A Guide To Supported Living In Florida

Sponsored by United States Department of Health and Human Services,
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Florida Developmental Disabilities Council, Inc.

PRODUCED FOR THE

BY PROGRAM DESIGN, INC.

January 2005

ACKNOWLEDGEMENTS

Without the contribution of persons using supported living services in Florida, the information found in this *'Guide'* would not have meaning. Their experiences and opportunities have inspired content and kept us focused on what really matters.

The authors would like to express their sincere appreciation to the Supported Living Advisory Committee. Committee members traveled hundreds of miles for meetings and donated their time and their extraordinary efforts, skills and talents to making this project a success.

Each member brought their unique style and expertise to the group, resulting in true consensus regarding the scope, style, and format of materials to be used. Not only did they contribute forms and share stories regarding people they know, they also shared their agencies' work. The effort was extraordinary and it was our pleasure to work with such committed and caring professionals.

Although meetings were lengthy, the group's tireless effort and passion for the field of supported living inspired the group's synergy. We owe a tremendous amount of gratitude to the following members:

Supported Living Advisory Group:

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Everyday People Do Extraordinary Things When They Put Their Heads Together!

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A special thanks to Sandi Smith, FDDC Contract Manager, and Ed Rousseau, Developmental Disabilities Program, Supported Living Coordinator, who provided continuous feedback, support and direction. Sandi's attention to detail, patience, and sense of humor have been invaluable. Ed's focus on a quality product and vigilance in making the most current information available were essential to meeting established timeframes.

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PREFACE

It wasn't that long ago when the road to services for individuals with developmental disabilities in Florida led to a 500 bed facility in Gainesville known as the Farm Colony for the Feeble Minded and Epileptic. This facility, later known as Sunland Center at Gainesville, was the first of five such institutions to be developed between 1950 and 1968 to offer services to persons with a wide range of disabilities. By 1970 the number of persons with developmental disabilities being served in these facilities reached a peak of 6,107.

During the early days, Florida's service system for persons with developmental disabilities was based on an institutional model. The choice offered to families was "stay at home or go to an institution." In the early 1970's winds of change blew though our nation. They did not bypass the state of Florida. The winds whispered news of less restrictive environments, integration not segregation, personal values, independence and community-based services. The Florida Legislature directed the Department of Health and Rehabilitative Services to undertake a massive reorganization of its service priorities and make community based supports the number one priority. The history of the Developmental Disabilities program is filled with shifting priorities and a renaissance of new thinking focusing on self-determination and personal choice.

Supported living is an example of a new way of doing business in supporting individuals with developmental disabilities. Supported living is an opportunity for adults with developmental disabilities to choose where, how and with whom they live. Persons in supported living receive personalized supports necessary to maintain their own private home. It is from our homes we greet the world, go to work, to shop and interact with others. It is in our home we show hospitality to our family, friends and neighbors.

In 1988 the Florida Developmental Disabilities Council provided a grant to initiate a supported living project designed to inform and assist individuals to achieve and maintain a home of their own in the community. Florida's supported living initiative started with approximately 200 participants. Today, over 2,700 persons participate in supported living. In Florida, and across the country, supported living is the fastest growing option for residential supports outside the family home.

The 2003 version of *A Guide to Supported Living in Florida* is the second revision to the first guidebook on supported living in Florida. It has been crafted to offer all individuals, family members, stakeholders, and professionals alike, the opportunity to understand and grasp the philosophical concepts, program requirements and values associated with supported living. Persons receiving services and their families will find relevant information to assist in the decision making process to determine whether or not to choose supported living. Professionals will find information about minimum requirements, philosophical and ideological concepts and best practices for success.

It goes without saying that persons with developmental disabilities have been patient in waiting for services that support opportunities to live everyday lives. Time itself ranks as public enemy #1. Consider the twenty years it took to build our institutional programs, and the twenty years it has taken to reverse the trend. A span of 40 years has elapsed. It is our job as consumers, families, advocates and professionals to be assertive in promoting positive values and quality of life for all persons with developmental disabilities. When time is lost, it cannot be found again. Making sure our tomorrows are not filled with empty yesterdays is a challenge for which we must all take responsibility.

One day, perhaps in the not too distant future it will be written:

"In Florida, not that long ago, the road to services for individuals with developmental disabilities led to a very familiar place....home."

Ed Rousseau,
Developmental Disabilities Program
Supported Living Coordinator

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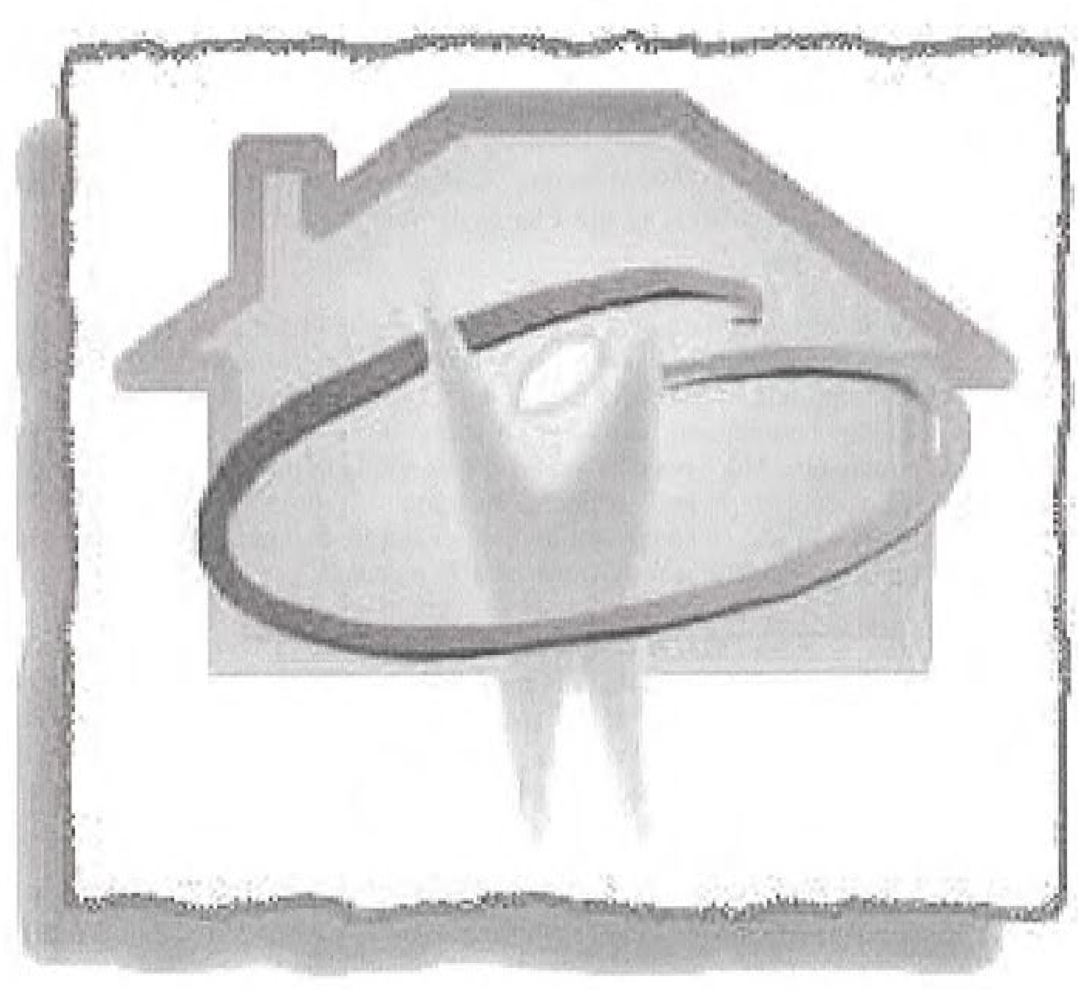
INTRODUCTION



INTRODUCTION

In an effort to promote and support the success of persons who use or are planning to use supported living services, this *'Guide'* is offered as a practical reference tool. Although it is anticipated this *'Guide'* will contain useful information for anyone interested in supported living, it is designed for use by:

- individuals receiving services;
- family members;
- guardians and advocates;
- supported living professionals;
- service providers;
- support coordinators; and
- Developmental Disabilities Program staff.

A Guide to Supported Living in Florida is one of three companion products developed by Program Design, Inc., under contract to the Florida Developmental Disabilities Council, Inc. These materials include:

- *A Guide to Supported Living in Florida* an update to previous versions developed in 1995 and 1997. It is intended for use as a reference tool during and after pre-service training. Pre-service training is a requirement for supported living coaching certification and this training is a major component of those requirements. The *'Guide'* is organized according to the sequence of events which guide supported living service acquisition. It provides specific information regarding roles, responsibilities and values. Sample forms, formats, and suggestions for service provisions are also included.

- *A Guide to Supported Living in Florida: Trainer's Guide* is utilized by trainers to direct the flow of supported living training. This document provides useful information for trainers including a narrative script, handouts, activities and experiences to reinforce learning. The *'Trainer's Guide'* is accompanied by a Power Point™ presentation and copies of overheads. The materials follow the sequence of information found in *A Guide to Supported Living in Florida.*

- *The Supported Living Liaison Network* provides a resource listing, by District/ Region, of participants who are willing to share their supported living experiences with those who are considering supported living as an option. This listing will link current supported living participants and service providers with individuals who want to explore supported living services and supports.

The development of these materials was directed by the Supported Living Advisory Committee comprised of individuals who receive supported living services, supported living professionals, supported living providers, support coordinators, guardians, advocates and family members, and representatives from the Florida Developmental Disabilities Council and the Department of

Children and Families, Developmental Disabilities Program. This group took a proactive approach to the development of materials and provided direction to every aspect of the process.

In addition to the advisory committee's direction, the development of materials was driven by a nationwide 'best practices' survey, whereby supported living practices from around the nation served as examples of what should (and should not) be included.

The primary authority reference for the content found in this *'Guide'* is the Developmental Services Waiver Services Medicaid Coverage and Limitation handbook. It will be important for the reader to maintain the most current version of the handbook which at the time of publication can be found at www.fdhc.state.fl.us/Medicaid/dev_serv/.

Using the Guide

As mentioned, the **layout** follows the natural progression of the supported living process as can be seen in the graphic representation on page xiii. Each component represents the eight chapters found in this *'Guide'*.

1. Defining Supported Living
2. Exploring Supported Living
3. Understanding Coaching Services and Requirements
4. Getting Started
5. Planning Supports
6. Documenting Progress
7. Supporting Success
8. Enhancing Quality

Each chapter begins with a ***"What You Will Find"*** divider listing the specific topics found in each chapter. Stories, experiences and sample formats are used throughout to illustrate content. All forms are made available courtesy of providers and family members throughout the state and can be copied and used as desired. It is important to note that the forms are offered as examples and are not endorsed by the Developmental Disabilities Program.

Text found in **framed boxes** throughout the document connote to items of importance. These boxes also represent slides or overheads that may be used during training. The information found below each box provides discussion related to its content. Each page is formatted with additional white space for jotting notes beside the text.

In order to maintain **gender neutrality, individuals and providers are referenced by random gender throughout this guide**. All persons having **legal guardians or guardian advocates**, must be involved in decision-making, as specified in the Court Order. Therefore, **references to the individual's decision-making are presumptive of appropriate legal representation, and the use of "individual or guardian" has been limited.**

A **Website Links** reference can be found, beginning on page W-1.

A ***Glossary*** of important terms can be found, beginning on page G-1.

The ***Bibliography*** begins on page B-1, and includes references and resources utilized in the compilation of these materials.

NOTE: At the time this *'Guide'* is published in May 2003, Developmental Services Medicaid Waiver Services are being reviewed by stakeholders participating in a redesign effort undertaken by the Agency for Health Care Administration and the Department of Children and Families. Whenever there are significant changes to the service information in this *'Guide'*, updates will be available on the websites of the Department of Children and Families, Developmental Disabilities Program (www.apd.myflorida.com) and the Florida Developmental Disabilities Council, Inc. (www.fddc.org). At all times, current service guidelines will be found in the Developmental Waiver Services Florida Medicaid Coverage and Limitations handbook.

The Supported Living Process:

Chapter One
Defining Supported Living

What You Will Find:

Introduction to Supported Living

Purpose of Supported Living

Overview of Supported Living

Characteristics of Supported Living

Eligibility for Supported Living

Chapter One: Defining Supported Living

Supported Living Vision

Supported living is described as: ***"People with {developmental} disabilities living where and with whom they want, for as long as they want, with whatever support is necessary to make that choice possible."*** (Bellamy & Horner)

Introduction

This guide is designed to help persons receiving supported living services achieve the vision described above. It provides the framework, tools, and processes used to support individuals in establishing themselves in the community. In order to accomplish this, it is important to understand the history of supported living, and identify best practices that will assure the freedom, choices, and autonomy supported living offers.

Achieving this vision can be challenging. Concepts and belief systems are not governed by rules and regulations, but state-funded initiatives and services are.

How do we assure people live the life they choose while also meeting regulations, allowing for dignity of risk, and first and foremost, assuring that the health and safety of those we support is never intentionally compromised?

This guide provides a functional framework for balancing the requirement of supported living services while striving to remain true to the philosophy supported living encompasses. It explores best practice and defines the rules and regulations which govern the supported living initiative.

Service and Philosophy

- Supported living as a *service* establishes supports needed for persons to live where, with whom and how they choose.
- Supported living as a *philosophy* guides and drives the approach to those supports.

Purpose of Supported Living

In a traditional program approach, services are provided to a group of people in the same way and at the same time, frequently in a segregated setting. All individuals receive similar services and are expected to follow the same rules. People usually are expected to "graduate" through a continuum of services as they learn more skills and become more independent.

In a person-centered (supported living) approach, each support or service is tailored to each individual's unique preferences and requirements. Because the focus is on one person at a time, people are not required to live in groups, and since supports are not tied to any particular location, they do not need to move through a training continuum in order to receive new or additional services. This individualization makes it possible for people to live in their own home in a completely integrated setting with necessary supports and skill training provided within the context of daily life. Supports and services are adjusted in response to changes in life circumstances without requiring people to move to a new location or setting.

People are not expected to demonstrate complete independence in order to participate in supported living. Instead, it is acknowledged that all adults should be able to live in their own homes in the community with whatever level of assistance is needed. An emphasis is placed on the development of non-paid supports, and people are encouraged to engage in natural, reciprocal relationships that focus on each person's abilities and unique gifts to the community.

In traditional residential living arrangements, an agency accepts funds for "slots" or "beds." They then seek people to fill these slots, fitting the person into an existing group home. This provider owns or rents the property, makes the rules, and determines who lives with whom, where they live, even who gets to stay in the home. Supported living is about individual choice, control of housing and assistance, respect, personalized care, and valued relationships. Operationally, the use of supported living funds, approaches to planning, and daily activities of staff differ dramatically from traditional approaches.

Supported living is about the person's preferences, opportunities, and control rather than the provider's. In "Revisiting Choice-Part 1," Michael Smull writes: "Preferences reflect what people want, while opportunities reflect what is available... Control is the authority to make use of an opportunity to satisfy a preference." Supported living is driven by the person's preferences regarding how and where she wishes to live her life. It focuses on supporting her exploration of the wide array of opportunities and means to reach her ideal home life, and to create new opportunities that might not yet exist, in order to

expand that dream. Supported living assures the person's authority over her own life.

Overview of Supported Living

In order to have a clear understanding of supported living, we must first understand the evolution of living options for persons with developmental disabilities.

History of Supported Living in Florida

- **Restrictive Environments, 1970s – 1980s**
- **Chapter 393, Florida Statutes, 1982**
- **Nonrestrictive Environments, mid-1980's**
- **Supported Living Project, 1988**
- **Supported Living Defined in Law, 1991**
- **Medicaid Community Supported Living Arrangements (CSLA), 1992**
- **"A Place of My Own," 1992**
- **Home and Community-Based Services Waiver (HCBS), 1995 (including Supported Living)**
- **Supported Living Training Curriculum, 1995**
- **"A Guide to Supported Living in Florida," 1995 and 1997**

Restrictive Environments – During the 1970s and 1980s, residential services were organized along a "continuum of placements" toward community life. Individuals with developmental disabilities were expected to meet specific criteria for each setting before moving onto the next (i.e. from the most to the least restrictive arrangements). The continuum began with the most restrictive living arrangement, i.e. a state operated institution, then a large congregate setting, i.e. Intermediate Care Facilities for persons with Developmental Disabilities (ICFs-DD), to a group home setting, where the individual had to conform to living with a large group of strangers in a house organized by rules and regulations to which all must comply, until finally earning the right to live independently. Many individuals, due to the nature of their disabilities and

the prerequisites established, failed to meet the requirements for progression to the next less restrictive setting along the continuum. As a result, few ever accessed the opportunities and experiences of independent living. The continuum emphasized matching people to places, rather than matching supports to people wherever and whenever necessary.

Chapter 393, Florida Statutes, 1982 – The state legislature found that the treatment of persons with developmental disabilities often unnecessarily placed individuals into unreasonably costly, large facilities that were ineffective in supporting persons to achieve self-determined lives. It further noted that redirection of state funded services was necessary to embrace the concept of "nonrestrictive environments," and avoid the costly problem of institutionalized services. Therefore, the legislature declared that greatest priority be given to the development and implementation of community-based services.

Chapter 393: Definition

Chapter 393 of the Florida Statutes defines supported living as "a category of individually determined services designed and coordinated in such a manner as to provide assistance to adult clients who require ongoing supports to live as independently as possible in their own homes, to be integrated into the community, and to participate in community life to the fullest extent possible."

Nonrestrictive Environments – In the mid-1980s, the notion of moving through the continuum (i.e., from the most to the least restrictive environment) was replaced with the concept of "non-restrictive" environments. The focus of "non-restrictive" arrangements was on assisting persons in establishing homes of their own and providing whatever supports were needed to enable the person to live there (Taylor, Racino, Knoll, & Lutfiyya, 1987). In many parts of the country, this "non-restrictive" concept was identified as supported living. Florida's supported living initiative resulted from a growing awareness that people who have developmental disabilities are as entitled to control their lives as other citizens. For many individuals, involvement in supported employment, working and holding responsible roles in the community, sparked a desire to live more fully in that community with personal freedom. A grass roots effort, including people who receive services, their families, friends, advocates, and service providers, began to assist individuals in moving from family homes and congregate residences to their own homes.

Supported Living Project, 1988 – The State Developmental Disabilities Program received a grant from the Florida Developmental Disabilities Council

to explore supported living arrangements and experiences in Florida and other states and to develop a model for more cohesive delivery of services in Florida. Creating New Opportunities: The Supported Independent Living Model was developed and focused on supported living for individuals able to live in the community with occasional or "drop in" support. It was anticipated that a second model, called "Supported Assisted Living," would be developed later for persons requiring more intensive support, such as "live-in" or 24-hour assistance. In March 1992, however, the supported living technical assistance team discussed the need to develop a more individualized and flexible system for all persons who have developmental disabilities, rather than differentiating between those who are fairly independent and those who require more intensive support. This redirection challenged the system to find ways to expand supported living as an inclusive service option for all adults receiving developmental disabilities services, regardless of the type or severity of their disability.

Supported Living Defined in Law, 1991 – Chapter 393,006, Florida Statutes, provided a definition of supported living which laid the foundation for the development of supported living services. The definition states that settings are individually designed for people "to live as independently as possible in their own homes, to be integrated into the community, and to participate in community life to the fullest extent possible."

Medicaid Community Supported Living Arrangements (CSLA), 1992 – As a result of the Supported Living Project in 1988, a model of supported living services was created and expanded as an inclusive opportunity for all people with varying abilities. Florida, along with seven other states, received a waiver to use Medicaid funds as a method for funding community services. The CSLA waiver was not reauthorized by Congress, and Florida requested and received a Supported Living Waiver.

"A Place of My Own," 1992 – Training materials were developed through the Supported Living Project to guide the implementation of supported living services and to assure the delivery of those supports and services was consistent with the person-directed philosophy of supported living.

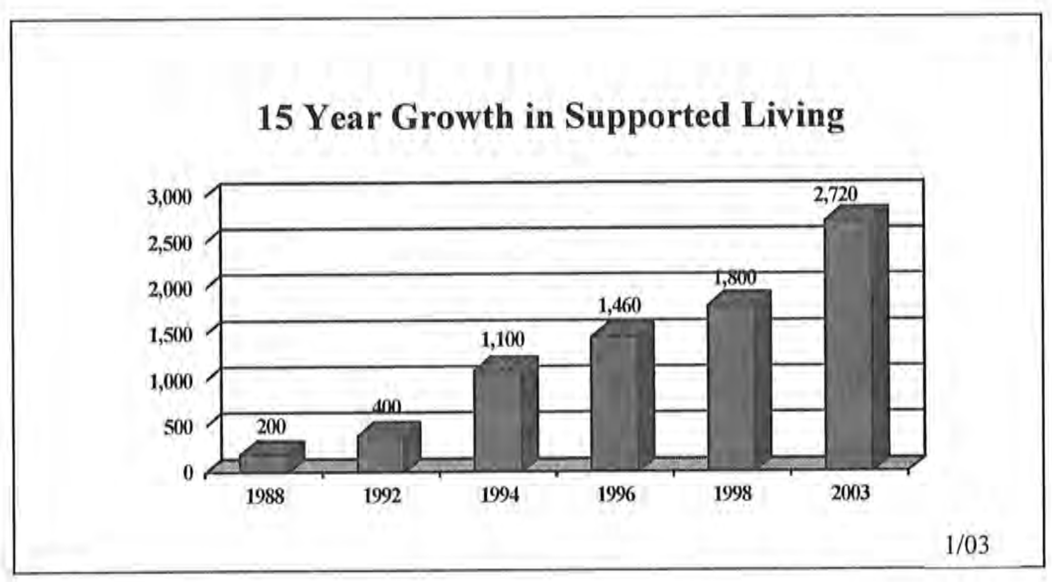
Home and Community-Based Services Waiver (HCBS), 1995 – Up to this point, Medicaid had provided funding to large residential facilities on behalf of persons who lived there. The Medicaid Waiver allowed states to waive a number of administrative regulations that governed these facilities, in order to support persons to live where and with whom they desired. The Supported Living Waiver was folded into this Home and Community-Based Waiver. Supported living, in addition to numerous other types of services, was

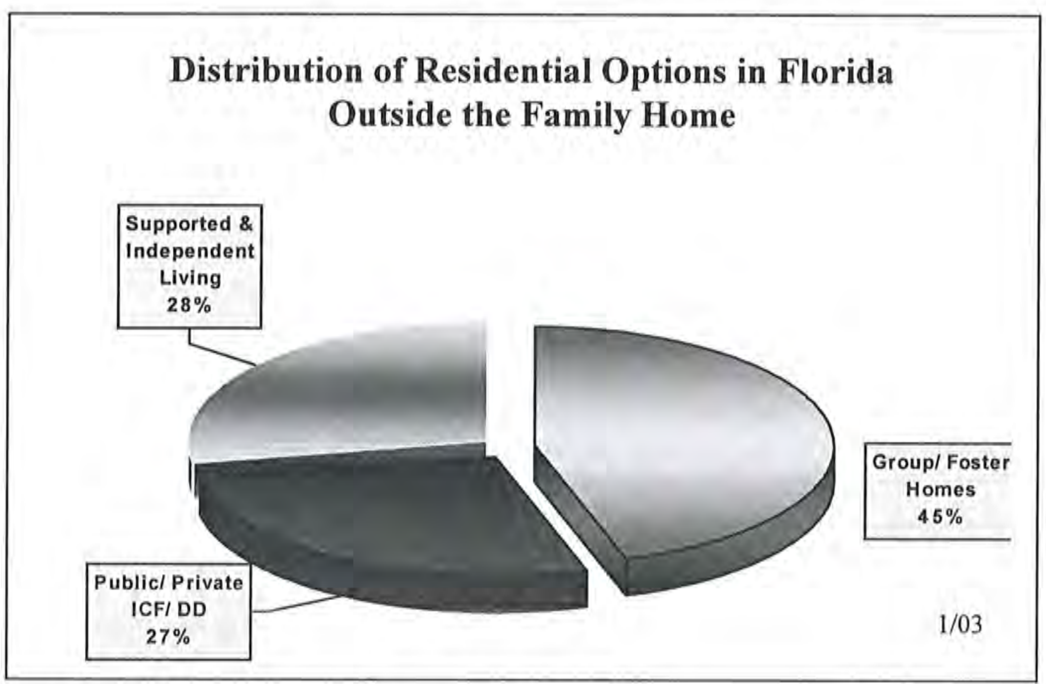
initiated as one of many Medicaid service options. For the first time, independent supported living providers applied for certification as Medicaid Waiver providers, which increased supported living options for people.

"A Guide to Supported Living in Florida and Trainer's Guide," 1995 – These guides were developed with a grant from the Florida Developmental Disabilities Council. Statewide training activities were conducted to provide pre-service training to district staff and providers.

"A Guide to Supported Living in Florida," 1997- This guide was updated to present supported living providers with information regarding the implementation of supported living services. The accomplishment of pre-service supported living training was required to qualify for Medicaid Waiver provider certification. As supported living evolved from a concept to a service option in Florida, the number of its citizens accessing the service grew dramatically.

In 1988, there were only 200 persons receiving supported living services. By 2003, more than 2,719 persons were receiving supported living services statewide, due, in part, to the Medicaid Waiver funding available. In addition to supported living options, the shift toward more community-based living options significantly increased. This meant approximately 75% of persons with developmental disabilities were living in their own homes or with family members rather than in group or institutional settings. This information is depicted in the graphs that follow:





Characteristics of Supported Living

Through supported living, individuals with developmental disabilities are able to live fully in the community. This includes living where any citizen in the community may live, developing relationships with people who do not have disabilities and are not paid staff, making daily decisions regarding how time will be spent, and having control over future plans. Supported living services are carried out amid the rhythms and routines of daily life. Supported living providers assist individuals with developmental disabilities by providing support in practical and familiar routines such as shopping, cooking, personal care, housekeeping, banking, socializing, and recreation. These may seem simple tasks, but in achieving these mundane aspects of living, we enjoy the commonality that is adult freedom. With freedom, comes unparalleled opportunity and promise... the gift of self-discovery, self-assurance, and infinite potential.

Characteristics of Supported Living

- People live in homes they control.
- Home selection and financing are separate from services.
- People define their own lifestyles

Characteristics of Supported Living, continued

- Providers use new ways to listen.
- Providers accommodate and support rather than "fix."
- Providers are sensitive and respectful of services in the person's home.
- People exercise control and choice regarding services and supports.
- Providers use flexibility in service delivery.

The following are some of the recognized characteristics of supported living:

- People live in homes of their own which they control. This means the person's name is on the lease of a home in the neighborhood and community he has selected. He lives with whomever he wants, and receives supports from whomever he chooses. If he doesn't like the services he is receiving, he can change providers, not his home.
- Selection and financing of people's housing is separate from the selection and financing of the services and supports they receive.
- People define the lifestyles they want. If a person's life experiences have been limited, she is given information and support to explore opportunities, discover preferences, and express them.
- People who formally and informally support persons with developmental disabilities learn and practice new ways of listening. They listen to what people want and to their dreams. In doing so, they redefine themselves as allies, helping people achieve their desires, and live as many or as much of their dreams as possible. As allies, people supporting others follow the person's lead, rather than decide "what is best on his behalf."
- Service providers redefine their role to one of accommodating and supporting the personal preferences and desired lifestyles of persons with developmental disabilities, rather than trying to "fix" them.
- Service providers learn how to be less intrusive in delivering services and supports, and are sensitive to and respectful of people's homes and the rights and courtesies associated with them.

- People exercise choice and control regarding the type and degree of services and supports they receive, and from whom they receive them.
- Service providers improve their ability and flexibility in delivering services rather than limiting personal choice, or offering a "one-size-fits-all" approach.

Supported living is a way of looking at how and where we commit our resources and provide support, by considering people one at a time and figuring out creative and non-traditional ways to provide what each person wants or needs.

Characteristics of Services and Supports

Characteristics of Services and Supports

- Individually - Designed Supports
- Personal Choice and Control
- Family, Friends, and Community Emphasized

Flexible, Individually-Designed Supports Based on Personal Preferences
Supported living services are individually designed, with flexible supports based not only on strengths and needs, but also on personal desires. The pursuit of personal dreams is recognized as an individual's right rather than a reward. Support is provided only where needed and can be arranged in ways that maximize the individual's abilities and compensate for skills an individual doesn't possess.

Supports are provided in accordance with the life outcomes the individual wishes to achieve and may include the teaching of new skills, assistance with activities the individual is unable to perform without support, and help in developing linkages with other people or resources in the community.

Maximized Personal Choice and Control
When people live in group settings, procedures and rules are established to operate the home considering the requirements of all household members. In order to accommodate everyone, some individuals may be subject to undesirable or unnecessary control over personal choices in their lives.

When people experience individualized supports and services, they are able to exercise greater control and personal choice in all areas of life. An individual in supported living lives in his own home, and it is the individual who establishes the procedures and routines by which the household is operated and through which daily life evolves. Some people may need encouragement to express their preferences and make decisions when they first move to supported living. Others, experiencing personal control for the first time, may make choices that seem inappropriate. Opportunities and support will promote good decisions.

Regarding Personal Choice:

Control: It's the little things that count.

- *Jack, from St. Petersburg, states he can "get coffee whenever I like" and "make sweet tea and keep it in the refrigerator." In his prior home, the kitchen was locked and only staff were allowed in.*
- *Donna reports, "I can make my own menu and change things when I feel like it. I can plan my own meals every week rather than eating from a menu every week."*
- *Janice, of Habilitation Management Services, says she never saw anyone as thrilled as "Amy," when she learned she could store her personal items in the bathroom, and not in the plastic box they made her keep in her bedroom when she was in the group home.*

Family, Friends and Community Supports

Connections to people, places, and activities create the most effective life for anyone who lives in a community. Friends and acquaintances often will notice problems and lend assistance before they intensify. Almost everyone depends on family and friends for support during difficult times and in the course of everyday life. Yet, service systems often prevent these important connections by surrounding individuals with others who are paid to direct their activities in programs and places that are isolated from community life. In supported living, people are encouraged and assisted to form or renew connections with other citizens and family members.

Providers of supports and services play a vital role in helping individual make connections to the community through thoughtful and sensitive actions. For example, taking an individual who has a developmental disability around to

meet all the neighbors may actually focus on the disability and create an expectation of dependency. Neighbors who have nothing in common are unlikely to form the close relationships that evolve naturally through activities of mutual interest. Yet, supporting someone to meet nearby neighbors as part of the incidental activities of moving in or during regular daily routines opens the way to neighborly hellos and conversation. Connection to a community member, an organization, a church, a business, or a public place often leads to everyday contact with a range of other people so that the individual becomes part of something that is focused around common interests and capacities rather than disability.

