

CF OPERATING PROCEDURE
NO. 140-8

STATE OF FLORIDA
DEPARTMENT OF
CHILDREN AND FAMILIES
TALLAHASSEE, May 13, 2020

COMMUNITY CARE FOR DISABLED ADULTS

This operating procedure describes the Community Care for Disabled Adults Program administered by the department.

BY DIRECTION OF THE SECRETARY:

(Signed original copy on file)

ROBERT K. ANDERSON
Assistant Secretary for
Operations

SUMMARY OF REVISED, DELETED, OR ADDED MATERIAL

In paragraph 4-4a(1), deleted phrase “some indicators” and added phrase “not substantiated findings with less than a preponderance of evidence.”

CONTENTS

Paragraph

Chapter 1 – INTRODUCTION TO THE COMMUNITY CARE
FOR DISABLED ADULTS PROGRAM

Purpose	1-1
Legal Base	1-2
Funding	1-3
History	1-4
Services	1-5
The Community Care for Disabled Adults Client	1-6

Chapter 2 – DEFINITIONS AND SCOPES OF APPROVED SERVICES

Purpose	2-1
Adult Day Care (ADC)	2-2
Adult Day Health Care (ADHC)	2-3
Case Management	2-4
Chore Service	2-5
Emergency Alert/Response Service (EAR)	2-6
Escort Service	2-7
Group Activity Therapy	2-8
Home Delivered Meals	2-9
Home Health Aide	2-10
Homemaker Service	2-11
Home Nursing Services	2-12
Interpreter Service	2-13
Medical Equipment and Supplies	2-14
Medical Therapeutic Services	2-15
Personal Care	2-16
Physical and/or Mental Examinations	2-17
Respite Care	2-18
Transportation	2-19

Chapter 3 – FEE ASSESSMENT PROCEDURES

Purpose	3-1
Statutory Authority	3-2
Why Assess for Fees	3-3
Procedures for Determining Fees to be Assessed	3-4
Exceptions to Fee Assessment Application	3-5
Handling Collected Fees	3-6

Chapter 4 – CLIENT ELIGIBILITY

Purpose	4-1
Appropriateness of Referral	4-2
Documentation of Disability	4-3
Prioritization of Clients	4-4

Chapter 5 – COMMON SERVICE REQUIREMENTS

Purpose	5-1
Common Requirements	5-2
Personnel Requirements	5-3
Training Requirements	5-4
Service Restrictions	5-5

CONTENTS (continued)

Paragraph

Chapter 6 – ROLE OF THE COMMUNITY CARE

FOR DISABLED ADULTS CASE MANAGER

Purpose	6-1
Goals of CCDA Case Management	6-2
Basic Client-Level Functions and Responsibilities of the CCDA Case Manager	6-3
The Case Manager's Development of the Case Record	6-4
The Case Manager's Development of the Case Record	6-5
The Role of the CCDA Case Manager Regarding Administrative Hearings	6-6

Chapter 7 – RESERVED

Chapter 8 – RESERVED

Chapter 9 – MAXIMIZING RESOURCES

Purpose	9-1
Determining Appropriateness of a Referral	9-2
Staffing to Assure Integrated and Complimentary Service Delivery	9-3
Programs Administered by the Department of Children and Families	9-4
Programs Administered by the Department of Health	9-5
Programs Administered by The Department of Education (DOE)	9-6
Non-Profit Organizations Serving Physically Disabled Adults	9-7
Various Social and Civic Organizations Serve Physically Disabled Adults	9-8

Chapter 10 – CONTRACT PURCHASE OF COMMUNITY CARE FOR
DISABLED ADULTS (CCDA) SERVICES

Purpose	10-1
Reference and Definition	10-2
Choosing to Contract for CCDA Services	10-3
The Region Program Specialist and the Contract Manager as a Team	10-4
Region Contracting Responsibilities for CCDA Program Specialists	10-5

Chapter 11 – PURCHASE OF COMMUNITY CARE FOR DISABLED ADULTS SERVICES
WITH VOUCHERS AND PURCHASE ORDERS

Purpose	11-1
Voucher and Purchase Order Authority	11-2
When to Use a Voucher or Purchase Order	11-3
Function of Vouchers and Purchase Orders	11-4
Steps Which the Region Program Office Must Follow for Service Procurement	11-5
Authorization for Payment Procedures	11-6
Payments to Vendors	11-7

Chapter 12 – RESERVED

Chapter 13 – RESERVED

Chapter 14 – GLOSSARY

Purpose	14-1
Definitions	14-2

Appendix A – Fee Assessment

Appendix B – Sample Invoice

Appendix C – Report Flowchart for Community Care for Disabled Adults Program

Chapter 1

INTRODUCTION TO THE COMMUNITY CARE FOR DISABLED ADULTS PROGRAM

1-1. Purpose.

a. This operating procedure is the Department of Children and Family Services' program document for the Community Care for Disabled Adults (CCDA) program.

b. The operating procedure provides region staff and contract providers with fiscal and programmatic requirements for implementation of the Community Care for Disabled Adults' policy, rule and statutory requirements.

1-2. Legal Base. The legal bases for the Community Care for Disabled Adults Program are Sections 410.602-606 and 20.19(4)(b)2d, Florida Statutes (F.S.), and the annual appropriations act with any proviso or instructions to the department.

1-3. Funding. The Community Care for Disabled Adults program is currently funded by general revenue funds. These funds are allocated to the Adult Services regional offices according to an allocation formula using the United States Department of Commerce's Census disability statistics for the State of Florida comparing disabled adults per region to the total number of disabled adults in the state. The Department of Children and Families must ensure that all available funding sources have been explored prior to using funds allocated to this program.

1-4. History. In 1984, the Community Care for Disabled Adults program was established in statute to provide disabled adults, age 18 through 59, in-home services needed to help them remain in their own homes in the community and prevent institutionalization.

1-5. Services.

a. The program is based on a brokerage of service approach for functionally challenged adults with disabilities. Services contracted through the Community Care for Disabled Adults Program include:

- (1) Adult day care;
- (2) Adult day health care;
- (3) Chore, such as house or yard work that doesn't require specialized staff;
- (4) Case management, which is coordination of services among programs;
- (5) Emergency alert response to monitor a person's safety at home;
- (6) Escort services for someone to accompany the client to and from services;
- (7) Group activity therapy;
- (8) Home delivered meals;
- (9) Homemaker;
- (10) Interpreter to provide help for clients with communication impairments;
- (11) In-home nursing services;

- (12) Personal care;
- (13) Respite care;
- (14) Transportation;
- (15) Medical equipment; and,
- (16) Home health aide services.

b. Transitional mental health counseling is also available to help disabled persons adjust to the onset of a disability and to cope with financial, legal and other personal problems.

1-6. The Community Care for Disabled Adults Client.

a. The Community Care for Disabled Adults program provides a link to community resources which help disabled adults to remain as productive and comfortable as possible, while enabling them to remain in their own homes for as long as possible. The program provides options for disabled adults that would otherwise not be available to them.

b. Many participants of the Community Care for Disabled Adults Program have disabilities which range from heart conditions and hypertension to arthritis and paralysis, to amputation and multiple sclerosis. Some were stricken with diseases like muscular dystrophy or polio. Whatever the cause, the victims of accidents, diseases or birth defects rely on family, friends and the kindness of others to help them maintain their independence in the community. For many, Community Care for Disabled Adults is the cornerstone of local care. It plays a vital role in providing adults with disabilities with long-term supports. It provides them with in-home services and empowers them to maintain their independence and remain in their own homes. Because the program is designed to serve totally and permanently disabled persons who are not eligible for assistance from other programs, it fills the gap in the service delivery continuum for adults with disabilities. It is the only state-funded community service program that provides in-home services to adults with circulatory disorders, cancer and multiple sclerosis.

Chapter 2

DEFINITIONS AND SCOPES OF APPROVED SERVICES

2-1. Purpose. The purpose of this chapter is to list and define the approved Community Care for Disabled Adults (CCDA) services and the minimum training and staffing standards for these services.

2-2. Adult Day Care (ADC).

a. Service Definition and Unit of Measure.

(1) Adult day care means a planned social program that provides a protective environment where supervision for the health, safety and well-being of adults who have functional impairments is provided.

(2) A unit of service is one hour of actual client attendance at the day care center. The travel time to and from the center is not counted in the daily attendance.

(3) Adult Day Care centers must be licensed by the Agency for Health Care Administration in accordance with Chapter 400, Part V, F.S., and services administered according with Chapter 58A-6, Florida Administrative Code (F.A.C.), the Adult Day Care rule.

b. Minimum Service Standards.

(1) To be licensed as an Adult Day Care Center, the following minimum basic services must be provided:

(a) A supervised, protective environment that promotes a non-institutional atmosphere;

(b) A variety of therapeutic, social and health activities and services (such as exercise, health screening, health education, interpersonal communication and behavior modification) which help to restore, remediate, or maintain optimal client functioning and increase client interaction;

(c) Leisure time activities designed to cultivate client self-expression, self-esteem and mental stimulation;

(d) Self-care training activities;

(e) Individualized rest periods or periods of relaxation or inactivity during the day;

(f) Nutritional services (meals/snacks); and,

(g) In-facility respite care for a functionally impaired adult for the purpose of relieving the primary caregiver.

(2) Adult day care centers, contracted with CCDA funds, offering the following OPTIONAL services must meet these service standards:

(a) Therapies. These services must be administered by staff qualified to provide such services and within the criteria established by relevant Florida Statutes.

1. Occupational Therapy as an adjunct to treatment for persons with physical and mental limitations will be provided by or under the supervision of an individual who is registered by the American Occupational Therapy Association, or a graduate of a program of occupational therapy approved by the Council on Medical Education of the American Medical Association and engaged in the supplemental clinical experience required before registration by the American Occupational Therapy Association.

2. Physical Therapy will be provided by or under the supervision of an individual who is a graduate of a program of physical therapy approved by both the Council on Medical Education of the American Medical Association and the American Therapy association, or the equivalent and licensed by the State.

3. Speech Therapy will be provided by or under the supervision of an individual licensed under Chapter 468, Part I, F.S., who has certification of clinical competence from the American Speech and Hearing Association, and who has completed the equivalent educational requirements and work experience necessary for certification, or who has completed the academic program and is acquiring supervised work experience to qualify for the certificate.

(b) Transportation. Transportation services consist of conveying participants from home to the adult day care center and return home. If the day care center does not provide transportation directly, arrangements must be made with available transportation providers. The client's physical limitation(s) must be considered when planning for transportation. Wheelchair clients may require an appropriately equipped vehicle. Provisions must be made to assist persons in getting on or off the vehicle, if needed.

(c) Nursing Service. Nursing service by a licensed registered nurse or licensed practical nurse, currently licensed in Florida, includes, but is not limited to: screening procedures for chronic diseases (e.g., hypertension, or diabetes); observation, assessment, and monitoring of clients health needs and daily functioning levels; administration or supervision of medications or treatments; counseling for participant, family or caregiver in matters relating to health and prevention of illness; and referral to other community resources with follow-up of suspected physical, mental, or social problems requiring definitive resolution.

c. Minimum Staffing Standards.

(1) Nursing Staff. A registered or licensed practical nurse, licensed by the State of Florida, must be on duty at the site during primary hours of program operation and available at other times.

(a) When the position is filled by a licensed practical nurse, this person must work under the supervision of a Registered Nurse.

(b) The registered or licensed practical nurse must be on duty at the site during the primary hours of program operation. If the nurse leaves the site, the administrator must be on the premises during the center's hours of operation.

(2) First Aid Certified Staff. No less than 2 certified staff persons must be on duty at the site during primary hours of program operation.

(a) These staff persons must be certified in an approved first aid course and Cardio-Pulmonary Resuscitation (CPR) training.

(b) These staff persons must be capable of recognizing symptoms of distress in this client population and must be at the center at all times.

(3) Center Director. The following major functions and duties, additional to those outlined in Chapter 58A-6, Florida Administrative Code, may be delegated to managerial staff but remain the responsibility of the Center Director:

(a) Recruits, screens and trains staff of facility;

(b) Plans and provides organized programs of pre-service and in-service training for staff;

(c) Interprets policies and procedures to staff and clients;

(d) Ensures integration and coordination between program and appropriate community resources;

(e) Maintains close supervision of staff in the following areas of operation: secretarial and bookkeeping; housekeeping; maintenance; transportation; food services; consulting services; and direct services;

(f) Evaluates the performance of each staff member;

(g) Assures accurate and timely completion of all records and reports, including those required for the Client Information System (CIS); and,

(h) Maintains program statistical data and records as required.

d. Minimum Training Standards.

(1) Policy training topics must include; medical record keeping, Adult Day Health Care policies and procedures, and monitoring for change (such as medical, psychological and social, and physiological changes with age and chronic diseases).

(2) Medical training topics must include; medical emergency procedures, rehabilitation therapies, and prescription drugs common to this population, as well as the interaction of those common drugs.

2-3. Adult Day Health Care (ADHC).

a. Service Definition and Unit of Measure.

(1) Adult day health care means an organized day program of therapeutic, social and health activities and services provided to disabled adults for the purpose of restoring or maintaining optimal capacity for self-care.

(2) A unit of service is equal to one hour of actual client attendance at the adult day health care center, including travel to or from the center if the adult day care center is providing the transportation with CCDA funds.

b. Minimum Operating Standards. Each center must provide services for a minimum of five hours per day, five days per week.

c. Minimum Service Standards. To be licensed as an adult day health care center, in addition to the basic services specified for an adult day care center, the adult day health center must provide or coordinate:

(1) Medical Services. Medical services can be provided by either the personal physician or advanced registered nurse practitioner of the client, a staff physician, or both, and must emphasize preventive treatment, rehabilitation, and continuity of care and also provide for maintenance of adequate medical records. An advanced registered nurse practitioner in accordance with protocols established in collaboration with the personal physician of the client or the site staff physician may supervise the health needs of clients.

(2) Medical Therapeutic/Rehabilitative Services. Medical therapeutic/rehabilitative services appropriate to the needs of the client must be provided by a contractor or by on-site staff and progress notes kept current.

(a) Physical Therapy. Progress notes must be written in the client's record and signed by the physical therapist as services are provided.

(b) Occupational Therapy. Progress notes must be written in the client's record and signed by the occupational therapist as services are provided.

(c) Speech Therapy. Progress notes must be written in the client's record and signed by the speech therapist as services are provided.

(3) Nursing. Nursing services must be rendered by registered nurses (RN) or licensed practical nurses (LPN) who work under the supervision of a registered nurse. Such nurses must evaluate quarterly, at a minimum, the particular needs of each client and provide for their care and treatment. Care and treatment will include medication supervision, health education and counseling, nutritional advice, act as a liaison with the participant's personal physician and caregiver or family,

coordinate provision of all other needed health services, and supervision of self-care services oriented toward activities of daily living and personal hygiene as provided by program aides in this service area. Narrative nursing notes must be entered in the client's medical record at least weekly indicating the individual's progress toward achieving health goals. More frequent notes are required if indicated by the client's condition.

