**WSC Job Aid for Cost Plans and**

**Significant Additional Needs Documentation**

CLIENT NAME: Click or tap here to enter text. iCONNECT ID: Click or tap here to enter text.

Date: Click or tap here to enter text. WSC NAME: Click or tap here to enter text.

When submitting a Cost Plan or SANs request, WSCs must follow the requirements in iBudget Rules 65G-4.0213 through 65G-4.0218, *Florida Administrative Code* (F.A.C.), and the iBudget Handbook, Rule 59G-13.070, F.A.C. Submitting complete documentation streamlines the process and avoids extra requests for additional information. Always send the **most recent** information that is **reflective of the current needs** of the client and documents the issues of concern.

**Sections A and B** are relevant to SANs submissions. **Section C** contains service specific documentation requirements for all services requested on a cost plan.

**Section A. Checkpoint for All SANs Submissions**

|  | **Actions to be taken prior to submitting a SAN request**  | **WSC Check Point** |
| --- | --- | --- |
| 1 | WSC tried to meet the needs within the current cost plan.  |[ ]
| 2 | WSC moved unallocated funds to meet needs, but funds were not sufficient to cover the need |[ ]
| 3 | WSC moved funds from unused services to meet needs, but funds were not sufficient to meet the need |[ ]
| 4 | WSC submitted the Certification of Available Servicesform within the last 30 days and submitted it to APD in accordance with 65G-4.0213, F.A.C.  |[ ]
| 5 | Support Plan and applicable amendments are current in the APD iConnect system.  |[ ]
| 6 | SANs request is completed accurately in APD iConnect. |[ ]
| 7 | QSI is reflective of the client’s current functional, behavioral, and physical status, and completed within the last three years. If the QSI does not reflect current information, the WSC notified APD immediately of the change. The WSC can indicate the date that APD was notified of the need for the new assessment in the request.  |[ ]