While a primary role of the supported living coach is often helping a person move into her own home, an equally important focus must be on how to effectively support the person in becoming a part of the community once the move has occurred. This is usually a slow process that evolves over time. To help promote involvement, the coach may need to begin by simply orienting the person to the neighborhood and what it has to offer. Assisting a person in exploring new activities and interests in the community is not only exciting, but can also serve as the cornerstone for the development of new and lasting relationships.

Eligibility for Supported Living

In supported living, housing monies are separated from support funds. The person with a disability decides where to live and selects a housemate if needed or desired. He purchases a home or signs a lease. Supports are developed individually, taking into account the needs and preferences of the person and his family.

An individual to whom the following applies should be considered "eligible" for supported living services:

Who is Eligible for Supported Living?

An individual who...

- ☑ is receiving services from the Developmental Disabilities Program.
- ☑ is at least 18 years of age.
- ☑ desires to live in his own home in the community.

Eligibility, continued

☑ is unable to live in her own home in the community without ongoing supports.

In the community, the basic criterion for living in one's own home is whether or not a person has the resources to live there. An additional criterion for supported living is whether adequate supports and services can be arranged for the person. When the answer is "yes," make sure that other circumstances do not become an excuse to deny an individual the opportunity to live in her own home.

The intensity of supports can be designed to meet the requirements of each individual. Many successful supported living arrangements in Florida and throughout the nation have been developed for people who have severe physical disabilities.

Sometimes, seemingly insurmountable behavioral challenges are reduced or disappear when the individual is in a supported living setting. Experience indicates that many individuals leave their histories of "behavior problems" behind when they move from congregate situations to supported living arrangements.

Andy's Story

After losing both parents as a very young child, Andy floated from family members to institutions to group homes, until moving to Florida when he was 11. He stayed with his sister for a few years until he was abandoned, and placed into an assisted living facility (ALF). Andy moved from ALF to ALF for years.

In 9 years Andy lived in 18 separate places, where he was physically, sexually, and psychologically abused. Food was taken from him on a regular basis for punishment, and he was assaulted by staff and consumers.

Andy lived in supported living before, and it failed him. He moved from a respite facility, after having been hospitalized from his earlier living situation. He moved into an apartment, with two others without any choice as to with whom he was going to live or where. Due to the need to move quickly, he was "placed" in the apartment before preparations were adequately made. He slept on the couch for weeks, waiting for one of the roommates to move to another apartment. The live-in staff was taking Andy's medications and had

problems of his own. There was little to no supervision or monitoring by the agency providing live-in staff and supported living coaching.

Andy's behavior continued to deteriorate and he was moved to another apartment without his involvement, or consideration of what was appropriate and effective for Andy. He did even worse there. The live-in staff was untrained and reacted emotionally and personally to Andy's behavior. Staff took Andy to a psychiatric hospital to have him hospitalized because they were "tired of dealing with him." The situation deteriorated quickly and Andy was "placed" in a group home for over one year. It took some time, but Andy finally moved into his own house last year.

Today, Andy lives in his own house with 24-hour staff, some who work with him during the day, and a live-in who stays with him at night. Due to his behavioral challenges, this is needed for Andy to remain safe and to become more independent and successful. He is doing well, with the help of a comprehensive and thorough level of supports. It is an ongoing effort to keep his supports communicating effectively and to ensure that his circle of support acts as a whole in providing him the assistance he needs in the way he needs it.

His level of supports is a model for the efficacy of supported living, and a lesson for all who wish to take this step.

Andy, and those who were with him through turbulent times, learned a great deal. He does poorly in environments where coercion is used as a way of "controlling." He reacts badly to unstructured environments and with a circle of support who do not communicate or are inconsistent and unreliable. He does poorly when he has to compete for the attention of staff. He is not successful in group living environments. He does better when supports are tailored to his needs and not based on a generic model.

Andy has done very well in his current supported living situation. This has been hard earned, by Andy and those who are invested in his success. He takes great pride in living in his own house. He loves having his own space. In group homes and ALF's Andy had no place to call his own. His room, which he usually shared, was not a haven or safe place. Staff would barge in at their leisure. Now, Andy knows his room is a place he can go and be unfettered. This is remarkable to him and one of the best things about where he lives.

He has become adept at saving money. He has learned to take care of his house and is proud of the job he does. He is becoming more skilled at doing

his own laundry and in other areas of daily living. His behavior has improved dramatically. He has not needed psychiatric hospitalization in over a year, where in the past this occurred regularly.

Andy's success is due to the type of supports he is getting, the dedication of those working for him, the training and competency of those involved, but most importantly, due to the honest caring and concern for Andy shared by those who know him, and see the person he wants to be.

Andy continues to teach us. The other day I was talking with him and, in his charming and congenial way, he said, "I'm doing great, aren't I? How come I'm so smart?" I smiled and told him he has come a long way. A long way from the pain and chaos of his past. But a long way still to go. Andy has the strength of spirit and resiliency to help us support him in getting there.

Ken Winn, Legal Guardian

People do not need to be completely independent or attain a certain skill level in order to live in their own home. Necessary instruction and assistance can be provided within the context of daily life.

People don't fail supported living... supported living fails them.

Individuals do not fail in supported living---arrangements sometimes fail to meet their personal needs and preferences. If one thing does not work, try another. There are unlimited ways to provide supports. The person, her friends, and supports should be persistent and dedicated to finding alternative strategies for success, when faced with a strategy that has failed. Like new strategies, sometimes a different person with a different perspective can find the way to success.

Chapter Summary

Knowing the definitions, history, and philosophy of supported living is not enough. It's just as critical to keep in mind what makes supported living different from traditional group living arrangements.

Supported living is not about…

… being treated like a child.

… earning privileges.

… being "ready."

… financial requirements.

… imposing limits.

… frequent moves.

… fitting into an established program.

… merely finding a home, but making a life in it.

Supported living is not about being treated like a child.
Adults with challenges in communication or affect are often viewed differently, as though they are children who lack capacity and therefore need others to make decisions for them. All adults enjoy a degree of choice and control over their lives. Individuals receiving supported living services enjoy a greater degree of control over their lives than do those living in group settings.

Supported living is not about earning privileges or being ready.
In traditional group living situations, once people are accepted they are thought of as needing to progress through some type of continuum. Staff determine what the person must accomplish before moving on to other types of living arrangements. An arbitrary criteria of needed skills may be used in making this determination. People are frequently not "allowed" to live in their own home until deemed "ready."

There is also a perception that those things which enrich daily life must be earned as privileges, rather than occur naturally. For example, people who live in their own homes don't require themselves to complete a task before going out. People in group living arrangements may often be required to clean their bedroom before going out.

Supported living doesn't require making people ready by simulating how it will be to live in a home, rather, it begins to immediately support people to live in their homes. Supports are flexible and are adjusted based on the person's changing needs, preferences, and desires.

Supported living is not about financial requirements.
People don't need a set amount of money in order to live on their own. Rather, supported living assists an individual in finding a place he can afford, given his financial situation. The coach may also assist in locating a roommate or offer suggestions to defray expenses.

Supported living is not about imposing limits.
Supported living is about clarifying expectations, so dreams may become reality. As an effective service, supported living is built upon the relationship that emerges between the individual receiving services and the person providing them. Getting to know the individual, how she learns best, and how she manages various situations will help the coach in supporting her to move beyond her own perceived limitations toward a desired life. Rhetoric like "you can't do this because…" is replaced with "let's see what it's going to take to support you in getting there."

Supported living is not about frequent moves.
In the past, when problems arose in group living arrangements it usually meant that someone had to move out of the home to alleviate the situation. Frequent moves are unsettling and can create a sense of loss. Supported living is about individualized services. Supporting people to live where and with whom they choose, in homes and neighborhoods in which they feel comfortable, often alleviates the need to move.

According to Klein (1994), this does not mean everyone must live alone, nor does it mean people must choose to live with a friend. It means if people want to live with someone else, they choose with whom they live. For example, some people with disabilities need intensive assistance to accomplish everyday routines. In these situations, people may choose to live with someone who can assist them or may have their assistance provided on a regular schedule or an "as needed" basis. This also means making an informed choice and knowing the full range of options. This may require trying a few options before finding the best one.

Supported living is not about fitting into an established program.
Although many of the places people live are called houses or homes, both people who work and live in these places describe them as programs. They often have professional sounding names, and meet the requirements of congregate living settings. Programs employ staff who come and go (generally in shifts) turning the "home" into a place of business and the driveway into a parking lot. This fact alone separates "programs" from the rest of the neighborhood.

At times, programs evaluate people's abilities through the use of assessments to determine and legitimize their programming. This information is then compiled and a score determines into which program a person fits. Supported living is not a program or simply a service, but a process through which persons are individually matched to living arrangements and learn to access the locale and all it has to offer. The types and levels of supports each person needs are developed, and may be provided by paid staff, friends, or others who wish to be involved in the person's life. These supports are not determined by criterion-referenced assessment. Places accessed, personal relationships, and the means for being successful at home and in the community are determined by the person's interests and wishes. There is no prerequisite to community-based life. There are needs and desires that must be addressed.

Supported living is not about merely finding a home, but is also about making a life in it.

Although supported living usually takes place in and around the person's home, having a nice home is not the only necessary component of supported living. Many people have a desire to be part of their community, experience life in their neighborhood, make friends, and contribute to their community through employment or other means.

Despite the common belief that people's presence in a community makes them an actual part of that community, in reality, this is hardly the case. People living in group settings generally spend their free time with those same groups. Going to the store or to a movie in a group does not connect a person to that community. Participation in the community occurs on an individual basis and valued roles in the community take time to develop.

Deciding how and where to live involves a process of self-exploration, research, and planning. For people who will move into their desired homes and define their own lives with the help of a supported living provider, the first step toward these decisions may actually be consideration of this service option as it compares to others that have been discussed in this chapter.

Chapter Two provides the kind of information all persons need in order to make an informed decision about whether to provide or obtain supported living coaching services.

Chapter Two
Exploring Supported Living

Chapter Two: Exploring Supported Living

Key Information for Decision-Making

- Supports and Services
- Roles and Responsibilities
- Planning Process
- Places to Live
- Liaison Network

Introduction

Prior to deciding to provide or obtain supported living services, interested persons need information about the:

- types of supports and services available and needed;
- role of the supported living coach and other support providers who may be needed;
- options for living arrangements;
- individualized planning process; and
- experiences of others who have received supported living services.

Supported living is one residential option in Florida's system of supports and services for persons with developmental disabilities. The majority of these supports and services are administered by the Agency for Health Care Administration (AHCA) and implemented by the Florida Department of Children and Families (DCF) Developmental Disabilities Program. This vast array of Medicaid Waiver services are identified in the Developmental Services Waiver Services Medicaid Coverage and Limitations handbook. This DS Waiver handbook includes descriptions, requirements, and qualifications for all Medicaid Waiver services. Copies of the DS Waiver handbook may be obtained through the AHCA website (www.fdhc.state.fl.us/medicaid/dev_serv/).

Successful community living depends on a coordinated network of support to ensure the individual receives assistance, training, and intervention at the right time and in the right way. This network, based on a partnership between formal (paid) and informal (non-paid) supports, may include many people, such as friends, relatives, providers of services and other community members.

This chapter discusses the array of paid supports and services that may be provided through the State's Developmental Disabilities Program. The type, intensity, and frequency of services and supports will need to be addressed when the person is exploring a supported living arrangement.

The Medicaid Waiver was expanded in Florida in 1993 as a means of adding federal funds to the much overburdened State general revenue funding. The Medicaid Waiver currently funds the majority of services for individuals with developmental disabilities statewide, and includes supported living coaching as one type of service option. While there are a wide array of services available through the Medicaid Waiver, funding approval for all services is contingent on the Department of Children and Families (DCF).

The Role of the Support Coordinator

The waiver support coordinator (WSC) serves as the individual's primary contact with the State Developmental Disabilities Program and other needed services and community resources, regardless of the funding source. By definition, support coordination is the "service of advocating, identifying, developing, coordinating and accessing supports and services on behalf of a recipient, or assisting the recipient or family to access supports and services on their own."

The provider of support coordination services, consistent with the limitations described in the DS Waiver handbook, is "legally and financially independent of persons or organizations providing (other) direct services." The Medicaid Waiver encourages each recipient to choose a waiver support coordinator who will coordinate services and supports and assist the person with individualized planning designed to enrich his life.

The planning document, the support plan (SP), and the accompanying plan for outlining the cost of each service, the cost plan, become the authorizing documents for all services and supports needed and desired by the individual. The cost plan identifies the service or support, and how much time and money has been approved for that service. The SP describes the services authorized on the cost plan through the identified goals, outcomes and actions. The

supported living coach, as with all providers, should implement services consistent with the SP goals and with the amount and duration authorized.

As changes occur regarding the need for supports and services both the SP and the cost plan may be updated. The individual and her guardian, if applicable, can work with the provider and the support coordinator to make adjustments to both the SP and the cost plan. It is the waiver support coordinator's responsibility to request service approval on the cost plan; however, if some elements of the cost plan are denied, it may be necessary to provide additional information to justify the need for that particular service.

The role of the waiver support coordinator may vary based on individual needs and desires, but overall, it is his responsibility to assist the person and her family in the planning and selection of providers, the coordination of all supports and services including the facilitation of communication among all involved parties, act as an advocate, and monitor health and safety across all settings where services are provided. Unlike supported living coaches, support coordinators do not provide training, instruction, or any direct services other than support coordination.

The Role of the Supported Living Coach

A supported living coach is a trained professional who provides assistance, training, and instruction in a variety of activities to support persons who live in their own homes. Supported living coaching always focuses on the health and safety of the individual both in and around his home. Supporting persons in maintaining good health, accessing community health care services, and promoting personal safety are essential components of the relationship that exists between the coach and the person receiving supported living services.

Supported living services are defined in the DS Waiver handbook as:

Supported Living Definition:

"The provision of supports necessary for an adult … to establish, live in and maintain a household of their choosing in the community. This includes supported living coaching and other supports." These services may include "assistance with locating appropriate housing, the acquisition, retention or improvement of skills related to activities of daily living such as personal hygiene and grooming, household chores, meal preparation, shopping, personal finances, and the social and adaptive skills necessary to enable (persons) to reside on their own."

Coach's Overall Responsibilities:

- **Assists** with locating housing and needed household supports.
- **Teaches** the acquisition, retention or improvement of activities of daily living such as:
  - personal hygiene;
  - grooming;
  - household chores;
  - meal preparation;
  - shopping;
  - personal finances; and
  - social and adaptive skills.
- **Coordinates** opportunities for connecting with community resources.
- **Provides** ongoing supports to maintain desired lifestyle.

The supported living coach assumes the main role in providing the ongoing life management support that an individual needs in order to live in and maintain his own household. This can include teaching new skills and/or providing assistance in the areas of support. In addition, the coach plays a pivotal role in assisting an individual to develop interdependent relationships with others in the community.

Supported living coaching is designed to provide instruction and assistance to individuals living in their own homes or apartments. This includes assistance with locating a place to live, negotiating a lease, paying bills and managing money. This also entails acquiring, maintaining or improving personal hygiene and daily living skills, money management, housekeeping, shopping, community awareness, and other skills necessary to successfully maintain a home and community relationships.

"If you think about life in your community, you are bonded through a similarity of locale, shops, churches, school district, and other community space, yet through the diversity of your neighbors and community, you are inspired to grow and develop. In allowing each person to be welcomed and accepted, all people grow." Al Condeluci,
Interdependence, The Route to Community

Working Together

Considerations for coaches and support coordinators who are working together to support persons in their own homes:

- **Be Partners:** Work with the individual and each other to support her in reaching her dreams. Remember this is the common goal.

- **Be Flexible and Creative:** Preferences and needs will vary from person to person as will the roles of providers. Together, search for non-traditional resolutions to problems and creative ways to establish and maintain support arrangements. Maintain as much flexibility as possible within the parameters of state and federal laws, rules, regulations, and guidelines.

- **Work it Out**: Address and discuss any areas of uncertainty. Identify possible areas of duplication and how they will be handled. Example: The support coordinator and the coach must work hand-in-hand to ensure people maintain eligibility for benefits (such as Social Security, Medicaid, etc.). There should be a clear understanding between all parties so that efforts are not duplicated or necessary activities overlooked.

- **Write it Down:** The individual support plan (SP) is the guiding document for all supports and services authorized on the cost plan. The expectations of the coach and support coordinator (as well as other support providers) should be clearly specified in the plan. The SP changes and is revised over the course of the year as the needs and desires of the individual change. It is a fluid document reflecting the person's desired outcomes, scope of service, and current situation.

- **Communicate:** Be sure the individual knows who to contact for assistance in certain situations and with certain tasks (i.e. Medicaid problems, emergency assistance, etc.).

Other Medicaid Waiver Services Typically Associated With Supported Living

While supported living coaching provides the training and support for the individual, there are other Medicaid Waiver services available to assist people to be successful in their own home. Each of the service providers must work cooperatively to assure the person receives the benefits of a cohesive support system. Several of the services discussed below cannot be used during the same time. The listing below is not all inclusive. Information describing these services and supports may be found in the current DS Waiver handbook.

Other Medicaid Waiver Services

- **Adult Day Training**
- **Behavior Analysis Services**
- **Chore**
- **Companion**
- **Homemaker**
- **In-Home Supports**
- **Non-Residential Supports and Services**
- **Personal Care Assistance**
- **Personal Emergency Response System**
- **Residential Habilitation Services**
- **Supported Employment**

Adult Day Training (ADT) services are intended to support the preparation of individuals in daily, valued routines of the community. This may include work-like settings that do not meet the definition for supported employment. ADT stresses training in the activities of daily living, self-advocacy, adaptive and social skills and are age and culturally appropriate. Persons may attend an ADT on a full-time or part-time basis.

Behavior Analysis services are utilized to assist individuals with challenging behaviors, which may impact their ability to live on their own. The Behavior Analyst develops a behavior intervention plan that is implemented by all service providers. The plan focuses on supporting individuals in learning or maintaining alternative behaviors while reducing existing behaviors of concern. The behavior analyst works with the individual's circle of support to

ensure that the individual's use of alternative behaviors is supported in all the environments in which she spends time (i.e. home, work , community, etc.).

Chore services are provided to maintain the individual's home and property as a clean, sanitary and safe living space. These services may include household duties such as washing floors, windows, and walls, tacking down loose rugs and tiles, replacing a broken window, or moving heavy items of furniture that make the home safe.

Companion services consist of non-medical care, supervision, and socialization activities provided on a one-on-one basis. This service must be provided in direct relation to the achievement of the individual's support plan (SP) goals. A companion may assist the individual with such tasks as meal preparation, laundry and shopping. This service does not entail hands-on medical care, but may provide light housekeeping tasks, incidental to the care and supervision of the individual. They may be scheduled on a regular long-term basis.

Companion services are not simply diversional in nature, but are related to specific outcomes desired by the individual. For example an acceptable activity could include going to the library, getting a library card, learning to use the library and checking out books or videos for personal use, etc. Companion services cannot be provided concurrently with Adult Day Training (ADT), Personal Care Assistance (PCA), and Non-Residential Support Services (NRSS).

Homemaker services are those general household activities such as meal preparation, laundry, vacuuming and routine household cleaning provided by a trained homemaker, when the person who usually handles these task is unable to perform them. The intent of this service is to ensure the individual's home remains clean, safe, and sanitary. These services cannot be used for supervision or personal care.

In-Home Supports may be a service used in conjunction with supported living coaching for individuals who wish to live in their own home but need additional assistance or support. In-home supports are services that provide assistance from a support worker(s) four to twenty-four hours per day. The support worker may live in the person's home and share living expenses (e.g. rent, utilities, phone, etc.) or work on an hourly (shift) basis.

This person(s) provides companionship and personal care and may assist with or perform the activities of daily living and other duties necessary to maintain the person in supported living. These services are not a replacement of supported living coaching. Some individuals in supported living may need

only the services of an in-home support worker, or only the services of a supported living coach. Others may need both services. When both services are used, the providers must coordinate their services to avoid duplication. A person receiving in-home supports is not eligible to receive some of the other services such as personal care, companion, or residential habilitation services.

Non-Residential Support Services are individualized training activities provided in a non-residential setting. These activities are age-appropriate and geared to enhancing the acceptable individual's behavior, increasing those qualities, which are integrative and normative in nature. Support services, which may be provided in a work-like setting, are a process used to attain the necessary skills to control the environment, increase acceptable behavior and provide integrative opportunities. These services are intended to support the participation of persons in daily valued routines in the community.

The primary functions of non-residential support services are the development of skills needed:

- for communication and socialization to support the individual toward maximum independence;
- to increase independent living in the community; and
- to maintain a living environment, use community resources and conduct activities of daily living.

This service cannot be provided concurrently with Personal Care or Companion Services.

Personal Care Assistance (PCA) assists persons, on a one-to-one basis, with eating and meal preparation, bathing, dressing, personal hygiene, and activities of daily living. PCA also includes activities such as assistance with meal preparation, bed making and vacuuming when these activities are essential to the health and welfare of the individual and when no one else is available to complete them.

PCA cannot be provided at the same time as Non-Residential Supports and Services, Companion, Adult Day Training, or In-home Support Services.

Personal Emergency Response is an electronic communication system that supports an individual in obtaining assistance in the event of an emergency. The person may also wear a portable "help" button while out or at home. The system is connected to the person's phone and programmed to signal a response center. The "help" button dispatches qualified personnel to the individual's location.

Residential Habilitation Services provide specific training activities that assist the individual to acquire, maintain or improve skills related to activities of daily living. The service focuses on personal hygiene skills such as bathing and oral hygiene; homemaking skills such as food preparation, vacuuming and laundry; and on social and adaptive skills that enable the individual, to live in the community. This training is provided in accordance with a formal implementation plan, developed with direction from the individual and reflects his goal(s) from his current support plan. When an individual lives in his family home or a licensed residential facility, and supported living is identified as a goal on the support plan, supported living coaching may be provided in conjunction with residential habilitation for up to 90 days prior to the individual moving to a home of his own. In a supported living arrangement, residential habilitation and supported living coaching may not be provided together.

Supported Employment services provide training and assistance in a variety of activities to support individuals in sustaining paid employment, which may be especially important for persons living in their own homes. The provider assists with the acquisition, retention, or improvement of skills related to accessing and maintaining employment. Supported employment includes activities needed to sustain paid work at or above the minimum wage. Supported employment services are not a requirement for persons utilizing supported living services.

Additional Supports and Services Are available for individuals who may also need therapies (e.g., physical therapy, speech therapy, etc.); transportation; consumable medical supplies nursing; dietician; durable medical equipment and supplies; environmental accessibility adaptations; medication reviews; private duty nursing; special medical home care; specialized mental health services; etc. Although all services and supports are available through the Medicaid Waiver, access depends on the availability of providers, funds, and the variability of budgets across the various districts and regions within the state.

Many of these services are essential in supporting people to achieve their dreams and assure their well-being. Individuals should be aware of the array of service options before indicating their desire for services. The support coordinator, along with the circle of support, can assist the person in identifying needed services.

Each supported living arrangement is unique, and the needs of individuals may change over time. Some people may initially only need the assistance of a supported living coach; however, as time passes they may require changes to existing supports or additional services to enable them to remain in their own

home. The support plan will specify and the cost plan will authorize the services that each person receives.

Other Services Do Not Replace the Coach

The Medicaid Waiver offers a vast array of services designed to support individuals in supported living. However, these services should in no way be seen as a replacement for the supported living coach.

The coach maintains the responsibility of promoting safety to assist the person in living on his own. **While the aforementioned services are all extremely valuable, each is independent of the other, and without the coach there is no central point of household coordination.** The coach provides twenty-four (24) hour "on call" services to assist in assuring emergencies are addressed as they arise. The education and experience required for supported living coaching certification is far more extensive than most of the other support services previously mentioned.

It is extremely important that the supported living coach and the support coordinator work together with the individual and her circle of support to identify the supports needed to live in her own home. Once these needs are determined, the individual and her family should interview providers to assure she is comfortable with the people who will be working for her in her own home.

The Support Planning Process

The Support Plan authorizes all services and supports.

When an individual selects a supported living coach and/or other service providers, those providers may become a part of the person's circle of support. The circle of support may include anyone the person chooses such as family, friends, providers, neighbors, etc. The role of the circle of support is to work in conjunction with the individual in planning for his life. This life planning process is referred to as the Support Planning (SP) process. The circle of support meets at least once each year to support the person during this process. As needs and desires change, the circle may meet at any time the person chooses to adjust the plan or to discuss strategies and approaches.

Each provider has the responsibility to provide information to the support coordinator annually. According to the DS Waiver handbook, this information is often submitted to the waiver support coordinator as an annual report within thirty days prior to the end of the support plan year. During the annual support plan meeting the circle of support assists the person in formulating personal goals and determining the types of supports and services which may be needed to achieve them. **Personal Outcome Measures** (POMs), as discussed in Chapter Eight, offer a method for supporting persons in determining personal goals and desired outcomes.

The supported living coach works directly with the individual and the support coordinator as the individual's advocate to plan, implement, and maintain the supported living situation. A partnership must therefore be built and maintained between the supported living coach, the individual, and the support coordinator, in order to assure the successful implementation of the support plan. Constant communication, creativity, and flexibility in addressing concerns and clarifying any uncertainty are key to maintaining an effective partnership. This partnership may extend to other members of the circle of support, and will vary significantly in intensity depending upon the person's needs and desires.

Places to Live

Once the individual has sought assistance in exploring service and support options, the next area of exploration regards the types of living situations available for consideration.

Sandy's Story

Sandy is 68 years old. He grew up on his family's dairy farm in Pennsylvania. He and his mother moved to St. Petersburg in the 1960's. In 1979, his mother was diagnosed with a terminal illness. Sandy had no other family, so he left the home and a lifetime shared with his mother to live in an Intermediate Care Facility for persons with Developmental Disabilities (ICF/DD). There, he learned to live without her, surrounded by 46 other people.

He lived there until 1991, when he moved into a 15-bed group home. The group home afforded less opportunities for going out, and many of the activities Sandy enjoyed at the ICF/DD were unavailable. However, he developed close relationships with his 14 house mates and staff.

As he grew older, Sandy began retreating from group activities, which severely limited his access to the community. He stopped going to church,

stores, restaurants, the riding stable, etc. He started going to bed before 6:30 on week nights, and spent the majority of every weekend in bed. He began engaging in problematic behavior to gain staff's attention and avoid activities.

His guardian approached Sandy about moving into his own home. No one was sure how he would react to the idea of supported living. Once it was described, Sandy's response was: "When do I move...before Christmas?"

At first it was difficult for Sandy to understand he had choices regarding every aspect of his living situation. Once it became clear, Sandy had a definite picture of what he wanted: a house without stairs, with a fenced backyard, with plenty of space to garden and enjoy the outdoors with his own dog. He also wanted to live close to the program he went to during the day and to his friends' homes. And he wanted to move in before his birthday, so he could hold his birthday party in his new home.

A house was found that matched Sandy's vision. He moved in two days prior to his birthday. There, he celebrated 68 years of living and the fact that for the first time, he had a home of his own. Sandy has had countless new experiences as a result of supported living. He sleeps in a double bed, decides what his meals will be and when he will eat them, buys his own groceries, walks nearly one mile daily... and the list goes on. In short, he enjoys the freedom, individuality, and contentment that can be realized through supported living.

Most people agree that everyone deserves a home; however, they sometimes disagree about what really makes a "home." According to John O'Brien, a nationally recognized consultant in the field of supporting people's disabilities, the elements of place, control, and ownership distinguish housing from a real home. In their own homes, people have a private and secure place for doing things that match up with the lifestyles they have chosen and that reflect their personal routines and tastes. Individuals who have a home control what happens there, including daily routines and who enters to visit or stay. Finally, people in a home have an investment in ownership or a legally assured tenancy.

Unfortunately, individuals who have developmental disabilities have typically been denied these things, often occupying housing that comes in a package with support services (such as a group homes, etc.). Many times, individuals have been expected to change residences as they acquired progressively more "independent" skills.

Supported living breaks from the residential continuum of the past, by directing attention away from physical settings and toward the services and supports needed and desired in order to become part of community life. Separating housing from support means that individuals do not have to live in a particular place, such as a group home, in order to receive the supports and services they want or need. When services and supports are tied to the person, and not to a facility or program, a person's home can remain the same even when services change, providers change, or life circumstances and needs and desires change.

Having a home is very important to most of us. We all need a place where we can have time and space for ourselves and feel safe, secure, and comfortable (Finding a Home: Practical Information About Buying or Renting A Home, 1995). While exploring supported living, it will be important to determine the types of homes available in the community where the person prefers to live. Homes may be represented by different types of structures including:

- **Apartment** A rental living unit usually within a complex of other units, all of which are typically owned by a corporation. Apartments within a complex are continuous buildings attached to each other. Many apartments are located in buildings of one or more stories, but some may be rented as a separate space attached to a home or garage. The living units may be offered in a variety of sizes and are usually priced from least to most expensive based on the size of the unit. The smallest unit is typically an "efficiency," which is characterized by one area that includes space for livingroom, dining and sleeping. Other units may include one, two, or more bedrooms and bathrooms, in addition to a living room, kitchen, and bathroom/s. Many persons may consider apartment complex living as optimal because of the proximity of the apartments to each other.

- **Condominium** (condo) A living unit within a complex, which can be purchased or rented, similar to an apartment, in which an individual or a corporation owns each separate living unit. A condominium management group provides oversight for all of the units within the complex for a fee. This fee is assessed to the owner of the unit to cover maintenance of landscaping and other amenities such as pools, spas, etc. If renting from the owner, it will be important to determine if the maintenance fee is included in the rent.

- **Townhouse** A living unit usually built as "side by side" housing. Townhouses can be one or more stories in height and share a common landscape or yard with other units. Like condos, a fee may be assessed to pay for the maintenance of the landscaping and other amenities such as pools, etc. If renting from the owner, it will be important to determine if

the maintenance fee is included in the rent. If purchasing, assure the fees, taxes, and insurance are included in monthly budgets.

- **House** Typically a building without other structures attached, within a neighborhood of other dwellings of a similar nature. Frequently, houses are characterized by a building with one or more bedrooms, a kitchen, living and dining areas, as well as exterior space including a yard or patio space.

- **Manufactured or Mobile Homes** A separate house, which can be moved from place to place. Like a house, manufactured homes have one or more bedrooms, a kitchen, dining, and living area, and some yard or landscaped areas. Most mobile homes are located in manufactured home parks, where each is assigned a lot. Although persons may rent or own their mobile home, there is usually a lot fee assessed monthly. When choosing a mobile home, make sure it complies with current building codes and standards.

Supported Living Liaison Network

When first considering supported living, many questions will arise. For many people, change is easier when supportive relationships are available. In many ways, supported living depends on the establishment of new relationship, and the continuance of those already formed.