(4) Social Work Services. Social work services to assist with personal, family and other problems that interfere with the effectiveness of treatment must be provided to clients and their families. Social services include a compilation of a social history and psychosocial assessment of formal and informal support systems, mental and emotional status, caregiver data, and information for planning for discharge. These services will be provided by the social work staff employed by the adult day care center and are not to be confused with the case management responsibilities of the CCDA case manager. [The CCDA case manager will complete the functional assessment of the client, will counsel in the development of a service plan, will arrange for services, and will provide ongoing monitoring of the client's situation to ensure that needed services are received].

(5) Transportation Services. Transportation from the client's home to the center and back home again, must be a function of the program. If the center does not provide transportation directly, arrangements for day care participants needing transportation must be established. The cost of this transportation is included in the rate paid to the contracted provider of the adult day health care service. The client's physical limitation(s) must be considered when planning for transportation. Wheelchair clients may require an appropriately equipped vehicle. There must be an escort on a bus or van to assist persons in getting on and off the vehicle when needed.

(6) Additional Medical Services. Dental, ophthalmology, optometry, hearing aid, and laboratory services will be offered.

d. Minimum Staffing Standards. In addition to the minimum staffing required for an adult day care center, the adult day health care center will provide the following staff:

(1) Nursing Staff. A registered nurse (RN) or licensed practical nurse (LPN) will be on site during the primary hours of program operation and on-call during all the hours the center is open. Arrangements will be formalized for obtaining the services of an RN or LPN in anticipation of potential absences, planned and unplanned, of the regular nursing staff. All LPN's must be supervised in accordance with Chapter 464, F.S.

(2) Social Worker. A social worker with a minimum of a Bachelor's degree in social work, sociology, psychology or nursing or a Bachelor's degree with at least 2 years of experience in a human service field. Services provided by program aides in this service area must be provided under the direct supervision of a social worker or of a case manager who meets or exceeds these standards (e.g., a Master's degree in a related field).

(3) Recreational Therapist. An activity director or recreational therapist with a Bachelor's degree in a social or health service field or an Associate's degree in a related field plus 2 years of experience. All services provided by program aides must be provided under the direct supervision of the activity director or recreational therapist. The certified recreation therapist may be retained as a consultant.

(4) Center Operator/Director. The Operator/Director will have a minimum of a Bachelor's degree in a health or social services or related field with one year of supervisory experience in a social or health service setting or hold an RN license with one year of supervisory experience or have five years of supervisory experience in a social or health service setting.

2-4. Case Management.

a. Service Definition and Unit of Measure.

(1) Case management means a client centered series of activities which includes planning, arrangement for and coordination of appropriate community-based services for an eligible Community Care for Disabled Adult client, and the appropriate community-based services are approved services, even when delivered in the absence of other services. It includes intake and referral, comprehensive assessment, development of a service plan, arrangement for service and monitoring of client's progress to assure the effective delivery of services and reassessment.

(2) A unit of service is one hour of elapsed time involved in the above-described case management activities.

b. Minimum Position Qualifications.

(1) Contracted case managers must possess a Bachelor's degree in social work, sociology, psychology, nursing, or related field. Other directly related job education or experience may be substituted for all or some of these basic requirements upon approval of the region Adult Services program office.

(2) Departmental case managers must be qualified as described by departmental job specifications.

c. Minimum Training Standards.

(1) Contracted and departmental case managers will receive pre-service training on the topics of training as set forth in paragraph 5-4 of this operating procedure, as well as on the following topics:

- (a) Use of assessment instruments;
- (b) Use of the Client Information System; and,
- (c) Overview of DCF services for adults, (across all programs).

(2) Contracted providers of case management are responsible for developing and conducting the above required in-service training in accordance with the scope of training as set forth in paragraph 5-4 of this operating procedure.

d. Recommended Staffing and Caseload Standards.

(1) The average caseload should not exceed 55 cases per full-time CCDA case manager, unless approved by the region Adult Services Program office.

(2) A caseload consists of those clients determined eligible and receiving case management.

2-5. Chore Service.

a. Service Definition and Unit of Measure.

(1) Chore service means the performance of house or yard tasks such as seasonal cleaning, yard work, lifting and moving furniture, appliances or heavy objects, essential errands, simple household repairs which do not require a permit or specialist, pest control, and household maintenance.

(2) A unit of service is one hour of actual time spent in the performance of listed or related chore service tasks for one or more clients. If the service is to be provided to a couple, the unit of service will be assigned to either the eligible husband or wife, preferably the one who usually performs chore duties.

b. Minimum Service Standards.

(1) Chore services should be of short duration performed for a client on a demand-response basis by a contracted provider.

(2) Tasks to be accomplished will be determined by evaluating the health and well-being of the client.

(3) Some chore tasks, such as errands or yard work, may be scheduled at regular intervals, if needed.

c. Minimum Training Standards. Pre-Service Training and In-Service Training will be conducted as set forth in paragraph 5-4 of this operating procedure.

2-6. Emergency Alert/Response Service (EAR).

a. Service Definition and Unit of Measure.

(1) Emergency alert/response service means a community based electronic surveillance service that monitors the safety of an individual in his/her own home by means of an electronic communication link with a response center. Components of the system transmit a specially coded signal via electronic digital equipment, over existing telephone lines to a central station offering surveillance services 24 hours a day, seven days a week. Upon receipt of such signal, the central station will alert and dispatch police, fire department, ambulance, friends and/or neighbors directing emergency services to the home of the client.

(2) A unit of service is one day (24 hours) of individual emergency response unit operation in a client's residence, regardless of actual emergency use by client. The units are counted by totaling the number of days the client receives services. Example: A client who has the unit in his/her home for the entire month of June has used 30 units (30 days in June of emergency alert/response service.)

b. Minimum Eligibility Standards.

(1) It must be determined that the client is especially vulnerable to medical or other emergency situations which have a likelihood of developing, given the particular client's profile (mental, physical, social) and/or living situation.

(2) It must be determined that emergency response service could prevent such situations from developing or escalating or could save the client from a life-threatening situation.

(3) Client must have, or be willing to arrange for, any special provisions needed for installation, such as private line telephone service.

(4) Client must be mentally and physically able to use the equipment appropriately.

c. Minimum Service Standards.

(1) The EAR service provides a means of responding to an emergency situation arising in the home setting involving a disabled adult. It does not provide emergency services, but rather contacts the appropriate personnel who will provide emergency services.

(2) All equipment is to be approved by the Federal Communications Commission (FCC) and both the button and the communicator must have proper identification numbers.

(3) The emergency response Central Receiving Station equipment consists of a primary receiver, a back-up receiver, a clock printer, a back-up power supply, and a primary and back-up telephone line monitor.

(4) The EAR equipment installed in the client's home consists of a portable button which sends a wireless signal, and a communicator which receives the wireless signal and then transmits the signal to the Central Receiving Station. The communicator has a digital dialer that is designed to provide an audible and visual indication of system operation for visual and hearing-impaired clients.

(5) The communicator is attached and does not interfere with normal use of the telephone. It has the capability of automatically seizing the telephone line, even if the phone is off the hook, dialing the number of the Central Receiving Station and giving identifying information about the client.

(6) Contracted providers will purchase, rent or lease the equipment that meets the above given specifications and arrange for installation, training and maintenance of the equipment.

(7) Contracted providers will designate an emergency response Central Receiving Station where emergency signals are responded to according to a specified operating protocol.

(8) Contracted providers will ensure that client, signal activity, and service records are maintained either by the provider or the response center.

(9) Contracted providers will arrange monthly phone calls to each client's home to test system operation, update records and provide direct client contact.

(10) The communicator should continually check for no-power conditions and indicate such conditions to the user. The communicator should check for an active telephone line at least once every 24 hours. If no signal is received the Central Receiving Station will contact the client to test the unit. If no test signal is received, service will be dispatched immediately.

(11) Batteries and telephone jack installation fees are costs incurred by the client, unless there is an inability to pay for these expenses. It is allowable for the project to purchase batteries and pay for installation if the client cannot pay.

d. Minimum Operational Standards.

(1) The contracted vendor will provide the contracting agency with appropriate personnel, operational and technical manuals and training.

(2) The contracted provider will make available to the department (upon request) those detailed manuals from the emergency response equipment vendor relating to operational aspects of the system including technical specifications, installation, testing and field coordination.

(3) The contracted provider will make available to the emergency response Central Receiving Station operations manuals which describe the CCDA program elements including record keeping and reporting procedures; equipment testing; installation in subscriber's home; user agreement; and suggested reporting forms and invoices.

e. Minimum Training Standards.

(1) Pre-Service Training. Contract service providers and/or DCF staff, and emergency response Central Receiving Station personnel will receive pre-service training on location and all operational aspects of the equipment, subscriber installation, equipment testing, and program implementation. Topics and scope of training will be as set forth in paragraph 5-4 of this operating procedure.

(2) In-Service Training. In-service training for staff providing emergency alert/response service will be regularly scheduled. Topics and scope of training will be as set forth in paragraph 5-4 of this operating procedure.

2-7. Escort Service.

a. Service Definition and Unit of Measure.

(1) Escort Service means the personal accompaniment of an individual to, and/or from service providers, or personal assistance to enable clients to obtain required services needed to implement the service plan.

(2) A unit of escort service is one trip. One trip is defined as one, one-way trip measured from a point of origin to a destination.

b. Minimum Service Standards.

(1) Escort service should be provided for clients who do not have anyone in their support system to assist them, or, whose support system does not yield an individual capable (mentally or physically) of providing the assistance.

(2) The person providing the escort service may not advise the client on any matter which may constitute conflict of interest.

c. Minimum Training Standards. Pre-Service Training and In-Service Training will be conducted as set forth in paragraph 5-4 of this operating procedure.

2-8. Group Activity Therapy.

a. Service Definition and Unit of Measure.

(1) Group activity therapy means a service provided to three (3) or more CCDA clients to prevent social isolation and to enhance social and interpersonal functioning. This service may include the following activities: physical, recreational, social interaction, and communication skill building through the use of groups.

(2) A unit of service is one client receiving group activity therapy for one daily session.

b. Minimum Eligibility Standards.

(1) Client must need the above described service in order to achieve a specific care plan goal which will help them to function more independently.

(2) Client must show measurable improvement in social, interpersonal, and communication skills through the provision of this service in order to continue to be eligible to receive the service.

c. Minimum Service Standards.

(1) Only a professional staff person with demonstrated abilities in group dynamics and skill in conducting the above described group activities may provide group activity therapy.

(2) Group activity therapy should provide an arena in which clients in need of service can increase their success in social interaction, communication, and interpersonal functioning.

(3) Group activity therapy is not considered a psychiatric service where medical treatment in the form of group therapy is provided.

d. Minimum Training Standards.

(1) Pre-Service Training. A total of 10 hours per year is required for contract service providers and DCF staff. The following topics, along with those listed in paragraph 5-4 of this operating procedure should be included:

(a) Group therapy and group dynamics; and,

(b) Recreational activities for the disabled client.

(2) In-Service Training. As set forth in paragraph 5-4 of this operating procedure.

2-9. Home Delivered Meals.

a. Service Definition and Unit of Measure.

(1) A home delivered meal is a hot or other appropriate, nutritionally sound meal that meets one-third of the Daily Recommended Dietary Allowances (RDA) served in the home to a disabled person who is homebound and at nutritional risk.

(2) The unit of service is one meal delivered.

b. Minimum Provider Standards.

(1) The CCDA service criteria will be met if the meals are provided by a contractor who is approved to provide home delivered meals that are funded by the Older Americans Act or by the Department of Elder Affairs' Community Care for the Elderly (CCE) Program.

(2) Each provider must serve home delivered meals at least once a day, five or more days a week.

(3) The nutrition provider must assure that each recipient of a home delivered meal:

(a) Has a home equipped with electricity, a stove with an oven that works, a working microwave oven, or a working toaster oven, and a freezer in which to store the meals.

(b) Has both the physical and mental capability (or a capable caregiver) to follow cooking directions and use the equipment.

(c) Is instructed on a regular on-going basis on the importance of following the directions for the storage and cooking of their delivered meals.

(4) Each provider must deliver the noon meal, if it is a hot meal, no earlier than 10:30 a.m. and no later than 2:30 p.m.

(5) Providers must maintain temperatures of 140 degrees Fahrenheit for hot foods being prepared and packaged at the home delivered meals site in accordance with Rule 64E-11.004, Florida Administrative Code for purposes of food safety.

(6) To avoid potential contamination of foods delivered as pre-portioned individual meals, providers must maintain the temperature of hot food items at 110-120 degrees Fahrenheit in transit and upon delivery to the meal recipient. Providers must maintain the temperature of cold foods at 41 degrees Fahrenheit or lower. All cold and hot food must be packaged and packed separately.

(7) Providers must assure that all pre-portioned foods are delivered to clients' homes within two hours of apportionment.

(8) Providers must package or pack all meals/food items in secondary insulated food carriers and transport the meals/food items immediately under conditions that will ensure temperature control during delivery and prevent contamination and spillage.

(9) Providers must conduct quarterly temperature checks on a random basis to assure that all food at the site, packaged and in transit to be delivered, is maintained and served at the proper temperature. Both the procedure and results of these temperature checks must be documented and maintained by providers for DCF monitoring review.

(10) Providers must clearly date and label each frozen meal with instructions for storage and cooking in large print.

c. Minimum Training Standards.

(1) Pre-Service. All contract service providers and departmental staff (volunteers or paid) involved in home-delivered meals service, whether in meal preparation or delivery, must receive pre-service training. Training will be appropriate to respective job duties and be conducted as set forth in paragraph 5-4 of this operating procedure. Training must minimally provide instructions for performing assigned tasks.

(2) In-Service. In-Service Training will be conducted as set forth in paragraph 5-4 of this operating procedure, Common Service Issues.

2-10. Home Health Aide.

a. Service Definition and Unit of Measure.

(1) Home health aide service means health or medically oriented tasks furnished to an individual in his residence by a trained home health aide under the supervision of a health professional. The home health aide must be employed by a licensed home health agency and supervised by a licensed health professional who is an employee or contractor of the home health agency.

(2) The unit of service is one hour (or quarter hour portion) of time spent performing designated home health aide services. It may include time spent in transit if the aide transports the client.

(3) This is a health maintenance service to be provided in compliance with the regulation of Home Health Care in Chapter 400, F.S.

b. Minimum Eligibility Standards.

(1) In order to be eligible to receive this service, the client's medical supervision must be under an established plan of treatment. A plan of treatment means a written instruction provided by the attending physician for the provision of health care to the disabled adult in his or her own home. The plan of treatment will include:

- (a) Care plan;
- (b) Types of services and equipment required;
- (c) Specific frequency of visits such as two times a week or three times a week for a specified length of time each visit;
- (d) Activities planned or prohibited;
- (e) Diet (regular or special);
- (f) Listing of medications and treatments; and,
- (g) Orders of the physician.