**Section B: Significant Additional Needs Criteria**

|  | **Examples of Documentation for SANs Request based on Type** | **WSC Check Point** |
| --- | --- | --- |
| 1 | **Documented history of significant and life-threatening behaviors*** Psychological assessments.
* Reports from psychiatrist for last 12 months to include all medication changes for the last 12 months.
* Discharge summaries of any Baker Act hospitalization in the last 12 months.
* Behavior assessments, plans, and data for last 12 months.
* If school-aged, current IEP, school behavior plan, and data,
* If under 21, documentation of attempts to obtain behavioral services through the Medicaid State Plan or behavior plan and data for the last 12 months for behavior services provided by the Medicaid State Plan.
* Incident Reports or police reports regarding behaviors for last 12 months.
* Confirmed Behavior Summary Report from the Region in iConnect.
 |[ ]
| 2 | **A complex medical condition that requires active intervention by a licensed nurse on an ongoing basis that cannot be taught or delegated to a non-licensed person** * Documentation from physician(s) or others who document the medically necessary situations.
* Prescription by physician, advanced practice registered nurse (APRN), or physician assistant with all changes in the last 12 months.
* List of specific nursing duties to be performed that cannot be performed by training others who are not licensed.
* Nursing care plan (if applicable).
* Documentation from Skilled Nursing Exception Process, if applicable.
 |[ ]
| 3 | **A need for total physical assistance with activities of daily living*** Updated QSI should be completed as appropriate. WSC does not need to attach this to the request.
* Documentation from caregivers of tasks that require total physical assistance.
 | [ ]  |
| 4 | **One Time or Temporary Need: Environmental Modifications*** Landlord approval, if home is rented (dated and signed).
* Ownership documentation of home by client or family.
* Bids per the iBudget Handbook:
* One bid for modification under $1,000
* 2 bids modifications between $1,000-$3,499 or explanation of why bid cannot be obtained
* 3 bids modifications $3,500 and up or explanation of why bids cannot be obtained
* Home Accessibility Assessment if over $3,500.
* Explanation of how modification would ameliorate the need.
 | [ ]  |
| 5 | **One Time or Temporary Need: Durable Medical Equipment*** Prescription and recommendation by physician, APRN, physician assistant, PT or OT.
* Documentation that durable medical equipment used by the client has reached the end of its useful life or is damaged, or the client’s functional or physical status has changed enough to require the use of Waiver-funded durable medical equipment that has not been previously needed.
* Three bids for items costing $1,000 and over or explanation of why bids cannot be obtained
 | [ ]  |
| 6 | **One Time or Temporary Need: Temporary Loss of Support from Caregiver(s)*** Description of why caregiver can no longer provide care with dates.
* Age and medical diagnoses of caregiver from the healthcare provider.
* Documentation from doctor(s) regarding caregiver’s ability to provide care.
* Special services or treatment for a serious temporary condition of the caregiver when the service or treatment is expected to ameliorate the underlying condition (fewer than 12 continuous months).
 | [ ]  |
| 7 | **Permanent or long-term loss or incapacity of a caregiver*** Description of why caregiver can no longer provide care with dates.
* Age and medical diagnoses of caregiver from the healthcare provider.
* Documentation from doctor(s) regarding caregiver’s ability to provide care.
 |[ ]
| 8 | **Loss of Medicaid state plan services due to age*** Medicaid Prior Service Authorization for all applicable services, such as personal care assistance and behavioral services.
* Documentation that other caregivers are not available.
 |[ ]
| 9 | **Loss of school-based services due to age*** Documentation of standard diploma if under age 22.
* Service specific documentation for services requested (see below).
 |[ ]
| 10 | **Significant decline in medical, behavioral, or functional status that requires provision of additional services that cannot be accommodated within current budget*** Documentation of change may be found in the QSI, support plan, or other service specific documentation (see Section C below).
 |[ ]
| 11 | **Need for meaningful day activity to foster mental health, prevent regression, or engage in meaningful community life activities*** Information contained in the support plan and professional needs assessment that documents this need, including the probability of regression without the service.
 | [ ]  |
| 12 | **Individual is in Crisis:*** Documentation that the client is homeless, a danger to himself, herself, or others, or his or her caregiver is unable to provide care.
 | [ ]  |
| 13 | **Risk of abuse, neglect, exploitation, or abandonment that can be mitigated with Waiver services*** Documentation found in abuse reports, incident reports, police reports, or the support plan
 | [ ]  |
| 14 | **Significant change in condition or circumstance*** Evidence of change identified in documentation from physician or others healthcare professionals that document the medically necessary situations.
* Evidence of decline in functioning identified in the QSI.
* Evidence of change found in behavioral documentation or mental health records.
* Documentation of change in caregiver’s health or status as evidenced by medical records or other supporting documentation.
* Documentation of change in age or living setting with loss of support as identified in the support plan.
 | [ ]  |
| 15 | **CDC + Participants only:** In addition to the above documentation, CDC+ participants must also provide the following:* Current approved purchasing plan.
* Documentation of efforts made to adjust budget within purchasing plan.
* Explanation on Savings available, including how it was adjusted to meet needs. If not adjusted, explain why.
* Current Account Reconciliation.
 |[ ]

**Section C. Service Specific Documentation Requirements**

These documentation requirements appear in the iBudget Waiver Handbook and must be provided in the APD iConnect system.

* For all services requiring service logs or progress notes, a minimum of the three (3) most recent months of documentation is required unless service has not been provided for at least three months.
* For services requiring a Quarterly Summary, include the most recent quarter. If the provider chooses to do a monthly summary instead of quarterly, provide a minimum of the three most current monthly summaries.
* Prescriptions, treatment plans, assessments, and plans of care for therapies and nursing must be less than 12 months old and based on current information regarding the client.
* The Behavior Analysis Services Eligibility (BASE) form must be less than 12 months old and reflect current behavioral needs. If behavior assistant services are requested, the form must be less than 6 months old. This form documents compliance with requirements identified in the iBudget Handbook for services that require review by the Regional Behavior Analyst.
* For Consumer Directed Care Plus (CDC+) Consumers, all documentation listed below is required if the consumer is using an iBudget Waiver provider. However, if the consumer is hiring someone to perform the service who is not a Waiver provider, all documents must be provided, with the exception of service logs, quarterly summaries, and daily progress notes.

| **Service** | **Service Specific Documentation Requirements**  | **WSC Check Point** |
| --- | --- | --- |
| **Adult Dental Services**  | **New and Continued Services:*** Invoice or treatment plan listing each procedure and negotiated cost
 |[ ]
| **Behavior Analysis Services**  | **New Service*** Copy of assessment report, if completed
* If assessment has not been completed, the support plan or other documentation describes the behaviors requiring intervention with dates.