Relationships take time to develop, whether formal or informal. The quality of these relationships, in terms of mutual respect, trust, and clear communication, often impacts the quality of each life experience.

As with any change or major move, making the choice to utilize supported living services and move into your own home can be difficult. Many people with developmental disabilities have spent their lives in large group living situations. Others, because of the need for additional supports and safety, have lived their entire adult lives in their families' homes. For many of these individuals, it may seem impossible to consider having their own home. Group living settings, by design, have a support network of their own. Frequently, parent and advocacy groups emerge from group situations to support each other through their similar experiences. New relationships may need to be initiated that will provide immediate support, even during the initial stages of exploring supported living.

The Supported Living Liaison Network was established in 2003 to link individuals who are living in their own homes to people and their families who are considering supported living as an option. Learning from others about their experiences with supported living services may make a difference in understanding the types of supports and services needed for success.

In addition to connecting individuals considering supported living services with those currently receiving services, the '*Network*' will also assist in linking family members. This provides opportunities to discuss fears and concerns regarding their children or siblings living on their own. Parents who have watched their son successfully transition into supported living may be able to answer questions that can only be answered by someone with similar experiences.

The '*Network*' provides a listing of individuals, organized by various categories, who are currently receiving supported living services. For each person or family member listed there is a brief biography which includes basic information about the person's supported living experiences. Persons who are considering supported living will be able to access contact information so they can talk with an individual and possibly visit him in his home. Visits will depend on each '*Network*' member's desired level of participation.

Supported living coaches and support coordinators will be able to access the listing of individuals by District or Region who have agreed to be part of the '*Network*'. The '*Network*' was developed and funded by the Florida Developmental Disabilities Council. Copies are available in print and on the internet beginning July, 2003, through each District/Region Developmental Disabilities Program and the Florida Developmental Disabilities Council Office (Phone: 800-580-7801 and web: www. fddc.org).

Chapter Summary

During the initial exploratory stage of decision-making, a general understanding of supported living is gained. Supported living provides for a wide-array of supports and services that are individualized to each person's unique situation. Some supports and services are funded as Medicaid Waiver services and some through general revenue (tax) dollars. The support coordinator and supported living coach are key to this service, and have clearly delineated roles and responsibilities. They work as a team, along with the circle of support, through the support planning process, always keeping sight of the person's desired home life, and finding the means to support the person in its attainment.

Unlike residential continuums of the past, people decide where their homes will be, and the type of housing they desire.

Chapter Three provides specific information regarding supported living coaching services and requirements. It includes details regarding qualification, certification, and training requirements.

Chapter Three: Understanding Coaching Services and Requirements

The first two chapters discussed the service delivery system, and knowing what types of home and living situations are preferred when considering supported living. Supported living offers an array of options; however, the ability to live successfully in supported living depends greatly on the individual's coach and other needed supports. The individual and her family should have a clear understanding of the coach's commitment to service implementation, as well as the requirements associated with the position.

Commitment

In order to be an effective supported living coach, it is desirable to have a basic belief system, consistent with best practices in the field of developmental disabilities. Supported living, along with supported employment, is often considered the foundation of supports for persons seeking self-determination.

> ***"What if you never got to make a mistake...***
> ***What if you were never given a chance to do well at something.***
> ***What if you were always treated like a child.***
> ***What if your only chance to be with people different from you was with your own family...***
> ***What if you never got to make a decision.***
> ***What if the only risky thing you could do was act out...***
> ***What if you had no privacy...***
> ***What if you grew old and never knew adulthood.***
> ***What if you never got a chance."***
>
> ***-excerpted from "The Dignity of Risk," which appeared in Changing Expectations/Planning for the Future: A Parent Advocate Manual by Dorothy Sauber, published by Association for Retarded Citizens, Minnesota.***

As the individual directs supported living services, the values associated with supported living coaching should guide service delivery. Ultimately, the belief system should be used as the framework around which all decisions are made. Values and beliefs should embrace the needs and desires of persons using

supported living services. Services and supports are most successful when these needs are addressed.

In order to be consistent with the values set forth and the overall needs identified by persons receiving supported living services, it will be important to commit to a consistent approach to service delivery. Habilitative Services of North Florida, a supported living coaching provider, identified their approach to service delivery around "The Top Ten Commitments of a Supported Living Coach:"

The Top Ten Commitments of a Supported Living Coach

A supported living coach should:

1. … fully believe that people should have homes of their own, in which they **"control their own front door."**

2. … support people to exercise **choice and control** in what services and supports they receive and from whom {rather than "taking what they can get"}.

3. … support people to **define the lifestyles they want**, and should provide opportunities and assistance in developing and expressing preferences for their desired lifestyle.

4. … define themselves as an ally in helping people **achieve** as much of what they want out of life as possible {rather than deciding what's "best" for the person}.

5. … accommodate and support the **personal preferences and desired lifestyles** of persons with developmental disabilities {rather than trying to "fix" them}.

6. … **really listen** to the opinions of those they support {rather than manipulating people into acquiescence and calling it "choice"}.

7. ... learn how to **be less intrusive** in the ways they bring services and supports into people's homes.

8. ... **be sensitive to and respectful** of people's homes and the rights and courtesies associated with them, and provide services that are delivered in different ways to different people in different places (**flexible**!), instead of offering a "one-size-fits-all" approach to supports.

9. ... **do what they promise** and keep the commitments they make to those they serve . . . making each individual feel as if they are the **only person** they support.

10. . ... allow people to think for themselves, dream their own dreams, and **write their own stories.**

Becoming A Certified Medicaid Waiver Provider

Persons providing supported living services must be certified as a Medicaid Waiver provider. Agencies or individuals who wish to be certified as providers of supported living coaching services must submit a completed Developmental Disabilities Medicaid Waiver Application, including all required attachments and assurances, to the Department of Children and Families (DCF) Developmental Disabilities Program in the District/Region where they wish to provide services. On accepting an application, the District/Region Developmental Disabilities Program will issue a certification to provide services.

Supported living coaching certification is valid statewide. Providers who wish to expand services to a new district shall notify the District/Region of their desire to become a provider in that district.

Provider Qualifications, Education, Experience, and Training
The supported living coach is a trained professional with experience in the field of human services. Supported living in the state of Florida has become a profession for many people. Supported living coaches may either work for an agency or operate their own supported living coaching business. All coaches, whether they are business owners or employed by a supported living agency, must meet the qualification requirements as outlined by the Department of Children and Families, Developmental Disabilities Program.

In order to determine if an individual is qualified to become a supported living coach, the Developmental Disabilities Office follows the guidance offered by the Developmental Services Waiver Services Medicaid Coverage and

Limitations handbook, and the requirements found in the "Core Assurances" identified in the Medicaid Waiver Services Agreement.

The DS Waiver handbook explains qualifications, experience, and training requirements, and the Core Assurances comprise administrative and programmatic requirements that must be signed by all Medicaid Waiver providers, regardless of the service. Proof the requirements identified in the DS Waiver handbook have been met, and the Core Assurances have been accomplished, must be provided for a supported living coach to become certified as a Medicaid Waiver provider.

The DS Waiver handbook includes the following as requirements for Medicaid Waiver supported living coaching certification:

SUPPORTED LIVING COACHING REQUIREMENTS

1. **Qualifications**
2. **Pre-Service Training and Ongoing Requirements**
3. **Core Assurances**

Qualifications:

- A **bachelor's degree** from an accredited college or university with a major in nursing, education, or social, behavioral or rehabilitative science. In lieu of a bachelor's degree, a person rendering these services has **an associate's degree from an accredited college or university with a major in nursing, education or social, behavioral or rehabilitative science and two years of experience**. Experience in one of the previously mentioned fields can substitute on a year-for-year basis for the required college education.

- **Level II background screening** must be completed for all supported living coaches. This process includes:
    - **Affidavit** of good moral character;
    - **Local background check**;
    - **Finger prints** submitted to FDLE (Florida Department of Law Enforcement) for screening;
    - 3 verified **personal references** and;
    - **Re-screening** performed every 5 years.

Pre-service Training and Additional Requirements
In addition to qualifications, the Department provides requirements for pre-service and on-going training as a framework for organizing supported living services. Pre-service training may be obtained through a certified provider or District/Region trainers. The following are the minimum training requirements of supported living coaching services:

At least **18 hours of pre-service training prior to assuming job responsibilities.**

At a minimum, training consists of:

Pre-service:
- A detailed review of all components of the 2003 publication, *A Guide to Supported Living in Florida.*
- Overview of Rule 65B-11, Florida Administrative Code (FAC)
- Overview of home modification
- Overview of affordable housing

Additional requirements include:
- **Training:**
  - Complete training covering those identified in the DS Waiver handbook and the Core Assurances such as HIV/AIDS training once every two years.
  - Maintaining current cardiopulmonary resuscitation (CPR) certification.
  - Eight (8) hours of ongoing annual in-service training including maintenance of certification (e.g. CPR, etc.)
- **An on-call system** that allows individuals' access to services for emergency response 24 hours-per-day, 7 days a week, including having a certified backup supported living coach to provide supports in the event the person's regular supported living coach is unavailable.

Core Assurances provide the terms and conditions by which the provider of Waiver Services agrees to be bound. Verification the provider agrees to meet these requirements may be denoted by his signature on the Medicaid Waiver Services Agreement. This agreement is signed when the individual completes the requirements for certification. Specific information for implementing most

of the components of the training and documentation requirements are addressed in **Chapters Five and Six.**

The Core Assurances, outlined in the DS Waiver handbook, include some of the following topics:

- The emphasis on individual choice and right.
- Responsibilities and procedures for maintaining health, safety, and well-being of individuals for whom services and supports are provided.
- Required documentation for supported living coaching services.
- Specific additional responsibilities under the Core Assurances and the Developmental Services Waiver Services Florida Medicaid Coverage and Limitations handbook.
- Due process procedures.
- Specific needs or characteristics of the individual(s) served as required to successfully provide services and supports.
- Mandatory meetings and training scheduled by the District/Region and/or Department.
- A written policy and procedure that identifies the rights and responsibilities of individuals receiving services.
- Written policies and procedures to address choice for individuals, including those with family involvement, guardians, or for those who have been adjudicated incompetent.
- A written policy and procedure to address the immediate reporting of any suspected incidents of abuse or neglect.
- A written policy and procedure to educate the individual and/or family/guardian about how to report abuse, neglect or exploitation.
- A written policy and procedure to use the personal outcome process to design person-centered supports and services, and to enhance service delivery in order to assist individuals in achieving personal outcomes.

- A written policy and procedure that prohibits solicitation of individuals through the use of fraud, intimidation, undue influence, including offering discounts or special offers that include prizes, free services or other incentives.
- A written policy and procedure that prohibits solicitation of an individual currently receiving services from another vendor for the purpose of inducing the individual to switch vendors through the use of fraud, intimidation, or exertion of undue influence on an individual.
- Written grievance procedures that are used to resolve conflicts that may arise between the individual, family, and/or guardian and the provider. The procedure contains all of the required and relevant information.
- Maintain a log of grievances filed.
- Written policies and procedures on a person-centered approach to service delivery.
- Written policies and procedures on promoting health and safety.
- Written policies and procedures on the safe administration and handling of medication, that includes staff training.
- Written policies and procedures on transitioning of individuals.
- Written policies and procedures on staff training, orientation, and in-service.
- Written policies and procedures on self-assessment.

Responsibilities of the Supported Living Coach

The supported living coach assumes the main role in providing the ongoing life management support an individual needs to live in and maintain his own household as defined in the individual's support plan. This can include teaching new skills and providing assistance in the areas of support listed earlier in this chapter. In addition, the coach assumes primary responsibility for assisting an individual in developing relationships with other members of the community if the person so desires.

As mentioned, meeting qualifications, understanding the service delivery system, and embracing the beliefs established in the field provides the

backdrop for the supported living coach's daily responsibilities. In order to receive payment for the supported living coaching services provided, the coach must provide verification that services are being provided. Specific billable job responsibilities are on pages 3-9 through 3-13 of the Guide. Additional information on rates and billable services can be found in the "Home and Community Based Waiver Final Published Rates – November 1, 2003" which can be accessed at the following Web site http://apd.myflorida.com. Billing Guidelines for Supported Living may also be obtained through your local Developmental Disabilities office.

Billable Support Services

- **Facilitating One to One Relationships:**

Assisting in the development and maintenance of ongoing relationships between individuals served and other persons including social etiquette, self-protection, appropriate social behavior, etc.

- **Meetings**

Time spent in person-centered meetings at which the person served is present including personal futures planning meetings, support plan meetings, quarterly progress review meetings, informal meetings, etc.

- **Time Spent working to coordinate services with other providers**

- **Direct Services** based on the implementation plan, and the requirements and responsibilities outlined in the DS Waiver Handbook. (list can be found on pages 3-9 through 3-13).

- **Assessments and Planning:** Also included is time spent completing and updating functional community assessments, financial profiles, implementation or transition plans, and relationship maps.

The Supported Living Coach is reimbursed through the "Program Related" component of the rate for the following. These activities may not be separately billed to the waiver as they are covered in the rate built for the service.

- **Documentation:** Time spent completing documentation of services through progress notes, completion of time intervention logs, progress reports, completion of billing statements, filing, setting up consumer records/ files, review and completion of release all release forms, grievance procedures, authorization forms, annual summaries, etc.

- **Supervision of Support Services:** Time spent in oversight activities geared to coordination and monitoring the quality of support services being provided and ascertaining whether all support services are being met. (e.g., determining whether the services and supports provided by an in-home or PCA provider are meeting an individual's needs.)

- **Quality Assurance Activities:** Time spent with monitoring activities including visits from Delmarva, responding to satisfaction survey reports, writing quality improvement plans and conducting self- assessments, reviewing data from projected service outcomes.

While there may be rare instances when the coach conducts activities on the person's behalf without him being present, it is essential he be actively involved in all activities whenever possible. Below are some examples of direct services a coach may provide:

Examples of Direct Service Provision May Include:

- Housing Procurement
- Household Maintenance/Management
- Safety/Emergency Procedures
- Meal Planning/Preparation
- Shopping/Consumer Skills
- Clothing Care
- Personal Grooming
- Money Management/Banking
- Third Party Benefits
- Time Management
- Support Counseling
- Community Connections
- Mobility/Travel Skills
- Civic Responsibilities
- Legal Assistance/Advocacy
- Interpersonal Communication
- Self-Medication/Health Management
- 24 Hour Emergency Assistance

Activities that may occur under each direct service provision may include, but are not limited to:

Housing Procurement:

- Reviewing classified ads
- Contacting realtors
- Looking at prospective apartments or houses
- Completing housing applications
- Filling out change of address forms
- Collecting boxes
- Making arrangements with a mover
- Signing the lease
- Paying utilities, Cable deposits
- Having keys made
- Having ID cards made, etc.

Household Maintenance/Management:

- Cleaning and care of floors, carpeting, walls, windows, and bathrooms
- Care and use of equipment and appliances
- Arranging and caring for furniture
- Dishwashing and clean-up after meals
- Bed making
- Making simple repairs or replacements
- Lining shelves, etc.
- Operating a television, VCR, DVD, or cassette player

Safety/Emergency Procedures:

- Locating, calling, and giving needed information over the phone in case of an emergency
- Answering doors and telephone cautiously
- Fire suppression/evacuation
- Preparedness for hurricanes and other natural disasters
- Basic first aid
- Self-protection

Meal Planning/Preparation:

- Principles of nutrition
- Meal planning
- Menu planning
- Food and utensil identification
- Use and care of kitchen utensils and appliances (dishwasher, toaster, etc.)
- Meal preparation
- Following recipes
- Setting the table
- Serving meals
- Storing leftovers, etc.

Shopping/Consumer Skills:

- Coupon clipping
- Shopping etiquette
- Storage of purchased items
- Tips and techniques for buying groceries, personal hygiene items, clothing, and household items
- Preparing a grocery shopping list
- Assistance in making and keeping appointments for services (haircuts, repairs, etc.) in person and by telephone
- Paying for services
- Interacting with salespeople or service providers
- Using the post office

Personal Grooming:
- Bathing
- Showering
- Washing hands and face
- Hair care and appearance including haircuts
- Care of teeth and mouth
- Shaving
- Feminine hygiene
- Selecting appropriate clothing for weather and type of activity
- Using deodorant
- Nail care

Clothing Care:
- Storage of clothing
- Sorting, Washing, and drying clothing and linens
- Operating washers and dryers (personal or coin operated machines)
- Ironing

Money Management/Banking:
- Developing/updating the financial profile
- Personal budgeting
- Opening, maintaining, and closing checking/savings accounts
- Using checkbook
- Communicating with the bank
- Using an Automatic Teller Machine (ATM)
- Paying bills
- Filing income tax returns

Third Party Benefits:
- Assistance with SSI/SSA/VA benefits, food stamps, Medicare, etc. (including reporting changes in income)
- Applying for rental assistance programs

Time Management:
- Telling time and using face of digital clock/watch
- Using alarm devices
- Taking wake up calls
- Reading and using a calendar
- Developing and using a schedule

Support Counseling:
- Discussing disappointments
- Developing and maintaining friendships
- Discussing intimate relationships
- Addressing roommate conflicts
- Addressing grief
- Addressing stress management
- Addressing anger
- Participating in community support meetings, such as Weight Watchers™, Alcoholics Anonymous ™, etc.

Community Connections:

- Churches
- Planning parties/social functions
- Adult education classes
- Swimming lessons
- Joining civic organizations/social clubs
- Bowling leagues
- Planning trips
- Being a good neighbor
- Membership in neighborhood associations
- Arts/crafts classes
- Athletic/recreational leagues

Mobility/Travel Skills:

- Mobility training
- Pedestrian safety
- Obtaining a driver's license
- Using taxi services
- Using public transportation
- Bicycle safety

Civic Responsibilities:

- Registering to vote
- Voting
- Volunteering
- Obeying laws
- Jury duty
- Citizenship (helping others, not littering, etc.)

Legal Assistance/Advocacy:

- Assistance in retaining attorney or advocacy services
- Acting as an advocate
- Assistance in self-advocacy
- Accompaniment to court appearances

Interpersonal Communication:

- Operating home/pay telephones and voice digital pagers
- Making and self-managing the placement of long distance calls
- Making/using lists of telephone numbers
- Telephone etiquette
- Conversational skills and manners
- Making needs known and conveying information
- Use of hearing aids
- Telecommunication devices for the deaf (TDD)
- Writing cards and letters
- Reading functional words
- Reading and using the newspaper
- Recognizing appropriate times for telephone calls and visits
- Understanding the difference between social calls and emergency calls, etc.

Self-Medication/Health Management:

- Using pharmacy services
- Taking over-the-counter medications
- Self-administration of medication/treatments
- Use of tracking charts
- Storage of medications
- Learning contraindications for various medications, etc.
- Assistance in making and keeping medical appointments
- Conveying information to health care professionals
- Assistances in actions promoting wellness (e.g. exercise, following diets, etc.)

24-Hour Emergency Assistance:

- Assistance in resolving health or interpersonal crises
- Accompaniment to hospital emergency room
- Managing stress/communicating anger/needs
- Keeping track of on-call support personnel
- Assistance in dealing with law enforcement officers
- Support in time of fire, weather or other disasters
- Hospital stays, illness at home, etc.

Other Supports and Services

All Medicaid Waiver services have minimum provider qualification requirements. Supported living coaches who desire to expand their service network may make application to provide other services. Each provider must meet the requirements for certification as outlined for that service. Providers must make application for each service through the District/Region Developmental Disabilities Program.

Termination of Supported Living Coaching Certification

The District/Region Developmental Disabilities Program will terminate a provider's certification when there is good faith reason to believe that the provider has engaged in any of the following:

- Submitted false information on the application for certification;
- Submitted a fraudulent invoice for services;
- Abused, neglected or exploited a person as defined by Chapter 415, Florida Statues, or committed any action that violates the minimum standards for good moral character set forth in s.393.0655, F.S.; or,

if an agency provider, failed to terminate or reassign a direct service staff person who has engaged in these actions;

- Lost a required professional certification, license, or registration;
- Financially benefited by borrowing or otherwise using an individual's personal funds; or
- Engaged in conduct that adversely affects the provider's ability to deliver services, including any action that renders the provider ineffective under the terms of the certification or affects the provider's ability for acceptance or trust by the department, citizens of the state or consumers.

Further, the Developmental Disabilities Program may terminate a provider's certification when there is good faith reason to believe that the provider has engaged in "actions of non-compliance" which are in conflict with:

- the Definitions and Core Assurances found in the "Developmental Services Waiver Services Medicaid Coverage and Limitations" Handbook, Final Filed Version;
- the Medicaid Waiver Services Agreement;
- standards identified in the Developmental Disabilities Supported Living Coaching Services, Monitoring Checklist/Protocol established by the Florida Statewide Quality Assurance Program (FSQAP);
- Chapter 415, Florida Statutes, regarding abuse, neglect or exploitation; and,
- Chapter 393, Florida Statutes, regarding the minimum standards for good moral character.

The District/Region Developmental Disabilities Program will notify a provider of termination in writing by certified mail. The notice will include the reasons for the termination and a statement that the provider has a right to respond within 20 calendar days. If a provider responds in a timely manner and the response provides the District/Region Developmental Disabilities Program Office with evidence that the reasons for termination were not valid, the termination will be lifted.

Termination of Provider Certification

Consistent with the DS Waiver handbook, Medicaid Waiver Services Agreement (Section IV), a provider's certification may be terminated as follows:

A. This Agreement may be terminated by either party without cause, upon no less than thirty (30) calendar days notice in writing to the other party unless a lesser time is mutually agreed upon in writing by both parties. Said notice shall be delivered by certified mail, return receipt requested, or in person with proof of delivery.

B. This Agreement may be terminated for the provider's non-performance or misconduct upon no less than twenty-four (24) hours notice in writing to the provider. Waiver by either party of any breach of any term or condition of this Agreement shall not be construed as a waiver of any subsequent breach of any term or condition of this Agreement. If the Department determines that the provider is not performing in accordance with any term or condition in this agreement, the Department may, at its exclusive option, allow the provider a period of time to achieve compliance. The provisions herein do not limit the Department's right to any other remedies at law or in equity.

Providers who voluntarily wish to terminate certification must notify the District/Region Developmental Disabilities Program in writing at least 30 calendar days prior to the date they wish the termination to be effective.

Notification to Individuals Receiving Services

The District/Region Developmental Disabilities Program is responsible for notifying the support coordinator when a provider of supported living is terminated or voluntarily resigns from being a provider. The support coordinator will advise the individual of her right to continue receiving supported living coaching services and assist her in locating a new provider. For this reason, the District/Region Developmental Disabilities Program will maintain a list of supported living providers who are willing to temporarily provide services until individuals can locate permanent providers.

For additional information regarding the requirements for each specific authority reference, it is suggested the provider contact their local district or regional office. Copies may also be obtained through the Department's website www.MyFlorida.com and the FSQAP at www.dfmc_florida.org. (1-866-254-2075).

Chapter Summary

Once requirements and qualifications are met, the supported living coach is prepared to provide services to individuals. That service begins with the WSC informing the individual regarding supported living coaching options, to ensure informed decisions can be made. Chapter Four addresses the series of actions which occur before the person moves.

Chapter Four
Getting Started

What You Will Find:

Choosing Supported Living Services

Deciding on a Coach

Updating the Support and Cost Plans

Service Authorization

Building a Relationship

Idnetifying Representative Payee and Fiscal Agent Responsibilities

Transition Between Providers

Individual Financial Profile
Functional Community Assessment

Chapter Four: Getting Started

Before moving from a group living situation, a family home, or other living arrangement to supported living, there are a series of actions to be taken. This Chapter, *Getting Started*, addresses those actions and serves as a reference to assist in organizing this initial stage of the process.

The Process for Getting Started:

The Person:

1. **Identifies** supported living coaching as **the service of choice**.
2. **Interviews potential** supported living **coaches**.
3. **Decides** on a coach.

The Support Coordinator (WSC):

4. **Updates the Support Plan (SP)** to include supported living coaching.
5. **Amends Cost Plan consistent with SP updates, and approved** by District/Region Developmental Disabilities Program.
6. **Develops service authorization (SA). The SA date becomes** the **effective date** of the service.

The Supported Living Coach:

7. **Begins initial information gathering to build relationship** (individual profile demographics, health and emergency profile, housing survey, etc.).
8. **Discusses handling of funds with individual and circle of support (i.e. representative payee, fiscal agent, etc.).**
9. **Implements policy for transitioning between providers,** if applicable.
10. **Reviews procedures with individual and family** (i.e., abuse, grievance, due process, rights, back-up staff, contact information, etc.)
11. **Completes Individual Financial Profile (IFP) and Functional Community Assessment (FCA)** based on current information.

Choosing Supported Living Services

For supported living to become a reality, the individual/guardian (a definition for guardian may be found in the Glossary) must decide that supported living is the preferred service option. Exploring supported living services, accessing the *Supported Living Liaison Network* to talk with people receiving supported living services, and understanding the coach's overall responsibilities, as previously discussed, support that decision making process.

Deciding to choose supported living involves the exchange of information that will allow people to make informed choices. Many individuals and families may believe people must be fairly independent in order to live in their own home. Some may reject the idea of a supported living arrangement, unless the waiver support coordinator (WSC) describes the long-term supports that could be made available. It is important for individuals to realize that supported living involves a unique network of support which varies for each person and may be needed on a short term or ongoing basis. Each supported living arrangement will be very different, as each is based on the person's unique needs and desires.

Support coordinators provide information to an individual who has expressed an interest in supported living. It is the support coordinator's responsibility to document a person's ability to give consent and make informed choices specific to individual circumstances, supports, and services. It is also important for the WSC to involve the guardian and family as needed and desired. All providers have a responsibility to provide information and counseling that is sufficient for the individual to understand the potential or probable results of decisions and choices.

Deciding on a Supported Living Coach

During discussions with the support coordinator, an individual determines which combination of supported living services would work best for him. Once this is decided, the **next step is to *find* a coach**. Just as choosing a doctor or a support coordinator is an important decision, choosing a supported living coach who matches the needs and personality of the individual is critical. Each coach has his or her own style and own way of doing business. Some people work better with a casual style while others may want their coach's manner to be "strictly business."

To select the appropriate coach, the individual (and anyone she chooses) should conduct interviews with supported living coaching providers. For individuals who may not clearly express their choices, a close friend, guardian, or family member should be involved in the interview and selection process.

Interview Process

- The support coordinator provides a list of local supported living coaches.
- The individual reviews the list with the support coordinator and determines how many coaches to interview.
- Coaches are contacted and interview appointments made. These interviews are arranged by the person and his family or representative, or by the support coordinator.
- Within reason, coaches should be willing to accommodate the individual's desired location and time of the interview.
- The individual and his family may choose to conduct the interviews without the support coordinator, or may ask the support coordinator to participate.

Support Coordinator Assists with the Interview Process
Keeping an interview process consistent can support the individual in making an informed decision. Asking the same questions of each potential coach provides a framework from which to base decisions. For individuals who may have trouble remembering each coach, or for those who do not communicate using traditional methods, pictures of each coach may be taken with a Polaroid® camera and attached to the interview format. This can prove helpful when choosing among several coaches.

The support coordinator may assist the individual and family in developing an interview form to assist with the process. The interview format should be individualized. Questions that are important to one person may be completely irrelevant to someone else. Graphics or pictures may be helpful in guiding the interview process.

In addition to the interview forms, it is suggested the individual obtain a copy of the coach's resume and references to get a clear understanding of his background.

The following is an example of an interview format, that includes a sampling of questions to consider:

Sample

Supported Living Provider Interview Format

Agency:____________________ **Interviewee:**_______________________

Date:____________________

1.How much experience do you have working with people in supported living?____

2.How many people do you currently work for?______________________________

3.What is your background/experience?

4.Where is your office located?____

5.Do you provide the coaching service or do you have staff that work for you? Please check one: Provide Service ❒ Staff provide service ❒

6.How many people does each person support?____________________

7.How do I get in touch with you if I need you?

Phone No.:________________

8.How can I reach you in an emergency?

Emergency Phone No.__________________________

9.How long will it typically take you to respond?

10. What happens if you or the person working for you can't make it? What is your back up system?____

11. How will you respect my choices?

____
____

12. How do you train your staff?______________________________
____
____

13. If I am not happy with your services or the services of your staff, what do I do?
____
____
____

14. How will you assist me in selecting my home? ____________________
____
____
____

15. What types of things will you help me with?
____
____
____

16. What are your connections in this community? ____________________
____
____

17. How will you help me to get to know my neighbors?__________________
____
____

18. Can you provide at least 3 references of people you are currently serving who I may contact? Yes________ No ________

Updating the Support and Cost Plans

Updating the Plans:

- Before the coach is selected, the **support coordinator must:**
    - **update the support plan** to add supported living coaching as a service; and
    - submit a **request for funding through the cost planning process.**

The individual, the support coordinator, and the coach must meet to discuss the types of supports needed in the home and delineate the responsibilities of each provider.

Supported living services, like other paid supports, must be authorized and provided according to the support and cost plans. An individual's unique needs, requirements, capacities, preferences, and personal dreams direct planning for all services, especially supported living. Each adult who receives developmental disabilities services has a support plan (SP) which, along with the cost plan and resulting service authorization, directs service delivery toward the person's desired future. It also includes a description of his present situation by describing his preferences and needs, and currently authorized supports, resources, and services.

The support coordinator discusses with the individual the number of supported living hours she needs from the supported living coach and other service providers, and submits the cost plan and a justification for supported living services to the District/Region Developmental Disabilities Program for approval. Assuring quality services while maintaining costs is a valuable skill. A strong partnership between the support coordinator and the supported living coach in negotiating rates and determining the most beneficial service options is invaluable.

Before the individual selects a coach, it is necessary for the support coordinator to **update the existing support plan** to reflect his desire. The contents of the support plan update are directed by the individual and the coach, and identify specifically what the individual hopes to accomplish as a result of supported living coaching within the support plan year. These outcomes and actions also change the services on the cost plan. Therefore, an **update of the cost plan** also needs to be completed by the support

coordinator to reflect the need for supported living services. Updates to both plans are then submitted to the District/Region Developmental Disabilities Program for approval.

Although support plans direct services for a one-year period, support planning is a fluid, ongoing process directed by the individual, not an isolated, annual event. It involves the individual, the support coordinator, and others (friends, family, service providers) selected by the individual. This group of persons, both friends and providers who willingly support the individual, is often referred to as the "circle of support." When planning for supported living, it is particularly important to include the people who are directly involved in the individual's life and who are willing to provide support in the community.

In the months prior to the individual's **annual support plan meeting**, the support coordinator is responsible for gathering information. Information is collected to reflect the person's present situation, and the support plan is updated by the support coordinator. The process repeats itself annually or as frequently as needed, and information must be gathered by the coach and other providers, and given to the support coordinator prior to the annual support plan meeting.