(2) This plan of treatment written by the attending physician must provide for delivery of health care services to the disabled adult in his or her own home.

c. Minimum Service Standards.

(1) The home health aide will perform only those activities contained in a written assignment by a health professional employee. Those activities include assisting the patient with personal hygiene, ambulation, eating, dressing and shaving.

(2) The home health aide may perform other activities as taught by a health professional employee for a specific patient. These include and are limited to: assisting with the change of a colostomy bag; a shampoo; or the reinforcement of a dressing; assisting with the use of devices for aid to daily living (walker, wheelchair); assisting with prescribed range of motion exercises which the home health aide and the patient have been taught by a health professional employee, assisting with prescribed ice cap or collar; doing simply urine tests for sugar, acetone or albumin; measuring and preparing special diets; measuring fluid intake and output; and supervising the self-administration of medications. This supervision means reminding clients to take medications, opening bottle caps for clients, reading the medication label to clients, observing clients while taking medications, checking the self-administered dosage against the label of the container and reassuring clients that they have obtained and are taking the correct dosage.

(3) The home health aide may not perform any personal health service that has not been included by the professional nurse in the patient's care plan. The home health aide will not at any time: change sterile dressings; irrigate body cavities, such as an enema; irrigate a colostomy or wound; perform a gastric lavage or gavage; catheterize a patient; administer medications; apply heat by any method; care for a tracheotomy tube; or administer eye drops.

(4) The home health aide must keep records of personal health care activities and the hours spent performing the tasks.

(5) The home health aide will observe appearance and gross behavior changes in the patient and report any changes to the professional nurse.

(6) A health professional staff person must evaluate the home health aide patient services in the home for the purposes of observing service delivery and the status of the client. The health professional must make a supervisory visit to the client's home at least every two weeks if the client needs skilled care and once every 62 days if the client needs only aide services.

d. Minimum Staffing Standards.

(1) The service must be provided by persons licensed under Section 400.471, F.S. or by independently licensed contractors under the supervision of a health professional.

(2) This service must be provided in compliance with Chapter 59A-8, F.A.C., Home Health Aide.

e. Minimum Treatment Plan Standards.

(1) The plan of treatment will be established and reviewed by the attending physician in consultation with agency staff involved in giving service to the patient. The reviews will be at such intervals as the severity of the patient's illness requires, but in any instance, at least every 30 days for CNA provided care or every 62 days if services provided by an LPN and shall include, but not be limited to the following:

(a) A diagnosis or identification of the disease/disability from its evident signs and symptoms.

(b) The types of remedial services to be employed as a part of the treatment plan and the equipment required to perform those services.

(c) The specific frequency and duration of the planned home health aide visits, such as two times a week or three times a week for one hour intervals each visit.

(d) Any recommended restrictions to the client's normal activities of daily living.

(e) Any recommended dietary restrictions.

(f) Attending physician's prescribed medications and medical treatments.

(g) The attending physician must date and sign the treatment plan.

(2) The case manager must make assessment of the need for home health aide services. The case manager must develop a care plan specifying frequency and duration of service, and formulated with the nurse supervisor, physician, licensed physical therapist, or licensed occupational therapist prior to the delivery of service.

(3) A registered nurse, either paid or volunteer, must be on staff or under contract as a consultant to make home visits to each client. The registered nurse will supervise the home health aides, assess whether the service plan is being carried out properly, attend or provide in-service training, review reports and records, and assist in employee performance evaluations.

(4) The home health aide records services rendered during each visit, completes time and attendance records, participates in performance evaluations, prepares incident reports as the need arises, and attends pre-service and in-service training.

(5) Home health aide care will not substitute for care provided by a registered or practical nurse, or a licensed therapist.

f. Minimum Training Standards.

(1) Pre-Service Training. The home health aide must have training in supportive services, which are required to provide and maintain bodily and emotional comfort and assist the patient toward independent living in a safe environment. If the aide receives training through a vocational school, licensed/certified home health agency, or hospital, the curriculum will be documented. If training is received through the agency, the curriculum will consist of at least 42 hours that include:

(a) Role of the home health aide, differences in families, ethics, and orientation to the agency (2 hours).

(b) Physical appearance and personal hygiene (1 hour). The following topics should be included: uniform; hair; hands and fingernails; cleanliness; teeth; makeup; perfume; jewelry and smoking.

(c) Supervision by a registered nurse registered physical therapist, occupational therapist, registered speech therapist (3 hours). The following topics should be included: role of the supervisor; role of the aide; role of the physician; role of the patient; plan of care; assignment of tasks; record keeping; and performance evaluation.

(d) Personal care services (24 hours), to include the following topics: bathing; dressing; toileting; feeding (eating); bed making; ambulation; body mechanics; transfer techniques; range of motion and exercises.

(e) Nutrition and food management (4 hours), to include the following topics: basic food requirements; purchasing of food; preparation of food; storage of food; serving of food; and special diets.

(f) Household management (2 hours), to include the following topics: care of bedroom, bathroom, kitchen; care of clothing; and safety in the home.

(g) Emotional aspects of disability, including death and dying (6 hours).

(2) In-Service Training. In-service training will be conducted as set forth in paragraph 5-4 of this operating procedure.

2-11. Homemaker Service.

a. Service Definition and Unit of Measure.

(1) Homemaker service means the performance of or assistance in accomplishing specific home management duties including housekeeping, laundry, meal planning and preparation, shopping assistance, and routine household activities by a trained homemaker. With region approval, it may include the purchase of home and/or cleaning supplies needed for the delivery of services. Otherwise, clients are responsible for purchasing their own cleaning supplies.

(2) The unit of service is one hour (or quarter hour portion) of time spent in the provision of designated homemaker duties by a trained homemaker. It does not include time in transit to and from the client's place of residence except when providing shopping assistance, performing errands or other tasks on behalf of the client. If the service is to be provided to a couple, the unit of service must

be assigned to either the eligible husband or wife, preferably the one who usually performs homemaking duties.

b. Minimum Service Standards.

(1) The homemaker may plan and prepare meals according to the client's dietary needs.

(2) The homemaker may perform light housekeeping.

(3) The homemaker may wash and dry dirty laundry at the client's expense, either at the client's home or at a Laundromat.

(4) The homemaker may repair the client's clothing at the request of the client.

(5) The homemaker may perform minor home maintenance (i.e. changing light bulbs).

(6) The homemaker may assist the client with shopping or shop for the client.

(7) The homemaker may assist the client with budgeting and paying bills.

(8) The homemaker may transport the client in the agency vehicle only with prior authorization by supervisor or case manager.

(9) The homemaker is responsible for all record keeping as required by the contracted agency.

(10) The homemaker is responsible for reporting changes in client condition or behavior to the supervisor.

(11) The homemaker is responsible for following established emergency procedures.

c. Restrictions on Service Standards.

(1) The homemaker must not engage in work that is not specified in the homemaker assignment.

(2) The homemaker must not accept gifts from clients.

(3) The homemaker must not lend or borrow money or articles from clients.

(4) The homemaker must not perform services requiring a public health nurse, a home health aide, or personal care worker to perform.

(5) The homemaker must not handle money unless authorized by the supervisor or the case manager and bonded or insured by the employer.

(6) The homemaker must not transport the client unless authorized by the supervisor or case manager.

d. Minimum Service Provision Log Standards.

(1) The homemaker is required to fill out a client service provision log.

(2) Any form used must record the following: the date of the visit; activities performed during the visit, and number of hours spent performing the activities.

e. Minimum Training Standards.

(1) Pre-Service Training. A total of 20 hours of pre-service training is required covering the following: CCDA program and purpose; medical and psychological aspects of disability; interpersonal relationships; nutrition and meal preparation; marketing and food storage; use of household equipment and supplies; planning and organizing household tasks; principles of cleanliness and safety of the home; record-keeping; agency policies and procedures; and emergency procedures.

(2) In-Service Training. In-Service Training will be conducted as set forth in paragraph 5-4 of this operating procedure.

2-12. Home Nursing Services.

a. Service Definition and Unit of Measure.

(1) Home nursing service means a part-time or intermittent nursing care administered to a client by a licensed professional or practical nurse or advanced registered nurse practitioner, as defined in Chapter 464, Florida Statutes. This service must be delivered in the place of residence used as the client's home, pursuant to a plan of care approved by a licensed physician.

(2) The unit of service is one hour of client contact by the registered nurse, advanced registered nurse practitioner or the licensed practical nurse.

(3) This is a health maintenance service which includes those routine health service(s) necessary to help maintain the health of a disabled adult.

b. Minimum Eligibility Standards.

(1) A physician's prescription/plan of treatment is required to obtain home nursing services.

(2) A request for continuation of services, signed by a physician, is required at sixty-two (62) day intervals.

(3) Funding sources inclusive of, but not limited to, Medicare, Medicaid and third-party payment must be exhausted prior to utilization of CCDA funding for provision of home nursing services.

c. Minimum Service Standards.

(1) Home nursing provides services that assist the client in his/her efforts to maintain an optimal level of health of body and mind. These services are to prevent the occurrence or progression of illness, thus decreasing the number of hospitalizations.

(2) Home nursing can be rendered through a home health agency, or provided by an independently practicing registered nurse, a registered nurse employed by a county health unit, or an independently practicing licensed practical nurse working under the direction of a registered nurse.

(3) Nursing services rendered in the home shall include observation, assessment, nursing diagnosis, care, health teaching and counseling, maintenance of health, prevention of illness, administration of medically prescribed medications and treatments, and the supervision and teaching of others in the performance of nursing tasks.

(4) Home nursing service will not be rendered in hospitals or skilled or intermediate care facilities.

d. Minimum Staffing Standards.

(1) A provider of home nursing services must hold a current license under Chapter 464, F.S.

(2) The home nursing provider must be operating within their scope of practice, and pursuant to the client's physician's plan of treatment.

e. Minimum Training Standards. Pre-Service Training and In-Service Training will be conducted as set forth in paragraph 5-4 of this operating procedure.

2-13. Interpreter Service.

a. Service Definition and Unit of Measure.

(1) Interpreter service means assisting a client to communicate despite a hearing or speech impairment or language barrier. Deaf individuals with multiple physical disabilities are even more challenged in their receptive and transmittal skills. They may require special communication efforts in sign language, oral/aural interpreters, voice interpreters, tactile interpreters or cued speech interpreters.

(2) A unit of interpreter service is one hour spent in providing interpreter service to and/or for a client.

b. Minimum Eligibility Standards.

(1) Client must have a communication barrier significant enough to prevent him/her from effectively and accurately receiving or giving information.

(2) Client must not be able to secure the service from his or her own support system.

c. Minimum Service Standards.

(1) Interpreter service is to be used to free clients from significant barriers to communication. Barriers: language and deafness.

(2) Interpreter service should be used to assist clients to access community resources, medical services, or social security, disability, or other governmental agency resources.

(3) All organizational units within the department of Children and Families must adhere to the department's operating procedures, CFOP 60-10, Chapter 4, Auxiliary Aids and Services for Persons Who Are Deaf or Hard of Hearing, when procuring these services for DCF clients.

d. Minimum Staffing Standards.

(1) Sign language interpreters are expected to abide by the Code of Ethics which appears in "Interpreting for Deaf People" (a Department of Health and Human Services publication). This code presents standards of ethical practice including an emphasis on confidentiality, impartiality, non-paternalism, and the continual development of skill.

(2) Language interpreters must possess valid certification as established by the national Registry of Interpreters for the Deaf (RID), the National Association for the Deaf (NAD), and/or have

been determined qualified to interpret by the Florida Registry of Interpreters for the Deaf, Inc. (FRID) through the "Quality Assurance (QA) Screening Program". By using RID or NAD certified or QA Screened interpreters in the appropriate circumstances, we protect consumer as well as departmental interests.

e. Minimum Training Standards. Pre-Service Training and In-Service Training will be conducted as set forth in paragraph 5-4 of this operating procedure.

2-14. Medical Equipment and Supplies.

a. Service Definition and Unit of Measure.

(1) The purchase of medical equipment and supplies for use by CCDA clients is allowable under the CCDA program. Medical equipment and supplies may be durable, such as walkers, wheelchairs, bedside commodes, etc., or it may be non-durable, such as bed pads, colostomy supplies, adult diapers, etc.

(2) There is no measurable "unit" of service for this category. Instead, providers are requested to maintain documentation regarding the expenditure of CCDA funds for this service. The following information should be tracked:

(a) Description of the kinds of equipment requested and needed, and how many requests were received for each (annually);

(b) Of the requests documented, how many received the needed equipment (annually);

(c) Itemization of durable equipment purchased: description, quantity, and price per item (annually);

(d) Number of clients utilizing each type of durable equipment purchased (annually);

(e) Itemization of non-durable equipment purchased: description, quantity, and price per item (annually); and,

(f) Number of times non-durable equipment/ supplies were given to CCDA clients.

b. Minimum Service Standards.

(1) The purchase of medical equipment and supplies should be used only as the last resource to provide the client with needed items.

(2) The purchase of medical equipment and supplies can include both durable and non-durable equipment. Case managers will explain to the clients that the durable equipment being loaned to clients is for their use only so long as they remain an active client in the program and their care plan deems the equipment necessary to their every day functioning.

c. Minimum Service Restrictions.

(1) Durable equipment should be loaned and returned to the program when the client no longer needs it, so that others may use it.

(2) Non-durable equipment/supplies are not to be reused.

(3) Expenditures of more than \$100.00 are to be approved by the region before purchase.

(4) Case managers may request verification from the client's physician for the necessity of any particular item or service.

(5) Supplies need to be related to the client's medical condition.

d. Minimum Training Standards. There are no Pre-Service or In-Service Training standards for delivery of this service.

2-15. Medical Therapeutic Services.

a. Service Definition and Unit of Measure.

(1) Medical Therapeutic Services means corrective or rehabilitative services which are prescribed by a physician or other appropriate health care professional licensed in the State of Florida, designed to assist the disabled person to maintain or regain sufficient functional skills to live independently in the least restrictive environment possible.

(2) Such therapies are necessary services for individuals who have suffered physical damage or debilitation due to disease, trauma or premature aging and may include occupational therapy, physical therapy, respiratory therapy, and services for individuals with speech, hearing and language disorders.

(3) The unit of service is one hour of client contact by the health professional in the client's place of residence or facility where the service can be provided (e.g., hospital outpatient rehab center.).

(4) This is a health maintenance service as defined by its respective practice acts in Chapter 486, F.S.

b. Minimum Eligibility Standards.

(1) A physician or nurse practitioner, or speech, occupational, or physical therapist, must prescribe the needed services.

(2) A request for continuation of services, signed by one of the professionals named above is required at every sixty-two (62) day intervals.

(3) A client receiving like services under another program component will not be regarded as eligible for duplicative medical therapeutic services. For example, a recipient of physical and occupational therapy while in an adult day care program will not be eligible for duplicative services in his/her place of residence or at a provider facility, unless the frequency of treatment(s) required does not correspond with the frequency of attendance at day care.

c. Minimum Service Standards.

(1) Services shall include occupational therapy, physical therapy, speech pathology and audiology. Definitions for these therapies may be found in the glossary.