**Continuation*** Service logs
* Graphic displays from the last quarter of acquisition and reduction target behaviors
* Behavior analysis service plan
* Quarterly summary of the most recent quarter that services were provided and training provided to caregivers
 |[ ]
| **Behavior Assistant Services**  | **New Service*** Recommendation from the Local Review Committee of behavioral needs documented on the BASE form within the last 6 months

**Continuation*** Recommendation from the Local Review Committee of behavioral needs documented on the BASE form within the last 6 months
* Service logs
* Quarterly summary of the most recent quarter that services were provided and training provided to caregivers
* Behavior analysis service plan, including the behavior assistant services with a plan for fading
 |[ ]
| **Consumable Medical Supplies/Personal Care Items**  | **New and Continued Services*** Listing of supplies
* Prescription is needed for:
* Ensure or other food supplements
* Hearing Aid Supplies
* Bowel Management Supplies
* Surgical masks
* Any exception requests

**Exception Requests*** Prescription
* Statement from Physician, APRN, or physician assistant of how the item is medically necessary, directly related to the developmental disability and why, without the item, the client cannot continue to reside in the community or current placement
 |[ ]
| **Dietitian Services**  | **New*** Prescription from physician, APRN, or physician assistant that identifies the specific condition for which service is being prescribed
* For nutritional supplements, provide a dietitian’s assessment documenting such need that is updated at least annually or includes an end date, if temporary

**Continuation*** Prescription from physician, APRN, or physician assistant that identifies the specific condition for which service is being prescribed
* Dietary management plan
* For nutritional supplements, provide a dietitian’s assessment documenting such need that is updated at least annually or includes an end date, if temporary
* Quarterly summary of the most recent quarter that services were provided
 |[ ]
| **Durable Medical Equipment**  | * Assessment and prescription by a licensed physician, APRN, physician assistant, physical therapist, or occupational therapist
* One bid for items under $1,000
* Three bids for all items $1,000 and over or documentation to show efforts were made to secure the three bids
* For items by exception, also include a statement from a physician, APRN, or physician assistant of how the item is medically necessary, directly related to the developmental disability, and without which the client cannot continue to reside in the community. Include Regional Office review obtained by the WSC with recommendation in APD iConnect.
 |[ ]
| **Environmental Accessibility Adaptations (EAA)** | * Prescription for adaptations and medical equipment
* Assessment documenting how the specific EAA is medically necessary and is a critical health and safety need, how it is directly related to the client’s developmental disability, how it is directly related to accessibility issues within the home, and how, without the identified EAA, the client cannot continue to reside in the current residence
* Documentation of approval from landlord, if home is rented
* One bid for EAA costing under $1,000
* Two bids for EAA costing between $1,000 and $3,499 or explanation of why bids cannot be obtained
* Three bids for EAA costing $3,500 and over or explanation of why bids cannot be obtained
 |[ ]
| **Life Skills Development- Level 1 (Companion)** | **New*** Documentation in the support plan that includes the training goals related to the service performed by the provider and a daily schedule

**Continuation*** Documentation in the support plan that includes the training goals related to the service performed by the provider and a daily schedule
* Service logs
 |[ ]
| **Life Skills Development- Level 2 (Supported Employment)** | **Phase 1 Services (obtaining a job)*** Documentation that client has already exhausted resources through the Division of Vocational Rehabilitation (VR). Documentation that supported employment services are not available from VR can be in the form of one of the following:
* A letter from VR
* Documentation detailing contact with a named VR representative to include the date and summary of the conversation

**Continued*** Quarterly summary of the most recent quarter that services were provided
 |[ ]
| **Life Skills Development-Level 3 (Adult Day Habilitation)** | **New** * Documentation to support the requested ratio as follows:
* 1:5 ratio – documentation of personal care needs that are typically identified in the support plan and QSI and/or behavior analysis services plan implemented by the ADT provider
* 1:3 ratio – documentation of intense level of personal care and/or behavior analysis services plan implemented by ADT provider and documentation that client meets behavior focus residential habilitation criteria by Regional Behavior Analyst. Personal care needs are typically documented on the support plan or QSI. Behavioral needs are documented on the BASE form
* 1:1 ratio – Behavior analysis services plan implemented by ADT and documentation that client meets intensive behavioral residential habilitation criteria by the Local Review Committee. Behavioral needs are documented on the BASE form

