by a solo practitioner or an agency, as well as a solo practitioner changing or expanding their status from solo practitioner to an agency. A provider must have no alerts or documentation cites indicating recoupment and have attained a satisfactory overall score on the last quality assurance monitoring conducted by the APD, AHCA or their authorized representative, and be approved by the APD Area Office in order to expand services.

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

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

provider, unless the recipient receives services in an APD service area where the family member is not certified to provide support coordination;

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

Support and Service Planning Requirements

The provider must be available to meet the recipient's needs and to perform the responsibilities for support coordination. The provider shall have an on-call system in place that allows recipients to access support coordination services 24-hours per day, 7 days per week. The APD Area Office must approve this on-call system.

Any time a back-up support coordinator is used during the provider's absence, the backup support coordinator shall be a certified and an enrolled waiver support coordinator. The name and contact information for the back-up waiver support coordinator shall be clearly communicated to the recipient and to the APD Area Office. Access to the provider or back-up provider shall be available, without toll charges to the recipient.

Waiver support coordinators should assist ADT recipients with information or referral to rehabilitation, vocational habilitation, and other employment services and employment opportunities available in their community. On an annual basis, waiver support coordinators shall provide service counseling for recipients currently in sheltered workshops or segregated work environments to apprise them of the options available to them for meaningful work activities and training. The support coordinator shall provide information to recipients on residential options available to them including owning or renting their own home with supports. This shall occur at a minimum of once a year during support planning but should also occur when anticipating a change in the residential situation.

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

- Complete or update tools, necessary to assist in identifying personal goals, needs and services prior to the development of the support plan; make decisions and informed choices;
- Complete the support plan, including required signature(s) of recipient or legal guardian;
- Complete the cost plan; and
- Complete the waiver eligibility work sheet.

When a recipient is newly enrolled to receive waiver services the support coordinator

must complete the support plan and cost plan within 60 days of the recipient's selection of the support coordinator.

In accordance with section 393.0651, F.S., the provider shall complete an annual report of progress.

The waiver support coordinator shall provide a copy of the notice of privacy practices required by HIPAA regulations to the recipient or legal guardian upon initial contact with the recipient, and at any time there is a significant change that necessitates the protection of a recipient's personal health information.

The waiver support coordinator will submit to the APD Area Office, no later than twenty calendar days prior to the support plan effective date, a new annual support plan and cost plan with supporting documentation. The APD Area Office will in turn respond no later than ten working days of its receipt of the cost plan, with a statement of approval or denial. Copies of the support plan and complete approved cost plan will be provided to the recipient or his guardian at any time they are requested, but at a minimum, within ten calendar days of the effective date of the support and cost plan. If changes to the support plan's effective date must be made by the support coordinator for purposes of case load management, the support coordinator shall notify providers 60 days in advance of the change.

For emergency support and cost plan requests, the waiver support coordinator will notify the APD Area Office of the crisis situation and provide the updated support plan, cost plan and supporting documentation, within three working days of becoming aware of the crisis.

The cost plan (plan of care) is updated annually by the support coordinator. An amendment to the plan to change services or to increase service intensity or frequency may only be submitted during the year if there is a documented significant change in the recipient's condition or circumstance that impacts on health, safety, or welfare, or when a change in the plan is required to avoid institutionalization. A comprehensive description of these changes, including updated assessment information and sufficient information concerning the change in service needs should be thoroughly documented in an update to the support plan and the waiver support coordinator's progress notes. Updates to the cost plan shall be initiated when the waiver support coordinator becomes aware of the need for change. The updated support and cost plans are submitted to the APD, for review and approval within five working days of the date the waiver support coordinator becomes aware of the need for change. The APD may request copies of the waiver support coordinator's progress notes, which support and describe the need for an updated cost plan. The APD Area Office will in turn respond within ten days of their receipt of the updated cost plan, with a statement of approval or denial. Within five working days of receiving the APD Area Office response, the waiver support coordinator will notify the service provider through submission of a new service authorization of the updated changes to the cost plan and the change in the needs of the recipient.

The provider shall assist the recipient in using family, neighborhood and community supports and services funded by private, city and county sources prior to seeking services funded by

federal and state sources. The provider shall assist the recipient in using Medicaid State Plan services prior to seeking services funded by the DD waiver. When services must be purchased by a source other than the DD waiver, the provider must work cooperatively with the APD Area Office in locating service vendors who meet the needs of the recipient in the most cost-beneficial manner possible.