(2) Payment for supplies and equipment deemed by the therapist or physician as reasonable and necessary to the success of the treatment rendered to the client, will be eligible under this program in accordance with project budgets. All resources will be exhausted prior to the utilization

of CCDA funds for the purchase of supplies or equipment for medical therapeutic services. THE CCDA PROGRAM SHALL BE THE PROVIDER OF LAST RESORT.

d. Minimum Education and Training Standards.

(1) Any provider of a medical therapeutic service must hold current license to practice in the State of Florida in the designated area of the services to be provided, and according to the prescription of a physician. The physician prescription must be renewed every 62 days.

(2) Pre-Service Training. None is required.

(3) In-Service Training. In-service training requirements can be met through attendance at professional meetings/conferences and/or required course work for continuation of registration, certification or licensure status. A minimum of six hours of meeting attendance, course work or other training related to the job function must be obtained per year; content and duration must be documented in staff and agency records holding documentation of the employee's professional qualifications.

2-16. Personal Care.

a. Service Definition and Unit of Measure.

(1) Personal care means services to assist the disabled adult with bathing, dressing, ambulating, housekeeping, supervision, emotional security, eating, supervision of self-administered medications and assistance with securing health care from appropriate sources. Personal care services do not include medical services.

(2) A unit of service is one hour (or quarter hour) of elapsed time spent in providing designated personal care services by a qualified personal care aide.

b. Minimum Staffing Standards.

(1) Personal care aides must be employed by a Lead Agency, a licensed home health agency under contract with the department or by an independent contractor under the supervision of a health professional.

(2) A registered nurse, either paid or volunteer, must be on the staff or under contract with the contracted personal care agency to make home visits to supervise personal care aides at least every 90 days.

(3) The registered nurse will assess whether activities in the service plan are being carried out properly; attend or provide in-service training; review reports and records; and conduct or participate in meetings to staff clients. All such activities shall be documented in the case record.

(4) The registered nurse must also participate in the performance evaluation of the personal care aide.

c. Minimum Service Standards.

(1) The personal care aide will assist the client with personal hygiene, dressing, feeding, transfer and ambulatory needs, including use of a wheelchair, crutches, or walker when applicable.

(2) The personal care aide will assist the client with toileting and/or use of a bedpan.

(3) The personal care aide will assist the client with self-administration of medications when ordered by the client's physician, and as prescribed in the personal care plan. The personal care aide may not administer the medication but may bring the medication to the client and remind the client to take the medication at a specific time.

(4) The personal care aide will assist the client with food, nutrition and diet activities including preparation of meals when essential to good health.

(5) The personal care aide will assist the client performing household services such as changing bed linens, when the performance is essential to good health.

(6) The personal care aide will accompany the client to clinics, physician office visits, or other trips, when health care needs require personal care assistance.

d. Minimum Service Restrictions.

(1) Personal care will not substitute for the care usually provided by a registered or practical nurse, therapist, or home health aide. The personal care aide WILL NOT change sterile dressings, irrigate body cavities, irrigate a colostomy or wound, perform gastric irrigation or enteral feeding, catheterize a client, apply heat by any method, care for a tracheotomy tube, administer medications, or provide any personal health service which has not been included in the patient care plan as prohibited by rules and regulations.

(2) Personal care services MUST NOT be confused with services that are commonly associated with homemaker and home health aide services. Services must be required SPECIFICALLY TO ASSIST THE CLIENT as outlined in the above sections.

e. Minimum Training Standards.

(1) Personal care aides must be trained in those supportive services that are required to make the client comfortable and to assist the client toward independent living in a safe environment.

(2) Pre-Service Training. The personal care staff will receive a minimum of thirty class hours of pre-service training. This training will include:

(a) Ethics and the role of the personal care provider (one hour).

(b) Physical appearance and personal hygiene (one hour).

(c) Supervision by registered nurse (three hours). This should include topics such as: role of the supervisor; role of the personal care aide; role of the physician; role of the client; plan of care; assignment of tasks; record-keeping and employee performance evaluation.

(d) Personal care services (eighteen hours), to include the following topics: bathing; dressing; toileting; feeding (eating); bed-making; ambulation; and body mechanics.

(e) Nutrition and food management (four hours), to include the following topics: purchasing food; preparation of food; storage of food; and serving of food.

(f) Household management (two hours), to include: care of bedroom, bathroom, kitchen; care of clothing and safety in the home.

(g) Physical, mental, and social aspects of disability; and the social aspects of death and dying (two hours).

(3) In-Service Training. In-Service Training will be conducted as set forth in paragraph 5-4 of this operating procedure.

2-17. Physical and/or Mental Examinations.

a. Service Definition and Unit of Measure.

(1) CCDA funds may be used to purchase the services of a physician or psychologist/psychiatrist/mental health professional in order for a CCDA client to receive needed medical or mental health services for the purpose of evaluation. Physical and mental examinations should not be provided for extensive treatment or treatment needed over time through numerous examinations. THE DPOAA MUST APPROVE EACH EXAMINATION BEFORE SERVICES ARE RENDERED.

(2) A unit of service is measured in episodes, with one episode (one unit) defined as one examination, either physical or mental, made by one physician, psychologist, or mental health professional (see glossary for definition).

(3) This is a health maintenance service as defined by Section 410.603(4), F.S., it is those routine health service(s) necessary to help maintain the health of the disabled adult.

b. Minimum Training Standards.

(1) Pre-Service Training. A provider of physical or mental examinations must hold a license in good standing to practice medicine, or to conduct psychological examinations, or in the case of professional mental health counseling, must be certified as a mental health professional.

(2) In-Service Training. There are no in-service training requirements.

2-18. Respite Care.

a. Service Definition and Unit of Measure.

(1) Respite care means relief or rest for a primary caregiver from the constant supervision, companionship, therapeutic and personal care on behalf of the client for a specified period of time. The purpose of the service is to maintain the quality of care to the client for a sustained period of time through temporary, intermittent relief of the primary caregiver.

(2) The unit of service is one hour or quarter hour of elapsed time spent in the provision of respite care services by a qualified worker.

b. Minimum Service Standards.

(1) Respite care may be provided for up to 240 hours per client per calendar year depending upon individual need. The service may be extended up to 360 hours as recommended by the client's case manager and with documented approval by their immediate supervisor. The service may be provided during a concentrated period or spaced throughout the year. The region may approve additional hours on a case by case basis.

(2) The case manager will determine the level and intensity of care required by a client. The case manager may obtain consultation from other service providers, the client's family, caregiver, physician, or nurse to determine the appropriate level of respite care needed.

(3) Respite care will not be substituted for the care usually provided by a registered nurse, licensed practical nurse, or therapist.

(4) In-home respite care may be provided by staff qualified as a homemaker, home health aide, personal care worker, sitter or companion, a combination of the above, or a trained volunteer, as long as service standards are met.

(5) Services provided for respite purposes will be classified as such and not as homemaker, home health aide, personal care services and the like, even though a homemaker or health aide may render the service.

(6) Respite care staff must be appropriately supervised. A health or social service professional must be available to supervise and provide in-service training to workers providing the respite services. If, for medical reasons, a home health aide must provide all or parts of the respite care services, a registered nurse or health professional must supervise the aide. As an alternative, an agreement may be developed with a visiting nurses association, the Red Cross, or a home health agency, to supervise respite staff.

(7) Respite care is to be provided in the CCDA client's home in familiar surroundings, however, when a respite caregiver is not available to go to the client's home, respite care may be provided in an adult day care facility, adult living facilities, or nursing home on a temporary basis. RESPITE CARE SERVICE MAY NOT BE PROVIDED TO RESIDENTS OF NURSING HOMES OR ASSISTED LIVING FACILITIES.

c. Minimum Education and Training Standards.

(1) Pre-Service Training. Staff or volunteers providing this service must receive at least twenty hours of instruction in the following areas:

(a) Health problems and care of disabled persons.

(b) Basic personal care procedures such as grooming.

(c) First aid and handling of emergencies. Formal written emergency procedures will be developed for the respite staff to follow should an emergency occur.

(d) Food, nutrition, meal preparation, and household management.

(2) In-Service Training. Training required is dependent upon level of care provided. If personal care is to be provided, the personal care standards must be met.

(3) Education required is dependent upon level of care provided; however, the respite worker must have the ability to read, write, and complete required reports.

2-19. Transportation.

a. Service Definition and Unit of Measure.

(1) Transportation service means the transport of a client to and/or from service providers or community resources. Any transportation essential to the implementation of the service plan is allowable. CCDA funds may not be used to purchase transportation vehicles.

(2) Transportation service is measured in trips: one trip is defined as one, one-way trip measured from a point of origin to a destination. The following are examples of measurement:

EXAMPLE: Client is taken from home to the doctor's office (1 trip). Client is then taken from the doctor's office to the drug store (1 trip). Client is returned from the drug store back home (1 trip). Total number of trips this episode is 3 trips.

EXAMPLE: Client is taken from home to rehab therapy.(1 trip) Client is taken from rehab therapy to the grocery store.(1 trip) Client is then taken from the grocery store to the drug store.(1 trip) Client is taken from the drug store back to the grocery store (forgot eggs).(1 trip) Client is returned from the grocery store back home.(1 trip) Total number of trips this episode is 5 trips.

b. Minimum Standards for Service Delivery.

(1) Services will be provided on a demand/response basis. Except for emergencies, clients must request services at least 24 hours in advance to facilitate efficient use of vehicles and staff.

(2) Existing transportation systems and equipment must be utilized before CCDA funds are used for transportation services.

(3) An ambulance, taxicab, common carrier, or project vehicle may provide services. The agency or the vehicle owner must provide excess liability coverage. Transportation services will be provided only by persons having a valid Florida driver's license. If volunteers are used, they must have a valid driver's license. Drivers who transport clients on a regular basis in project vehicles must have a valid Florida Chauffeur's license.

(4) When transporting one or two clients, a driver may act as an escort provided that the case manager determines that the client cannot be left alone while receiving the services, and the client's needs will not interfere with the driver's ability to safely control the vehicle. In such instances, only one or the other may be counted in units of service, transportation trips or escort hours.

(5) If the need to supervise a client will interfere with a driver's ability to safely transport, the provider will send another qualified staff person along to provide supervision of that client.

c. Minimum Provider Service Standards.

(1) Must be in compliance with federal, state and local regulations as well as those regulations issued by the Department.

(2) Transportation providers must document that staff personnel and volunteers are fully trained to provide the services offered by the transportation program.

(3) Transportation providers must obtain and maintain minimum vehicle insurance coverage on all provider owned or leased vehicles in accordance with the Division of Risk Management.

(4) Transportation providers must document that all drivers who transport clients on a regular basis in provider vehicles have:

(a) A valid State of Florida Chauffeur License.

(b) Minimum of one year's driving experience with vehicles similar to those to be operated for the project.

(c) A safe driving record acceptable for insurance coverage.

(d) Successfully completed an American Red Cross or similar program to meet health emergencies and accidental injuries.

(e) Document that volunteers who drive privately owned automobiles to transport clients meet standards as set forth in CFOP 60-30, Chapter 5, Volunteer and Intern Program.

(f) Report all unusual incidents, accidents or problems to proper authorities to be investigated and to employee's supervisor to be recorded on provider files.

d. Minimum Training Standards.

(1) Pre-Services Training. A total of ten hours is required for contract service providers and DCF staff. The following topics should be included in the training: interpersonal relationships; operation of vehicle and equipment; and accident and emergency procedures in the event something may happen to the client while being transported. Training will be conducted as set forth in paragraph 5-4 of this operating procedure.

(2) In-Service Training. Contract service staff providing medical transportation must be scheduled regularly for in-service training to augment or refresh knowledge in any of the above listed areas. In-Service training will be conducted as set forth in paragraph 5-4 of this operating procedure.

Chapter 3

FEE ASSESSMENT PROCEDURES

3-1. Purpose. The purpose of this chapter is to explain in simple terms the schedule of fees for services to be charged to the disabled adult whose income exceeds the Institutional Care Program (ICP) limit. The assessed fee amounts will be collected based on the disabled adult's ability to pay.

3-2. Statutory Authority. The statutory authority for this fee is established in Section 410.606(6), Florida Statutes (F.S.), and the schedule of fees is defined in Rule 65C-2.007, Florida Administrative Code (F.A.C.), Fee for Services:

a. Section 410.606(6), FS., reads "The department and providers shall charge fees for services that the department provides a disabled adult whose income is above the existing institutional care program eligibility standard, either directly or through its agencies or contractors. Services of a specified value may be accepted in lieu of a monetary contribution."

b. Rule 65C-2.007, F.A.C., reads "Priority for services is based on need for services combined with the income level of the prospective client. First, eligibility must be determined through the administration of a functional assessment and verification of the client's income. If the income is above the existing institutional care program eligibility standard then a fee for services will be assessed. Once an applicant is deemed eligible and a priority candidate for services, a determination shall be made as to a dollar amount that the applicant will be charged for those services based on an overall ability to pay. Partial payments may also be assessed."

3-3. Why Assess for Fees.

a. The concept of fee assessment is to help increase the number of clients to be reached by the CCDA program. Fee collection permits applicants who would otherwise not meet a stringent, income eligibility criteria to participate in the program.

b. It also allows expansion of the program through the increased funding base created by the client fees being remitted back into the program.

3-4. Procedures for Determining Fees To Be Assessed.

a. The case manager shall request information from the applicant or his spouse, relative or guardian if needed, as follows:

(1) Monthly income to include all earnings, payments and pensions to the applicant. Assets are not included.

(2) Expenses to include housing and utilities, telephone, food, medical expenses, transportation and insurance.

b. Necessary monthly expenses shall be subtracted from monthly income as defined in to determine the applicant's disposable income and overall ability to pay.

c. Applicants who have \$200.00 or more remaining after expenses have been subtracted shall be assessed a fee toward the cost of service received.

d. The applicant will be asked to pay 10 percent of his disposable income or the unit cost of the service he is to receive, whichever is less. The unit cost will be determined from the most recent unit cost report of the provider or the fixed rate charged in a contract.

e. At the time the ability to pay is determined, the applicant shall attest to the truthfulness of his financial status by signing a written statement.

f. Redetermination of a client's ability to pay shall be on an annual basis. The client may request redetermination based upon a change of financial status.

g. The fee formula is attached (Appendix A to this operating procedure). Central Office does not collect this data. Fees are region specifically tracked and managed as are their budgets.

3-5. Exceptions to Fee Assessment Application.

a. In those situations where the applicant is currently receiving a service on a private pay basis and can continue to pay for the service, he shall not receive the service under state Community Care for Disabled Adult funds.

b. If the service is available on a private pay basis from another agency and the client assessment has determined that the applicant can pay for the service, then the applicant shall be referred to the other agency for the services.

c. However, if the applicant is able to pay for a service, but the service is not available from any other agency, and he is in need of the service, then the Community Care for Disabled Adults provider shall provide the service, inform the applicant of the dollar amount or in-kind service, and require such fee toward the cost of the service.

d. If the client is unwilling to pay the assessed fee or contribute the in-kind services of specific value, services shall be denied.