**Continuation*** Documentation to support the requested ratio as stated above
* Quarterly summary of the most recent quarter that services were provided
 |[ ]
| **Life Skills Development Level 4 (Prevocational Training)**  | **New** * Documentation to support the requested ratio as follows:
* 1:5 ratio – documentation of personal care needs which are typically identified in the support plan and QSI and/or behavior analysis services plan implemented by the ADT provider
* 1:3 ratio – documentation of intense level of personal care and/or behavior analysis services plan implemented by ADT provider and documentation that client meets behavior focus residential habilitation criteria by Regional Behavior Analyst. Personal care needs are typically documented on the support plan or QSI. Behavioral needs are documented on the BASE form
* 1:1 ratio – Behavior analysis services plan implemented by ADT and documentation that client meets intensive behavioral residential habilitation criteria by the Local Review Committee. Behavioral needs are documented on the BASE form

**Continuation*** Documentation to support the requested ratio as stated above
* Quarterly summary of the most recent quarter that services were provided
 |  |
| **Occupational Therapy** | **New*** Prescription by a physician, APRN, or physician assistant
* Current occupational therapy assessment
* Plan of care

**Continuation*** Prescription by a physician, APRN, or physician assistant
* Current occupational therapy assessment
* Plan of care
* Daily progress notes for days service was rendered and billed for a minimum of three months
* Quarterly summary of the most recent quarter that services were provided
 |[ ]
| **Personal Emergency Response Systems** | * Documentation to support that the client lives alone or is alone for significant parts of the day and has no regular caregiver for extended periods of time and otherwise requires extensive routine supervision. This documentation can be provided in the support plan or as part of a daily schedule
 |[ ]
| **Personal Supports** | **New*** Documentation that includes a description of the duties to be performed by the provider and a daily schedule for the client

**Continuation*** Documentation that includes a description of the duties to be performed by the provider and a daily schedule for the client
* Copy of service logs
 |[ ]
| **Physical Therapy** | **New*** Prescription by a physician, APRN, or physician assistant
* Current physical therapy assessment
* Plan of care

**Continuation*** Prescription by a physician, APRN, or physician assistant
* Current physical therapy assessment
* Plan of care
* Daily progress notes for days service was rendered and billed for a minimum of three months
* Quarterly summary of the most recent quarter that services were provided
 |[ ]
| **Private Duty Nursing**  | **New*** Prescription by a physician, APRN, or physician assistant
* Current nursing assessment
* Nursing Care Plan
* List of duties to be performed by the nurse
* Documentation that client requires active nursing interventions on a continuous basis for over two consecutive hours per episode

**Continuation*** Prescription by a physician, APRN, or physician assistant
* Nursing Care Plan with Annual Updates
* Daily progress notes for days service was rendered and billed for a minimum of three months
* Quarterly summary of the most recent quarter that services were provided. Summaries should include details regarding health status, medication, treatments, medical appointments, and other relevant information
* List of duties to be performed by the nurse
* Documentation that client requires active nursing interventions on a continuous basis for over two consecutive hours per episode
 |[ ]
| **Residential Habilitation/ Behavior Focus**  | **New*** Support plan identifies need based on living setting chosen by the client
* BASE form completed by the Regional Behavior Analyst documenting that behavior focus criteria are met

**Continuation*** Support plan identifies need based on living setting chosen by the client.
* BASE form completed by the Regional Behavior Analyst documenting that behavior focus criteria are met
* Quarterly summary of the most recent quarter that services were provided
 |[ ]
| **Residential Habilitation/****Enhanced Intensive Behavior (EIB) and EIB Medical**  | **New*** Documentation of transition from Comprehensive Training and Education Program (CTEP)
* Support plan identifies need based on living setting chosen by the client
* BASE form completed by the Regional Behavior Analyst documenting that intensive behavior criteria are met
* Global Behavior Service Need Matrix (IB Matrix)

**Continuation*** Support plan identifies need based on living setting chosen by the client
* BASE form completed by the Regional Behavior Analyst documenting that intensive behavior criteria are met
* Global Behavior Service Need Matrix (IB Matrix)
* Quarterly summary of the most recent quarter that services were provided

**EIB Medical Only*** Documentation from the Regional Medical Case Manager
 |[ ]
| **Residential Habilitation/****Intensive Behavior**  | **New*** Support plan identifies need based on living setting chosen by the client
* BASE form completed by the Regional Behavior Analyst documenting that intensive behavior criteria are met
* Global Behavior Service Need Matrix (IB Matrix)

**Continuation*** Support plan identifies need based on living setting chosen by the client.
* BASE form completed by the Regional Behavior Analyst documenting that intensive behavior criteria are met
* Global Behavior Service Need Matrix (IB Matrix)
* Quarterly summary of the most recent quarter that services were provided
 |[ ]
| **Residential Habilitation/****Standard or Live-In** | **New*** Support plan identifies need based on living setting chosen by the client