The supported living coach, as well as others who work for the individual in her home, is an integral part of the information gathering process. The coach will draw information from the individual financial profile (IFP), the functional community assessment (FCA), housing survey once the home is selected, and other documentation. Once supported living is identified on the SP, and the person begins receiving supported living coaching services, an annual report will be written and submitted to the support coordinator 30 days prior to the end of the support plan year.

The support plan also includes the person's future view and the personal goals he desires to achieve toward that future during the coming year. Supports and services identified as needed and desired to achieve personal goals on the annual support plan must also be identified on the cost plan, and submitted to the District/Region Developmental Disabilities Program Office for approval. Any changes in supports or services throughout the year must be identified on both the support and cost plans and resubmitted for approval from the District/Region Developmental Disabilities Office.

Service Authorization

When the support and cost plans are returned and approved, the supported living provider, along with other providers as needed, receive a service authorization form indicating the effective date of the service. Service authorization, as the name implies, indicates the date for initiating services as well as the date by which specific requirements are to be addressed. The

coach has 90 days from the effective date to assist the individual in locating a home.

Building A Relationship

Once the coach receives service authorization, he begins the process of getting to know the person. This process occurs over time and includes gathering information to determine interests, needs, habits, routines, and desires.

In addition to getting to know the person, information gathering is an important tool for developing the individual's record and/or office files. According to the Core Assurances, the supported living coach must develop policies regarding the contents of records. The individual's record must include evidence the provider has reviewed the following with the individual:

Important Points to Discuss:
On-call system; back-up supports; rights and responsibilities of persons receiving services; reporting abuse and neglect or exploitation; and grievance procedures for conflict resolution including maintaining a log.

Gathering information means spending time with the person, his family, friends, and existing providers. Although discussions with the person are extremely valuable, time spent across a variety of settings also provides valuable insight into the person's interests and capacities.

Record reviews and discussions with those who know the individual best may also provide valuable information related to preferences, interests, routines, etc. It is important to obtain a signed consent from the individual prior to reviewing any records or other written information.

Validating information with the individual is an important part of the process. Validation supports accuracy and helps assure that prior history and interests do not continue to guide services, if unwarranted or undesired.

Information gathering is an ongoing process that will continue to occur throughout the year. Information can be accessed through ongoing notes, progress reports, interviews, reviews, etc. As the individual's situation and needs continue to change as part of the fluid process of daily life, the coach should rely on all available resources to assure services are current and responsive.

Most of the initial information collected about the individual should be recorded on an individual profile or basic demographic page or format. This information should be available in the front of the record for easy access, as it includes contact information, emergency instructions, directions to the person's home, etc. It's a good idea to review this basic information as needed, but at least annually. Most coaches find it helpful to incorporate this review as part of their preparation for the annual support plan meeting. This includes updating records to assure information is current and accurate. In addition, while respecting the person's confidentiality, the coach will want to assure there are current signed release of information forms prior to sharing information.

A sample profile, courtesy of Habilitative Services of North Florida, follows.

PROFILE

DEMOGRAPHICS

NAME ____ DOB ________ SEX ______________
first full middle last

ADDRESS ________________________________ TELEPHONE NUMBER____________

____

DIRECTIONS TO HOME:

SOC.SEC.# ______________ MEDICARE# ______________ MEDICAID#______________

PARTICIPANT IN SUPPORTED LIVING SINCE________________________________

COMPETENCY STATUS____

IF ADJUDICATED INCAPACITATED OR HAS A GUARDIAN ADVOCATE:

GUARDIAN NAME________________________________

ADDRESS________________________________

____

PHONE NUMBER________________________________

EMERGENCY CONTACT ________________________________
RELATIONSHIP ________________________________
ADDRESS ________________________________

____

PHONE NUMBER ________________________________

OTHER FAMILY/FRIENDS/NEIGHBORS WHO HELP WITH PLANNING AND/OR PROVIDE SUPPORT:

______________	______________	______________
name / relationship	name / relationship	name / relationship
address	address	address
phone #	phone #	phone #

PREFERRED HOSPITAL ______________________________ PHONE NUMBER__________________________

PHARMACY OF CHOICE ______________________________ PHONE NUMBER __________________________

✓ ONE:

_______ INDIVIDUAL TAKES AND MONITORS HIS OR HER MEDICINE INDEPENDENTLY

_______ SUPPORTED LIVING SPECIALIST PROVIDES SUPERVISION FOR SELF-ADMINISTRATION OF MEDICATION

_______ CARE STAFF PROVIDE ADMINISTRATION OF MEDICATION

WHO DOES THE PERSON WISH TO BE CONTACTED ABOUT ANY MEDICATION ISSUES OR QUESTIONS? ____________________ PHONE NUMBER ______________ (PERSON SHOULD BE ENCOURAGED TO CONSIDER THEIR LEGAL GUARDIAN, PRIMARY CARE PHYSICIAN, PHARMACIST, OR THE DISTRICT'S CONSULTING R.N.)

MEDICATION ALLERGIES	OTHER ALLERGIES

INDIVIDUAL HEALTH AND MEDICAL CHARACTERISTICS (ALSO SEE SUPPORT PLAN)

PRIMARY DISABILITY

SECONDARY DISABILITY

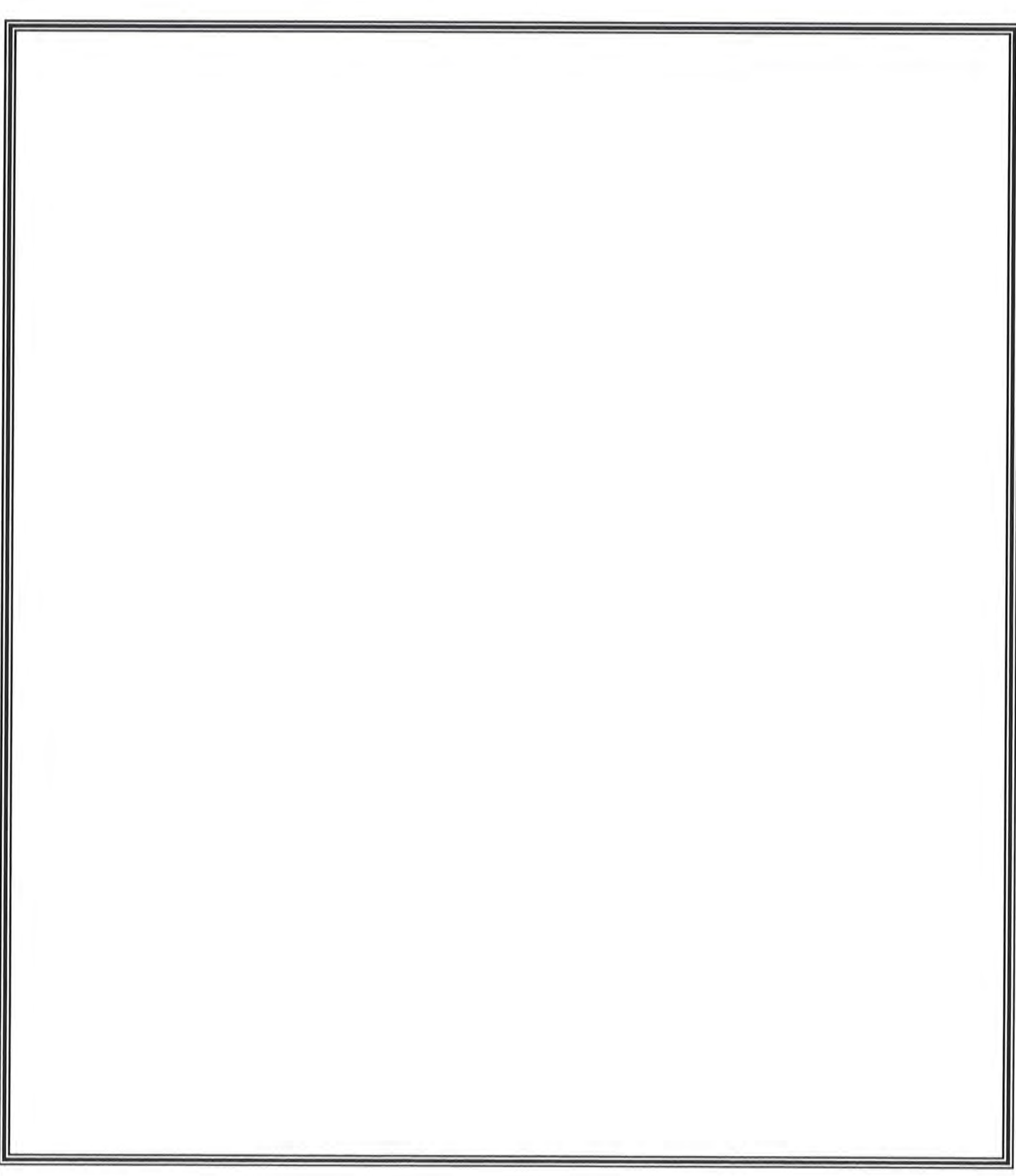
_______ HIGH BLOOD PRESSURE?

_______ DIABETES?

_______ SEIZURE DISORDER?

IF SO, TYPE

OTHER MEDICAL CONCERN ____



SERVICES DIRECTORY

SUPPORT COORDINATOR____

____

____

SUPPORTED LIVING SPECIALIST__________________________________

____

____

OTHER PAID SUPPORT PROVIDERS

NAME____

SERVICE ____

PHONE NUMBER ____

NAME____

SERVICE ____

PHONE NUMBER ____

NAME____

SERVICE ____

PHONE NUMBER ____

NAME ____

SERVICE ____

PHONE NUMBER ____

LIVING ARRANGEMENT

✓ ONE IN EACH CATEGORY:

_____ HOUSE _____ APARTMENT _____ MOBILE HOME _____ CONDOMINIUM

_____ ALONE _____ WITH SPOUSE _____ WITH FRIEND (S)

_____ WITH FAMILY MEMBER ________OTHER _________ OWN _____ RENT/LEASE

IS PERSON'S NAME ON THE LEASE OR MORTGAGE? _____ (COPY MUST BE IN FILE)

SECURITY DEPOSIT? _____ HOW MUCH? _________ REFUNDABLE?

IF RENTING, MANAGER/OWNER'S NAME

PHONE ________________________________

IF PURCHASING, MORTGAGE HOLDER ________________________________

ACCOUNT NUMBER ________________________________

FINANCIAL INFORMATION

(ALSO SEE FINANCIAL PROFILE)

IS SUPPORTED LIVING COACH THE FISCAL AGENT? ________YES ________NO

CHECKING ACCOUNT: BANK ________________________

ACCOUNT # ________________________

SAVINGS ACCOUNT: BANK ________________________

ACCOUNT # ________________________

CREDITORS NAME ________________________

ADDRESS ________________________

ACCOUNT # ____________________ PAYMENT________________

NAME ________________________

ADDRESS ________________________

ACCOUNT # ____________________ PAYMENT________________

INSURANCE

TYPE_______________________________________

CARRIER_______________________________________

AGENT_______________________________________ PHONE _______________________________

POLICY #_______________________________________

TYPE_______________________________________

CARRIER_______________________________________

AGENT_______________________________________ PHONE _______________________________

POLICY #_______________________________________

TYPE _______________________________________

CARRIER_______________________________________

AGENT_______________________________________ PHONE _______________________________

POLICY #_______________________________________

VOCATIONAL INFORMATION

EMPLOYER ____

ADDRESS_______________________________________ PHONE _______________________________

NATURE OF WORK ____

SUPERVISOR____

SCHEDULE____

EMPLOYER____

ADDRESS_______________________________________ PHONE _______________________________

NATURE OF WORK ____

SUPERVISOR____

SCHEDULE____

Identifying Representative Payee and Fiscal Agent Responsibilities

During the information gathering process, the coach should work with the person, his family or guardian, as applicable, and his circle of support to determine how personal finances will be organizd and monitored once he moves into his own place.

Susan

Susan nearly lost all her financial benefits due to inadequate monitoring by the supported living coach. This could have jeopardized her independent living successes by bringing them to an abrupt halt.

Susan was employed and her work hours were carefully controlled each month to maintain SSDI eligibility. When she decided on supported living, staff from the previous provider transferred financial monitoring responsibilities to the new supported living coach. She had some money in her checking account at the time of transition. The supported living coaching provider agency obtained a start-up supplement for Susan to offset her moving expenses.

Susan began working alot of hours, and the provider was holding her bills for payment. Staff from the prior agency had kept in touch with Susan, and grew concerned when hearing of her increased work hours. The support coordinator was contacted, and over $2,000.00 was found in Susan's checking account, placing her services at risk.

Susan's supported living coach had no understanding of the financial implications and impacts regarding benefits. Nor was the coach adequately monitored by the supported living coaching provider agency.

Susan came very close to losing a host of benefits related to SSDI. She would have been left without the resources to stay in her home. A crisis was narrowly averted.

Author Unlisted to Maintain Privacy

A representative payee is an individual who has been given authority by the Social Security Administration (SSA) to receive and manage federal benefits when the person is unable to manage his own money. The representative payee (aka: "rep payee") receives the benefit payment on the person's behalf and is required to account for expenditures on behalf of the person for whom it is intended.

If the person has not been adjudicated incapacitated or does not have a guardian advocate over finances, she may choose whomever she wants as

her rep payee: herself or a friend or relative. If the person has been adjudicated or has a financial guardian advocate, this is the only person who may select the rep payee. The rep payee has a huge responsibility, as he must assure the person's monthly obligations (e.g. rent, utilities, etc.) are met, and that she has access to her money on an ongoing basis for food and personal needs.

In some instances the supported living coach serves as the rep payee, as he is often the person who sees the individual most frequently. He can assure her finances are responsive to current need, and that adequate financial planning is in place to assure future plans are addresed. However, this should only occur when the person requires that level of intervention and there is no one else to assume the responsibility. This decision should be fully discussed with the person and the circle of support.

It is important to remember that most individuals receiving services (i.e. supported living coaching, etc.) through the Medicaid Waiver receive the majority of their income through Supplemental Security Income (SSI). The rep payee must assure the individual maintains financial eligibility for services and support to continue. According to the current Financial Eligibility Standards for SSI-Related Programs, the individual can maintain no more than $2000 in total assets including checking and savings accounts, etc.

For additional information related to this topic, please refer to the Centers for Medicare and Medicaid Services' website at www.cms.hhs.gov

Serving as Fiscal Agent
When no other options are available, the coach may serve as the fiscal agent for the person's finances. This includes situations where the provider serves as representative payee and/or cosigner on bank accounts, maintains physical possession of banking records, or otherwise controls the individual's finances.

The following are required when serving as fiscal agent:

Fiscal Agent Requirements:

- The consent of the individual served, guardian, or guardian advocate (as applicable);
- Documenting the individual needs support to manage his money;
- Approval of the individual's circle of support as being necessary;
- Funds placed in an account in the name of the individual and not co-mingled with any other funds or agency accounts; and
- Accurate records, under the full control of the provider, documenting the disposition of all funds.

Procedures for Management of Individual's Funds

All support in the areas of finance, budgeting, checkbooks, and related areas involving the use of money should be provided in the least restrictive and least intrusive means possible. Funds and records should be maintained in the individual's own home unless it is determined by the individual, her guardian, and the support coordinator that she is unable to manage her own funds to such an extent that it would endanger her well being.

It should be documented in progress notes from both the supported living coach and the support coordinator, that the individual has approved of funds and/or records being kept by the provider.

Assuming responsibility for an individual's finances is a major responsibility, which could place the coach in a liable situation. The following are prohibited actions for supported living coaches:

Supported Living Coaches May Not:

- Be, or apply to become, legal guardian for an individual receiving supported living coaching services from that provider;
- Benefit financially by borrowing or otherwise using the personal funds of an individual in supported living; or
- Enter into the dual role of landlord and supported living provider to an individual.

The supported living coach must also follow specific procedures for financial management when acting as a fiscal agent.

Procedures and Practices for Financial Management by Fiscal Agents

Procedures:

- Individual and support coordinator **determine the level of intervention** needed for handling financial records and checkbooks.
- Interventions are **consistent with documentation on the initial functional assessment** and/or in progress notes.
- **Informed consent** of the individual, guardian, or guardian advocate will be required. Develop a consent form and have copies available.
- Funds in **individual accounts and not co-mingled** with any other funds, or agency accounts.
- **Major discrepancies in financial records will be reported** as indicated by District policy to the support coordinator.
- Quarterly, the **support coordinator reviews bank records, bank statements and other financial records** maintained with support from the coach.
- The **need for ongoing fiscal agent services is reviewed** quarterly and documented in the coach's progress notes.

Best Practices:

- **Maintain the person's checkbook in a safe and secure place.**
- **Assure the coach works closely with the individual during budget planning to ensure funds are available as needed.**
- **Assure all transactions are made in the person's presence (including writing checks, making out deposit slips, entering transactions in register, performing monthly bank reconciliation, etc.**

Transitioning Between Providers and Reviewing Procedures with the Individual and Family

For persons already receiving supported living coaching services, and desiring to change supported living providers, the coaches (both existing and newly selected) must initiate a transition planning process to assure the transfer of supported living services is successful. The waiver support coordinator is the facilitator of this process.

The newly selected coach must review her procedures regarding the transition process with the individual and his guardian or family. In addition, the coach is also required to discuss other policies and procedures (i.e. abuse, grievances, etc.) identified in the Core Assurances and Documentation Requirements for Supported Living Coaches discussed in Chapter Three. This review provides individuals with needed information in order to consider all options, and make fully informed decisions.

Completing the Individual Financial Profile and Functional Community Assessment

Once supported living funding is approved, the supported living coach assists the individual in the formal completion of an Individual Financial Profile as part of required documentation, and begins assisting the individual in finding a home. Completion of an Individual Financial Profile (IFP) form is a requirement of the supported living coach prior to the initiation of approval for a monthly in-home subsidy or start-up funds.

The following description is found in the Developmental Services Waiver Services Florida Medicaid Coverage and Limitations handbook:

> The Financial Profile is an analysis of the household costs and revenue sources associated with maintaining a balanced monthly budget. The analysis will substantiate the need for a monthly subsidy or initial startup costs, and should be a source of information for determining strategies for assisting the person in money management. The supported living provider is to assist the individual in completing the Individual Financial Profile (IFP) and submitting it **to the support coordinator no more than 10 days** following the selection of housing by the individual. This also applies **when the individual relocates to a new home or apartment.**

The IFP provides a framework from which to determine the person's financial needs. Gathering information to discuss one's financial

status will be beneficial in understanding the types of support decisions to be made. This will assist the individual in making informed decisions about her need for income, roommates, the types of living environments, location, etc.

In completing the financial profile, the person and her coach will be considering such items as:

- Current monthly income;
- Anticipated living expenses such as rent/mortgage, utilities, food, cable, transportation, etc.;
- Employment expenses such as uniforms, lunches, etc.; and
- Personal expenses such as costs associated with clothing, health supports, etc.

A sample Individual Financial Profile, courtesy of Pinellas Care Systems, Inc., of St. Petersburg, Florida, may be found on the following pages. This sample includes the required components. Providers may choose to use this format, adapt portions of it, or develop their own forms to meet the requirements.

Individual Financial Profile

Date					
Name		SS# :			
Address					
Number of Roommates Sharing Expenses		IHSS?	Yes	No	
Savings Account Balance		as of			
Checking Account Balance		as of			

I. Monthly Income Received

Staff Person Assisting in Profile Completion		
Employment		
SSA		
SSI		
Social Security Representative Payee		
VA Benefits		
Food Stamps		
Other (specify)		
Total Monthly Income		

II. Projected Monthly Expenses

See Attachment "A" for In-Home Support Services/Roommates.

A. HOUSING:		
1. Rent/Room & Board		
2. Utilities		
3. Telephone		
4. Cable TV		
5. Garbage		
6. Lawn Service		
7. Other (specify)		
	Housing Subtotal:	
B. FOOD/HOUSEHOLD		
C. TRANSPORTATION		
D. PERSONAL		
1. Entertainment		
2. Clothing		
3. Personal Items		
4. Health Related		
5. Insurance		
6. Paid Roommate		
7. Paid Neighbor		
8. Homemaker:		
9. Spending Money @ $ /week:		
10.Laundry Money:		
11.Other (specify):		
	Personal Subtotal:	
	Total Monthly Expenses:	

III. Comparison of Monthly Income with Projected Monthly Expenses

Total Monthly Income:		
Total Monthly Expenses:		
Monthly Income minus Monthly Expenses:		
To meet projected expenses, present monthly income will be:	Sufficient	
	Insufficient	

IV. Start-up Expenses

Comparison of Shared Start-up Expenses For In Home Support/Roommates

	In-Home Supports:	Individual:	Roommate 1:	Roommate 2:	**Total Expenses:**
A. First month rent:					
B. Last month rent:					
C. Security deposit:					
D. Electric deposit:					
E. Electric hook-up:					
F. Telephone deposit:					
G. Telephone hook-up:					
H. Cable installation:					
I. Furnishings:					
J. Household supplies:					
K. Pantry stocks:					
L. Moving costs:					
M. Other (specify):					
Total Start-up Expenses:					

V. Comparison of Available Funds with Projected Start-up Expenses for Individual

Savings Account Balance:		
Checking Account Balance:		
Subtotal – Savings and Checking Balance:		
Amount needed to meet any financial obligations prior to move:		
Subtotal - Funds Available (Savings and Checking minus financial obligations):		
Amount to remain in savings account for emergencies, etc. (living expenses for 2 months is suggested):		
Subtotal - Funds Available minus Emergency Funds:		
Total Start-up Expenses:		
TOTAL START-UP FUNDS REQUESTED:		

A positive total represents surplus savings for the individual and no start-up grant should be needed.
Negative total represents the maximum amount of start-up funds by the individual.

VI. Individual Start-up And Monthly Subsidy Recommendations

___ Based on the figures above, a **start-up grant** of________ is recommended for _____________ 200_ (year).

___ Based on the figures above, a **monthly subsidy** of _________ to commence in _____________ 200_ (year) is recommended.

___ Based on the figures above, monthly income and other personal financial resources are sufficient to meet both start-up and monthly expenses. **No financial assistance is requested at this time.**

Signatures:

Individual: ______________________________/ Guardian:____________________________________

Supported Living Provider:____

Date Submitted to Support Coordinator: _____________

Support Coordinator ____

Date returned to Supported Living Provider: ____________

Guardian/ Advocate: ____

District/Region Office:

Start-up Grant _____ Denied _____ Approved for $ __________

Monthly Subsidy _____ Denied _____Approved for $ __________

Authorizing Signature: ____

ATTACHMENT "A"

Comparison of Shared Monthly Expenses For In Home Support/Roommates.

* *In Home Supports and Services, will pay $________________ toward rent (an equal proportion of rent and utilities).*
* *The individual/roommate(s) is/are responsible for the balance of the rent and all of the utilities.*
* *Receipts and expense forms will be maintained.*

	In-home Supports	Individual	Roommate 1	Roommate 2	Total Expenses
HOUSING: 1. Rent/Room & Board					
2. Utilities					
3. Telephone					
4. Cable TV					
5. Garbage					
6. Lawn Service					
7. Other (specify)					
HOUSING Subtotal:					
FOOD/HOUSEHOLD					
Total Monthly Shared Expenses:					

***NOTE TO SUPPORT COORDINATOR**: Please return pages one and two (with your signature) to the Supported Living Provider as soon as possible. Pages one through three are submitted to the District Office. Return page three to the Supported Living Provider after the District Office has approved or denied start up/subsidy request.*

Functional Community Assessment

Once the Individual Financial Profile (IFP) has been completed, it is time to gain a detailed perspective of the person's strengths and abilities within a community setting. This is accomplished by completing a functional community assessment (FCA). Beyond the information attained via this assessment, often, the process of its completion results in the person and coach gaining insights about each other. The basis of a continued rapport and ongoing relationship is often formed. This strengthens the person's ability to develop a plan for living on his own, and the coach's ability to support him in the best ways possible.

The supported living coach is responsible for helping the individual complete a functional community assessment of his capacities within a community setting. This assessment provides the basis for identifying the types of training, assistance and intensity of support to be rendered by the provider. It is a tool designed to assist the provider in becoming familiar with the individual. It should encompass all areas of daily life including relationships, medical and health concerns, nutrition, sexuality, first aid, emergency situations and other safety considerations, personal care, household management, money management, community travel and mobility, community connections including leisure interests, and other life management skills.

Consideration should also be given to the individual's "non-negotiables"—things that he finds intolerable and that create negative emotions or behaviors and things, activities, settings, or situations that the person must have in order to be content. To get an accurate picture of the individual's passions, preferences and routines, a review of the assessment should include discussion with those who know the person best, and should be accomplished prior to the move, and annually thereafter.

The sample Functional Community Assessment (courtesy of Habilitative Services of North Florida Inc.) found on the pages that follow touches upon each of the aforementioned areas to be explored. The information gleaned offers a springboard for further inquiry or discussion; it also provides the framework for developing a specific plan that identifies needed supports, resources, modes of "delivery," specified responsibilities and timelines. This information is essential in assuring a smooth, safe, successful transition from the person's current living arrangement into his own home for the first time and should be updated annually.

FUNCTIONAL COMMUNITY ASSESSMENT

INDIVIDUAL'S NAME ____________________

STAFF PERSON COMPLETING ASSESSMENT ____________________

MONTH/YEAR ORIGINAL ASSESSMENT COMPLETED ____________________

A. MEDICATION ____________________

1. Does this person take prescribed medication? _____Yes _____No

   (If YES, complete remaining questions in Section A. If NO, respond to question 2 only and proceed to Section B.)

2. How will the person obtain and self-administer over-the-counter medications not prescribed by a physician?

   ____

   ____

3. Can the person independently place an order for and obtain a prescription from their physician?

   _____Yes _____No

   If NO, describe support or training needed:

4. Can the person independently notify their physician and/or pharmacist of all over-the-counter medications being used? _____Yes _____No

   If NO, describe support or training needed:

   ____

   ____

5. Check which one of the following apply:

_____ Individual is capable of handling his/her own medications without supervision.

_____ Individual will need supervision with the self-administration of medication according to Developmental Disabilities Program Policy Directive #01-01.

Explanation:____

____

____

Which staff will be providing supervision? ____________________

_____ Individual will need staff to administer his/her medication according to Developmental Disabilities Program Policy Directive #01-01.

Explanation:____

____

Which staff will be administering medication? ____________________

6. Can the individual independently take proper medications to work, on vacation, or to activities away from home? _____Yes _____No

If NO, describe support or training needed:

____

____

B. NUTRITION

1. Can the person plan his/her own menus? _____Yes _____No

If NO, describe support or training needed: ____________________

____

____

2. Is the person on a special diet monitored by a physician? _____Yes _____No

If YES, describe the diet: ____

____

____

Explain medical condition that prompted the diet: ____________________

____

____

3. Can the person independently purchase his/her on groceries? ____Yes ____No

If NO, describe support or training needed: ____________________________

____

____

4. Can the person independently prepare his/her own meals? _____Yes _____No

If NO, describe support or training needed: ____________________________

____

____

5. Can the person independently set the table for dining? _____Yes _____No

If NO, describe support or training needed: ____________________________

____

____

6. Can the person eat his/her meals without assistance? _____Yes _____No

If NO, describe support or training needed: ____________________________

____

____

C. SEXUALITY

1. Can the person differentiate between a casual relationship and an intimate relationship?

   ________Yes _____No

   Describe any areas of concern:______________________________________

   ____

   ____

2. Does the person have understanding of sexually transmitted diseases (e.g., HIV/AIDS, etc.)?

   ________Yes _____No

   If NO, describe support or training needed: __________________________

   ____

   ____

   ____

3. Is the person aware of their right to say, "No"? (Does the person understand the difference between consensual and non-consensual sex?) _____Yes _____No

   Describe any areas of concern:______________________________________

   ____

   ____

4. If applicable, does the person have a functional understanding of protected sex and birth control?

   ________Yes _____No

   Describe any areas of concern: ______________________________________

   ____

   ____

D. FIRST AID

a. Can the person administer basic first aid to himself/herself and access/use a first aid kit?

_____Yes _____No

If NO, describe support or training needed: ________________________

____

____

____

E. SERIOUS ACCIDENTS AND ILLNESS

1. Can the person recognize when he/she is ill or injured and requires outside help or attention?

_____Yes _____No

If NO, describe support or training needed: ________________________

____

____

____

2. Can the person access the following emergency assistance if needed:

Dial 911? _____Yes _____No

Access Hab. Services' 24-hour pager? _____Yes _____No

Summon a roommate or neighbor? _____Yes _____No

If NO, describe support or training needed: ________________________

____

____

____

F. SEVERE WEATHER AND OTHER NATURAL DISASTERS

1. Does the person know how to respond to severe weather and other natural disasters?

   _____Yes _____No

   If NO, describe support or training needed: ____________________

   ____

   ____

   ____

G. FIRE AND SAFETY CONSIDERATIONS

1. Did the person demonstrate the proper use of a fire extinguisher?___Yes____No
2. Can the person self-evacuate through an accessible exit? _____Yes _____No

   If NO, describe support or training needed: ____________________

   ____

   ____

   ____

3. Does the person know where to go if they need to be temporarily relocated?

   _______Yes _____No

   If YES, where? ____________________

   If NO, describe support or training needed: ____________________

   ____

   ____

   ____

H. PERSONAL CARE

1. Is the person independent in his/her self care? _____Yes _____No

   If NO, describe specific areas of support or training needed:

   ____

   ____

   ____

   If NO, will the person need personal care assistance or in-home supports?

   _____Yes _____No

   If YES, have these services been arranged by the support coordinator?