3-6. Handling Collected Fees.

a. Fees collected must be remitted back into the CCDA program.

b. All state and provider staff directly handling assessed monies must be bonded under a group fidelity bond in individual amounts of \$25,000 and insured. Bonding is to ensure that every person, who has access to or control over funds collected through the program, is covered by a bond against loss resulting from employee dishonesty.

c. Each Project Director must be individually bonded for \$100,000. The cost of the bonding shall be borne by the provider agency.

d. Clients shall have the opportunity to perform volunteer services in lieu of making payments, in accordance with departmental procedures.

e. Client payments shall be directed to the provider agency and may be used to expand the Community Care for Disabled Adults program.

Chapter 4

CLIENT ELIGIBILITY

4-1. Purpose. The purpose of this chapter is to set criteria to be used by case management staff for determining applicant eligibility for Community Care for Disabled Adults (CCDA) Program services.

4-2. Appropriateness of Referral. The case manager should use a screening process to determine whether the applicant has been appropriately referred to CCDA. To be eligible for CCDA services, the applicant must:

a. Be 18 through 59 years of age; and,

b. Have one or more permanent physical or mental limitations that restrict the ability to perform normal activities of daily living (ADL) (see glossary definition) as determined through the initial functional assessment and documentation of disability.

4-3. Documentation of Disability. In order to receive CCDA services the case manager must establish that the prospective client is in fact disabled. Disability can be verified in one of the following ways:

a. If the applicant receives Supplemental Security Income (SSI), Social Security Disability Income (SSDI), or some other disability payment, then disability has already been established. To confirm this, the CCDA case manager must see a check, awards letter, or other evidence that indicates that the applicant is disabled. The case manager must document this verification in the case file.

b. If the applicant is not receiving a disability payment, the case manager must obtain confirmation of disability and place documentation of the same in the case file. The documentation must be in the form of a written statement from a licensed physician (Medical Doctor or Doctor of Osteopathic Medicine), licensed nurse practitioner, or mental health professional (See glossary definition). The statement must include the applicant's diagnosis, prognosis and the client's level of functioning and need for assistance due to the disability. Either the client or the case manager can obtain the statement. Once the case manager has established disability, the case manager must complete the Adult Services Client Assessment Form.

4-4. Prioritization of Clients.

a. Florida Statute 410.604 states that services are to be prioritized to applicants who are not receiving comparable services from other agencies, such as the Division of Vocational Rehabilitation and the Division of Blind Services Programs of the Department of Education, or the Brain and Spinal

Cord Injury Program of the Department of Health. As program vacancies occur, the case manager will search the waiting list for the highest assessment score to fill that vacancy. When there are two or more clients who have the same score and the program does not have the means to serve both clients, the case manager must prioritize the clients for service. The case manager will consider the earliest intake date and the following items as part of the prioritization process for filling the program vacancy:

- (1) The applicant is a victim of a report of abuse, neglect, or exploitation that has verified findings or not substantiated findings with less than a preponderance of evidence;
- (2) The applicant's income is at or below the prevailing Institutional Care Program (ICP) eligibility standard;
- (3) The applicant's risk of placement in an institution;
- (4) The applicant's projected annualized cost of care;
- (5) The services can be accessed through another means such as Medicaid, Medicare, or private payment;
- (6) The applicant's informal support network; and,
- (7) The geographic availability of resources within the applicant's community.

b. IF A CLIENT HAS BEEN IDENTIFIED BY ADULT SERVICES AS HAVING INDICATORS OF ABUSE, NEGLECT, OR EXPLOITATION AND IS "AT RISK", THEN SUCH A CLIENT MUST RECEIVE THE HIGHEST PRIORITY FOR SERVICES.

Chapter 5

COMMON SERVICE REQUIREMENTS

5-1. Purpose. The purpose of this chapter is to identify and address requirements common to all Community Care for Disabled Adults (CCDA) services described in chapter 2 of this operating procedure.

5-2. Common Requirements. The following is a list of the requirements that are common to all services:

a. All client information is confidential and will only be disclosed with the written consent of the client or guardian. Procedures must be established to protect confidentiality of records and to obtain the individual's informed consent prior to release of confidential information.

b. Persons and/or agencies providing services will:

(1) Develop training curriculums for pre-service and in-service training as required by operating procedure policy.

(2) Meet all statutory licensing and certification requirements.

(3) Complete a level I background screening on all employees in an employment position that allows direct service contact with any client receiving services through the Adult Services program. The screening will include employment history checks and statewide criminal correspondence checks through the Florida Department of Law Enforcement and may include local criminal record checks through local law enforcement agencies.

- (4) Comply with continuing education requirements.
- (5) Obtain any required state or local permit.
- (6) Meet building codes and standards.
- (7) Obtain any required insurance.
- (8) Deliver services only to clients living in a private residence.

5-3. Personnel Requirements. Contracted and departmental direct service personnel (inclusive of case managers) will comply with certain requirements.

a. Paid and Volunteer Staff. All staff in direct contact with clients will:

- (1) Only handle the client's money if required by the service provided;
- (2) Not disclose confidential information; and,
- (3) Not accept monetary or tangible gifts from clients.

b. Volunteer Staff. Providers will incorporate volunteers and other community resources whenever possible and assure that services are delivered efficiently by coordinating with other agencies to obtain appropriate services.

5-4. Training Requirements. Providers will establish procedures to recruit, train, schedule, and evaluate both paid and volunteer staff and the completion of each of these procedures by individual staff will be documented in provider or personnel records.

a. Pre-service Training. Paid staff and volunteers who have direct contact with clients will participate in a basic orientation called pre-service training before providing services on a regular basis and within 6 weeks of hire. This training will consist of a minimum of 6 hours training covering the following topics:

- (1) Overview of prevalent disabilities served by the Community Care for Disabled Adults (CCDA) program and the medical and psychological aspects of those disabilities;
- (2) Overview of the CCDA program, its purpose, philosophy, policies and procedures;
- (3) Overview of the Adult Services Network;
- (4) Interviewing techniques to be used with disabled adults;
- (5) Abuse, neglect, exploitation and incident reporting;
- (6) Local agency procedures and protocols;
- (7) Client confidentiality;
- (8) Safety and home accident prevention;
- (9) Emergency procedures to follow in the event of a crisis during the course of service delivery; and,

(10) The use of assessment instruments, development of care plans, and record-keeping procedures.

b. In-service Training. Unless stated otherwise in Chapter 2 of this operating procedure, both provider and region office staff will update their respective training curriculums and provide in-service training annually to their direct service staff.

(1) Providers will update their training curriculums and provide a minimum of three hours in-service training annually for provider staff.

(a) When providers are enrolled by Region Office staff, the Region Office will assure that providers' training curriculums are updated and annual training is provided.

(b) When providers are enrolled by another agency, that agency will assure that providers are appropriately licensed and trained.

(c) Region Office staff will update training curriculums and provide a minimum of three hours in-service training annually for adult Services staff.

(2) A qualified person will provide all training.

(3) The region may negotiate the required training methods and training materials within the provider contract or the region may allow the required training methods and training materials to be determined by the provider. All training curriculums must meet Office of the Secretary, Education and Training (OSET) guidelines and include the disability issue criteria established in Chapter 5 of this operating procedure.

5-5. Service Restrictions. The following restrictions are applicable to service delivery and billing of approved CCDA services:

a. Travel time to and from the client's home, except for case management, is not counted in units of service unless travel time is specifically included as part of the service as documented in chapter 2 of this operating procedure; and,

b. All sources of federal, state or insurance funds (excluding local match) external to CCDA program funds must be exhausted prior to spending CCDA state general revenue funds for any approved CCDA service.

Chapter 6

ROLE OF THE COMMUNITY CARE FOR DISABLED ADULTS CASE MANAGER

6-1. Purpose. The purpose of this chapter is to clarify the role of the case manager in arranging and coordinating in home and community services to eligible clients. These guidelines provide the case manager with the needed knowledge and skills to efficiently perform client-level intervention and system-level intervention case management tasks.

a. The primary goal of a case manager is to optimize client functioning by providing a client centered series of activities involving planning, and the arrangement for and coordination of appropriate community-based services for an eligible Community Care for Disabled Adult (CCDA) client. Client-level case management includes:

(1) Intake and referral;

- (2) Comprehensive uniform assessment;
- (3) Development of a care plan;
- (4) Arrangement and coordination of client services; and,
- (5) On-going monitoring of the client's progress to assure the effective delivery of services.

b. The secondary goal of the case manager is to explore and enhance departmental relations with existing and prospective service providers to improve the client service delivery system. System-level case management includes:

- (1) Analysis of the strengths and limitations of the provider network;
- (2) Defining how the agency and the provider network systems can both work together to positively affect clients and strive to optimize this positive working inter-relationship;
- (3) Selecting strategies to improve the region service delivery system; and,
- (4) Assessing the effectiveness of those strategies and continuing to repeat and revise steps 1 through 3.

c. When case management is the only service a prospective client needs, then it is appropriate that it be provided by CCDA, as long as the use of CCDA funds for this purpose is the last resort for obtaining the service. It must be determined that the referral needs only case management services, and not guardianship services. Employees holding positions funded partially or wholly by the CCDA program (this includes service contract providers and DCF staff) are prohibited from serving as a client's guardian.

d. The case manager must ensure that each client receives appropriate assistance by providing accurate and complete information about the extent and nature of available services and by helping the client decide which services will best meet his or her needs.

e. The case manager must make every effort to foster and respect maximum client self-determination and ensure the client's right to privacy.

f. CCDA case management includes tracking service expenditures and ensuring that the total cost, estimated or actual, for each individual receiving Community Care for Disabled Adult services is kept below the average general revenue portion of a Medicaid nursing home bed within the region area. This amount will vary region by region.

6-2. Goals of CCDA Case Management. Contracted and departmental case managers are an important link between our disabled adult clients, contracted providers and the community services the clients need. Some specific goals of a CCDA case manager are listed below.

a. Accelerate the client's access to a continuum of care extending from arrangement of in-home services to institutional placement by providing clients with a single-entry point into the community care service system.

b. Link disabled adults with natural supports and services in the community.

c. Monitor the physical and mental well-being of clients.

- d. Ensure a maximum range of service options that reflect clients' preferences in terms of providers, where services are provided, hours of services, and ways in which services are provided.
- e. Prevent unnecessary duplication of services to the CCDA client by other county and state agencies.
- f. Ensure the changing needs of clients are addressed to avoid or reduce unnecessary dependence upon a service that becomes inappropriate, as the client's needs change.
- g. Encourage client independence and self-sufficiency.
- h. Acknowledge client feedback and document gaps in the service delivery system to provide information for program planning and budgeting.
- i. Nurture departmental and provider relationships and provide support to the provider and the client in order to foster a productive partnership between the two.

6-3. Basic Client-Level Functions and Responsibilities of the CCDA Case Manager.

- a. Identifies Community Resources. The CCDA case manager has the responsibility for knowledge of federal, state and community resources in order to coordinate the best service package for eligible clients.
- b. Receives Referrals. A separate intake worker or the CCDA case manager may receive and screen referrals. The Intake form (CF-AA 1022 or DOEA Form 111A) is used for each client referred. A separate Telephone Screening form (DOEA Form 111D) may be used in areas with a high volume of calls, to determine the prioritization of clients receiving an in-home Adult Services Client Assessment, form CF-AA 3019. The intake worker or CCDA case manager will determine whether further action is needed, or whether the applicant should be referred to another agency. If the intake or screening indicates that further action is needed, the CCDA case manager must, within three working days of the receipt of the referral, make a contact with the applicant to schedule a home visit and face-to-face assessment of the client's situation. The home visit must be conducted as quickly as possible, but no later than 14 days from receipt of the referral.
- c. Completes Adult Services Client Assessment with the Applicant. The CCDA case manager should complete an Adult Services Client Assessment with the applicant using the Adult Services Client Assessment Form (CF-AA 3019), within 14 days of the receipt of an appropriate CCDA referral. The assessment will determine the client's level of functioning, existing resources, service needs and barriers to meeting those needs. An assessment completed for a DCF client subsequently referred to the CCDA program from another DCF program, can be used if the assessment was made within 90 days prior to CCDA program receipt of the referral.
- d. Assesses the Applicant for Fee Collection. If the CCDA applicant is determined eligible and has an income that is above the institutional care program eligibility standard, then the CCDA case manager must assess the applicant to determine the appropriate fee, if any, to be charged for each service delivered. Instructions for fee assessment and the necessary forms to be completed for this process are contained in paragraph 3-7 of this operating procedure.
- e. Obtains an Authorized Release of Information Form. The case manager will request that the client complete a Release of Information Form (CF-ES 2613) so that necessary information can be shared with service delivery staff and agencies involved in providing appropriate services.
- f. Develops a Care Plan. If the applicant is determined eligible for CCDA services after the Adult Services Client Assessment is completed, the case manager must develop an individualized care

plan (CF-AA 1025) and open a case file for the client. Care Plan development and determination of services to be authorized are discussed in chapter 8 of this operating procedure. The care plan, developed with the client, caregiver and immediate family, must contain:

- (1) A description of the barriers to the client's daily functioning;
- (2) Measurable and clear outcomes desired by members of the care plan team, the agencies and people involved and responsible for service provision; and,
- (3) The amount, frequency and duration of the services to be provided.

g. Arranges for Services Needed by the Client. As quickly as possible, the CCDA case manager must arrange for services authorized on the individual care plan. All referral contacts and communication with other state service agencies and with ancillary community resources conducted on the client's behalf must be documented within the narrative of the individual client's case record. The case manager may negotiate for services with the provider through a purchase order or voucher method of payment or the case manager may decide to contract for services. The use of purchase orders and vouchers as CCDA service funding mechanisms is addressed in chapter 11 of this operating procedure. Contracting for CCDA services is addressed in chapter 10 of this operating procedure. In those instances where the CCDA case manager is also the program contract manager, the case manager must discuss the following details with the case management provider agency:

- (1) The abilities and functioning barriers of each client to be served by the provider; and,
- (2) The service amounts, duration, and intensity of services to be provided.

h. Provides Follow-up. The CCDA case manager must conduct and document, in the case record, follow-up contacts with each new provider to whom a client has been referred for services within thirty days of referral to ensure that services have begun.

i. Maintains Ongoing Communication with Other Agencies. The CCDA case manager will coordinate with other agencies to improve the quality of services to the client, provide valuable information, and save time by preventing duplication of services. Since case management is most often not referral alone, but a planned approach for serving clients over time, it is important that a high level of inter-agency communication and coordination be maintained. This is especially important when multiple agencies provide services to the same client. Case managers are encouraged to meet regularly with other appropriate agencies to staff mutual clients and nurture inter-agency relationships.

j. Documents Case Activities. Good case recording is integral to case management. At any point in the on-going case management process where the CCDA case manager feels a notation should be entered relevant to the case, they should not hesitate to enter it. Cases without ongoing progress notes are considered cases without ongoing action. Progress notes reflect case flow and should be consecutively related to each other so a reader can easily understand the transactions that have taken place. The entries should always be dated accordingly. Progress notes are meant to be concise, to the point, and indicative of pertinent case action. An independent reviewer must be able to identify client status and services and obtain a good overview of case management. The record may also serve as a tool to track improvement in the performance of the case manager. The following information must be documented in the narrative of the case record:

- (1) Follow-up contacts to other service providers regarding services for the client;
- (2) Telephone contacts;
- (3) Agency contacts in which client information has been released;

- (4) Case staffing involving the client;
- (5) Client progress or any changes in the client's status; and,
- (6) All other pertinent information received or shared relative to the client.

k. Reviews and Monitors Care Plan. Care plan review and home visits must take place at least quarterly, or more frequently depending upon the individual client. The CCDA case manager will establish a care plan review schedule for home visits or face-to-face contact with each client. The CCDA case manager will also monitor for continuity of services and changes in the client's functioning that warrant modification to the care plan.

l. Reassessment of Client. The CCDA case manager must complete an Adult Services Client Assessment (form CF-AA 3019) on each client for case management, as well as care planning and service coordination purposes at least once every year. The entire form is completed initially and annually at reassessment. A new form is used each year. **(This form may be updated once ONLY in a different color ink.)** Reassessment information results are to be used in annually modifying and updating the care plan.

m. Terminates Services. After a review and update of the client's situation, a decision to discontinue a client from services can be made with the client and, when appropriate, with his family or caregiver. Case termination is further described in paragraph 6-5 of this operating procedure.

n. Makes Referrals to Florida Abuse Hotline Information System. CCDA staff and their subcontractors are required by Section 415.103, Florida Statutes to report any knowledge or suspicion of abuse, neglect, or exploitation to the Florida Abuse Hotline Information System at 1-800-96ABUSE or 1-800-962-2873. (Reference CFOP 140-2 for further guidelines.)