**Continuation*** Support plan identifies need based on living setting chosen by the client
* Quarterly summary of the most recent quarter that services were provided
 |[ ]
| **Residential Nursing Services**  | **New*** Prescription by a physician, APRN, or physician assistant
* Current nursing assessment
* Nursing Care Plan
* List of duties to be performed by the nurse
* Documentation that client requires active nursing interventions on a continuous basis for over two consecutive hours per episode

**Continuation*** Prescription by a physician, APRN, or physician assistant
* Nursing Care Plan with Annual Updates
* Daily progress notes for days service was rendered and billed for a minimum of three months
* Quarterly summary of the most recent quarter that services were provided. Summaries should include details regarding health status, medication, treatments, medical appointments, and other relevant information
* List of duties to be performed by the nurse
* Documentation that client requires active nursing interventions on a continuous basis for over two consecutive hours per episode
 |[ ]
| **Respiratory Therapy**  | **New*** Prescription by a physician, APRN, or physician assistant
* Current respiratory therapy assessment
* Plan of care

**Continuation*** Prescription by a physician, APRN, or physician assistant
* Current respiratory therapy assessment
* Plan of care
* Daily progress notes for days service was rendered and billed for a minimum of three months
* Quarterly summary of the most recent quarter that services were provided
 |[ ]
| **Respite**  | **New** * Documentation that personal care assistance has been sought through the Medicaid State Plan
* If provided by a licensed nurse, a prescription from a physician, APRN,, or physician assistant
* Support plan identifies the need for respite and the schedule

**Continuation*** Support plan identifies the need for respite and the schedule
* If provided by a licensed nurse, a prescription from a physician, APRN,, or physician assistant
* Documentation that personal care assistance has been sought through the Medicaid State Plan
* Service logs
 |[ ]
| **Skilled Nursing** | **New*** Prescription by a physician, APRN, or physician assistant
* Current nursing assessment
* Nursing Care Plan
* List of duties to be performed by the nurse
* Documentation that client requires active nursing interventions on an intermittent or part-time basis
* Annual exception letter from the Agency for Healthcare Administration (AHCA)

**Continuation*** Prescription by a physician, APRN, or physician assistant
* Nursing Care Plan with Annual Updates
* Daily progress notes for days service was rendered and billed for a minimum of three months
* Quarterly summary of the most recent quarter that services were provided. Summaries should include details regarding health status, medication, treatments, medical appointments, and other relevant information
* List of duties to be performed by the nurse
* Documentation that client requires active nursing interventions on an intermittent or part-time basis
* Annual exception letter from the Agency for Healthcare Administration (AHCA)
 |[ ]
| **Special Medical Home Care** | * Nursing care plan and revisions
* Annual Nursing assessment
* Daily progress notes or service logs for dates of service rendered at a minimum for the last 6 months
* Prescription for service
* List of duties to be performed by the nurse
* Authorization by APD state office nursing staff
 |[ ]
| **Specialized Mental Health Counseling**  | **New*** Prescription by a physician, APRN, or physician assistant
* Current specialized mental health assessment

**Continuation*** Prescription by a physician, APRN, or physician assistant
* Current specialized mental health assessment
* Daily progress notes for days service was rendered and billed for a minimum of three months
* Quarterly summary of the most recent quarter that services were provided
 |[ ]
| **Speech Therapy**  | **New*** Prescription by a physician, APRN, or physician assistant
* Current speech therapy assessment
* Plan of care

**Continuation*** Prescription by a physician, APRN, or physician assistant
* Current speech therapy assessment
* Plan of care
* Daily progress notes for days service was rendered and billed for a minimum of three months
* Quarterly summary of the most recent quarter that services were provided
 |[ ]
| **Supported Living Coaching**  | **New*** Information in the support plan documenting the service need and demonstrating that the service is not duplicative of other services in place

**Continuation*** Information in the support plan documenting the service need and demonstrating that the service is not duplicative of other services in place
* Daily progress notes for the three most recent months, including documentation of activities, supports, and contacts with the client, other providers, and agencies with dates and times, and a summary of support provided during the contact, follow-up needed, and progress toward achievement of support plan goals
* Quarterly summary of the most recent quarter that services were provided
 |[ ]
| **Transportation Services** | **New and Continuation*** Documentation in the support plan that client requires transportation to/from a community-based Waiver service
* Rate requested should match the rate listed on the provider’s Medicaid Waiver Services Agreement Addendum
 |[ ]