   _____Yes _____No

I. HOUSEHOLD MAINTENANCE/MANAGEMENT

1. Is the person able to independently maintain his/her home? _____Yes _____No

   If NO, describe specific areas of support or training needed: ____________

   ____

   ____

2. Can the person monitor his/her household for basic repairs needed and safety concerns such as leaky faucets, frayed electrical cords, etc.? _____Yes _____No

   If NO, describe specific areas of support or training needed: ____________

   ____

   ____

3. Can the person contact the landlord and/or service technicians for needed repairs?

   _____Yes _____No

   If NO, describe support or training needed: ____________________

   ____

   ____

4. Does the person know how to secure exterior doors and windows, etc. at night or when he/she leaves the house? _____Yes _____No

   If YES, do they consistently remember to do so? _____Yes _____No

5. Is the person aware of their right to ask would be visitors to identify themselves and to refuse entry if they so desire? _____Yes _____No

J. MONEY MANAGEMENT

1. Can the person make simple purchases (up to $10)? _____Yes _____No
2. Can the person count change? _____Yes _____No
3. Can the person write checks to pay bills or make purchases? ____Yes ____No
4. Can the person sign their checks? _____Yes _____No
5. Can the person make bank transactions independently? _____Yes _____No

   If NO, describe areas of concern:______________________________

   ____

   ____

6. Can the person prepare a basic budget? _____Yes _____No
7. Can the person follow a basic budget? _____Yes _____No

   If NO, describe areas of concern:______________________________

   ____

   ____

8. Can the person exercise appropriate assertiveness when others ask him/her for some/all of their money? _____Yes _____No

   If NO, describe areas of concern:______________________________

   ____

   ____

9. Does the person require Habilitative Services to serve as their fiscal agent?

____Yes ____No

If YES, justify:____

____

____

____

K. COMMUNITY MOBILITY

1. What will be the person's routine method of mobility in the community?

____

____

____

2. Can they access transportation services independently? ____Yes ____No

If NO, describe areas of concern:______________________________

____

____

3. Can the person cross streets safely? ____Yes ____No

If NO, describe areas of concern:______________________________

____

____

____

4. Does the person practice community safety (awareness of others, handling strangers, etc.)?

_____Yes _____No

If NO, describe areas of concern:____________________________

____

____

L. INTERPERSONAL / RECREATION / LEISURE

1. Can the person engage in casual, friendly conversation in person with others?

_____Yes _____No

If NO, describe areas of concern:____________________________

____

____

2. Can the person call people on the telephone? _____Yes _____No

3. Can the person plan/participate in their own community activities (shopping, movies, shows, sporting events, health clubs, parks, etc.) _____Yes _____No

Which activities do they participate in routinely? ____________________

____

____

Describe areas of concern: ________________________________

____

____

4. Can the person manage their own free time? _____Yes _____No

Describe areas of concern: ________________________________

____

____

OTHER THINGS TO KNOW:

DATE	NOTES/UPDATES	INITIAL

Chapter Summary

Getting started in supported living involves a series of decisions and actions on the part of the individual, her guardian/guardian advocate, and the supported living coach. Not only has the person interviewed potential coaches and decided on a provider, the support plan has been updated and supported living coaching has been approved as the person's service of choice on the cost plan. A service authorization or the effective date of the service has been established in order to identify the time frames for specific requirements (i.e. submission of the IFP, etc.) to be accomplished. To ensure the person's health and safety, a move should not occur prior to authorization and the coordination of all supported living services identified on the support plan.

Now that procedures for getting started are fully underway and a relationship is emerging between the individual and her coach, they must begin to explore the steps necessary to move. The next two chapters, five and six, will discuss the requirements needed to make the move a reality. Such requirements include the development and implementation of transition and implementation plans; the final update to the Individual Financial Profile; if needed, requests and approval for additional funding; and completion of the Housing Survey.

Chapter Five
Planning Supports

What You Will Find:

Developing Transition and Implementation Plans

Selecting a Home

Environmental Accessibility

Request for Additional Funding

Housing Survey

Chapter Five: Planning Supports

The initial process of supported living, described in Chapter Four, sets the stage for a detailed planning process to begin.

In order to assure appropriate supports and services are identified and approved, the following steps must be completed by the supported living coach.

Planning Supports:

The Supported Living Coach –

1. Develops a transition plan.
2. Submits transition/implementation plan to WSC no more than 30 days after service authorization (effective) date.
3. Assists with housing selection.
4. Updates Financial Profile no more than 10 days following housing selection.
5. Submits request for additional funding to WSC prior to signing of lease/mortgage documents.
6. Completes Housing Survey and submits it to WSC 10 days following housing selection.

According to the Developmental Services Waiver Services Medicaid Coverage and Limitations handbook, the supported living coach has ninety (90) days from the date of the person's selection of a provider, to assist the individual in locating a home and obtaining the needed supports and services. "Billable" days are the equivalent to the number of days the supported living coach may bill for time in getting to know the individual, completing the necessary paperwork, and supporting him in locating a safe and desirable home. For individuals moving into their first home, it is suggested the entire ninety (90) day period be utilized to allow sufficient time to assure a successful move.

Once the support and cost plans are approved, the supported living coach develops an implementation plan or a transition plan. These plans address the

supported living goals from the support plan. Part of the transition process is the idea of a formal implementation plan to identify how ongoing supports will be provided. The transition plan and the Functional Community Assessment (FCA) must be finalized by the time the move occurs. Copies of these plans must be maintained in the individual's record.

In situations where a supported living coach initiates services to an individual already living in his own home, the implementation plan must be completed in the first thirty days. The Florida Supported Living Rule (65B-11 F.A.C.) dictates that the implementation plan or transition plan must be implemented no later than thirty calendar days from the service authorization (effective date) for continuation of services. The implementation plan is updated annually, consistent with the support planning process.

During the ninety day period while the individual and his coach are planning and preparing for the move, many requirements must be addressed. The implementation plan or transition plan will be developed, at a minimum, within thirty days of the initiation of supported living services (service authorization/effective) date according to the DS Waiver handbook. However, waiting thirty days to begin services is not a good idea.

The supported living coach should start working with the individual and her circle of support as soon as possible. This approach assures the individual can begin working on her goals at the start of the move. Consistency is important in the learning process, and a lapse can result in the loss of skills already attained.

The purpose for this initial work is to identify potential resources, assist in locating housing and assist the person in making preparations to move into a home of her own. This process is known as transition planning.

Developing a Transition Plan and/or Implementation Plan

A transition plan is completed for individuals who are in the initial phase of seeking homes of their own or moving to new homes. This plan is substituted for the implementation plan. Once the individual has transitioned to his own home, an implementation plan is developed within the next thirty days and submitted to the support coordinator.

Successful transition into supported living requires that everyone involved in the person's circle of support collaborate to make certain there is a shared

vision, and mutual understanding of the supports needed and that all services are in place prior to the move. The circle must also be committed to focusing efforts on supporting and including the individual in the community. This collaboration begins well in advance of the person's move into his own home or apartment.

It doesn't matter so much how you get organized, just that you stay organized! (Author Unknown)

As with the reference above, good planning is an essential part of supported living services. Transition planning for before the move helps ensure that needed supports and services are in place to promote the person's comfort, health and safety. Planning for during the move (e.g., assuring the individual is accompanied by someone with whom she feels comfortable, her favorite personal items are packed in the car with her, etc.) for persons who may need additional support on the actual day of the move, could make a big difference in the person's comfort and satisfaction. Planning for after the move lays the foundation for a successful transition to life in a different place with new friends, neighbors, and community connections.

Working closely with the support coordinator and the individual's family will help assure that concerns are not overlooked and that small issues do not have big consequences. Changing one's home can have as much impact on the family as on the individual.

Listening to everyone's fears until they are understood and resolved is an important part of supporting persons and their families. Most stated fears (e.g. "People will be mean to him." "How do we teach him to address strangers coming to the door?" etc.) are valid and should be addressed during transition planning.

Supported living coaches are encouraged to actively listen to the members of the circle of support, and address issues and concerns as part of the transition and implementation planning process. Planning Ahead, A Handbook for Parents, Family Members and Guardians of Adults with Disabilities, available from the Florida Developmental Disabilities Council and the District/Region Developmental Disabilities Program is a helpful resource for families and includes a brief section on "Transition."

Transition Plan or Implementation Plan
In most instances, a transition plan is necessary to guide the transition process. However, in some situations an implementation plan will be the guiding document. How does one determine which type of plan applies? The following may be helpful in assisting with that decision.

A transition plan is completed for individuals who are in the initial phase of seeking homes of their own or moving to new homes. Under these circumstances, this plan is substituted for the implementation plan. Once the individual has transitioned to his own home, an implementation plan is developed.

Transition or Implementation Plan

1. When the individual is **moving from a non-supported living situation,** such as from a group setting or his family's home, and the supported living coach is using the 90 billable days to support the person in locating a home and assuring supports are in place, the development of a **transition plan is necessary and required.**

2. If the individual is **already receiving supported living coaching services** and will not be using the 90 billable days in locating a home (e.g. has chosen a new coach, has chosen to move to a new place, etc.), the supported living coach should **develop an implementation plan within 30 days of the *effective date to support the attainment of the person's goal in the support plan.**

3. **Implementation plans** are **developed within thirty (30) days after the individual has moved** into her new place. The implementation plans are adjusted as needed through the support plan year.

4. **Implementation plans** for persons using supported living services are **developed at least annually**, consistent with the effective date of the support plan.

5. Regardless **of the type of plan being used, the plan must be submitted to the support coordinator within 30 days from the *effective date.**
   * = as indicated on the Service Authorization

Transition Planning
As mentioned, a transition plan serves as a guide in supporting an individual's move. There is no set format or form to be used. Each plan should be adjusted to meet the individual's needs and desires. At a minimum, transition plans include a listing of items to be accomplished during the transition period and an indication of responsibility for each item. A few examples of items to consider in assuring a successful move include:

Mike

Mike had lived all his life in an institution. Through much persistence by advocates, he obtained a court order to be released from the facility and be allowed to move into his own place. Unfortunately, the court order gave such close time frames that good transition planning was not possible.

Mike moved on a Friday afternoon and left the facility with approximately $600 in cash that he withdrew from the institution's "bank." On Saturday morning Mike began to enjoy his new-found freedom. He called a taxi and asked the driver to take him on a ride to the nearest beach, 1-1/2 hours away. The taxi driver waited for him as he spent some time walking along the beach and talking with all the pretty girls.

Mike then took a 2-1/2 hour ride to another city, and while there met a gentlemen who needed a bus ticket. Mike was glad to help out. The last trip he took was to return to the institution, visit and "show off" to his old buddies. When he finally returned home, he had exhausted all of his cash. Now in need of money, he made a deal. He sold all of his new furniture to some neighboring college students for $200. When his supported living coach was finally able to locate him (Sunday afternoon), he was out of money and had no furniture except his television set which he had, in a fit of boredom, taken completely apart. Although things eventually worked out for Mike, everyone involved learned an invaluable lesson about the importance of good transition planning.

Transition Plans/Guides May Include*:

- Visiting an array of homes in different neighborhoods.
- Assuring needed paperwork is completed in a timely fashion (such as Individual Financial Profile, etc.)
- Setting up needed supports and services (e.g., transportation, pharmacy, etc.)
- Making moving arrangements, etc.,
- Addressing needed emergency and safety issues,
- Obtaining needed household items, etc.

*Note: For persons moving from ICFs or institutions, the WSC is responsible for assuring specific transition guidelines are met.

An example of a Transitional Guide format courtesy of Collier Connections, Inc. follows:

Collier Connections, Inc.
Supported Living Coaching Service
TRANSITINAL GUIDE

Name:

		Dates	Support Person
1.	Discuss housing needs with regard to transportation, proximity to work, and person's preference, roommates and community accessibility. Begin Functional Community Assessment.		
2.	Visit and compare an array of potential housing and surrounding neighborhoods.		
3.	Make final housing selection		
4.	Complete Individual Financial Profile (IFP) including proposed start-up stipend and/or supported living stipend request, if needed and submit to WSC.		
5.	If housing and IFP is approved, meet with prospective landlord to complete rental application process and pay deposit / application fee.		
6.	Identify target move in date and confirm with landlord.		
7.	Transfer / open bank accounts.		
8.	Develop a list of needed household start up items (or share of total) with approximate cost and shop for these items.		
9.	Prepare start up grocery list.		
10.	Transfer prescriptions to local pharmacy if needed.		
11.	Request any necessary adaptive devices or special equipment.		
12.	Make arrangements for moving / contact local movers.		
13.	Obtain boxes and begin packing.		
14.	Make necessary transportation arrangements from new home, learn new bus routes.		
15.	Finalize moving plans including; schedule tome to sign lease / pick up keys and inspect new home, electric hook-up, telephone, cable and water if necessary.		
16.	Change address on State ID / driver's license.		
17.	Move and begin to unpack / get settled. Complete Housing Health and Safety Checklist and distribute to WSC.		
18.	Complete and distribute Change of Address form.		
19.	Grocery shop for start up supplies.		
20.	Review post-move support, learn emergency access numbers.		
21.	Meet new neighbors, become familiar with new neighborhood.		

Implementation Plan

Implementation plans must be completed within thirty days of the move or finalized by the time the move occurs.

Implementation plans are an integral part of the support planning process and provide a framework for assisting the individual in acquiring the skills, habits and routines she desires. As discussed, in situations where a supported living coach initiates services for an individual already living in his own home, the implementation plan must be completed in the first thirty days following the effective date. These plans are developed with direction from the individual and include specific strategies and supports to meet support plan goals. Learning objectives may also be included in the implementation plan.

The Functional Community Assessment (FCA), discussed in previous chapters, is the basis for identifying the types of instruction and assistance, as well as the intensity of supports identified in the implementation plan. The information obtained from the FCA forms the foundation for the development of the Implementation Plan. This assessment addresses all areas of daily life. It must be completed prior to the move, and updated annually.

The FCA assists the coach in understanding how the person learns, the routines and habits that may be useful when living on one's own, and the types of things which may support the person in being productive, etc. When compared with the person's personal goals, the FCA provides the baseline information needed to direct the person's path toward achievement of these goals identified on the support plan.

Implementation plans are an integral part of the support plan process and provide a framework for assisting the individual in acquiring the skills, habits and routines she desires. The Developmental Services Waiver Services Medicaid Coverage and Limitations handbook defines implementation plans as follows:

Implementation Plan Definition:

"A plan developed with direction from the (individual), which includes information from the current support plan, and other pertinent sources. The specific areas of training and strategies to meet support plan goal(s) for each person will be addressed in the implementation plan. Training objectives appropriate to the programs and services may also be included in the implementation plan."

As mentioned, the implementation plan is directed by the desires and needs of the individual. The supported living coach ensures the plan is written in a way that supports the person in achieving the life she desires.

The implementation plan provides a clear picture of those things the individual and the supported living coach have agreed to work toward for the coming year. For the coach, the implementation plan serves as an individualized job description regarding the coach's role in the person's life. For the individual, the plan offers a description of how services will be provided in order to meet the goals identified on the support plan.

Copies of the implementation plan, approved by the individual, should be furnished to the individual, guardian and to the waiver support coordinator at the end of the thirty day period.

At a minimum, according to the DS Waiver handbook, the implementation plan includes:

Implementation Plan includes:

1. Name, address and contact information of person served.
2. Goal(s) from the support plan to be addressed.
3. Strategies employed to assist in meeting SP goals.
4. System for data collection and assessing progress in achieving SP goals.
5. Modification of the implementation plan, based on assessment of progress, to assure goal achievement is attained.
6. Frequency of supported living coaching services and the specific areas of support required by the individual to live in his own home.
7. How home, health and community safety needs will be addressed, and supports needed to meet those needs.
8. How natural and generic supports available through family, friends, neighbors, and the community-at-large will be used.

Implementation Plan, continued

9. Person responsible for providing coaching services.
10. When coaching will be provided.
11. Method for accessing the supported living coaching provider 24 hours a day, 7 days per week for emergency assistance.

The following are **examples** of implementation plan formats courtesy of Habilitative Services of North Florida and Pinellas Care Systems, Inc. of St. Petersburg, Florida.

SUPPORTED LIVING IMPLEMENTATION PLAN

NAME: PHONE:

ADDRESS:

EFFECTIVE DATE:

SUPPORT COORDINATOR:

SUPPORTED LIVING SPECIALIST:

24-HRS. DAY / 7 DAYS PER WEEK & BACK-UP CONTACT NUMBERS (Check one):

EXPLANATION OF NEED FOR SUPPORTED LIVING COACHING SERVICES:

This explanation can be found in the Individual Cost Guidelines, the Personal Outcome Measures and the Current Situation sections of the individual's support plan. Also refer to the Functional Community Assessment.

GOAL(S) FROM SUPPORT PLAN TO BE ADDRESSED

THE NON-NEGOTIABLES

The things you might as well accept. Those lifestyle choices which are essential to well-being and a reasonable quality of life . . . the core values. Positive non-negotiables are essential for life to be tolerable and pleasant. Negative non-negotiables make life totally unpleasant and intolerable.

INDIVIDUAL PREFERENCES

The things that are important. These make a major contribution to quality of life but are not as critical as the non-negotiables.

STRATEGY FOR ADDRESSING HOME, HEALTH, AND COMMUNITY SAFETY NEEDS	STRATEGY FOR <u>SUPPORTS</u> NEEDED TO ACHIEVE SUPPORT PLAN GOAL(S) (Include frequency and time frames)
• Maintain a current medical information sheet. • Encourage and/or facilitate the completion of an annual physical and dental examination. • Review seasonal precautions such as severe weather preparedness, proper dress, adequate heating, hypothermia, heat exhaustion/stroke, dehydration, etc. • Assist with equipping home with first aid kit, fire extinguisher, smoke detector, and disaster kit and review their use quarterly. • Work with local emergency management organizations as needed to ensure safe evacuation during natural and/or chemical disasters. • Complete a quarterly health and safety review and housing survey (on the Quarterly Meeting Worksheet). Any concerns will be addressed, and ongoing concerns will be reported to the Department. • Additional training and support needed:	

STRATEGY FOR TRAINING NEEDED TO ACHIEVE SUPPORT PLAN GOAL(S)

TRAINING GOAL #

Frequency of Training

Targeted Completion Date

Methodology Be Used: ___ Modeling ___Physical Assistance ___ Role Playing
___ Videos ___ Visualization ___ Verbal Prompting ___ Problem Solving
___ Incidental Learning ___ Consultation ___ Details / Process to be used:

PROGRESS NOTED/ ADJUSTMENTS MADE (REVIEW DATE)	PROGRESS NOTED/ ADJUSTMENTS MADE (REVIEW DATE)	PROGRESS NOTED/ ADJUSTMENTS MADE (REVIEW DATE)

USE ONE PAGE FOR EACH TRAINING GOAL

STRATEGY FOR ACHIEVING PERSONAL GOALS

PERSONAL GOAL # ______________________________ ______________________________ ______________________________ ______________________________ ______________________________ **TARGETED ACHIEVEMENT DATE:**________________ **ACTION PLAN:** ________________ ______________________________ ______________________________ ______________________________ ______________________________ ______________________________	**PERSONAL GOAL #** ______________________________ ______________________________ ______________________________ ______________________________ ______________________________ **TARGETED ACHIEVEMENT DATE:** ______________________________ **ACTION PLAN:** ________________ ______________________________ ______________________________ ______________________________ ______________________________ ______________________________
PROGRESS NOTED/ ADJUSTMENTS MADE: **(REVIEW DATE ________)** **(REVIEW DATE ________)** **(REVIEW DATE ________)**	**PROGRESS NOTED/ ADJUSTMENTS MADE:** **(REVIEW DATE ________)** **(REVIEW DATE ________)** **(REVIEW DATE ________)**

STRATEGY FOR USE OF NATURAL AND GENERIC SUPPORTS AND LINKS TO COMMUNITY	
WHAT ROLE WILL FAMILY MEMBERS PLAY?	**WHAT ROLE WILL NEIGHBORS AND FRIENDS PLAY?**
HOW WILL COMMUNITY GROUPS / ASSOCIATIONS (CHURCHES, CLUBS, ETC.) BE USED?	**HOW WILL THE PERSON USE LOCAL BUSINESSES, SERVICES, AGENCIES, ETC? (DON'T INCLUDE OTHER MED. WAIVER FUNDED SERVICE PROVIDERS.)**

DATA COLLECTION SYSTEM TO BE USED TO ASSESS PROGRESS IN ACHIEVING GOALS:

At the time of the support coordinator's quarterly meeting with the individual, the supported living specialist will complete a quarterly meeting worksheet. This worksheet will document the review of all support and training services, note progress made in achieving goals, and record any changes in program direction and/or this plan requested by the individual and/or family/guardian. Data related to success achievement will also be added to this implementation plan. The annual summary will record the progress made on each goal during the support plan year.

AUTHORIZATION

What level (# of hours) of Supported Living Coaching Services is authorized on the service authorization?

__________________hours per ______________

NOTE: SERVICES CANNOT BEGIN OR CONTINUE WITHOUT A CURRENT SERVICE AUTHORIZATION.

SIGNATURES

Support Coordinator Signature____

Individual (or Legal Guardian) Signature:_____________________________________

Courtesy of Habilitative Services of North Florida.

IMPLEMENTATION PLAN

Individual's Name		Social Security #	
Address		Phone #	
Date Services Began			
Support Plan Date			
Date Support Plan Received			
SP Effective Date			
Implementation Plan Date			
SPA Form Received			
Copy to Guardian		How sent?	
Copy to WSC		How sent?	
Guardian/Parent		Phone #	
Family/Friend		Phone #	
Support		Phone #	
Program Administrator and Supported Living Coach (es)		Phone #	

SIGNATURES

Individual	
Guardian	
Informants	
Supported Living Coach	

The instrument used for evaluation of the individual's monthly progress is the case notes/service notes and logs. The method for accessing a supported living staff person 24/7 is through staff pagers/cell phones.

STAFF AND NATURAL SUPPORTS

HEALTH AND MEDICAL ISSUES

HOME & COMMUNITY SAFETY NEEDS & SUPPORTS

IMPLEMENTATION PLAN

Implementation Plan Date	
Individual	

PERSONAL GOAL

SUPPORT SERVICES

Home Care	Health & Safety	Financial	Self Care & Personal Growth	Comm. Integration & Leisure Time	Other (specify)

SUPPORT PROVIDER

SLC	Transportation	Companion	PCA	NRSS	IHSS	Other (specify)

STAFF PERSON(S) RESPONSIBLE FOR SUPPORT/SERVICES

ANTICIPATED COMPLETION DATE	
DATE OF AMENDMENT(S)	

SUPPORTS/SERVICES NEEDED

ACTION PLAN

Courtesy of Pinellas Care System, Inc. of St. Petersburg, FL

Selecting A Home (Excerpts Courtesy of Dale DiLeo)

When Selecting a Home, Consider:

- Density
- Personal Rights
- Affordable Housing
- Separating Housing from Supports
- Accessibility
- Fair Housing Act
- Home Ownership

Density

Once the person's preferences and capacities have been explored, it is time to locate and select a place to live. Finding a home is the most important element of the transition planning process.

In supporting the individual in finding a home, it is important to consider density, personal rights, aspects of affordable housing, restrictions on provider-owned housing, and home ownership.

As with any initiative, supported living is at risk of being turned into a "business" that is not about people but about staff convenience. For this reason there are rules concerning the number of people in supported living who can live in the same small geographical area (density). Persons using supported living services can utilize no more than ten percent of the housing in a city block, subdivision, neighborhood, apartment or condo complex, or mobile home park. Waivers of this density requirement can be made by the District/Region Developmental Disabilities Program Administrator but must be based on the choice or request of the individual. Waivers must be approved prior to the move.

Living in supported living frees the person from the confines of state or provider owned housing. Individuals in supported living live with no more than two other persons with disabilities and share control of the home with those persons. These requirements are included in Florida Administrative Code in the Developmental Services Waiver Services Medicaid Coverage and Limitations handbook,

The goal of supported living is to create opportunities for individuals to become a part of their community. Historically, people in group homes and other congregate settings have not "fit into" their neighborhood due to the

obvious difference in their home (e.g. vans in the driveway, people going in and out, etc.). If neighborhoods become "communities of individuals in supported living", they too will have difficulty truly becoming part of their community.

Respecting Personal Rights
Individuals in supported living, by not occupying state or provider owned housing, experience greater opportunity to maximize personal control of their home environments and daily routines. Because everyone has the same right to privacy, any home visit requires agreement of the individual ahead of time and should be conducted with sensitivity, courtesy, respect, and restraint from unwarranted intrusion. Under most circumstances, the support coordinator, supported living coach and other support providers should phone ahead before making an unscheduled visit and, upon arriving, knock and wait to be invited inside. Except for life-threatening emergencies, an individual's home should be entered only when the individual extends an invitation or permission. Everyone enters as a guest because of the individual's freely given hospitality.

Affordable Housing
Over the last few years, supported living has provided more individualized and normalized living options for Florida citizens with developmental disabilities. One of the barriers to supported living in this state is the lack of affordable housing.

Most individuals with developmental disabilities earn below the poverty level, and often cannot afford market rents in many areas, leaving them with limited housing options. These include leasing homes or apartments in undesirable areas, sharing their home with others in similar circumstances, or moving into pre-existing facilities that congregate people based on their deficits or challenges.

Although locating affordable housing may be challenging, there are many resources available to assist individuals in stretching their budgets. These various ideas and initiatives may be found in Finding A Home: Practical Information About Buying Or Renting a Home, available from the Florida Developmental Disabilities Council, website for download (www.fddc.org).

Examples of initiatives that offer assistance related to housing may include:

Affordable Housing Considerations:

- **Do I want to share my home so I can share expenses?**
- What is the **best place for my home** (close to employment, community connections, transportation, services, supports, etc.)
- **Renting?**
  - from a trust
  - from a friend
  - shared home programs
  - housing assistance groups

- What **costs will I be responsible for**, given the various options?
- **Rent subsidies?**
  - Department of Housing and Urban Development (HUD) Section 8
  - Farmers Home Administration (FMHA)
  - State programs (Local Housing Finance Agency- 850-488-4197)
  - Local governments (Contact local county and city housing office)
- **Home Ownership?**
  - Equity sharing programs
  - Shared property owner
  - Home Buyers Club
  - Local, state, or federal housing programs for financing, subsidies, etc.
  - Low interest loans (e.g. Federal Housing Administration, Fannie Mae financing options, etc.)
- **Assistance with Utilities and Food**
  - City and county subsidies
  - Power company subsidies
  - Food banks, cooperatives, "Meals on Wheels," etc.
- **Others**
  - Churches
  - Community garden cooperatives (fresh fruit and vegetables, etc.)
  - Non-profit organizations (e.g., Salvation Army, etc.)

Things to Consider When Looking for a Home

During transition planning, the coach and the individual have looked at those items to be considered when determining affordable housing options. To decide which housing option will best meet the needs and desires of the individual, consider the following (Finding A Home):

1. The best place to live is one selected by the individual that offers a variety of resources important to him. While a number of these were mentioned above, it is important to differentiate the context in which they are reviewed. For example, proximity may first be thought of in terms of the cost or savings involved when considering the affordability of the housing location. It may also be important to review these resources and their proximity in terms of the quality they bring to the person's life. Such things may include nearness to:
   a. employment or other meaningful day interests;
   b. accessible public or private transportation routes;
   c. needed services such as medical or community centers, etc.;
   d. places of interest such as churches, movies, shopping, etc.; and
   e. community services such as fire protection, police, social services, city parks and recreation, etc.

2. Does the individual wish or need to share his or her home? Many persons find that having a roommate provides companionship as well as reduces expenses. However, sometimes sharing a home can be challenging. Everyone needs "down time" and personal space. Sharing a home may mean compromising some things that may be important. Ask the support coordinator about local district or regional lists of individuals seeking roommates.

3. If having a roommate or someone to share expenses with is a viable option, it will be necessary to work out how expenses will be shared. Having a personal budget outlined will assist with determining options.

4. When exploring specific housing options, the person has two choices-buying or renting. For many, ownership represents security, while others may see it as a serious responsibility. Renting offers a lot of flexibility when compared with ownership. When renting, the landlord/person who owns the property pays the costs of property taxes, and repair. The decision to rent or own is a very personal one and something to be considered when deciding where and with whom to live.

A resource for accessing information related to housing is TAC, Inc., located in Boston, Massachusetts. TAC, Inc., can be accessed through their "housing

link," and offers "Section 8 Made Simple." This and other housing assistance information may be found at: http://www.tacinc.org

Separating Housing From Supports

The current Florida Supported Living Rule (65B-11.005 F.A.C.) and DS Waiver handbook prohibits providers of supported living services and members of their immediate family from owning the homes of the people they support. These rules state the following concerning this issue:

Eligible Support Living Settings

I. Chapter 65B-11.005 F.A.C. - Selection of Housing:

- *The individual shall select a home available for lease or sale to any member of the community based on the individual's own choice and personal financial resources with assistance from the supported living coaching provider as needed.*

II. DS Waiver handbook:

- *The following criteria identify an eligible supported living setting:*

a. The **name of the individual appears on the lease or mortgage** either singularly, with a roommate(s), or with a guarantor;

b. **Neither the supported living coaching provider nor the immediate family of the supported living provider shall serve as landlord** or have any interest in the ownership of the housing unit, and

c. **No more than three persons** who have developmental disabilities live together in a single housing unit.

d. The homes of **individuals receiving supported living coaching services shall account for no more than ten (10) percent of the housing** in the smallest identifiable geographical area in which the homes are located, which may be a city block, subdivision, etc. The individuals' homes shall be scattered, noncontiguous, and dispersed throughout that area.

Selection of Housing, continued

e. ***Waivers** of item (d) above **may be** granted, as previously discussed, by the District/Region Developmental Disabilities Program Administrator. The waiver may be granted in situations where individuals desire to live more closely together.*

Providers who succeed in offering more affordable living options in attractive neighborhoods, but keep housing ownership and management with the service provider, still constitute a conflict of interest prohibited by the DS Waiver handbook and the Florida Supported Living Rule (65B-11 F.A.C.). The reason is that individuals may possibly need to negotiate issues with a support provider who is also her landlord. The dual role of landlord and support provider can potentially diminish the person's control over her home.

In addition, fixed housing options (e.g., a supported living arrangement where individuals move in and out of the residence operated by the provider), even affordable ones, are not aligned with the principles of choice and supported living. As current residents leave, new applicants must apply for provider-controlled housing in locations and with existing roommates that are not necessarily freely chosen – a scenario not unlike a traditional group home.

These types of agencies typically select homes that fit a profile that includes one-story construction and location within a certain distance of shopping and services. This is because most agencies believe flexibility is needed for homes to be rentable to the greatest numbers of people. The approach contradicts core values of supported living in which homes are developed from each individual's perspective, not some perceived common denominator.

Supported living is based upon the premise that individuals choose where and with whom to live. This premise relies on an open market within a desired community. Providing affordable and attractive housing, but only under conditions of small groups of people with disabilities, solves a financial need but at the cost of still limiting options among people already limited by income, discrimination, and few choices of living arrangements.

Still another reason to separate housing and services is the challenges of property management. Maintaining a home in good repair is often difficult, time-consuming, and can potentially take away from the time and resources of the provider. Concerns related to damages, repairs, vacancies, capital

replacement, late rent payment, lease violations, and the like will certainly tax any agency providing residential services and supports.

Creating an Accessible Barrier-Free Home (Courtesy of Beth Kofsky, Stein Gerontolocial Institute, Accessible Housing Division).

An accessible barrier-free home environment for persons with a disability can be successfully achieved by starting with a comprehensive assessment. This assessment will ultimately assist individuals to remain as independent as possible. Persons with a disability can live, work, attend school and participate in the community if the home environment promotes, encourages, and provides opportunities for independent living.

To maximize use of the Environmental Accessibility Assessment, a team approach should be utilized. To assist in the process, a self-conducted *Environmental Accessibility Checklist* could be completed.