6-4. The Case Manager's Development of the Case Record.

a. Definition and Purpose.

(1) The case record is the source document maintained by the CCDA case manager for each client. It contains all of the client information necessary to justify the provision of service(s).

(2) The case manager must update the case record at regular intervals so that accurate and current information is available regarding the client's needs, medical and mental status, next of kin, attending physician, service(s) provided by the CCDA program, and all other agencies serving the client. The case record should provide a brief description of the client so that in the absence of the case manager, continuity of services may be ensured.

b. Contents of the Case Record. The case manager is responsible to ascertain that all case records contain the following information:

- (1) A completed Adult Services Client Assessment Form, CF-AA 3019, not more than one year old;
- (2) A current care plan, CF-AA 1025, which has been completed at least annually and updated quarterly or more if necessary;
- (3) A Financial and Medical Release Form, CF-ES 2613, signed by the client allowing the case manager to make arrangements for the provision of services;

- (4) A copy of the Client Information System (CIS) Form, form CF-AA 3012, containing all pertinent information, not more than a year old;
- (5) Documentation of client's disability (per paragraph 2-3 of this operating procedure);
- (6) Documentation of the client's income and assessment for fee collection, if applicable;
- (7) A copy of the referral/intake form, DOEA Form 111A or CF-AA 1022; and,
- (8) A case narrative which includes documentation of referrals made to other community service providers and a summary of client contacts.

6-5. Case Manager Tasks Related to Record Closure/Service Termination.

a. A client's case must be closed for one or more of the following reasons:

- (1) Client is no longer eligible (age, disability status); or,
- (2) Services are no longer needed: or,
 - (a) Improvement; or,
 - (b) Refuses to continue services; or,
 - (c) Family or other persons intervening; or,
 - (d) Transferred to other program(s); or,
- (3) Change in placement: nursing home, other institution, or hospitalized; or,
- (4) Client's behavior is abusive or disruptive; or,
- (5) Client refuses to pay assessed fee or account is delinquent; or,
- (6) Client moved out of service area; or
- (7) Client died.

b. When a client's case is terminated, the CCDA case manager must record a brief explanation of the reason for the termination and the termination date in the case record.

c. When a client has not received any service(s) for a period of six months then the case should be terminated, with appropriate documentation in the case record justifying closure.

d. The termination of services to a client will be reported by updating the Client Information Form (CF-AA 3012).

e. The client shall be notified in writing of the termination of a service(s), except for conditions (3) and (7) above. CF-AA 1114 (Notice of Ineligibility or Change in Service Status) may be utilized when notifying the client of termination of services.

6-6. The Role of the CCDA Case Manager Regarding Administrative Hearings. The department is required to provide a system of administrative hearings whereby applicants for, or recipients of, general

revenue social services may challenge decisions concerning eligibility or receipt of services made by the department or one of its designated service contract providers.

a. Challenges may be made upon denial of a CCDA application for services or when the Department or provider notifies the CCDA client of any action which would terminate, suspend, or reduce CCDA services which are being received.

b. Service recipients who are dissatisfied with the provision of CCDA services have the right to request an Administrative Hearing.

c. Authority for an Administrative hearing is found in Chapter 120, Florida Statutes, Administrative Procedure Act. Procedures to follow in requesting an Adult Services Administrative Hearing can be found in the Adult Services Due Process Rights Brochure, CF/PI 140-43, and must be utilized by CCDA staff, applicants and clients.

Chapter 7

COMPLETING A NEEDS ASSESSMENT AND PRIORITIZING CLIENTS FOR SERVICE (this chapter will be added at a future date)

Chapter 8

CARE PLAN DEVELOPMENT (this chapter will be added at a future date)

Chapter 9

MAXIMIZING RESOURCES

9-1. Purpose. The purpose of this chapter is to acquaint Adult Services staff with the various state and federally funded service programs which exist in the State of Florida to serve adults with disabilities. Knowledge of these programs will facilitate the integration of interagency services to ensure the most efficient use of Community Care for Disabled Adults funding.

9-2. Determining Appropriateness of a Referral. The case manager's resources and expertise can guide the applicant through the complex community service delivery system and assist him/her in gaining access to the various services and programs available in the community.

a. Information gathered through an initial telephone assessment can help the case manager determine if the referral to Adult Services is appropriate, or if a referral to another agency would be more appropriate.

b. When the initial telephone assessment does not disclose enough information to make such a determination, the case manager will complete a more thorough screening to better identify the applicant's problems and present to him/her useful solutions to those problems. This screening will discern factors impeding the applicant's functional independence, physical and nutritional stability and psychosocial well-being which may put the applicant at risk for remaining in the community.

c. The Adult Services referral process for service programs administered by agencies external to Adult Services, and for ancillary community services is outlined in a best practices training guide found on the Adult Services web page.

9-3. Staffing to Assure Integrated and Complimentary Service Delivery. The Adult Services case manager may request a staffing of any client case that presents complex medical or service delivery issues.

a. The inter-agency staffing is held to:

- (1) Prepare an integrated and coordinated care plan;
- (2) Clarify agency roles;
- (3) Assign financial and service responsibility; and,
- (4) Assure a seamless, complimentary service delivery.

b. The Adult services case manager will act as the lead case manager. The lead case manager will be responsible to:

- (1) Conduct a Comprehensive Assessment of the applicant for services;
- (2) Request the staffing;
- (3) Identify and notify the applicant/family and the agencies or programs appropriate to participate in the staffing;
- (4) Make arrangements for the staffing;
- (5) Develop a care plan that addresses all the areas of need that were identified through the comprehensive assessment process and that identifies the individuals/agencies who will be responsible for assuring that appropriate services are delivered;
- (6) Distribute a copy of the written care plan to all members involved in the staffing; and,
- (7) Arrange and conduct at least annual (or more often as determined necessary by the lead case manager) staffing to review the care plan and request reports from each participant in order to facilitate a written update of the care plan.

c. The Adult Services Program Administrator or designee will resolve conflicts that may occur as a result of the staffing. This person will have the authority to make decisions about funding and other issues raised during the staffing that could not be resolved by staffing participants.

9-4. Programs Administered by the Department of Children and Families.

a. The Home Care for Disabled Adults (HCDA) program provides case management and caregiver subsidy payments as an incentive for a person or group of persons to provide care for an adult who is 18 to 59 years of age and permanently disabled in a family-type living arrangement. It provides three types of subsidies:

- (1) A basic subsidy to assist with food and personal needs;
- (2) A medical subsidy to reimburse for the cost of prescribed medical care not covered by Medicaid, Medicare or other third-party insurance; and,
- (3) A special subsidy to assist with the purchase of special high and low-tech assistive devices and specialized medical care.

b. The Adult Cystic Fibrosis Program (ACFP) program goal is to assist with the extraordinary costs incurred directly by adults with cystic fibrosis (CF) and increase the independence, dignity, and quality of life for CF adults. This program provides:

- (1) Case Management;
- (2) Adult Day Health Care;
- (3) Alternative Treatment Therapies;
- (4) Pharmaceuticals;
- (5) In-Home Care Supplies;
- (6) In-Home Care Services;
- (7) Personal Care;
- (8) Nutritious Food;
- (9) Vitamins and Nutritional Supplements;
- (10) Out-Patient Preventive/Primary Care; and,
- (11) Out-Patient Mental Health Care.

c. The Developmental Disabilities (DD) program provides adults with mental retardation or such conditions as autism, cerebral palsy, spina-bifida or Prader-Willi syndrome with the following community-based and home-based services to prevent or reduce inappropriate institutional care:

- (1) Adult Day Training;
- (2) Companion Services;
- (3) Environmental Modifications;
- (4) Occupational Therapy and Assessment;
- (5) Personal Emergency Response Systems;
- (6) Residential Habilitation;
- (7) Specialized Group Homes;
- (8) Support Coordination;
- (9) Psychological Assessment;
- (10) Respite Care;
- (11) Wheelchairs and Related Adaptations;
- (12) Supported Employment;
- (13) Room and Board;

- (14) Behavioral Analysis and Assessment;
- (15) Homemaker and Chore Services;
- (16) Consumable Medical Supplies;
- (17) Non-Residential Habilitation;
- (18) Personal Care Assistance;
- (19) Physical Therapy and Assessment;
- (20) Private Duty Nursing;
- (21) Speech Therapy and Assessment;
- (22) Supported Living Coaching;
- (23) Skilled Nursing;
- (24) Transportation;
- (25) Dental Services;
- (26) Family Care Program; and,
- (27) Medical Services.

d. The DCF Mental Health (MH) and Substance Abuse (SA) programs offer supportive services to adults who are experiencing mental health or substance abuse problems. Assistance is provided in attaining skills and behaviors needed to function successfully in living, learning, work and social environments. Some of the services offered are:

- (1) Case Management;
- (2) Assessment;
- (3) Primary Medical Care;
- (4) Day Care;
- (5) Partial Hospitalization;
- (6) Transportation;
- (7) In-Home and On-Site Services;
- (8) Crisis Stabilization;
- (9) Prevention/Intervention;
- (10) Respite Services;
- (11) Supported Housing/Living;

- (12) Room and Board with Supervision;
- (13) Information and Referral;
- (14) Behavioral Health Services; and,
- (15) Supported Employment.

e. The Aged or Disabled Adult Home and Community-Based Services (ADA/HCBS) Waiver provides the following services to adults aged 18 through 59 with disabilities and frail persons aged 60 years or older, who meet financial and functional criteria for nursing home placement:

- (1) Adult Day Health Care;
- (2) Adult Companionship;
- (3) Environmental Modifications;
- (4) Case Management;
- (5) Personal Emergency Response Systems;
- (6) Case Aide;
- (7) Attendant Care;
- (8) Counseling;
- (9) Escort;
- (10) Respite Care;
- (11) Health Support;
- (12) Family Training and Support;
- (13) Pest Control;
- (14) Home Delivered Meals;
- (15) Homemaker;
- (16) Consumable Medical Supplies;
- (17) Risk Reduction;
- (18) Personal Care;
- (19) Physical Therapy;
- (20) Occupational Therapy;
- (21) Speech Therapy;
- (22) Specialized Medical Equipment and Supplies; and,

(23) Skilled Nursing.

f. The Developmental Disabilities Home and Community-Based Services (DD-HCBS) Waiver provides the following services to individuals with mental retardation and/or developmental disabilities:

- (1) Residential Habilitation;
- (2) Adult Day Training;
- (3) Support Coordination Services; and,
- (4) All of services listed in paragraph 9-4c of this operating procedure.

g. DCF also administers the Developmental Disabilities Supported Living Waiver which provides the following services to individuals with mental retardation and/or developmental disabilities who meet nursing home level of care:

- (1) Supported Living Coaching;
- (2) Personal Care Services;
- (3) Environmental Modifications;
- (4) In-Home Support Services; and,
- (5) Adult Day Programs.

9-5. Programs Administered by the Department of Health.

a. The Children's Medical Services (CMS) program provides services for children with special health care needs. Any child between birth through 21 years of age currently enrolled in Medicaid or a DCF program along with his/her sibling(s) is eligible for the CMS services. Services provided include case management, referral, pediatric screening and specialty clinics. Specialty clinics include, but are not limited to:

- (1) Cardiac;
- (2) Hematology/Oncology;
- (3) Neurology;
- (4) Spina-bifida;
- (5) Orthopedic;
- (6) Pulmonary/Respiratory Disease;
- (7) Gastroenterology;
- (8) Aids;
- (9) Otolaryngology;
- (10) Adolescent and Young Adult;

- (11) Renal;
- (12) Ophthalmology;
- (13) Apnea;
- (14) Cerebral Palsy;
- (15) Craniofacial;
- (16) Cleft lip and Palate;
- (17) Diabetes;
- (18) Cystic Fibrosis;
- (19) Neonatal;
- (20) Rheumatic Fever; and,
- (21) Pediatric Surgery.

b. The Brain and Spinal Cord Injury (BSCI) program began in 1973 with the organization of a committee for promoting better care to individuals who sustained traumatic brain or spinal cord injury. The committee's first major activity was to have the Florida Legislature establish the nation's first Central Registry requiring that all agencies report brain and spinal cord injuries to the Central Registry. The BSCI Program provides:

- (1) Acute Care;
- (2) Inpatient and Outpatient Rehabilitation Care;
- (3) Transitional Living Services;
- (4) Adaptive Equipment;
- (5) Home Modifications; and,
- (6) Other Services Necessary for Community Reintegration.

NOTE: The funding source for the Brain and Spinal Cord Injury Program is established in legislation through the "Impaired Drivers and Speeders Trust Fund."

c. The Department of Health also administers the Brain and Spinal Cord Injury (BSCI) Home and Community-Based Services Waiver to adults between the ages of 18 and 64 who meet the state definition of traumatic brain injury and/or spinal cord injury. The BSCI-HCBS Waiver provides the following services to persons with brain and spinal cord injuries:

- (1) Personal Care Assistance;
- (2) Attendant Care Services;
- (3) Companion Services;
- (4) Life Skills Training;

- (5) Behavioral Programming;
- (6) Personal Adjustment Counseling;
- (7) Community Support Coordination;
- (8) Rehab Engineering Evaluations;
- (9) Assistive Technology and Adaptive Equipment; and,
- (10) Environmental Accessibility Adaptation.