A copy of support plan information, pertinent to the provider, and an approved service authorization will also be provided to other providers of services to authorize and initiate service delivery by the effective date of the approved support and cost plans. Through conversations with the recipient, those who know the recipient well, and through review of the service vendor's documentation, the waiver support coordinator monitors the recipient's involvement in purchased services to determine if the activities meet the recipient's expectations. The waiver support coordinator will determine that these services are age and culturally appropriate; address the need for which they are intended; and provide appropriate challenges, motivation and experiences to meet the recipient's identified goals.

When services must be purchased by the DD waiver, the provider shall locate potential service vendors who are qualified to meet the needs of the recipient in the most costbeneficial manner possible. The provider may recruit qualified vendors who are acceptable to the recipient and assist them with waiver enrollment procedures. The waiver support coordinator must assure that purchased supports and services do not exceed the annual limits of the current approved cost plan(s) for recipients served. The waiver support coordinator shall use the ABC system to regularly monitor service utilization and expenditures. If the support coordinator becomes aware that supports and services are in excess of the annual limits of the approved cost plan, he will notify the APD Area Office and provider as soon as the excess is known to them.

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

The provider shall maintain each recipient's central record in accordance with APD procedures. The central records remain the property of the APD. The APD retains the right to review, retrieve, or take possession of a recipient's central record at any time.

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

The provider is responsible for the cost of the electronic access to the APD's intranet site as well as entering, updating and assuring the accuracy of demographic information pertinent to the recipient in the ABC system. Failure of the waiver support coordinator to enter, update and assure the accuracy of this information could result in recoupment of funds paid to the waiver support coordinator.

The provider shall comply with all written procedures established by the APD regarding the transition of recipients from developmental disabilities support coordinators or other waiver support coordinators to the provider.

For recipients residing in supported living arrangements or licensed residential facilities and who are taking any psychiatric or anti-epileptic medications, the support coordinator will document in the progress notes attempts and efforts to assure:

- A comprehensive psychiatric medication review is completed annually by a licensed psychiatrist, neurologist, or an advanced registered nurse practitioner (ARNP.) who acts pursuant to a protocol with the psychiatrist or neurologist.
- A medication review by a licensed consultant pharmacist is conducted at least annually.

The recipient receives follow-up reviews by the psychiatrist, neurologist or ARNP at a frequency established by these practitioners. If the frequency of review established by the psychiatrist, neurologist or ARNP is less frequent than every ninety days, documentation for their rationale will be provided. This documentation will be maintained in the recipient's central record.

If while serving a recipient, the recipient chooses another support coordination provider, the current provider shall render quality services for the recipient until the end of the month, when the transfer to the new support coordination provider takes place, unless otherwise instructed by the APD. Additionally, the current provider shall assist the recipient in making a smooth transition to the new support coordination provider.

When a new support coordination provider is selected by the recipient; the support coordination services agency is downsized; or the support coordination services are terminated, either voluntarily or involuntarily, the waiver support coordinator shall assure that all appropriate central record information is transferred to the new provider or to the APD Area Office, as directed, within two weeks of the effective date of the action.

Note: Refer to the medication review service section for additional information.

Documentation Requirements

For reimbursement* purposes, the provider must meet certain basic billing requirements. These include support coordination notes, which adequately document the support coordination services rendered and which are individualized. Exceptions granted by the APD to any requirements set forth in the assurances or policy must also be documented. All documentation must be filed in the recipient's central record prior to billing. For full support coordination, the provider must have, at a minimum, two contacts with or activities on behalf of recipients each month in order to bill to Medicaid. For limited support coordination, the provider must have a minimum of one contact with or activity on behalf of recipient each month in order to bill Medicaid. Prior to submitting a claim for payment of support coordination services for a recipient, the provider shall complete the following:

1. *Have on file in the recipient's central record, the recipient's current support planning information to include the individually determined goal information, the APD-approved assessment, a current waiver eligibility worksheet, a current support plan and current approved cost plan; and
2. Full support coordination: *Have at least one face-to-face contact monthly with recipients living in a licensed residential facility or supported living situation. Have at least one face-to-face contact every three months for recipients living in their family home, and two of those contacts per year will be held in the recipient's residence at six-month intervals.
3. Limited support coordination: Have at least two face-to-face contacts per year, with a minimum of one of the contacts being in the recipient's home. One face-to-face contact should occur at the time of support planning and the second face-to-face contact should occur at approximately a six month interval.
4. Face-to-face contacts shall relate to or accomplish one or more of the following:

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

*For recipients in supported living, residing in their own home or residing in licensed facilities, a face-to-face visit with the recipient in the recipient's place of residence is required every three months. If the recipient lives with his family, the face-to-face contact with the recipient in the residence is required every six months for full support coordination, and once a year for limited support coordination. The recipient or family may not waive the required visit(s) in the home. The need for more frequent face-to-face visits may be determined by the recipient, family or primary caregiver. The waiver support coordinator shall document this preference in the support plan. The purpose of the face to face visit is to discuss progress/changes to the individual's goals, status of any unresolved issues, and satisfaction with current supports received.

*For recipients receiving supported living coaching services, it is the waiver support coordinator's responsibility to schedule a quarterly meeting with the recipient and the supported living coach. The purpose of this meeting is to:

- Revise the individual's progress toward achieving goals and determine if services are being provided in a satisfactory manner, consistent with the individual's needs.
- Review the health and safety checklist, housing survey, financial profile and financial records to determine if there is a need for follow up with unresolved issues or changed needs. The waiver support coordinator shall document the results of each meeting in the progress notes.

This quarterly meeting with the recipient and the supported living coach, unless the supported living coach is excluded at the request of the recipient, may satisfy the quarterly face-to-face meeting requirement above, provided the meeting takes place in the recipient's home.

*Conduct at least one other contact or activity per month. These contacts or activities are not merely incidental, but are planned and shall relate to or accomplish those items, previously identified in 4 (a-f). These contacts or activities may be either with the recipient or with other persons, such as family members, service vendors, community members and others, and may be conducted face-to-face or via telephone, letter writing or through e-mail transmission. Administrative activities such as typing, filing, mailing, or leaving messages shall not qualify as contacts or activities, nor do calls to schedule meetings, setting up face to face visits or scheduling meetings with the individual's employer, family, providers, etc.

Upon receipt of a determination that terminates or reduces the level of services, the support coordinator will, within ten business days of receipt of the determination, inform the recipient of the decision and submit a revised service authorization to the service provider. If the determination affects the provider immediately, the support coordinator must contact the provider by phone call, fax or other method to inform him of the need to immediately revise the services being provided with notification that the service authorization will be sent to the provider to document the change. If the support coordinator does not follow these procedures and this results in the provider not being notified of the service change, the support coordinator may be subject to recoupment of the services that were provided when the service provider was unaware of the need to change the level of service provision. Upon receipt of a determination of approval of a new service, the support coordinator must issue a service authorization within ten business days of receipt of the determination.

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

1. A copy of all of the recipients' support plans and approved cost plans in their central records;
2. Documentation in the central records that the basic billing requirements were met for the months in which the provider was reimbursed for services;
3. Documentation in the support coordination notes and the support plan of activities and contacts that assisted the support coordinator in meeting individually determined goals;
4. Documentation that the support coordinator facilitated opportunities for community involvement as determined by the support plan goals. The notes clearly and adequately reflect services provided in sufficient detail;
5. Documentation in the central records that a face-to-face visit with the recipient was conducted in their place of residence, including those recipients in supported living, quarterly meetings with the recipient and their supported living coach;
6. Documentation that service authorizations were provided to all service providers within three consecutive calendar days of the support coordinator receiving approval of the service; and
7. Current and correct demographic information for each recipient, including current health and medical information and emergency contacts.

In addition, the provider is expected to document in all recipient central records all other support coordination services, activities or contacts that assisted him in meeting support plan outcomes or personal goals, become more integrated into communities and address each recipient's or family's concerns. Support coordination notes should adequately and clearly document all support coordination services provided to a recipient.

If the provider plans to transport the recipient in his private vehicle, at the time of enrollment, the provider must be able to show proof of valid: 1) driver's license, 2) car registration, and 3) insurance. Subsequent to enrollment, the provider is responsible for keeping this documentation up-to-date.

*Indicates reimbursement documentation.

Place of Service

This service may be provided in the recipient's residence or anywhere in the community.

Special Considerations

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

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

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

The provider will be responsible for the cost to access any APD or AHCA required management, claim submission information or data collection systems.