Suggested team members to support this process may include:

- Persons receiving services
- Family member(s)
- Support Coordinator
- Supported Living Coach
- Caregiver(s)
- Clinical or health care provider(s)
- Environmental Accessibility Specialist
- Engineer
- Contractor
- Architect
- Interior Designer
- Rehabilitation Technology Provider

Environmental accessibility modifications should create a safe/accessible and independent living environment based upon the person's specific needs and desires. The section on Environmental Accessibility Adaptations found in the DS Waiver handbook will further assist in understanding the guidelines regarding coverage of what can and cannot be completed under waiver funding.

A copy of the *Environmental Accessibility Checklist* used to assist individuals in determining their home accessibility needs follows.

Date: ________________

ENVIRONMENTAL ACCESSIBILITY CHECKLIST

Name: ____

Phone: ( ) ________________________ **Other: ( )** ________________________

Address: ____

City: ________________________ **State: FL** **Zip:** __________

The purpose of the survey is to assist in determining your Environmental Accessibility & Barrier-Free housing needs prior to the on-site assessment.

Please answer all questions carefully. Respond by checking off and providing the information for the areas to your specific needs within your current home environment. Thank you for your assistance in completing the survey.

1. I need accessibility to my front entrance. ☐ **No** ☐ **Yes: check item that applies.**

- ☐ ***check if entrance is not at front of home***
- ☐ **Ramp** ____
- ☐ **Walkway** ____
- ☐ **Railing** ____
- ☐ **Larger entry way** ____
- ☐ **Special door opener**____________**Garage or other door** ____________
- ☐ **Lift system/ other** ____
- ☐ **Other, explain:** ____

2. I need retrofitting in my bathroom. ☐ No ☐ Yes: check item that applies

- ☐ Change Shower (to rolling style, curbless) ______________
- ☐ Grab bars ______________
- ☐ Roll under sink ______________
- ☐ Door widening ______________
- ☐ Roll under vanity ______________
- ☐ Lift system ______________
- ☐ Special equipment ______________
- ☐ Non-slip flooring ______________
- ☐ Other, explain: ______________

3. I need retrofitting in my kitchen. ☐ No ☐ Yes: check item that applies

- ☐ Sink: Roll under ______________ Lower ______________
- ☐ Cabinets: Lower ______________ New ______________
- ☐ Counter: Lower ______________
- ☐ Stove: Front controls ______________ Roll under ______________
- ☐ Floor: ______________
- ☐ Other accessible appliances: ______________
- ☐ Other, explain: ______________

4. I need retrofitting to my bedroom. ☐ No ☐ Yes: check item that applies

- ☐ Grab bars ______________
- ☐ Railing ______________
- ☐ Door widening ______________
- ☐ Shelving ______________
- ☐ Flooring ______________
- ☐ Bed system ______________

- ❑ Lift system ______________________________
- ❑ Other, explain: ______________________________

5. I need retrofitting to my:

   CHECK: ❑ living room ❑ family room ❑ dining room

   - ❑ Railings ______________________________
   - ❑ Door widening ______________________________
   - ❑ Ramping ______________________________
   - ❑ Special Equipment ______________________________
   - ❑ Grab bars ______________________________

6. I need retrofitting in my hallway areas. ☐ No ☐ Yes: state location of______

   ____

   ____

   ____

   ____

7. Other retrofitting requests. Explain: ______________________________

   ____

   ____

   ____

   ____

   ____

8. Signature: ______________________________

   Please print name ______________________________

   If not the person needing modification, please state relationship: ______________

Please return to:

OFFICE USE ONLY	
Completed over the phone:___________________ **Person taking information**___________________ **Other notes:**___________________________ _______________________________________	**Completed by Individual:**_______________ **Date received in mail** _________________

Fair Housing Act

When considering places to live, it may be important for the supported living coach to be aware of laws related to affordable housing. Title VIII of the Civil Rights Act of 1968 (Fair Housing Act) offers protection against discrimination. Having access to this knowledge may assist the coach in working with property owners in supporting persons to live in a desired, affordable, location.

> ***The Fair Housing Act prohibits discrimination "related to the sale, rental, and financing of dwellings, and other housing-related transactions, based on race, color, national origin, religion, sex, familial status (including children under the age of 18 living with parents or legal custodians, pregnant women, and people securing custody of children under the age of 18, and handicap (disability)."***

Access to additional information regarding the Fair Housing Act, including grievance procedures and enforcement, may be obtained on the "Homes and Communities" website for the US Department of Housing and Urban Development (HUD) at http://www.usdoj.gov/crt/housing/title8.htm

Home Ownership

In the words of disability advocate John O'Brien, people with disabilities "know only stairs that are never their own." According to O'Brien, "Today's service systems developed around the unspoken assumption that people could not have both severe disabilities and homes of their own."

> ***"People with disabilities, like all of us, have a strong need for a real 'sense of place.'"***

"People with a sense of place comfortably inhabit and personalize their homes. They choose the ways they want to invest their time, skills, energy, and money in the routines of homemaking... a sense of place offers people a physical and emotional base from which to depart and to which to return... Control of the threshold, the power to invite others in or keep them out, give people who are at home the capacity to offer the gift of hospitality..."

Home "ownership" does not have to mean that the individual with a disability, who may not have many financial resources, must hold the mortgage to a house. But it does mean at a minimum that he or she is the signer of the lease, owns the things in the home, and has selected the roommate(s) and hired support people.

According to the National Home of Your Own Project (Klein & Wilson, 2000), home financing is creative and specific to each person's assets and needs. Lending institutions are acknowledging public benefits as a viable source of income for borrowers. Individuals obtain mortgages they can afford and the lenders sell more mortgage loans to a new-found customer base with a stable income stream.

Some of the major areas of concern involve savings, credit and employment. Individuals who receive SSI and Medicaid funds, for example, cannot accumulate assets in excess of $2000.00 without jeopardizing the Social Security benefits that would fund their mortgage payments. Because of these resource restrictions, persons receiving public benefits do not have the ability to accumulate enough money for down payment and closing costs. Poor or no credit is an ongoing concern as most people with disabilities have lived most of their lives in situations where their finances were managed by others. They have never had the opportunity to develop a credit history.

Finally, many individuals with disabilities do not have employment that provides sufficient income, but they do have a steady income source from public benefits. Rather than simply dismiss the possibility of obtaining a mortgage, lenders around the country are establishing new lending criteria. They are reassessing the importance of savings and employment as the foundation for granting a mortgage.

Just like any other home-buyer, the participant usually works through a private lender or housing finance agency for the primary loan. Down payment and closing costs are then secured through secondary loans and grants from a variety of funding sources. Three ways in which down payments, closing costs, repairs, and renovations are financed through subsidies include:

1. Secondary Loans (promissory notes secured by second mortgages) from state housing finance authorities; HUD HOPE 3 and HOME funds; and Federal Home Loan funds.

2. Gifts from family, friends, or civic groups; and

3. Grants and loans
   – community block grant funds;
   – state housing finance agencies;
   – contributions from the seller;
   – private foundations;
   – state and local affordable housing programs;
   – endowments for first-time home buyers;
   – from state and local human service agencies; and

- state developmental disabilities agencies.

Supported living coaches are creative problem-solvers who often "think out of the box." Knowing options, resources or where to locate the most current information is the starting place for supporting a person in buying a home. Being an advocate also leads to opportunities and answers that have not yet been considered, or attempted. As many a coach has discovered, there is truth to the old adage: "Where there's a will, there's a way."

Completing the Individual Financial Profile

As mentioned, the Individual Financial Profile (IFP) is completed no more than ten (10) days following the selection of a home and submitted to the support coordinator. For persons receiving a monthly stipend, an IFP must be completed quarterly by the coach.

Including this step in the transition plan will help assure the transition is a smooth one.

Requesting Additional Funding

The support coordinator may also request start-up funds or a monthly in – home subsidy if it is needed, and no other options are available. Approval of these funds varies from district to district based on the availability of funds.

If the Individual Financial Profile (IFP) indicates a need for a subsidy, one time or recurring, the request must be submitted and approved by the District/Region before the person signs a lease.

An **in-home subsidy** is a set amount of general revenue money which may be provided to persons with a demonstrated need for financial assistance. This financial assistance can be provided directly to the individual or provider and includes such expenses as utilities, food, and other household expenses. Because of recent budget appropriations, these are becoming even more scarce.

Chapter 393, Florida Statutes, outlines the categories of allowable expenditures for in-home subsidies. The following are approved categories:

- rent
- toiletries
- utilities
- food

- clothing
- other household items
- household supplies

Subsidies may not be used for:

- A contractor for the provision of services and supports to the consumer.
- Medical or dental services.
- Medicines, medical supplies, or adaptive equipment or aids.

Start up funds may be provided to individuals beginning supported living services if funds are available. These funds are considered start-up grants and may assist with purchasing items needed for the new home, initial deposits for rent and utilities, etc.

Adequate justification for these funds must be provided to the support coordinator who submits the request to the District/Region for review. The coach and members of the circle of support need to assist the individual in obtaining the items he will need to begin life in a new home. These items may come from family and friends, thrift shops, or department stores, depending on the budget. Supporting the person in obtaining needed items is the responsibility of the supported living coach.

Completing the Housing Survey

As another part of the housing search, the supported living coach helps the individual survey a prospective home to ensure that it is safe to inhabit. The supported living coach must forward a copy of the survey to the individual's support coordinator within ten (10) working days after the home is selected.

The survey should be updated quarterly and made available for review by the support coordinator at the time of the support coordinator's quarterly home visit. This quarterly update must include a review of the individual's current health, safety and well being. Should deficiencies be noted in the Housing Survey, a waiver must be requested and approved by the District/Region Developmental Disabilities Program Office prior to moving into the home.

An example of an Initial Housing Survey format, courtesy of Habilitative Services of North Florida, follows.

SUPPORTED LIVING SERVICES
INITIAL HOUSING SURVEY

NAME ____

ADDRESS____

____

DATE OF SURVEY____

MOVE-IN DATE ____
(If before date of survey, explanation must be included)

_______ Individual's name is on the lease/mortgage.

_______ Copy of lease has been placed in individual's records at HSNF office.

_______ The dwelling is located in an area which accounts for no more than 10 percent of the houses or 10 percent of the units in an apartment complex.

_______ No more than two other people who have developmental disabilities reside in the home

_______ Flush toilet in separate bathroom, in working condition

_______ Fixed basins (kitchen and bathrooms) with hot & cold water, in working condition

_______ Shower or tub with hot & cold water, in working condition

_______ Bathroom has at least one opening window or exhaust ventilation

_______ Water from hot water heater not more than 120°F

_______ Non-skid surfaces are present in all bath tubs and shower stall floors. (Removable rubber mats or adhesive strips are acceptable.)

_______ Suitable place to store, prepare, & serve food in sanitary manner

_______ Garbage can / bin

Initial Housing Survey (cont.)

_______ Stove or range of appropriate size, in operating condition

_______ Refrigerator of appropriate size, in operating condition

_______ Kitchen sink with hot & cold water

_______ A portable fire extinguisher is located in kitchen

_______ Sink drains into approved public or private system

_______ Separate living room & at least one bedroom

_______ Safe heating & cooling that reaches all rooms (unvented room heaters than burn gas, oil, kerosene not acceptable)

_______ One operative window in each living & sleeping room

_______ Window dressings are adequate to maintain privacy

_______ At least two electric outlets in the living area, kitchen, & each bedroom

_______ At least one smoke detector is mounted in an appropriate location and functions (fresh batteries!)

_______ No serious defects in interior / exterior walls, ceiling, or floor; floor should not move when walking

_______ No visible safety hazards are apparent, including empty light sockets, frayed cords or wires, or discoloration around electrical sockets

_______ Roof structure is firm

_______ No danger of tripping in stairways, halls, porches, walkways

_______ Free of dangerous levels of air pollution from carbon monoxide, sewer gas, fuel gas, dust, etc.

_______ Air circulation adequate throughout

Initial Housing Survey (cont.)

_______Water supply free of contamination

_______Alternate means (doorway for individuals using a wheelchair) of escape available in case of fire

_______Handicap facilities are available and accessible for individuals using a wheelchair

_______If required, grab bars are mounted in appropriate locations.

_______ Free of lead base paint

_______ Elevator in safe, operating condition (if applicable)

_______ Free of rodent infestation

_______Neighborhood free of health hazards such as dangerous walks steps, poor drainage, sewage hazards, abnormal air pollution, excessive accumulation of trash, rodent infestation, or fire hazards

_______ Unit able to be used freely & maintained without unauthorized use by other individuals

Any other comments regarding the individual's housing that should be considered:

Waivers requested (if any)_______________________________________

Date waiver requested ___________ Date waiver approval received_____________
(copy of approval must be attached.)

Supported Living Coach Signature ________________________
Date ____________

Support Coordinator Signature _____________________________
Date____________

(Form courtesy of Habilitative Services, Inc. of North Florida)

Chapter Summary

Through well thought-out, thorough transition and implementation planning, and timely completion of other required documents (i.e., IFP, Funding Requests, Housing Survey), the supported living coach has taken the final steps necessary to assure the person's smooth transition into a supported living arrangement.

When selecting housing, the coach has carefully considered density, personal rights, affordability, and accessibility. A review of resources that may be utilized, should the person prefer home ownership to other housing options, has been made, and financial arrangements are in place.

Chapter Six focuses on the move itself, and the implementation of supports and services in the person's new home.

Chapter Six
Documenting Progress

What You Will Find:

Methods for Documenting Person's Progress

Requirements for Service Verification

Writing Progress Notes

Examples of Progress Notes

Suggestions for Documenting Progress

Annual Written Reports

Chapter Six: Documenting Progress

As discussed in previous chapters, the implementation plan serves as a job description for the coach. Based on the strategies or approaches identified on the implementation plan, the coach establishes a method for collecting information. In this way, the coach documents the person's progress. Key aspects of this process include:

Documenting Progress

1. Methods for documenting the person's progress.
2. Requirements of service verification.
3. Progress notes.
4. Annual written reports.

This process serves two important functions:

Documentation:

- Assures progress toward goals (individualized)
- Verifies service provision (If it isn't written, it didn't happen!)

First, it assures the individual is making progress toward his desired goals. Second, it provides verification that supported living coaching services were provided as described in the support plan and approved on the service authorization.

Documentation should summarize the success of instructional techniques and, when necessary, emphasize the need for adjustments to either the implementation plan or learning strategies. Each person is unique and the

development of approaches to learning and information gathering techniques should reflect that individuality. If an individual is not making progress within an amount of time considered reasonable, adjustments to the implementation plan, coaching or instructional methods and/or supports should be made.

Methods for Documenting the Person's Progress

Documentation methods, which demonstrate the individual is progressing toward her goals, may be as varied and unique as needed or desired. Information may be collected in any number of formats based upon the implementation plan. The implementation plan includes both the goals identified on the support plan, and an action plan for each goal. Each action plan should describe the approach or strategies needed to support the individual in achieving the particular supported living goal. The approaches and strategies identified on the implementation plan should be completed in collaboration with and approved by the individual.

The methods of documentation should be consistent with both the personal goal and the actions. For example, if an individual's personal goal is to "get better at fixing meals" and the 'agreed upon' action plan describes approaches to preparing crockpot and microwave meals, documentation might include the person's progress toward the approaches listed, such as menu planning (e.g., beef stew, chili, hamburgers, etc.) obtaining recipes, assembling the ingredients, correct use of the microwave and crockpot, etc.

Personal responsibility plays an important role in documentation. As much as possible, the coach should support the person in maintaining his own progress. Not only does personal reporting and tracking promote good habits, it supports the individual in maintaining everyday routines.

Examples for documenting the person's progress toward goals may include:

- Charts and graphs to document household chores, laundry, taking medications, etc.
- Use of a personal calendar (individual data collection) to record banking deposits, calling for a taxi, appointments, etc.
- Menu planning and shopping lists.
- "To-Do" lists which include methods for achievement of goals.
- Progress notes relating to SP goals, that include observations, results of discussions, the person's satisfaction, etc.
- Noting results of progress toward the various components of an activity (task analysis of actions and strategies, etc.), with a simple system of pluses and minuses.

Documentation Requirements for Service Verification

The intent of the Medicaid Waiver is to "support persons to live as independently as possible in their own home," "to achieve productive lives" and prevent institutionalization. Documentation should show evidence that the supported living coach is supporting this endeavor.

Privacy
Of great importance to the supported living coach are the requirements related to privacy established under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). This privacy rule establishes protected health information (PHI) related to the person's physical or mental health condition, the provision of health care and payment for services. Thus, this applies to persons receiving supports through the Medicaid Waiver including supported living. Protected information is applicable through any form of communication used by the supported living provider, such as e-mail, fax, on-line databases, voice mail, a video/audio recording or conversation. PHI also relates to the person's past, present, or future.

On-line training regarding HIPAA is available and required for all Medicaid Waiver providers to assure the person's confidentiality and privacy are protected. (www.skillnetlearningcenter.org)

While the information collected is critical to the person achieving success in supported living, it also provides verification that the supported living coach is providing services as authorized and as envisioned on the support plan. The supported living coaching provider must complete documentation as mandated in the Developmental Services Waiver Services Florida Medicaid Coverage and Limitations handbook and Rule 65B-11.

Although many of the requirements and examples are provided in other chapters, a summary of documentation requirements is provided below:

Requirements:

1. Service Logs;
2. An Individual Implementation Plan and/or Transition Plan;
3. Annual Report;
4. Annual Satisfaction Survey;
5. Documentation of Quarterly Meeting;
6. Initial Housing Survey;
7. Current Demographic Information;
8. Performance Data; and
9. Progress Notes.

1. A copy of service logs (time intervention log) supported by progress notes, for the period being reviewed. Progress notes verify services and justify the coach's monthly billing. Supported Living Logs include times and date of service and a summary of the supports provided during contact with the individual, as described in Chapter 65B-11.014, F.A.C. and the DS Waiver handbook.

2. An individual implementation plan and/or transition plan (as discussed in Chapter Five).

3. An annual report, summarizing the person's (overall) progress toward achieving the goals from the support plan. The annual report includes objective (fact-based) information reflecting the results of training and supports provided over the course of the year, as well as subjective information (opinions) and recommendations. The annual report is submitted to the individual or guardian and the support coordinator 30 days prior to the end of the support plan year.

4. Annual Satisfaction Survey (as described in Chapter 65B-11.008, F.A.C.). At least annually, individuals receiving supported living services will be asked to complete a survey that addresses satisfaction with supported living services. While it is the provider's responsibility to assure the individual has the opportunity to complete the survey, staff providing direct supported living services to the individual may not assist in the survey activity for the person. The results of the survey are maintained in the individual's record and a copy is forwarded to the waiver support coordinator for review and placement in the central file.

5. Documentation of a quarterly meeting in which the individual, the waiver support coordinator, and the provider review the current supported living services. The person's waiver support coordinator is responsible for arranging and scheduling the quarterly meeting. The purpose of this visit is to update the housing survey to assure that the home continues to meet basic health and safety standards and to determine if supported living coaching services are being carried out as identified on the support plan. If the supported living coach is acting as fiscal agent for the individual, reconciled bank statements and other financial records should be reviewed by the supported living coach and the waiver support coordinator at the time of the quarterly visit. This review is documented (unless the supported living coaching provider is excluded from the meeting) in the progress notes.

6. An initial housing survey containing quarterly updates of the person's health and safety status. The housing survey will be updated quarterly and made available to the waiver support coordinator at or prior to the

quarterly meeting. Documentation of the meeting and subsequent recommendations will be made in the individual's record.

7. Up-to-date information regarding the demographic, health, medical and emergency information and a complete copy of the current support plan, if approved by the individual/guardian, must be kept in the individual's record.

8. Performance data on the selected service outcomes must be maintained. The supported living provider establishes a systematic method for collecting progress information toward outcomes and personal goals. Data is reviewed periodically and corrective measures are put into place when data indicates the goal is not being achieved.

9. Progress notes which include:

   - documentation of activities;
   - supports and contacts with the individual, other providers and agencies;
   - dates and times of contacts;
   - a summary of support provided during the contact;
   - any follow-up needed; and
   - progress toward achievement of support plan goals.

Writing Progress Notes

> *"In supported living, the primary documentation is progress notes... the coach's obligation is to get away from artificially structured activities ..."*
>
> Dennis Shelt, Community Circles, St. Petersburg, Florida

On-going progress notes, although individualized to reflect the person's present situation and progress towards goals, also describe the services provided by the supported living coach (occasionally referred to as case notes).

Progress notes provide a narrative description of the interactions between the coach and the individual, as well as the supports and services provided on the person's behalf. This challenges coaches to maintain documentation that clearly describes activities that lead to the individual's desired outcomes.

Services provided to persons in supported living are ongoing and dynamic. The level of support changes in response to the person's evolving needs. This

is a significant departure from the traditional approach where focused skill training occurs at discrete intervals.

Progress notes may include the results of objective (factual) and subjective (interpretive) information. Frequently, progress notes summarize the personal data collected by the individual (e.g. charts, calendars, etc.) as well as interactions and observations obtained from friends, family, and neighbors.

Progress notes also provide a chronicle or historical record of the coach's efforts in finding the right approach to learning. Periodic reviews of notes may assist the coach in providing person-centered supports. By analyzing patterns and trends the coach may help the individual to learn which approaches are most effective for day-to-day living.

Coaches should review documentation maintained in the person's home by others such as medication administration records, logs from live-in staff, etc. Results of these reviews should be documented in progress notes to reflect both the person's progress and verification of coaching services.

Following is an example of a progress note adapted from Community Circles, Inc. The example clearly documents activities and demonstrates progress toward goals on the support plan.

Sample Suggested Progress Note:

Name: Ray Brown

Coach: Dennis Shelt

Date: 3/18/03, 3:00-4:30 p.m.

Goal: "I want to learn how to manage my own money."

I went to Ray's apartment to assist him with his weekly deposit. He maintains a calendar on his refrigerator and places a check mark on our regular "Tuesday" deposit days. When completed, he turns the "check mark " into an "X" to indicate completion. He completed the budget worksheet, but needed reminders (i.e. sometimes pointing to the correct box, and occasionally statements such as "don't forget to record ______", etc.) to transfer information correctly onto the deposit slip. He experienced difficulty knowing what information to put on each line, even with the sample deposit slip provided. I observed him squinting. When asked about it, he stated "I see Okay." However, after some discussion he did agree to make an eye appointment.

Ray updated his check register independently, but I had to remind him to endorse his paycheck. We rehearsed his interaction with the teller, which he completed without reminders. I encouraged him to go to the bank by himself, but he asked me to accompany him. When we got to the bank, Ray asked me to "come to the teller" with him. I told him I would be " in the lobby area to assist if necessary". Ray completed the transaction without assistance and was very proud ("I did it myself!") my help was not needed.

Next step: Ray has an appointment with the eye doctor next week. Discuss with doctor Ray's age and potential need for reading glasses to assist with completing banking transactions.

____

Signature

"Common Sense" Suggestions for Documenting Progress:

- Date each entry. Assure the year is included along with the month and day.
- Documentation should reflect specifically what the person is trying to accomplish. For example, if the person is attempting to learn to purchase dry bleach from the vending machine at his apartment complex, information should reflect his status in purchasing the bleach, rather than simply a component of the process, such as identifying the coins (e.g., two quarters and a dime) needed.
- Notes should be legible. Data must be sufficient to verify progress or lack of progress.
- Do not use correction tape or fluid. Strike through (with a single line) and initial errors.
- Avoid blank spaces.
- If data is to be collected by someone else, assure the individual is aware of exactly what to record and how it should be recorded.
- The coach should observe implementation sessions, completed by others (e.g., in-home support staff) in order to evaluate the effectiveness of the information.
- Several sources of information (e.g., in-home supports, behavior analyst, etc.) may be needed to establish a "big picture" of progress.
- Common words or phrases *to use:* " I helped..." "I assisted..." "I showed..." "I demonstrated..." "I explained..." "After much discussion..." "We discussed..." etc.
- Common words or phrases *not to use*: "I trained..." "...was lazy", "...gave reinforcement," etc.
- Notes should be respectful and assure confidentiality as requested and required.
- Bottom line, ask yourself: "Given the information collected, am I able to determine if the person is improving, losing, or maintaining skills or routines, is staying healthy and free from abuse, neglect, and exploitation?"

Annual Written Reports

Annual reports provide an overall picture of the individual's status over the past support plan year, and must be submitted to the support coordinator thirty days prior to the end of the support plan year. A copy of the report should also be submitted to the individual/guardian/guardian advocate.

As previously discussed, the DS Waiver handbook describes an annual written report as a summary of "the individual's progress toward achieving the goal(s) from the support plan (as required in Chapter 393, F.S.)." The annual report includes objective (fact-based) information reflecting the results of training and supports provided over the course of the year, as well as subjective information (opinions) and recommendations.

A summary of monthly and ongoing progress notes at the end of each support plan year, when combined with information obtained from service logs, the Functional Community Assessment, the Individual Financial Profile, Quarterly Housing Surveys, the Annual Satisfaction Survey, and other evaluations (i.e., medical reports, etc.), contributes much of the content for the annual report.

Suggestions for Writing Annual Reports

- Don't just report on skills or instruction, provide an overall picture,
- Justify continuation or deletion of goals.
- Provide *specific details* regarding accomplishments and progress toward goals.
- Avoid vague terms such as "doing fine," etc.
- Identify "big issues" (e.g., social/relationships, health concerns, risks etc.)
- Explain where the person is towards stated goals and his desired future (Personal Outcomes, etc.)
- Identify "small" concerns which, if ignored, could become crises.

Chapter Summary

Progress must be documented as required by the state. Service logs, support plans, implementation and/or transition plans, annual reports, annual satisfaction surveys, quarterly meeting reports, housing surveys, and progress notes, when combined, provide useful information. Beyond meeting requirements, this documentation helps in identifying patterns and trends, modifying approaches, and assuring progress toward goals.

Chapter Seven focuses on strategies and methods for supporting the person's continued success in the community.

Chapter Seven: Supporting Success

Thorough planning, detailed documentation, and careful analysis of the person's progress are all factors contributing to the individual's success. However, additional components must be addressed to assure and promote success.

Supporting Success

1. Know the person.
2. Establish a system of communication.
3. Assure health and safety:
   - handling everyday emergencies
   - responding to natural disasters
   - obtaining a complete health history
   - considerations for persons with physical and health challenges
   - considerations for person with behavioral challenges
   - obtaining informed consent
   - ensuring advanced directions
   - ensuring medication is administered as prescribed
4. Understand abuse, neglect, and exploitation.
5. Consider liability issues.

In order to promote success, a good coach needs to educate herself on the individual's situation before providing supports.

Educate yourself on the individual's situation *before* providing supports.

Understanding the individual, how he learns best, conditions that may impact health or learning, and his habits, routines, relationships and preferences, will help assure successful endeavors.

Roller Coaster Ride

"After the individual makes the transition to a home of his own, the work really begins. I like to compare supported living to riding a roller coaster.

You and the consumer buy a ticket, then you wait around. You talk and get to know each other. You bond and share lots of anticipation. You inch forward. That's the transition phase.

Finally, you and the consumer get to the front of the line. This is what you both have been working toward. Get in! Hold on tight! Here we go! No turning back now (at least not without a lot of fuss)!

As a supported living coach your job is to ride life's roller coaster with the individual. Sometimes things move slowly and sometimes they move fast. Sometimes you go up-side-down and other times you go in circles. Sometimes you even go backward. There are dips and bumps and moments when you fear you are about to free-fall. It's fun! It's scary! It's exhilarating! It can keep you young or make you ill.

That's the roller coaster! That's supported living! That's life! Are you up for the ride?"

-Dennis Shelt; *Community Circles Inc.*, St. Petersburg, FL

The supported living coach visits the person's home on a frequent basis. When the person first moves, the supported living coach may need to visit daily. As the person adjusts, visits can be less frequent. The coach should be observant and diligent in sensing subtle changes in the person and her home, the support services staff, and the environment and act upon those changes immediately. In many instances, crisis can be averted, or stability maintained, by quick response to such changes. Equally important, the coach should also look for things that do not change, and that should have been addressed as a form of follow-up, for example, when implementation plans are not being followed, or an ongoing concern remains unaddressed.

Crises occur when little things go unnoticed or are not acted upon!

Establishing a System of Communication

Good planning to avoid crises includes establishing an on-going system of communication to assure that all involved parties are aware of situations, issues, and potential problems. A coordinated effort among all persons supporting the individual (whether formally or informally) must be made in sharing information as part of the ongoing monitoring of the person's situation. Care must be taken to assure the person's right to privacy, while supporting him in maintaining stability and continued success. It is crucial that communications are open and effective, as intensification in areas of support may be needed at any point in the person's life.

> **"A good coach has to learn to anticipate..."**
>
> Ann Millan, Parent

Without effective ongoing monitoring, and communication that is open and timely among all involved parties, overnight the person could be facing a crisis.

For example, a change in apartment management may result in upheaval to the renter's routine. Residents of a complex may be required to find a local laundromat because it is decided that on-premises laundry rooms will be closed, and all appliances removed; buildings may require tenting for termite fumigation, and residents notified in writing of the need to prepare their units and vacate within 24 hours; apartments may undergo renovation, and old gas appliances replaced by newer electrical ones.

In this one area of the person's life, a domino effect is possible. New ways of maintaining the household may need to be learned (e.g. how to get to the nearest laundromat and operate different washers and dryers, how to cook on an electric vs. a gas stove), or immediate supports provided to avert a crisis (e.g. a motel room must be found, a suitcase packed, plans for meals made, and the apartment prepared prior to termite treatment and upon re-entry).

Additionally, any one potential crisis, in any one area of the person's life, can significantly impact other areas. A renter who must vacate the premises for 48 hours may suddenly be living in temporary housing far from the bus route used to get to and from work. The sudden lack of laundry facilities in the house may result in the person's wearing soiled garments to work, and being "written up" for the same. Even more damaging, a person who is unfamiliar with the need to protect living things from the fumigation process might return to her apartment to find a beloved fish or cherished plant has died. In the worst case, the person may unknowingly begin eating from utensils and dinnerware without washing them first, and ingest poisonous residue.

When in doubt, spread it out.

The supported living coach, in partnership with the support coordinator, the individual/guardian/guardian advocate and his family, should assure that each circle of support member understands and uses the system of communication established as a means of assuring safety. Sharing responsibility for communications increases the likelihood that things are addressed in a timely manner.

"You shouldn't take over my whole life because I need your help with part of it."

-Courtesy of Ann Millan.

An effective system of communication is one that is responsive to the needs and desires of the individual. There may be instances when the coach has tried to make changes to the instruction or coaching methods, yet finds the individual is still not making progress. There may also be occasions when the individual changes his or her mind regarding a goal identified on the support plan. These issues should be discussed with the individual and the support coordinator via telephone or during the quarterly meeting, if timely, and the plan changed.

On-going communication with the support coordinator and the circle of support can be helpful. As the adage "two heads are better than one" implies, the more people attempting to support the individual by brainstorming ideas, the greater the potential to find the means to successfully accomplish that end.