9-6. Programs Administered by The Department of Education (DOE).

a. The Division of Blind Services (DBS) program is designed to ensure the greatest possible efficiency and effectiveness of services to the blind. The Division compiles and maintains a complete register of the blind in the state, which describes the condition, cause of blindness, and capacity for education and industrial training, with such other facts as may seem to the division to be of value. The Division:

- (1) Assists in finding employment;
- (2) Teaches trades and occupations;
- (3) Assists in marketing of products made in home industries;
- (4) Assists in obtaining funds for establishing enterprises; and,
- (5) Assists in activities that contribute to self-support efforts.

b. The Division of Vocational Rehabilitation (DVR) program is focused on employment issues and the workplace. The Division provides the following needed supports to persons capable of working with assistance:

- (1) Technical Training;
- (2) Post-Trauma Rehabilitation;
- (3) Adaptive Technology;
- (4) Placement; and,
- (5) Probationary Job Coaching Services.

9-7. Non-Profit Organizations Serving Physically Disabled Adults. The Centers for Independent Living (CIL) were created through the mandate of the Rehabilitation Act of 1973 (as amended 1992) to maximize leadership and empowerment among people with significant disabilities. The CIL's provide:

- a. Peer Counseling;
- b. Information and Referral;
- c. Assistive Technology;
- d. Individual and Systems Advocacy; and,

e. Independent Living Skills Training.

9-8. Various Social and Civic Organizations Serve Physically Disabled Adults. There are numerous agencies and organizations (both local and national) that provide a wide range of information and referral and direct services to persons with disabilities. It is incumbent upon all DCF program staff to develop resource directories of those agencies in their communities that provide such services. Some examples are:

- a. Churches;
- b. Hospice;
- c. Kiwanis;
- d. Shriners;
- e. Elks;
- f. American Cancer Society;
- g. United Cerebral Palsy Association;
- h. American Lung Association;
- i. Epilepsy Foundation;
- j. American Lung Association;
- k. Lupus Foundation; and,
- l. Numerous others.

Chapter 10

CONTRACT PURCHASE OF COMMUNITY CARE FOR DISABLED ADULTS (CCDA) SERVICES

10-1. Purpose. The purpose of this chapter is to outline statewide procedures to be used to contract with community providers for CCDA client services. It is important that procedures for these activities be consistent and maintained in a standardized format.

10-2. Reference and Definition. This chapter intentionally omits instructions or procedures described in CFOP 75-2, Contract Management System for Contractual Services. To advance the case manager's support of the contract manager and for informational purposes, the CCDA case manager may find, in CFOP 75-2, the policies and procedures for the procurement of contractual services starting with the purchasing process and proceeding through writing the contract document, executing and monitoring it.

10-3. Choosing to Contract for CCDA Services.

a. When. Regions may elect to enter into contracts with provider agencies when the frequency, volume or supplier of services can be predetermined, and both delivery and performance are predictable. When performance and cost uncertainty exist, the case manager may decide to purchase

the service(s) by means of purchase order or voucher. Purchase of services through a departmental purchase order or by way of voucher will be discussed in Chapter 11 of this operating procedure.

b. Why. Contracting and pricing policies are based on the assumption that the type of contract selected directly influences the provider's performance. Providers must be motivated to perform efficiently and to control costs through good management decisions made on a daily basis. The contracting process exists only to help the department deliver effective human services.

c. How. There are two broad categories of contract types:

(1) Fixed Price Contracts. With this type of contract, the provider guarantees the performance of the contract. This contract is an agreement to pay a specified price when the services called for by the contract have been delivered and accepted. No price adjustment is made for the original work after award regardless of the provider's actual cost experience in performing it.

(2) Cost Reimbursement Contracts. With this type of contract, the scope of the work cannot be adequately described for the provider to project performance; therefore, he or she produces agreed upon products to be submitted at agreed upon intervals for reimbursement. The Department reimburses the provider for actual costs incurred either upon completion of the contract or by these periodic invoices. The Department must audit each periodic invoice for allowable charges and closely track that contract specifications are being met to authorize the provider to continue performance under the contract.

d. Who. The contract manager is responsible for enforcing the performance of administrative and programmatic terms and conditions of the contract. The region program specialist for the CCDA program must assist the region contract manager in ensuring that contracts with CCDA providers for the provision of CCDA services are:

(1) Developed in a fashion so as to ensure that the department protects the funds it disburses;

(2) Developed to derive the maximum return of services from those funds; and,

(3) Developed in compliance with applicable state and federal laws, rules, and regulations governing the elected funding procedure for services.

10-4. The Region Program Specialist and the Contract Manager as a Team.

a. It is the region program specialist's responsibility to share his or her disability expertise with the contract manager during contract development. The program specialist has valuable knowledge of the disabled adult provider network that can assist in keeping contract performance costs down and service quality up. He or she must work in concert with the region contract manager to:

(1) Promote service delivery flexibility when the standard delivery methods don't accommodate;

(2) Procure access to appropriate service providers and coordinating a seamless service delivery continuum; and,

(3) Foster creativity, resourcefulness, communication, and client concern between network providers of services to disabled adults.

b. The region program specialist must provide the contract manager with:

- (1) Clear and detailed service specifications which meet the client's needs;
- (2) Acquired knowledge of available service providers and service options;
- (3) Warning of any anticipated program or client problems which may materialize during the contract period; and,
- (4) Any client specific information which will assist the contract manager in contract negotiations.

10-5. Region Contracting Responsibilities for CCDA Program Specialists.

a. Conducting the Community Needs Assessment. A needs assessment can identify unmet needs in the community, provide evidence of support for policy options, and increase public involvement in policy making. It is the region program specialist's responsibility to conduct an annual community needs assessment of the adults with disabilities residing within the region three months prior to each new fiscal year.

(1) If done well, the needs assessment is both a process and a method.

(a) As a process, it can build leadership, group cohesion, and a sense of local involvement in the community.

(b) As a method, the needs assessment is a tool that helps a community plan for and implement strategies that make the best use of existing resources and offer the best response to local conditions.

(2) A disabled adult's needs assessment should answer five questions:

(a) What are the needs adults with disabilities, and how well are local agencies meeting those needs?

(b) How well are disabled adults doing in the community?

(c) How do consumers and providers view the existing service delivery system?

(d) What services exist, and what gaps and overlaps make it difficult for adults with disabilities to get needed help?

(e) Are other reform initiatives that focus on disabled adult issues underway, and how can their efforts be linked?

(3) The traditional approaches to needs assessment focus on community assets, resources, and activities as well as gaps, barriers, or emerging needs. Effective methods for data gathering for an assessment include focus groups, community forums, surveys, and action research. Here are brief descriptions of the three most popular methods:

(a) The survey is one of the more popular approaches to needs assessment. While surveys can provide excellent information for needs assessment, surveys require expertise, time, and resources to be accurate and relevant and usually produce a lower response rate than say, community forums. Survey mode may be sent by mail and self-administered, face-to-face personal interview, conducted by telephone or made available by web invitation. Each of these modes has its

advantages and disadvantages in terms of ease of administration, staffing requirements, training and supervision, cost, and reliability of results.

(b) Community forums, another type of needs assessment, provide participants a vehicle for expressing their opinions on community issues. The forums help validate assumptions and offer community agencies the ability to assist in assessing program needs and gaps. Community forums are conducted to gain a better understanding of the public's perception of the needs and desires of its adults with disabilities. Forums work best when they occur at convenient times for working family members and in locations accessible by public transportation. A discussion guide should be used to keep participants on task. The discussion guide contains the questions that will be asked to participants during the discussion sessions. The extent to which the process is participatory and inclusive will affect the degree to which your strategies reflect community concerns.

(c) Focus groups can also be used to do needs assessments. Focus groups are structured, moderated discussions that bring together small groups of people (usually six to 12) in neutral settings to talk about specific issues. Effort should be made to recruit participants from a variety of settings adequately representing the disabled adult population and the community providers serving this population. One DCF staff member moderates the group discussion, one facilitates information coordination and gathering, and another serves as note-taker. All focus groups should be tape-recorded. Focus group participants should be informed that, since the sessions are being taped to ensure accurate recall, they should not mention names or give identifying information during discussions. Confidentiality will be maintained by using first names only. For quality output from the process, and to compile enough data to validate the assessment, four to six focus groups should be consecutively conducted. Each focus group should be steered by a discussion guide.

b. Processing Needs Assessment Data into a Plan. The region program specialist is responsible for analyzing the data from the surveys and focus groups. He or she then must use the findings of that analysis to develop an Annual Region Service Plan which will serve as a workable infrastructure for a seamless, coordinated service delivery system for adults with disabilities. This plan should:

- (1) Supply general demographic characteristics of the region;
- (2) Identify the number of adults with disabilities in their region in need of in-home services;
- (3) List the specific service needs of the adults with disabilities residing in the region who have voiced a service need;
- (4) Compile a listing of known private service providers, volunteer agency staff, religious organizations, social organizations and other existing state and county agencies available to meet the needs of their community's adults with disabilities;
- (5) Compile a listing of standard unit cost rates for identified community and private provider services; and,
- (6) Project service needs and spending trends for their adult clients for the coming fiscal year.

Chapter 11

PURCHASE OF COMMUNITY CARE FOR DISABLED ADULTS SERVICES
WITH VOUCHERS AND PURCHASE ORDERS

11-1. Purpose. The purpose of this chapter is to establish the region's responsibility with regard to the use of vouchers and purchase orders and to define the CCDA program's minimum standards for management of the vouchering process, its obligations, its payables and its disbursements.

11-2. Voucher and Purchase Order Authority. The legislature has granted authority in statute for the department to negotiate, enter into, and execute purchases, contracts and agreements for CCDA services. Florida Statutes 410.602 states that the department is to encourage innovative and efficient approaches to program management and service delivery.

11-3. When to Use a Voucher or Purchase Order.

a. When the frequency, volume or supplier of services cannot be predetermined and cost uncertainty exists, regions may elect to purchase the service(s) by means of purchase order or voucher. According to subsection 287.057(3)(f), F.S., program service purchases which total, on a completed project cost basis less than \$25,000 do not require the use of the competitive procurement process.

b. CCDA region staff may elect to use vouchers or purchase orders as payment to vendors for any goods or services that meet the above statutory criteria and are not covered by an existing contract of service.

11-4. Function of Vouchers and Purchase Orders.

a. Purchase Orders. A purchase order establishes a legal contract between the department and the vendor for an encumbrance upon the department for service/goods delivered by the vendor. It is used when the service/goods being purchased will be needed on an ongoing basis.

(1) The purchase requisition, which is a pre-numbered triplicate copy form, is the first step of an official purchase order.

(2) A properly approved purchase requisition permits the department to make vendor purchases, to pay vendors for goods and services when received, and to charge the appropriate program account.

(3) Purchase requisitions should be checked to ensure:

(a) Completeness;

(b) Correctness/accuracy;

(c) Copies of all relevant documents (as per the requisition form instructions) are attached;

(d) Account numbers are correct (errors may lead to delay in the issue of purchase orders); then,

(e) The original and duplicate copies are sent to the purchasing office for processing.

(4) Where the purchase requisition is for the purchase of direct client services, a copy of the Client Service Authorization Form must be attached to the purchase requisition.

(5) It is the responsibility of the authorized financial delegates to satisfactorily determine in respect to each requisition:

(a) That a logical and justifiable choice has been made with regard to price, quality, quantity and delivery; and,

(b) That funds are available to cover the cost of the purchase.

b. Vouchers. A voucher represents a negotiated payment owed by the department to the vendor for prior authorized service/goods delivered by the vendor. Vouchers are used for unexpected, one-time purchases.

(1) Payments for the purchase of goods or services are based on vendor's invoices.

(2) Such payments are made when there is reasonable assurance that the commodity or service has been delivered as specified on the Client Service Authorization Form and received in an acceptable condition by the eligible client it was intended for.

(3) Each region reviewing or approving invoices for payment is responsible for developing and implementing procedures to provide for the timely processing of vendor invoices. Acceptable guidelines for payment procedures are outlined in paragraph 11-7 of this chapter.

(4) Region vouchering procedures must begin with the stages of vendor selection and delineate all accounting processes from region voucher review and approval through submitting vouchers to the State Comptroller who in return disperses state warrants (cash) to the vendor.

(5) Appendix B to this operating procedure offers an example invoice form to copy and use or to follow when creating a region-specific invoice form. Invoices created by the region must include, minimally, all information fields as contained on the example invoice form.

11-5. Steps Which the Region Program Office Must Follow for Service Procurement.

a. Step One. The Program Specialist must identify the service need(s) of the eligible client and the required conditions for service delivery.

(1) The client's Care Plan will define the service need and conditions.

(2) The availability of provider resources and the region budget will establish the extent to which that need can be met.

b. Step Two. The Program Specialist must secure the availability of funding for the identified need.

(1) Review prior year's total expenditures.

(2) If the region had experienced over-expenditure in the prior year or was compelled to transfer funds from another source to realize their client obligation, adding new clients or attempting to expand service delivery this new fiscal year would not be advisable.

(3) If the region's prior year allocation adequately met the region's identified client obligation for that fiscal year, then prudent consideration may be given to expanding service delivery if such delivery can be reasonably annualized.

c. Step Three. The Program Specialist is ready to select a service provider.

(1) Potential providers must be screened to ensure adequate competition (comparative price and quality) and to ensure that necessary qualifications will be met to accomplish intended service delivery.

(2) The Florida Vendor Registration System is a good place to start the search for innovative, reliable, and competitive vendors who have know-how and can demonstrate more effective and efficient ways of satisfying the state's requirements. Use of the Vendor Registration System allows fair and open competition to exist in all procurement activities in order to avoid the appearance of and prevent the opportunity for favoritism and to inspire public confidence that purchase agreements are awarded equitably and economically.

(3) Other sources to research for provider resources are; local Information and Referral Directories, region list of currently active providers, file list of reliable, past providers, and the phone book.

(4) When the transaction will involve delivery of a direct client service, it is important that the selected provider's proposal:

(a) Comply with performance specifications developed by the case manager;

(b) Contain a provider's management approach (choice of funding mechanism) efficient and logical to perform the required services; and,

(c) Support that the provider's organization appears stable and capable of meeting the staffing levels necessary to sustain service performance?

(5) When the transaction will involve purchase of a durable/non-durable item or medical equipment, documentation must be kept on file that:

(a) A comparative price analysis been conducted to compare the offeror's price with at least three other provider prices for a similar item; or,

(b) A comparison been made to a past purchase price by the Department to establish reasonableness; and,

(c) A value analysis been completed to look at the item and the function it performs so you can determine if the product, as it is now produced is the best possible product in terms of value or if there would be a better substitute?