Assuring Health and Safety

John

A few days after John moved to his first apartment, I was invitied over to have dinner. He greeted me at the door in his swimming trunks with a plate of homemade tacos. He explained he had never cooked anything before and chose tacos for dinner because he could, even though it was Tuesday and at the group home "Taco Bell nights were the last Thursday of the month". John's coach explained that in the group home where John had lived for 14 years, they went to Taco

Bell on a routine schedule and John was thrilled he didn't have to wait until the end of the month to enjoy a taco.

During dinner, I noticed John refused any salsa or hot sauce for his taco. Having known John for about 15 years, I asked about the salsa. He said he "never had used it" and wasn't sure why. He told me that later he and his coach were going to "check-out" the hot tub.

When I asked John and the coach about any health concerns, neither was aware of any. I remembered that I had read somewhere, years before, that John's body had an unusual reaction to intense heat. Yet, John was not aware of the possibility and the information was not available in his new home. We made a few calls back to the group home and discovered that immersion in a hot tub could have dire consequences for John's heart, and hot sauces might create similar problems. The absence of this piece of health information might have cost John his life.

Obviously, this information should have been in John's support or transition plan and provided to John and his support staff. This information could have been used to educate John about the use of the hot tub compared to the pool, and the use of sauces and salsas, and methods for making good decisions. In addition, an evaluation by a physician might also assist John and his support staff in understanding the full impact of heat (e.g., outside temperatures, etc.) on John's daily life in Florida. This might assist John and his coach in assuring the concern remains at the forefront, and the information about his heart is provided to the support coordinator for updating his support plan.

Health and safety are issues that should be addressed any time there is a concern as well as at the time of the support plan meeting for every individual in supported living. Supported living coaches and other providers contribute to the support plan in many ways throughout the year. The annual reports submitted to the support coordinator prior to the support plan meeting offer valuable information related to safety and wellness. In addition, as discussed, pertinent information shared during quarterly housing reviews and from routine interactions may also be reflected in the support plan. Questions/concerns regarding health and safety should always be raised immediately and discussed with the individual and WSC.

Sharing information, both required and through daily interactions, will help assure that training and support are provided to the person as needed. The strategies and approaches for addressing safety concerns must be found on the implementation plan.

The DS Waiver handbook's definition for supported living coaching services states: "the Implementation Plan must contain…how home, health, and

community safety needs will be addressed and the supports needed to meet these needs."

Prior to the development of the annual Individual Support Plan (ISP), the Functional Community Assessment and Quarterly Housing Surveys conducted by the supported living coach, and other evaluations from pertinent providers, may indicate the need for additional instruction or supports in certain areas of health and community safety.

An important responsibility of the supported living coach is to observe health and safety issues on a frequent and ongoing basis and report any concerns. The supported living coach may be observing supports provided by other providers such as in-home supports, homemakers, Non-Residential Supports and Services (NRSS), etc. The supported living coach may need to address these issues, and involve the support coordinator when appropriate. The scheduled quarterly meeting with the support coordinator is a good time to discuss general areas of concern related to health and safety. Immediate concerns should be addressed as they are identified.

As mentioned, areas required for promoting wellness and safety may be found in the Developmental Services Waiver Services Florida Medicaid Coverage and Limitations handbook and Chapter 65B-11 F.A.C. Although previously discussed, the following is a summary of items to consider and review when planning for health and safety:

Requirements for Assuring Health and Safety:

- Transition plan meeting to communicate health and safety.
- Completion of an initial **housing survey** to ensure the home is safe.
- Documentation of a **quarterly meeting with WSC to update housing survey** for assuring that the home continues to meet basic health and safety standards.
- Maintenance of current **demographic information** regarding health, medical and emergency information in the record.
- Maintenance of copies of the **current support implementation/ transition plans** in the record.
- **Development of implementation plans that include strategies** for addressing home, health, and community safety needs.
- Completion of **the Functional Community Assessment**, which addresses "medical and health concerns."

- Completion of an **Annual Written Report**, which might include information on nutrition, medications, medical, and health concerns, mental health challenges, first aid, safety concerns (e.g., fire evacuations, etc.), relationships, personal care, etc.

Plan for Everyday Emergencies

It is also important to think in terms of basic safety in the home. Appliances such as smoke detectors and fire extinguishers should be installed and kept in working order. First aid kits, "bee sting" kits, and other basic response kits should be kept, purged once "effective dates" pass, and restocked. Additionally, the person should be instructed in their use.

Natural Disaster Preparedness

Every individual in supported living should have a "disaster preparedness plan" for large-scale emergencies. This plan should be tailored to his or her location, situation, and needs.

Not only does the coach consider everyday safety, it is also important to plan for natural or human disasters such as hurricanes, tornadoes, terrorism, floods, riots, 911 situations, and other large-scale emergencies. When Hurricane Andrew devastated the Miami area in 1992, many people who had developmental disabilities were temporarily "lost" to their service providers. Few agencies or individuals were prepared to deal with the chaos caused by massive destruction of neighborhoods, power outages, transportation obstacles, and communication disruptions.

As a result of this experience, the Florida Developmental Disabilities Council funded the 'Disaster Preparedness Project', which has provided training around the state and developed materials for use by professionals, families, and individuals.

One publication, Are You Ready? Disaster Preparedness For People in Supported Living and its companion videotape contain practical information that can be used to help individuals prepare for emergency situations. Contact your local Developmental Disabilities Program Office or the Central Office at (850) 488-4257.

In addition, many local newspapers throughout Florida publish "pull-out" Hurricane Preparedness Guides that detail evacuation zones, routes and shelter locations and emergency kit/home owner preparations. These are often made available to the general public, free of charge, and can be found at designated locations, such as grocery stores, drug stores, and post offices.

A blank "Disaster Plan for Persons Served in Supported or Independent Living" is included courtesy of Lynne Daw, Developmental Disabilities Program, District II, to assist in supporting persons in planning for emergencies.

DISASTER PLAN FOR PERSONS SERVED IN SUPPORTED OR INDEPENDENT LIVING

Directions: This plan must be completed with each person served in a supported or independent living arrangement (ABC components 11 or 01). The disaster plan is incorporated as part of the support plan and must be kept current. A copy is to be submitted as part of the annual cost plan/support plan packet and as changes occur during the support plan year. Copies must also be furnished to the individual/guardian/guardian advocate and to all parties assigned responsibility in the plan.

Name, address & phone Number	
Brief description of living arrangement	
Name, address, & phone # of next-of-kin or other person to contact in case of emergency	
Name, phone #, cell phone # and pager # of: - Support coordinator - Supported living coach - Res. Hab provider - In-home support provider	
Is this person ambulatory or non-ambulatory?	
Identify any sensory impairments	
List relevant health issues	
List all adaptive equipment and current meds used	
Is this person registered with County Emergency Mgmt. as a person with special needs, if so, month/year registration was last updated	
In case of mandatory evacuation where will this person go? (Be specific).	
How will this person get there? (Be specific).	
Name of person responsible for:	
-insuring person has all recommended disaster-preparedness supplies in stock	

DISASTER PLAN FOR PERSON SERVED IN SUPPORTED OR INDEPENDENT LIVING

-insuring person has recommended first-aid items in stock	
-insuring that person has evacuation supplies prepared	
-insuring that person is trained to use disaster-preparedness and first-aid supplies	
-notifying person of potential disaster	
-notifying person of the necessity to evacuate	
-insuring that transportation is arranged in the event of evacuation	
-insuring that adaptive equipment and medications accompany person in evacuation	
-insuring that evacuation supplies ("evacuation bag") accompany person in evacuation	
-serving as a companion to person while in special needs circumstances	
-verifying person's health and safety within 2 hrs. after Emergency Mgmt. makes announcement it is safe to go out	
-assisting the person to assess damage to home and whether it is safe to return home	
-notifying Developmental Disabilities of any client injury or illness or significant damage to client property as a result of disaster	
-training person in all aspects of this plan	

This disaster plan is current as of _________ and has been reviewed with the client and all parties assigned responsibility in the plan.

____ ____

Client Signature Date Support Coordinator Signature Date

Updated:____

Copy: client, central record, DD, all parties assigned responsibility in plan

Maintaining Health History and Information

Over the period of a lifetime, many things happen to people, which involve health information. When the person moves from place to place and from physician to physician, this information may stay in the person's personal health record at the physician's office. Most physicians' offices purge and store records every three years, so if you need information from an old record, it might not be there. Missing parts of the record may contain information that would change the choice of a present course of treatment. For example, what is the date of the last tetanus booster? Is one needed now? Has the person ever been immunized against Hepatitis B? Would there be ill effects if the person has been immunized already and we immunize again?

The health history should be complete and available so members of the circle of support and persons providing services are able to access information needed. It's a good idea that historical information is available for every health appointment, especially for initial appointments with new health care professionals.

Historical information should include a summary of key events (e.g. illnesses, hospitalizations, diagnosis, treatments, etc.) recorded over time related to the person's health. The health history should remain with the individual in her home and be kept as current as possible. It's a good idea to schedule periodic updates to the information, so that it is current at all times. Should the person become hospitalized, or receive emergency treatment of any kind, this information will be critical to medical staff.

An example of a Medical Passport format containing current health information and history follows. *Courtesy of Lynne Daw, Developmental Disabilities Program, District II.*

MEDICAL PASSPORT

Name: ____

Residence:____________________ Dates: from:________ to:__________

Residence:____________________ Dates: from:________ to:__________

Residence:____________________ Dates: from:________ to:__________

Residence:____________________ Dates: from:________ to:__________

Health Care Coordinator:________________ Dates: from:________ to:__________

Health Care Coordinator:________________ Dates: from:________ to:__________

Health Care Coordinator:________________ Dates: from:________ to:__________

Health Care Coordinator:________________ Dates: from:________ to:__________

Current Medical Information and History

Name:________________________________Medicaid/Insurance ID number__________________________

SS#____________________DOB___________Legally competent to make health care decisions Yes___No___

Address____Phone#_______________________

Next of kin/guardian/health care advocate___________________________Phone#_______________________

Relationship___________________Support Coordinator______________Phone#_______________________

Primary physician ____Phone #______________________

Specialists____Phone #______________________

Psychiatrist ______________________Phone #_________________ Psychiatric Diagnosis_______________

Developmental Disability________________________________ Date of last complete Physical Exam _______

Allergies____ Medication Alert____________________

Medical Diagnoses

_____________________________ _____________________________ _____________________________

_____________________________ _____________________________ _____________________________

_____________________________ _____________________________ _____________________________

Immunizations current ___Yes ___No   Hepatitis vaccine ___A ___B ___Immune status ___ Carrier status

Tetanus vaccine date____________ Flu vaccine date__________

Pneumonia vaccine date _________________

Health maintenance procedures____

Medications	Purpose	Dose

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Current Medical Information and History

Problem List of past 12 months	Date	Treatment
______________________	__________	____________________________
______________________	__________	____________________________
______________________	__________	____________________________
______________________	__________	____________________________
______________________	__________	____________________________
______________________	__________	____________________________
______________________	__________	____________________________

Current Problem____

____New symptoms ____Reoccurrence

NUTRITION

Diet_________________________ Food Texture___________________Supplements ____________________

___Independent eating ___Needs supervision ___Needs some physical assistance ___ Needs total assistance

___Nutrition via tube ___Liquids only ___All nutrition

Formula and schedule_________________________________

SPECIAL NEEDS

___Vision impaired ___Hearing impaired ___Ambulatory ___Non-ambulatory

Assistive devices used

___Hearing Aid ___Glasses ___Communication device ___Wheelchair

___Walker ___Dentures ___Positioning device ___Other

___Toilets independently ___Needs assistance ___Needs a toileting schedule

___Continent of bowel and bladder ___Incontinent bladder ___Incontinent bowels

Behaviors which could interfere with treatment	Interventions
____	__________________________
____	__________________________

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Current Medical Information and History

RECENT MEDICAL HISTORY

Hospitalizations past 2 years	Date	Surgery (All known)	Date
____________________	________	____________________	________
____________________	________	____________________	________
____________________	________	____________________	________

Emergency Medical Care	Date	Treatment
____________________	________	______________________________
____________________	________	______________________________
____________________	________	______________________________

Specialist seen	Date	Reason
____________________	________	______________________________
____________________	________	______________________________
____________________	________	______________________________

Diagnostic Tests (Lab, X-ray, EKG, EEG, etc)

Test	Date	Result
____________________	________	______________________________
____________________	________	______________________________
____________________	________	______________________________

EMERGENCY CARE (If going to the emergency room fill in this section)

Primary Physician notified ___Yes ___No Specialist notified ___Yes ___No Time____________

Vital signs (if possible) Temperature___________ Pulse_____________ Respiration__________

A Diefendorf RN CDDN 2/00

Nursing Services
Just as important as the health history, the individual receiving nursing services or who may be in need of nursing supports, should have a nursing assessment completed and in his central record. In general, the nursing assessment should reflect the person's health and any influences on the person's health. Most assessments include a review of the individual's health history.

The coach will want to review the nursing assessment as a form of introduction or review to the person's needs and overall situation. This review will help clarify the types of therapeutic supports and nursing services the person needs or is receiving.

Supporting Persons with Physical and Health Care Challenges

Some individuals who receive supports and services through supported living arrangements may experience physical or health care challenges, which will need to be addressed by the coach. These challenges or conditions are often associated with the maintenance of good health and physical well being.

Some individuals may require additional support from in-home staff, as well as from nurses or therapists (e.g., physical, occupational, nutritional, speech, etc.). These services will be authorized on the support plan and should be a part of the identified provider's implementation plans.

Seizures are a common condition among persons diagnosed with a developmental disability. It will be important for the coach to be aware of the specific type of seizures the person experiences and understand their impact on the person's daily life.

Service providers who support individuals with complex challenges related to positioning, movement, eating and/or nutrition may comprise a network of supports typically referred to as "physical and nutritional management". If someone is in need of these types of supports and services, the coach might expect to see specific plans in the record (i.e., dining plan, physical management plan, therapeutic equipment plan, etc.) which address these specific needs. In addition, persons with complex health care challenges may receive supports through nursing services where a nursing care plan or health care plan might also be included in the record.

Persons with physical, nutritional, and health care supports in place may require additional support from the coach and the support coordinator to help

assure effective communication among all members of the circle of support, as well as the oversight to assure provision of these services.

Although not responsible for the coordination of services, the supported living coach should be aware of the person's needs, consistent with the additional plans. The support coordinator provides primary coordination and oversight for the health care of the individual when there are concerns or problems with implementation. As an advocate for the individual, the coach will communicate these clearly and in a timely manner with the individual/guardian/guardian advocate, support coordinator, nurse, and/or therapist.

As discussed earlier, establishing a system of communication among all parties will be essential to assuring the safety and health of the individual. Coaches should maintain a record of communications to assure that follow-up on issues and concerns are addressed in a timely manner.

Supporting Persons with Challenging Behaviors

One of the most challenging areas for supported living coaches is the assurance that adequate supports are in place for persons considered to have serious reputations or challenging behaviors. These individuals are typically persons who have "become famous" as a result of their reactions to the services they are offered.

Information obtained from coaches around the state indicates that persons with challenging behaviors do extremely well when services and supports are adjusted to address their needs and desires. Promoting choice, while important for all people, is especially important for persons who are telling us, by their actions, they want to exercise control over their own lives. Encouragement, opportunity, and careful integration into inclusive life experiences will be invaluable. As persons gain power and skills toward their desired lifestyle, they often may need less intervention.

Individuals with challenging behaviors typically access services from a behavior analyst and may have a "behavior intervention plan" in their records. These plans are extremely important to the individual's success, and all staff who interact with the individual should be trained to implement the identified procedures. Again, the coach will need to establish an effective system of communication with the behavior analyst and all staff implementing the plan to ensure its success.

Consistency among providers, settings, and routines becomes important for persons experiencing behavioral challenges. The coach and, where appropriate, in-home supports will need to work in partnership to minimize these types of stressors.

The challenge for the coach is to continue to assure that planning is centered on the individual's needs and desires (e.g., housing location, type, access to the community, etc.), and that supports are adjusted to meet those needs. Ultimately, careful planning and consideration with the individual and his circle of support will help assure the person's safety. Maintaining a balance between choice and its impact on safety will be an ongoing consideration, and one which should be addressed by the entire circle of support.

A handbook written by Michael Smull and Susan Burke Harrison entitled Supporting People with Severe Reputations in the Community, is available through the National Association of State Directors, Alexandria, Virginia (703-683-4202). This may serve as a valuable resource for coaches in supporting persons with significant reputations.

Informed Consent

'Informed consent' is a term used in the field of human services to indicate whether the person can give consent to a decision once she has the facts and information needed to make that decision. This involves the capacity to fully understand what is being consented to and its possible consequences. It also involves the capacity to make a decision and to communicate or indicate the decision of consent.

Persons who have been adjudicated incapacitated by a court or who have had a guardian advocate appointed cannot legally give informed consent; neither can some persons who have never been adjudicated incompetent. Copies of adjudications and indications where the individual cannot provide informed consent should be found in the person's central record (maintained by the support coordinator).

Obtaining this information will assist the coach in understanding what types of decision-making and communication will be necessary on the person's behalf (e.g., guardians, family members, etc.).

The physician must obtain informed consent for use of psychotropic medication, surgery, and any invasive procedure, including diagnostic procedures such as x-ray or swallow studies. The ability to give informed consent should be planned for by the coach and the circle of support.

Indication of the person's legal status regarding informed consent should be available to the support staff who may accompany the person to health care treatments or emergency services.

The support coordinator's role is to address these issues and assure that adequate supports are in place for proper health care to occur. The coach's role is to understand the person's situation, and assure proper emergency procedures are in place.

Advanced Directives

Life planning is an important part of the aging process. As we move into adulthood, most of us think about how we choose to live our lives. This process involves good planning and making some difficult decisions about how to take care of our health.

For many persons, having control over all aspects of life is extremely important. If a person does not have a guardian/guardian advocate over health care, a way of establishing control during health emergencies and long illnesses is to establish advanced directives. The supported living coach needs to be aware of the individual's advanced directives, should the need arise to inform others of the person's decision. If the person has a legal guardian or guardian advocate over health care decisions, these decisions must be made by that person.

As mentioned, understanding the person's ability to provide informed consent is the first step in determining his wishes for care, should he become incapacitated and not be able to direct the process. In instances where a guardian has legal responsibility, the guardian and the individual should make their wishes known and copies of the advanced directives should be placed in the person's central record. Staff who support the individual will need to have this information available.

Examples of the types of information that might be found in the record include the following:

Sources of Information for Advanced Directives

- Living Will
- Health Care Surrogate Designation
- Organ donor
- Guardianship

Sources of Information for Advanced Directives, continued

- DNR (Do Not Resuscitate) orders
- Pre-paid funeral expenses
- Burial/cremation services

A Living Will describes the person's desires regarding the dying process. It identifies circumstances (e.g., terminal condition, etc.) and the intention for treatment under specific circumstances. A Health Care Surrogate designation identifies persons who may provide informed consent for medical treatment and surgical and diagnostic procedures in the event the individual is determined to be incapacitated. A sample Living Will and Health Care Surrogate form, courtesy of *Partnership for Caring, Inc.* follows:

INSTRUCTIONS	
	# FLORIDA LIVING WILL
PRINT THE DATE	Declaration made this ______________ day of ______________, ________ (day) (month) (year)
PRINT YOUR NAME	I, ____, willfully and voluntarily make known my desire that my dying not be artificially prolonged under the circumstances set forth below, and I do hereby declare that:
PLEASE INITIAL EACH THAT APPLIES	If at any time I am incapacitated and __________I have a terminal condition, or __________I have an end-stage condition, or __________I am in a persistent vegetative state
	and if my attending or treating physician and another consulting physician have determined that there is no reasonable medical probability of my recovery from such condition, I direct that life-prolonging procedures be withheld or withdrawn when the application of such procedures would serve only to prolong artificially the process of dying, and that I be permitted to die naturally with only the administration of medication or the performance of any medical procedure deemed necessary to provide me with comfort care or to alleviate pain. It is my intention that this declaration be honored by my family and physician as the final expression of my legal right to refuse medical or surgical treatment and to accept the consequences for such refusal. In the event that I have been determined to be unable to provide express and informed consent regarding the withholding, withdrawal, or continuation of life-prolonging procedures, I wish to designate, as my surrogate to carry out the provisions of this declaration:
PRINT THE NAME, HOME ADDRESS AND TELEPHONE NUMBER OF YOUR SURROGATE	Name: ____ Address: ____ ____Zip Code:__________ Phone: ____
© 2000 PARTNERSHIP FOR CARING, INC.	

FLORIDA LIVING WILL (CONTINUED)

PRINT NAME, HOME ADDRESS AND TELEPHONE NUMBER OF YOUR ALTERNATE SURROGATE

I wish to designate the following person as my alternate surrogate, to carry out the provisions of this declaration should my surrogate be unwilling or unable to act on my behalf.

Name: ______________________________

Address: ______________________________

______________________________ Zip Code: __________

Phone: ______________________________

ADD PERSONAL INSTRUCTIONS (IF ANY)

Additional Instructions (optional):

SIGN THE DOCUMENT

I understand the full import of this declaration, and I am emotionally and mentally competent to make this declaration.

Signed: ______________________________

WITNESSING PROCEDURE

TWO WITNESSES MUST SIGN AND PRINT THEIR ADDRESSES

Witness 1::

Signed: ______________________________

Address: ______________________________

Witness 2:

Signed: ______________________________

Address: ______________________________

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Courtesy of **Partnership for Caring, Inc** 6/00
1620 Eye Street, NW Suite 202 Washington, DC 20006 800-989-9455

INSTRUCTIONS	
	FLORIDA DESIGNATION OF HEALTH CARE SURROGATE
PRINT YOUR NAME	Name: ______________________________ (Last) (First) (Middle Initial)
	In the event that I have been determined to be incapacitated to provide informed consent for medical treatment and surgical and diagnostic procedures, I wish to designate as my surrogate for health care decisions:
PRINT THE NAME, HOME ADDRESS AND TELEPHONE NUMBER OF YOUR SURROGATE	Name: ______________________________ Address: ______________________________ ______________________________ Zip Code: __________ Phone: ______________________________
	If my surrogate is unwilling or unable to perform his or her duties, I wish to designate as my alternate surrogate:
PRINT THE NAME, HOME ADDRESS AND TELEPHONE NUMBER OF YOUR ALTERNATE SURROGATE	Name: ______________________________ Address: ______________________________ ______________________________ Zip Code: __________ Phone: ______________________________
	I fully understand that this designation will permit my designee to make health care decisions and to provide, withhold, or withdraw consent on my behalf; to apply for public benefits to defray the cost of health care; and to authorize my admission to or transfer from a health care facility.
ADD PERSONAL INSTRUCTIONS (IF ANY)	Additional instructions (optional):
© 2000 PARTNERSHIP FOR CARING, INC.	

FLORIDA DESIGNATION OF HEALTH CARE SURROGATE (CONTINUED)

I further affirm that this designation is not being made as a condition of treatment or admission to a health care facility. I will notify and send a copy of this document to the following persons other than my surrogate, so they may know who my surrogate is:

PRINT THE NAMES AND ADDRESSES OF THOSE WHO YOU WANT TO KEEP COPIES OF THIS DOCUMENT

Name: ____________________

Address: ____________________

Name: ____________________

Address: ____________________

SIGN AND DATE THE DOCUMENT

Signed: ____________________

Date: ____________________

WITNESSING PROCEDURE

TWO WITNESSES MUST SIGN AND PRINT THEIR ADDRESSES

Witness 1:

Signed: ____________________

Address: ____________________

Witness 2:

Signed: ____________________

Address: ____________________

Courtesy of **Partnership for Caring, Inc** 6/00
1620 Eye Street, NW Suite 202 Washington, DC 20006 800-989-9455

Organ donor cards indicate the individual's desire to donate her organs upon her death. Florida has specific laws related to donorship. The person's wishes related to this topic should be documented and known to support staff.

Guardianship is a legal method used for protecting a person's rights and ensuring his health and safety. However, guardianship takes away the person's right to decide. There are many different types of guardians, and it will be important for the coach to understand the guardian's role and responsibilities related to the person's wishes and directives.

DNR **(Do Not Resuscitate)** orders are established with the physician, and identify the person's desire to not be resuscitated, should breathing or heart beat stop. Information about DNRs should be available, when established, in the record, and staff made aware of the person's desires.

Pre-paid funeral and cremation services may also be found in the person's central record. They indicate the person's wishes related to service providers.

Although this information may be difficult to process, it will be important for the coach to understand the person's wishes and assure that good planning is in place to support these outcomes.

Medication Administration/Treatments

Taking medication is a daily activity for many people. Persons with developmental disabilities typically are prescribed more medication than the general population. There are a number of concerns which surround the administration, use, and impact of medications, special techniques and treatments (e.g., multiple types and combinations of medications, testing blood sugar levels daily, etc.). These issues may affect other areas of the person's life (e.g., eating, sleeping, learning, etc.).

Medication/Treatments

The supported living coach:

- Monitors impacts of medicine/treatment on the person.
- Establishes and oversees system for documenting medication administration (Policy Directive #01-01).
- Partners with WSC to coordinate communication re: possible side effects.

Medication Policy Directive
Persons who support and live with individuals with developmental disabilities find that medications add more complexity to the daily routine. As an example, a drug which controls seizures may produce fatigue to such a degree the person is unable to stay awake.

When supports are provided for medication administration, the supported living coach assures that a system for training staff and documenting the administration of medication is in place. For the coach to assure these supports are in place, it is important that she has an understanding of the purpose, and precautions associated with the medications being used. If the individual is learning to take and order his own medication, a system for monitoring this process should also be established. When a health care professional (i.e., a nurse) is involved, the coach and in-home supports should obtain direction from that professional. Policy Directive #01-01 regarding Medication Administration and Supervision of Self–Administration of Medication provides direction and specific procedures for the provision of unlicensed staff to administer medications. Copies of this policy may be available through the District/Region Developmental Disabilities Program.

Observing for possible side effects of medications is everyone's responsibility. Thus, it is important the coach and the support coordinator work in partnership to ensure providers and, when needed, informal (unpaid) supports are aware of the medications the individual uses and their potential and identified side effects.

Sample Medication Administration Records (MARs)
Three **blank** sample medication/treatment records follow, one for medications and ongoing treatments (such as special shampoo, skin treatments, etc.), one for medications used on an as-needed (PRN) basis, and one for the authorization by the individual for self-administration of medications. (Note: If the individual is independent with medications, these forms do not apply.)

Medication/Treatment Record

Name:	Physician:	Month/year:

Medications	Time	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31

Treatments																																

Initial	Signature/Title

Allergies

PRN Medication/Treatment Record
Ordered

Start Date	Stop Date	Medication & Dose/Treatment	Route & Purpose & Special	Frequency Instructions

Administered

Start Date	Stop Date	Medication & Dose/Treatment	Reason	Results	Signature

COMMUNITY CIRCLES, INC.
SUPPORTED LIVING
AUTHORIZATION FOR ADMINISTRATION AND ASSISTANCE TO SELF-ADMINISTER MEDICATIONS

Developmental Disability Program Policy Directive #01-01 allows unlicensed supported living staff who have been trained by and have had their skills validated by a Florida registered nurse to administer or supervise the self-administration of medication by individuals. Assistance to self-administer medications may include the following activities performed by the trained, supported living staff:

If medication is kept in the original container:

1. Taking medication, in its previously dispensed, properly labeled container, from where it is stored and bringing it to the individual.
2. In the presence of the individual,
   a. reading the label and opening the container,
   b. telling the individual what amount of medication he/she should remove from the container (or in the case of inhaled medications, the number of premeasured doses to be taken, and instructions as to where the inhaler is to be used in the mouth or the nose),
   c. giving the container to the individual and observing the individual as he/she removes the medication from the container to ensure that he/she removes only the quantity of medication that is prescribed,
   d. observing the individual as he/she takes the medication,
   e. checking to make sure that the individual has actually taken the medication (i.e., that he/she has actually swallowed the medication), and
   f. closing the container.
3. Assisting in the application of topical medications.
4. Assisting in the placement of a patch by which medication is administered.
5. Assessing whether the individual is properly self-administering oral or nasal inhaler medication.
6. Returning the medication to proper storage.
7. Keeping a record of when supervision of self-administration of medication occurs. That record should include the individual's name, date, time, dosage, name of medication, and signature of person supervising the self-administration.

If the individual uses a pill reminder container:

1. Where appropriate, observing the individual place medications in his weekly pill reminder container, and providing direction as to which pill should be placed in the weekly pill reminder container, and in what quantities.
2. Locating the weekly pill container, which should be maintained in a safe location within the home.
3. Opening the correct slot in the weekly pill reminder container, and providing verbal instructions to the individual as to which pill or pills should be taken at that time.
4. Observing the individual take the medication, and checking afterward to be sure that the medication has actually been swallowed.
5. Closing the weekly pill reminder container.

6. Returning the weekly pill reminder container to its safe location.
7. Keeping a record of when supervision of self-administration of medication occurs. That record should include the individual's name, date, time, dosage, name of medication, and signature of person supervising the self-administration.

Developmental Disability Program Policy Directive #01-01 also allows unlicensed Supported living staff who have been trained and have had their skills validated by a Florida registered nurse to administer medication to individuals with whom they have an ongoing relationship. Supported living staff may administer medications under the following circumstances:

1. Supported living staff may only administer prescription medications, which are prescribed on a "PRN" or as needed basis and which meet the criteria specified in the December 4, 2002 amendment to Policy Directive #01-01 regarding the administration of PRN medications.

2. Supported living staff may not administer prescription medications by injection.

3. Supported Living staff may administer nebulizer treatments according to the March 10, 2004 amendment to Policy Directive #01-01.

Y I have been informed of this policy and consent to have trained, unlicensed supported living coaches who have an ongoing relationship with me provide me with assistance in self-administering my medications.

Y I have been informed of this policy and consent to have trained unlicensed supported living coaches who have an ongoing relationship with me to administer my medications to me.

Y I have been informed of this policy and wish to administer my medications independently without assistance from supported living staff.

Y I have been informed of this policy and wish to have someone other than my supported living staff provide me with assistance in self-administering my medications or administering my medications to me.
Name of designated trained individual: ______________________________

Y I do not currently take prescription medication and do not need my supported living staff to provide me with assistance in self-administering my medications or administering my medications to me at this time.

______________________________ ______________________
Consumer Signature Date

______________________________ ______________________
Guardian Signature Date

Abuse, Neglect, and Exploitation

In accordance with Chapter 415.1034, F.S., all providers supporting persons with developmental disabilities and their employees must follow procedures for reporting abuse, neglect and exploitation. The law states that anyone who knows, or has reasonable cause to suspect that someone is being abused, neglected or exploited, should immediately report such information to the central abuse registry and tracking system, using the statewide toll-free telephone number (1-800-96ABUSE or 1-800-962-2873).