(6) **Be sure that you feel comfortable with an estimate before relying on it as a basis for determining a price to be fair and reasonable.**

d. Step Four. The Program Specialist will complete a Client Service Authorization form. This form documents:

(1) Demographic information on the provider agency from whom the service/equipment purchase is being made;

(2) Demographic information on the client for whom it is being purchased; and,

(3) The authorized units and delivery times and conditions under which the service will be performed.

11-6. Authorization for Payment Procedures.

a. The Region Program Office may approve for payment only those invoices that show, through verification of an approved method, that the vendor and unit of service was priority authorized, the goods/service has been delivered and that an eligible client has received the goods/services.

b. Before presenting the vendor's invoice to his/her Supervisor for review for payment, the case manager must validate that the services being billed for are the services listed on the Client Service Authorization form and that the vendor billing for those services has received prior authorization to bill for the services. The case manager will review:

(1) Client Service Authorization Form. The case manager must verify that the units of service delivered are only the units identified in the Client Service Authorization Form and are designed to meet the care plan needs of the client. The Service Authorization Form lists all services approved for purchase and the vendor selected to deliver the service/good.

(2) Supporting Documentation. The case manager must review the reference file of vendors for supporting documentation of; selected vendor's original bid (showing service/good being purchased and the cost per unit) and related correspondence validating selection of said vendor, an objective record of past vendor experiences with the selected vendor, all vendors contacted for estimates for this service/goods and their quotations, any controversial bid awards and justification for selection of said vendor and examples of prior vendor approvals for comparable goods/services.

c. To ensure the department's economic and efficient procurement of services, the department approves vouchers for payment only if one or both of the above sources is attached to the submitted voucher.

d. To ensure that payment transactions are approved without any influence and to avoid the appearance of a conflict, the following region authority levels should review all CCDA invoices prior to authorization of payment (see Appendix C for a flowchart example of the Region Program Office Invoice Processing Procedure):

- (1) Human Service Counselor (case manager); and/or,
- (2) Program Operations Administrator; and/or,
- (3) Program Administrator; and, if applicable,
- (4) Regional Processing Center in Tallahassee.

e. The reviewing authorities must verify that:

(1) Each unit of service delivered by the vendor was delivered according to departmental standards of service delivery; and,

(2) The client accepted and received the good(s) or service(s) being billed for.

Authorization for payment may not be made based exclusively on a vendor's monthly statement or other summary of amounts.

f. A copy of the signed and approved CCDA voucher for general revenue payment to the vendor must be distributed to each of these four entities:

- (1) Accounting;

- (2) State Comptroller;
- (3) Vendor; and,
- (4) Region Unit.

11-7. Payments to Vendors.

- a. Vouchers for payment must be supported by a valid purchase order or, in instances where a specific purchase order was not issued, by an original copy of the vendor's invoice.
- b. Written notice is mailed to a vendor if an invoice is not approved or if a submitted invoice is inaccurate for any reason.

Chapter 12

CONTRACT MONITORING (this chapter will be added at a future date)

Chapter 13

MONITORING OF VOUCHERS AND PURCHASE ORDERS (this chapter will be added at a future date)

Chapter 14

GLOSSARY

14-1. Purpose. It is important to understand the clinical terminology related to eligibility determination for CCDA services and the acquisition and delivery of those services to adults with disabilities. This chapter contains a list of the most common terms used in the administration of the CCDA program. Some of these definitions are adopted from the contract instruments developed by the department's Office of Contracted Client Services, and some are legislatively established.

14-2. Definitions.

- a. "Activities of Daily Living" means those basic activities performed in the course of daily living, such as dressing, bathing, grooming, eating, toileting, and ambulating.
- b. "Adult Day Health Care" means an organized day program of therapeutic, social and health activities, and services provided to disabled adults for the purpose of restoring or maintaining optimal capacity for self-care.
- c. "Adult Day Care" means a program of therapeutic social and health activities and services provided to adults who have functional impairments, in a protective environment that provides as non-institutional an environment as possible.
- d. "Case Management" means a client centered series of activities which includes planning, arrangement for, and coordination of appropriate community-based services for an eligible Community Care for Disabled Adults client. Case management is an approved service, even when delivered in the absence of other services. Case management includes intake and referral, comprehensive

assessment, development of a service plan, arrangement for services and monitoring of client's progress to assure the effective delivery of services and reassessment.

e. "Chore Service" means the performance of house or yard tasks such as seasonal cleaning, essential errands, yard work, lifting and moving furniture, appliances or heavy objects, simple household repairs which do not require a permit or specialist, pest control and household maintenance.

f. "Client" means a service eligible adult at least eighteen years old, but under sixty years of age, who has one or more permanent physical or mental limitations that restrict his/her ability to perform normal activities of daily living, and impede his/her capacity to live independently or with relatives or friends without the provision of Community Care for Disabled Adult services.

g. "Contract" means a formal written agreement between the department and an individual or organization for the procurement of services. A *contract* consists of the Standard Contract, Program Specific Model Attachment I (PSMAI)/Attachment I, *including special provisions where appropriate*, plus any other attachments or exhibits deemed necessary. Per Chapter 287, Florida Statutes, a contract must be signed by both parties prior to services being rendered.

h. "Emergency Alert Response Service" means a community based electronic surveillance service system established to monitor the safety of individuals in their own homes and which alerts proper assistance to the client in need.

i. "Escort Service" is the personal accompaniment of an individual to and from service providers or personal assistance to enable clients to obtain other required services needed to implement the service plan.

j. "Group Activity Therapy" is a service provided by a professional staff person to three or more eligible clients and may include, but is not limited to, the following activities: physical, recreational, educational, social interaction, and communication skill building through the use of groups. The purpose of this service is to prevent social isolation and to enhance social and interpersonal functioning.

k. "Health Care Professional" means any person who has completed a course of study in a field of health care, such as a nurse. The person is usually licensed by a governmental agency, such as a board of nursing, and becomes registered or licensed in that health care field. In some instances, the person is certified by a state regulatory body, such as with a certified nurses' aide.

l. "Home Delivered Meals" means a hot or other appropriate, nutritionally sound meal that meets one-third of the current daily recommended dietary allowances served in the home to the homebound disabled adult.

m. "Home Health Aide Service" means a health or medically oriented task furnished to an individual in his residence by a trained home health aide. The home health aide must be employed by a licensed home health agency and supervised by a licensed health professional who is an employee or contractor of the home health agency.

n. "Homemaker Service" means the performance of or assistance in accomplishing household tasks including housekeeping, meal planning and preparation, shopping assistance, and routine household activities by a trained homemaker. With region approval, it may include the purchase of home and/or cleaning supplies needed for the delivery of services. Otherwise, clients are responsible for purchasing their own cleaning supplies.

o. "Home Nursing Service" means part-time or intermittent nursing care administered to an individual by a licensed professional or practical nurse or advanced registered nurse practitioner, as

defined in Chapter 464, F.S., in the place of residence used as the individual's home, pursuant to a plan of care approved by a licensed physician.

p. "Institutional Care Program (ICP)" means a state program that provides financial supplements to disabled adults and elderly who are determined eligible for a nursing home level of care.

q. "Interpreter Service" means assistance in communicating provided to the disabled adult client with a speech or hearing impairment or language barrier.

r. "Medical Equipment or Supplies" means durable or non-durable goods purchased for the purpose of enabling the client to remain in his own home.

s. "Medical Therapeutic Services" means those corrective or rehabilitative services prescribed by a physician or nurse practitioner licensed in the State of Florida. Provided by a professionally licensed, registered or certified individual, these services are designed to assist the client to maintain or regain sufficient functional skills to live independently. Such therapies include physical, occupational, speech - language therapy, and respiratory therapy.

t. "Personal Care Services" include, but are not limited to, services as: individual assistance with or supervision of essential activities of daily living, such as bathing, dressing, ambulating, supervision of self-administered medication, eating, and assistance with securing health care from appropriate sources. Personal care services shall not be construed to mean the provision of medical, nursing, dental or mental health services by the personal care service staff.

u. "Physical/Mental Exam" is the purchasing of services of a physician or psychologist/psychiatrist/mental health professional for clients who would otherwise be unable to purchase services.

v. "Respite Care" means relief or rest for a caregiver from the constant supervision, companionship, therapeutic and personal care on behalf of a client for a specified period of time. The purpose of the service is to maintain the quality of care to the client for a sustained period of time through temporary, intermittent relief of the primary caregiver.

w. "Transportation Service" means the transport of a client to and from service providers or community resources.

Fee Assessment

When a client is determined eligible for services and services are available and his/her income is over the institutional care program eligibility standard, a fee for services must be assessed. In order to assess a fee the following steps must be taken.

- a. Monthly income must be determined, including earnings, payments and pensions. Assets are not included.
- b. Expenses shall be determined, including housing, utilities, telephone, food, medical expenses, transportation, insurance and other necessary expenses. The household expenses will be in relation to what percentage the client's income is to total household income.
- c. Necessary expenses, as determined in b., shall be subtracted from the monthly income to determine the applicant's disposable income and overall ability to pay. Applicants who have \$200.00 or more remaining after expenses are subtracted shall be assessed a fee.
- d. The fee assessed will be equal to 10% of the disposable income of the client, or the total unit cost of the services(s) to be received, whichever is less. The fee will be assessed monthly. The unit cost used for this exercise will be the statewide, average unit cost for that service as provided by Central Office.
- e. Clients shall have the opportunity to perform volunteer services in lieu of making payments.
- f. Redetermination of the client's ability to pay shall be made on an annual basis. The client may request redetermination based upon a change of financial status.

EXAMPLE A

Client A is a 40 year old white male, who lives with his wife and two children. He was stricken with multiple sclerosis four (4) years ago. He spends the majority of his time in a wheelchair. He can ambulate with two canes, but his gait is poor and it is very fatiguing to him.

He was referred to CCDA by FPSS. They had received a referral from a concerned neighbor. Client A is left alone all day with no caregiver.

Client A has an income of \$1,193.

It has been determined that this client is priority and there is an opening at the adult day health care program. Client A's income is \$1,193 and his expenses are as follows:

Rent.....	\$475
Utilities.....	70
Phone	50
Food	350
Vitamins (for MS)	50
Gas.....	100
Laundry	60
Misc. (sundries)	50
Insurance	<u>100</u>
	\$1,305

Client A's costs are more than his income, therefore no fee would be assessed.
(1,193 – 1,305 = – 112)

EXAMPLE B

Client B is a 35 year old white male who lives by himself. He is paraplegic resulting from a diving accident six years ago. He has no family nearby, but his neighbor is quite helpful when he needs assistance. He drives an adapted van and works a little bit out of his home. He is in need of homemaker services.

Client B has an income of \$1,548

It has been determined that this client is priority and there is an available homemaker. Client B's income is \$1,548 and his expenses are as follows:

Rent.....	\$475
Utilities.....	100
Phone.....	50
Food	150
Medicine	50
Gas.....	100
Laundry	60
Misc. (sundries)	50
Insurance.....	<u>100</u>
	\$1,135

Client B's disposable income is \$413 ($1,548 - 1,135 = 413$). Therefore, he must pay either \$41.30 or the total unit cost for homemaker service he will receive from the provider, which is $\$9.44 \times \text{five units of service}$, or \$47.20. Since the unit cost is more, the client will pay \$41.30 every month toward the cost of the service he receives.

If a client was to receive more than one service then the total of all the unit costs or 10% of his disposable income would be assessed, whichever is less.

ASSESSED FEE WORKSHEET**CLIENT(S) NAME(S):** _____**1. INCOME(S) AND SOURCE(S):**

<u>SOURCE</u>	<u>AMOUNT (NET MONTHLY)</u>
_____	\$ _____.
_____	\$ _____.
_____	\$ _____.
_____	\$ _____.

2. TOTAL INCOME NET (Total of Net Monthly Amount Column) (2) \$_____.**3. MONTHLY EXPENSES:**

- A. FOOD \$ _____.
- B. RENT/HOUSING \$ _____.
- C. UTILITIES \$ _____.
- D. MEDICAL CARE/MEDICINES \$ _____.
- E. INSURANCE (S) \$ _____.
- F. TRANSPORTATION \$ _____.
- G. TELEPHONE \$ _____.
- H. OTHER (SPECIFY PER INSTRUCTIONS)
- _____ \$ _____.
- _____ \$ _____.
- _____ \$ _____.

4. TOTAL EXPENSES (Total of lines A through H) (4) \$_____.**5. NET DISPOSABLE INCOME (Subtract line 4 from line 2) (5) \$**_____._____
Prepared By_____
Date

Sample Invoice



DEPARTMENT OF CHILDREN AND FAMILIES
OFFICE OF ADULT SERVICES
MONTHLY REQUEST FOR PAYMENT AND EXPENDITURE REPORT

Exhibit _____

PROVIDER FED. ID # _____

NAME AND MAILING ADDRESS OF PAYEE:

CONTRACT AMNT.: _____

REIMBURSEMENT YTD.: _____

CONTRACT BALANCE: _____

DATE: _____

CONTRACT #: _____

PERIOD OF SERVICE PROVISION: _____

Name of Service or Description of Materials	Units/ Quantity	Amount Per Unit/ Episode	Total Amount Due
Total Match Required for Contract: _____			Total Payment Requested

	This Month	YTD
Local Cash Match		
Local In-Kind		
Total Deductions		
Remaining Match Balance		

Signature of Preparer: _____ Date Completed: _____

Approved By: _____ Title: _____

* If this invoice is for a fixed price contract, the request for payment will be determined by dividing the length of the contract into the contracted amount (example: \$12,000 [allocation] divided by 12 months [the length of the contract] = \$1,000 payment request). On a cost reimbursement contract, the payment request will be the monthly request expense.

CHILDREN AND FAMILIES USE ONLY

Date Invoice Received: _____

Approved By: _____ Date: _____

ORG	EO	OBJ	DESC.	AMNT.	OCA	

Report Flowchart Community Care for Disabled Adults Program

Report Due	From Whom	To Whom	Due Date(s)
Quarterly Cumulative Summary Reports:			
- three month	*See provider requirements below.	Central Office	October 30
- six month	*See provider requirements below.	Central Office	February 15
- nine month	*See provider requirements below.	Central Office	April 30
- twelve month	*See provider requirements below.	Central Office	August 15
Contract Monitoring Schedule	Region Program Office(s)	Central Office	July 30 th for each new fiscal year
Contract Monitoring Reports	Region Program Office(s)	Central Office	Due annually on all CCDA contracts. Due within 30 days of the Region exit interview with the provider. Required corrective action plans (CAP's) are due within two weeks of region receipt of the corrective action plan.
Annual Region Service Plan	Region Program Office(s)	Central Office	Draft plan must be submitted by May 1 of the preceding fiscal year and a final plan must be submitted by September 30 of the year being planned for.
Provider Update Report	Region Program Office(s)	Central Office	July 15 th for each new fiscal year

*Only providers of case management services must submit Quarterly Cumulative Summary Reports to the Region Program Office. These reports are to include management program data (e.g., client identifiable data) according to negotiated instructions provided by the regions.

Required submission dates of Quarterly Cumulative Summary Reports by the provider to the Region Program Office may be negotiated through the provider contract.