Requirements Related to Abuse, Neglect, and Exploitation

Supported living coach must:

- Develop and implement policy regarding rights and responsibilities of persons receiving services.
- Develop and implement policies and procedures for reporting.
- Maintain validation that abuse training has been provided to each employee.
- Maintain evidence that training regarding abuse, neglect, and exploitation has been provided to individuals receiving services and their family/guardian.
- Maintain documented incident reports in a separate file.

Supported living providers, like all Medicaid Waiver providers, must ensure, consistent with the Core Assurances outlined in the Medicaid Waiver Services Agreement, that processes are in place to protect individuals from abuse, neglect, and exploitation. Specifically, the provider must outline policies and procedures regarding the rights and responsibilities of persons receiving services, and procedures for reporting abuse as outlined in Florida Statutes.

Verification that all employees have received the specific training required to report abuse, neglect, and exploitation must be maintained in provider records for each employee. This training documentation should include the topic, length of training session, date and location of training, name and signature of trainer, and name and signature of person(s) in attendance. Additional documentation will be necessary for proof that abuse training and information has been provided to individuals receiving services and their families.

The Abuse Registry encourages individuals to report abuse via the Hotline. In some instances, the call must be followed-up with submission of a written

report. Each District/Region maintains forms for reporting significant events or unusual incidents, including abuse, neglect, and exploitation.

Liability Concerns

Supporting people to live in their own homes is not a structured and controlled, routine business. It places the supported living provider into the real life challenges of an occasionally chaotic and "messy" world. Many providers of supports and services have questions about legal liability. What if a person in supported living is injured or comes to harm? Who is liable? Will someone be sued? Unfortunately, there are no clear-cut answers to these questions.

The issue of legal liability depends on many circumstances and can only be addressed through an examination of individual situations. However, there are ways to demonstrate that a reasonable professional standard has been followed in the provision of supports and services. The following are some suggestions made by Legal Counsel, consulted by the original Supported Living Project, for the former Department of Health and Rehabilitative Services.

Liability

- Informed consent for supported living services should be obtained and documented.
- Supported Living Coach (SLC) provider should have functional assessments that show how training and assistance (including the intensity of support) were identified.
- Supports should be provided as authorized by the Support Plan.
- SLC maintains documentation:
  - When an individual's decision appears to not be in his best interest.
  - Verifying that alternative choices have been offered.
  - Justifying any intervention that prevents him following through on his decision.

It may, at times, seem challenging to balance liability concerns with the rights of the individual to take risks. People need to make and have informed choices. It is the responsibility of all involved (i.e., the network of supports, the support coordinator, and the supported living coach) to respect the person's right to choose, and to provide the information and counseling necessary to assure the choice is an informed one. All possible consequences and/or outcomes of a decision should be explained.

There is value in taking risks. The dignity of risk taking is a characteristic that has social value. Risks are a natural aspect of the human experience, and are integral to the world.

Risk taking can be mitigated with careful planning and a stable support network. Supported living coaches must balance the need to exert external control and provide an appropriate amount of advice for persons with challenging behaviors. Potentially harmful choices and behavior may require specific interventions, as discussed previously in this chapter.

Choice and behavior that may result in harm to the person or others should not be ignored. The coach should carefully consider the following when planning interventions, supporting informed choice, and the dignity of risk:

Informed Choice/Risk-Taking

The coach should consider:

- Do I have consent of the person with legal authority over this situation?
- History - What is the person's previous experience in making decisions, and ability to learn from experience?
- Consequences - What's the worst-case scenario?
- Control- Does the person have low self-esteem? Is the person dependent on staff or family or the system?
- Safeguard - Can the person advocate for his rights? Is it appropriate for an advocate to represent him?

The least intrusive means of support is the best means of support. Each situation and occurrence should be handled individually. The supported living coach should seek out advice, and consult with the person's circle of support. It is critical that communication remains open and fluid. In cases of extreme emergencies, such as an individual's arrest, the supported living coach and waiver support coordinator must be immediately notified.

Every human being has the right to learn from her mistakes, and to likewise achieve success and enjoy the self-worth and dignity won from her victories.

Remember: The best way to reduce risk is through careful planning and coordination, provision of adequate supports tailored to individual needs, use of common sense and good judgment, and a person's establishment of a solid network of natural support in the community.

In essence, when quality supports and services are provided, documented, and verified, litigation and liability potentials are minimized. As in "Andy's" situation, referenced in Chapter One, when supports are adequately and appropriately provided, supported living results in profound changes in all aspects of a person's well being. In order to achieve a standard of excellence, internal monitoring and self-assessment are key.

Chapter Summary

In order to support success, consideration must be given to the person's daily health, safety and security. Open, ongoing communication, both formal and informal, among all involved is critical to assuring that potential crises are averted. The supported living coach plans for everyday emergencies and natural disasters, and is fully familiar with the person's current and past medical history.

Documents related to informed consent and advanced directives are carefully followed and made available, along with relevant medical information, in the person's record. Any unique requirements of persons with physical and health challenges, and those with challenging behaviors are monitored, along with medication administration. The supported living coach is also informed regarding applicable laws related to abuse, neglect and exploitation. Finally, the coach balances his personal liability concerns with the person's right to make informed decisions and take risks.

With success assured, the coach continually stays focused on enhancing the quality of service. Chapter Eight focuses on the requirements and methods surrounding quality enhancement.

Chapter Eight
Enhancing Quality

What You Will Find:

Quality is not an Option

Self Assessment

Timetable for Requirements

Support Coordinator's Responsibilities

Getting Organized

Annual Quality Reviews

Monitoring Protocol

Tips For Preparing for the Annual Review

Satisfaction Surveys

Dissatisfaction

Personal Outcome Measures

Chapter Eight: Enhancing Quality

Supported living is about individual choice, control, respect, personalized supports, and valued relationships. Procedurally, approaches to planning and organization differ dramatically from a traditional service delivery system.

> **"Quality is not an option."**
>
> Courtesy of Ann Millan

Excellence is frequently synonymous with 'quality.' When working with people and supporting them through life changes, anything less than excellence might be considered mediocrity or even failure.

Individualization, flexibility and fine tuning of services in response to life circumstances, distingushes supported living apart from many other service options. One of the greatest challenges for a supported living provider is to remain focused on one person at a time. Maintaining quality over time, both at the individual and procedural levels, requires continual self-examination and improvement practices.

Because people utilizing various supported living services live in their own homes and not in licensed state or provider owned housing, they experience increased opportunities to exercise personal control. It is challenging to monitor service provision without intruding or interfering in the person's life. The supported living coach must find ways to balance the right to privacy with the obligation to ensure services are delivered in a manner that provides for the health, safety and security of the individual.

Supported living represents a significant departure from the way residential services and supports have been provided in congregate settings such as institutions or group homes. Quality enhancement activities for these licensed facilities have typically meant structured reviews by people who may be strangers to the person receiving services. Unfortunately, the most intimate details of someone's life have sometimes been examined in ways that did not recognize his right to dignity and privacy. In supported living, quality enhancement activities involve not only the coach and the individual receiving

services, but also her circle of support, including family, other providers, friends, neighbors, and anyone else the person chooses.

In the past:

Quality enhancement (assurance) meant preparation and involvement in annual surveys by the funding agency.

Quality assurance has traditionally consisted of a review of services provided during the previous year. By then, quality services either have or have not occured. Enhancement means thinking about the effectiveness of services on a daily basis. The word 'enhancement' is used to describe the process of movement toward quality. Assurance, as in 'quality assurance,' by definition promotes an intent or a pledge toward improvement.

Enhancement activities are those daily interactions which occur in the person's home or associated community setting, including neighborhoods, businesses, employment, etc. They may include learning new things, opportunities for growth, establishing daily routines, spending time with friends and acquaintances, maintaining health and wellness, etc.

Support Coordinator's Responsibilities Regarding Quality: Partnering with the Supported Living Coach

As mentioned, a variety of individuals are involved to assure the individual is receiving quality supports and services. The support coordinator is responsible for reviewing all supports and services received, including supported living services. The support coordinator can be a valuable asset in the quality enhancement process.

"Regulations and oversight cannot take the place of common sense and good judgment."

The Support Coordination Guidebook, Florida Developmental Services Program Office, July 2002.

The support coordinator, along with the supported living coach, has specific responsibilities for monitoring the health and safety of individuals utilizing supported living services. These include:

Review of Housing Survey:
After the supported living coach has assisted the individual in locating a home, as discussed, the support coordinator will review the housing survey forwarded by the supported living provider to determine if the proposed home meets eligibility guidelines. If repairs or other corrections are required, the support coordinator may give conditional approval of the residence; however, all unacceptable conditions must be corrected before the individual takes up residence. The housing survey is updated annually or any time there is a change in residence or a significant change to the existing home, by the provider and individual, with a copy of the update provided to the support coordinator. A sample format was provided previously in this *'Guide'*.

Monthly Contact:
The support coordinator should have monthly face-to-face contact with the individual in supported living. This monthly contact may be initiated by either the support coordinator or the individual, and may occur within a variety of settings (e.g., day program, restaurant, etc.). Should any issues arise as a result of this contact, the support coordinator should contact the coach and initiate appropriate follow-up. After a specified period of time, the support coordinator should contact the coach to verify the issue has been resolved.

Quarterly Home Visits:
Quarterly, at least one of the monthly face-to-face contacts should be conducted in the person's home. The support coordinator should make quarterly home visits, at mutually agreed upon and pre-arranged times. The purpose of these visits is to review the housing survey updates to ensure that the residence continues to meet basic health and safety standards, to interview the supported living provider and individual to determine if the supported living services identified on the support plan are being implemented as authorized, and to review the overall support network to determine if any changes are needed.

A review of the individual's need for a subsidy to meet living expenses should also be evaluated. In addition, if the supported living coach serves as the individual's fiscal agent, appropriate financial documents should be examined. Results will be shared with the supported living provider and the designated District/Region Developmental Disabilities Program staff person responsible for supported living. If issues are identified that require follow-up by the coach, the support coordinator should contact the coach to verify the appropriate actions have been taken.

Follow-up on Unresolved Issues:
The support coordinator must notify the coach's supervisor and/or the District/Region Developmental Disabilities Program if the coach does not respond to issues identified through monthly contacts or quarterly home visits, if subsequent monitoring reveals a repetition of the same issues, or if it appears that issues are not being addressed effectively by the coach.

Examples of quarterly formats are provided in the pages that follow. These forms are neither required nor prescribed, but are offered as examples for documenting quarterly requirements conducted with the support coordinator.

- A "Quarterly Home, Safety, and Health Review" is provided courtesy of Community Circles, Inc., to address the quarterly review of the person's home.
- A "Supported Living Quarterly Meeting Worksheet" is provided courtesy of Habilitative Services, Inc., of North Florida which addresses documentation of the quarterly meeting requirements with the WSC.

QUARTERLY HOME, SAFETY, AND HEALTH REVIEW

Name:		
Address:		
City:	State:	Zip:
Phone:	Email:	

Support Coordinator:		
Agency:		
Address:		
City:	State:	Zip:
Phone:	Fax:	

Date of Review:

1. The neighborhood is free of disturbing noises, reverberations, and health hazards such as adverse environmental conditions, dangerous walks and steps, instability, flooding, poor drainage, septic tank back ups, sewage hazards or mudslides, abnormal air pollution, smoke or dust, excessive accumulation of trash, vermin or rodent infestation, or fire hazards. **Y N N/A**

2. No danger of tripping in stairways, halls, porches, or walkways. **Y N N/A**

3. Residence is free of vermin, rodents, or insect infestations. **Y N N/A**

4. Residence is free of maintenance issue such as leaky roof, loose doorknobs, torn screens, etc. No major defects in walls, ceiling, or floors (floors do not move when walking) **Y N N/A**

5. Residence is free of unpleasant odors such as urine, sewage, or molds. **Y N N/A**

6. There are no visible safety hazards such as empty light sockets, frayed electric cords, discoloration or exposed wires at electrical outlets, or excessive use of extension cords. **Y N N/A**

7. If dwelling was built before 1978 and houses children 7 years or younger, there has been an inspection for lead-based paints. **Y N N/A**

QUARTERLY HOME SAFETY, AND HEALTH REVIEW, Page Two
Consumer Name:

Date of Review:

8. Doors open, latch, and lock properly. Exterior doors have deadbolts. Locks that are present can be easily manipulated by the consumer. **Y N N/A**

9. There is at least one window in each living and sleeping area. Windows have screens and locks that are easily manipulated by the consumer. Windows have adequate coverings to provide privacy when needed. **Y N N/A**

10. Bathroom has at least one opening window or exhaust fan. **Y N N/A**

11. Floor coverings are appropriate, acceptable, and safe (there is no danger of tripping). **Y N N/A**

12. There are at least two electrical outlets (one can be overhead) in the living area, kitchen, and each bedroom. **Y N N/A**

13. There is a ceiling or wall mounted light fixture in the kitchen and bathroom. **Y N N/A**

14. There is adequate lighting throughout the residence to carry out normal activities. **Y N N/A**

15. There is adequate and functional heating and cooling with adequate ventilation (unvented room heaters that burn gas, oil, or kerosene are not acceptable). **Y N N/A**

16. The residence is free of dangerous levels of air pollution from carbon monoxide, sewer gas, fuel gas, dust, etc. **Y N N/A**

17. Plumbing is in good working order with a flush toilet in a private bathroom with a fixed basin and tub or shower, both with hot (not over 120 degrees F) and cold water. Kitchen sink is present with both hot (not over 120 degrees F) and cold water. **Y N N/A**

18. Water supply is free of contaminates. **Y N N/A**

19. Non skid surfaces are present in all bath tubs and showers stall floors. If tub/shower does not have a non-skid surface, removable rubber mats or adhesive strips are acceptable. **Y N N/A**

20. If appropriate, grab bars are mounted in appropriate locations. **Y N N/A**

QUARTERLY HOME SAFETY, AND HEALTH REVIEW, Page Three
Consumer Name:

Date of Review:

21. Kitchen has suitable space to store, prepare, and serve food in a sanitary manner. Stove and refrigerator are present and in working condition (all burners on gas stove function, pilot lights are lit, and no gas odor is present). **Y N N/A**

22. Garbage can/bin is present. **Y N N/A**

23. First aid kit is complete and available. **Y N N/A**

24. At least one smoke detector is mounted in an appropriate place and functions. **Y N N/A**

25. A portable fire extinguisher is located in the kitchen and consumer can demonstrate knowledge and ability to use it. **Y N N/A**

26. Consumer can identify closest fire exit and alternative exit and can identify procedures to follow in case of a fire. **Y N N/A**

27. Consumer has a plan in place to deal with hurricanes and other natural disasters. **Y N N/A**

28. Consumer has emergency numbers readily accessible. **Y N N/A**

29. Review with consumer "Notice of On Call System" form. **Y N N/A**

30. Consumer has emergency numbers readily accessible. **Y N N/A**

31. Review with consumer "Grievance Procedure" form. **Y N N/A**

32. Consumer expresses satisfaction with service as currently provided. **Y N N/A**

Provide and explanation of an "N/A" responses:

QUARTERLY HOME SAFETY, AND HEALTH REVIEW, Page Four
Consumer Name:

Date of Review:

Provide an explanation of "No" responses. Include specific plan to address with target completion date:

CURRENT MEDICAL PROVIDERS:
(Provide address and contact information for new providers only.)

Physician:

Specialty:

Address:

City:	State:	Zip Code:

Phone:	Fax:

QUARTERLY HOME SAFETY, AND HEALTH REVIEW, Page Five
Consumer Name:

Date of Review:

CURRENT MEDICAL PROVIDERS (CONTINUED):

(Provide address and contact information for new providers only.)

Physician:		
Specialty:		
Address:		
City:	State:	Zip:
Phone:	FAX:	

Physician:		
Specialty:		
Address:		
City:	State:	Zip:
Phone:	FAX:	

Physician:		
Specialty:		
Address:		
City:	State:	Zip:
Phone:	FAX:	

CURRENT MEDICATIONS:

Name:	Dosage:	Frequency:
Prescribing Physician:		
Reason for medication:		

Name:	Dosage:	Frequency:
Prescribing Physician:		
Reason for medication:		

QUARTERLY HOME SAFETY, AND HEALTH REVIEW, Page Six
Consumer Name:

Date of Review:

Name:	Dosage:	Frequency:
Prescribing Physician:		
Reason for medication:		

Name:	Dosage:	Frequency:
Prescribing Physician:		
Reason for medication:		

Name:	Dosage:	Frequency:
Prescribing Physician:		
Reason for medication:		

(Provide address and contact information for pharmacist only if new provider.)

Pharmacist:		
Pharmacy:		
Address:		
City	State:	Zip:
Phone:	FAX:	

MEDICAL VISITS:

Examinations:	Recommended Frequency	Last Appointment	Next Appointment
Physical:	Annual		
Dental:	Semi-Annual		
Eye Exam:	Annual **(Bi-annual if no glasses)**		
Tetanus:	Every 10 years		
Prostrate (Male):	Annual		
Pap Test (Female)	Annual		
Mamogram (Female):	Annual		

QUARTERLY HOME SAFETY, AND HEALTH REVIEW, Page Seven Consumer Name:

Date of Review:

MEDICAL VISITS (Continued):

Other Examinations:	Date	Reason for Visit:

RELATIONSHIP MAP (USE OF NATURAL AND GENERIC SUPPORTS):

Name:	Relationship:
Address:	Phone:
Type of Support:	

Name:	Relationship:
Address:	Phone:
Type of Support:	

Name:	Relationship:
Address:	
Type of Support:	

Name:	Relationship:
Address:	Phone:
Type of Support:	

Name:	Relationship:
Address:	Phone:
Type of Support:	

SL Coach Signature/Date:
Consumer Signature/Date:

SUPPORTED LIVING QUARTERLY MEETING WORKSHEET

INDIVIDUAL'S NAME ______________________________ DATE ______________

PRESENT AT REVIEW: ______________________________

____

____

REVIEW OF SERVICES (Support Coordinator initial)

_______ Supported Living Coaching Services are being carried out as identified on the Support Plan.

_______ Services and supports relate directly and positively to the goals the individual wishes to achieve and the individual's identified needs.

_______ Services are being carried out as specified on the implementation plan.

_______ The current level of supports appear to be adequate to meet the individual's needs.

NOTES: ______________________________

____

____

REVIEW OF IMPLEMENTATION PLAN (Supported Living Specialist initial)

_______ Strategy for addressing home, health and community safety needs has been followed.

_______ Supports are being provided as specified on the implementation plan.

_______ Training is being provided as specified on the implementation plan.

_______ Progress (or lack thereof) toward achieving success in training goals has been noted (and dated) on the implementation plan.

_______ Personal goals are being pursued as specified on the implementation plan.

_______ Progress (or lack thereof) toward achieving personal goals has been noted (and dated) on the implementation plan.

_______ The implementation plan has been reviewed with the individual and/or family/guardian to determine if changes in program direction and/or the implementation plan are needed.

_______ Yes_______ No (If yes, note the date of the changes on the implementation plan.)

_______ Strategy for use of natural and generic supports is current.

_______ Financial profile has been updated and subsidy agreement reviewed.

NOTES: ______________________________

____

____

HOUSING SURVEY UPDATE (☒)

Produced for the Florida Developmental Disabilities Council
By Program Design, Inc. 5/03

_______ Lease in individual's file is current and individual's name is on the lease/mortgage.

_______ The dwelling remains located in an area in which persons with disabilities account for no more than 10 percent of the houses or 10 percent of the units in an apartment complex.

_______ Flush toilet in separate bathroom, in working condition

_______ Fixed basin with hot & cold water, in working condition

_______ Shower or tub with hot & cold water, in working condition

_______ Bathroom has at least one opening window or exhaust ventilation

_______ Water from hot water heater not more than 120°F

_______ Non-skid surfaces are present in all bath tubs and shower stall floors. (Removable rubber mats or adhesive strips are acceptable.)

_______ Suitable place to store, prepare, & serve food in sanitary manner

_______ Garbage can / bin

_______ Stove or range of appropriate size, in operating condition

_______ Refrigerator of appropriate size, in operating condition

_______ Kitchen sink with hot & cold water

_______ A portable fire extinguisher is located in kitchen

_______ Sink drains into approved public or private system

_______ Separate living room & at least one bedroom

_______ Safe heating & cooling that reaches all rooms (unvented room heaters that burn gas, oil, kerosene not acceptable)

_______ One operative window in each living & sleeping room

_______ Window dressings are adequate to maintain privacy

_______ Doors & windows functional & lockable

_______ Locks can be easily manipulated by the individual

_______ A ceiling or wall light fixture in bathroom & kitchen

_______ Adequate lighting to carry out normal activities

_______ At least two electric outlets in the living area, kitchen, & each bedroom

_______ At least one smoke detector is mounted in an appropriate location and functions (fresh batteries!)

_______ No serious defects in interior / exterior walls, ceiling, or floor; floor should not move when walking

_______ No visible safety hazards are apparent, including empty light sockets, frayed cords or wires, or discoloration around electrical sockets

_______ Roof structure is firm

_______ No danger of tripping in stairways, halls, porches, walkways

_______ Free of dangerous levels of air pollution from carbon monoxide, sewer gas, fuel gas, dust, etc.

_______ Air circulation adequate throughout

_______ Water supply free of contamination

_______ Alternate means (doorway for individuals using a wheelchair) of escape available in case of fire

_______ Handicap facilities are available and accessible for individuals using a wheelchair

_______ If required, grab bars are mounted in appropriate locations

_______ Free of lead base paint

_______ Elevator in safe, operating condition (if applicable)

_______ Free of vermin and rodent infestation

_______ Neighborhood free of health hazards such as dangerous walks & steps, poor drainage, sewage hazards, abnormal air pollution, excessive accumulation of trash, vermin or rodent infestation, or fire hazards

_______ Unit able to be used freely & maintained without unauthorized use by other individuals

_______ Dryer lint filter is clean & individual reminded to check after every use

NOTES: ____

____

HEALTH AND SAFETY REVIEW (☒)

_______ 24- Hour Pager Use Reviewed / Verified

_______ Fire evacuation reviewed

_______ Use of fire extinguisher reviewed

_______ First aid and hurricane/disaster kits complete

_______ Disaster evacuation procedures reviewed

_______ Seasonal weather precautions reviewed

_______ Pedestrian safety reviewed

_______ Bicycle safety reviewed

_______ Medication interaction precautions reviewed

NOTES: ____

____

FISCAL AGENT REVIEW (Support Coordinator initial)

_______ Checkbook/passbook reviewed and initialed by Support Coordinator

_______ Bank statements reviewed by Support Coordinator

_______ Cash bag, receipts, and journal reviewed and journal initialed by Support Coordinator

NOTES: ____

____

____

MISCELLANEOUS REVIEWS/UPDATES (Supported Living Coach Initial)

_______ All information on consumer profile is current

_______ Individual reminded of Due Process Rights, grievance procedures, right to select services providers, right to be present for all staffings and meetings concerning them, right of informed choices, right to confidentiality, and right to be treated according to Bill of Rights for Adults with Developmental Disabilities.

_______ Individual reminded of abuse reporting procedures (1-800-96-ABUSE).

NOTES: ____

____

____

SIGNATURES:

Support Coordinator ____

SL Coach ____

Individual or Guardian ____

Courtesy of Habilitative Service of North Florida, Inc.

> **"If you're not getting it done or making progress, let someone else try."** Ryan Krampitz

Supported living coaches are responsible for organizing supports and services around a series of individualized quality enhancement activities. Quality assurance and enhancement must be personalized to address the person's overall wellness, safety, happiness, training, opportunities, and satisfaction with supports and services. Thus, quality assurance of supported living services must include at least two basic components:

- The review and analysis of the projected service outcomes, enhancement services, and supports being delivered (as identified in the DS Waiver handbook); and
- The development, implementation, and oversight of basic health and safety measures.

Continuous Quality Improvement

Culture of Excellence:

- **Ongoing Quality Enhancement**
  - Plan
  - Implement
  - Assess
  - Modify/Train
- **Mutual Support**
- **Celebrate Success!**
  - Agency
  - Staff
  - Individual

Any quality business regularly reviews its business plan and provides a self-assessment of the services provided. As discussed, self-assessment is a requirement of supported living coaching providers. Developing a climate of ongoing self-assessment, in which agency and individual staff successes are celebrated, staff are mutually supportive, and problems are identified and readily corrected, can result in a culture of excellence.

In addition, ongoing meetings and individual evaluations in which success, as well as concerns, are discussed can be beneficial. This information assists in identifying procedural strengths, areas for improvement, and unmet training and instructional needs.

Effective supported living providers meet challenges posed by the ever-changing reality of people's lives, through flexibility and perseverance. At the same time, they meet the requirements of system processes. In other words, they work like a winning team, applying skills in timely ways while following the rules.

When utilized effectively, system processes can provide a framework through which supports can be individually identified, effectively provided, fully analyzed, modified for improvement, and monitored appropriately. In doing so, people's lives are greatly enhanced - not just those who achieve personal dignity and rights via supported living arrangements, but also those who may, for the first time, gain the opportunity to meet the "newcomer," and benefit from his or her participation in the community.

Self-Assessment

By establishing systems that consistently involve ongoing oversight and analysis, individuals are more likely to receive services as envisioned on the support plan and thus experience increased satisfaction. Systems for ensuring quality must contribute to improved services and supports. The method for determining this level of quality is self-assessment.

Self-assessment, required annually, reviews:

- organizational capabilities required to meet the person's outcomes or goals;
- service requirements identified in the DS Waiver handbook; and
- the provider's policies and procedures by identifying the extent to which they are consistent with daily practice.

All providers are required to conduct self-assessments. This annual assessment, according to the Core Assurances for Providers (found on the Delmarva Web Site at http://www.dfmc-florida.org, select: Public Site; select: Provider Resources, select: Review Tools Download) will assist in determining the extent to which the provider is developing and maintaining person-centered processes. Maintaining these processes will assist the individual in achieving personal outcomes or goals, choice, social inclusion, relationships, rights, dignity, respect, health, security and satisfaction.

Self-assessment surveys include an annual review of:

- individual records;
- interviews to determine if provider actions support achievement of personal goals; and
- annual satisfaction surveys.

Based on the results of a review of records, interviews, and satisfaction surveys, the supported living provider develops a Quality Improvement Plan, addressing those areas identified as needing improvement. The Quality Improvement Plan and the Self-Assessment are reviewed during the annual suvey conducted by the provider, as identified in the statewide quality assurance program. A sample "Self Assessment Records Review" form is provided on the following page.

SELF-ASSESSMENT RECORDS REVIEW

Customer Name:____ Date:______________

SERVICE:____ WSC:__________________

RECORDS REVIEWED BY:____

Directions: Score a plus (+) when the requirement is present. Score a minus (-) when the requirement is not present. All minuses should be corrected in order to be in compliance with the requirements for audit and billing of the Medicaid Waiver Services Agreement.

- ❑ An individual record is maintained for the customer
- ❑ There is a current support plan on file (at a minimum, the page of the support plan related to the service being provided.)
- ❑ There is current service authorization in the file
- ❑ There is a current release of information which is specific to whom the information is being provided, and is time limited
- ❑ Demographic information is complete and current
- ❑ Emergency contact information is complete and current
- ❑ All activity is clearly documented in the daily progress notes which contain all required elements
- ❑ There is an annual report which includes:
  - ❑ objective, fact based information on the individual's progress toward meeting previous years outcomes
  - ❑ subjective information and opinions
  - ❑ recommendations for the coming year
  - ❑ there is documentation that the annual report was given to the support coordinator and to the individual/guardian within 30 calendar days before the end of each support plan year.
- ❑ There is a current implementation plan which contains:
  - ❑ name, address and contact information of individual served
  - ❑ goal from the support plan that the service will address
  - ❑ strategies employed to help the person in meeting support plan goals
  - ❑ system to be used for data collection and assessing the individual's progress
  - ❑ the frequency of supported living coaching services
  - ❑ how home, health and community safety needs will be addressed and the supports needed to meet these needs
  - ❑ the method for accessing the provider 24 hours per day, seven days a week for emergency assistance
  - ❑ a description of how natural/generic supports will be used
  - ❑ strategies for helping the person in money management
- ❑ There is evidence that the implementation plan was submitted with the first full month of billing or within 30 calendar days of the effective date of the service authorization
  - ❑ The supporting documents are submitted to the waiver support coordinator prior to billing
  - ❑ All documentation has been filed prior to billing
  - ❑ There is a completed functional assessment with annual updates

- ❑ The service provider meets the definition as described in the Medicaid coverage and limitations handbook
- ❑ There is a housing survey in each file, which was forwarded to the WSC within 10 days of selection of housing
- ❑ Updates to the housing survey have been conducted quarterly
- ❑ Copy of initial financial profile is in the file, which was submitted to the support coordinator within 10 days of selection of housing
- ❑ Copy of individual financial profile was submitted to the support coordinator prior to the lease being signed if the person needed a subsidy
- ❑ Copy of lease/mortgage is in the file as proof that individual rents/owns his/her own home
- ❑ Copy of the annual satisfaction survey is in file
- ❑ Proof that the copy of the annual satisfaction survey was sent to WSC
- ❑ Copy of signed grievance procedure is in file
- ❑ Documentation of the quarterly meeting is in the file

Getting Organized

When it comes to quality services, there are really two things the supported living provider should remember:

Quality Services Come from Two Places:

- **Implementation of personal goals identified on the SP, and**
- **Assurance that all requirements, as identified, are met.**

Completion of the required documentation will not, by itself, constitute a quality enhancement review. An *analysis* of the information gathered for documentation; along with input from others, including other service providers involved with the individual; observations of the person across a variety of settings; reviews of progress toward personal goals, record reviews including health summaries; medication administration records, incident reports, etc.; meetings with the circle of support when necessary; the results of satisfaction surveys; and interviews with the individual involving satisfaction and the attainment of personal outcomes and/or goals, will support an effective system of quality review for enhancement activities.

Using the information obtained with and for the individual and the required documentation throughout the year, the resulting products should be the required Self-Assessment and the Quality Improvement Plan. These two documents validate the provider's efforts at quality enhancement and self improvement.

Being organized not only helps to assure quality services are being provided, but also assures that a mechanism is in place, through which the coach may periodically assess the effectiveness of his quality review system. For example, the coach may explore the effectiveness of the established communication system to determine whether the information is accurate and getting to all who need to know; he may evaluate his methods for assessing the consumer's satisfaction with supported living services if observations of the individual's behavior are not consistent with satisfaction survey results, etc.

A simple quote to remember relates to organizing and maintaining systems:

"It doesn't matter so much how you get organized, just that you stay organized."

Author Unknown

An effective supported living coach works hard at meeting the requirements as outlined by the State and Federal Government, while supporting persons in moving toward their desires as outlined by the support plan. All quality enhancement systems should reflect both aspects.

Timetable for Keeping Up with Documentation

Self-assessment activities (i.e., record reviews, interviews and satisfaction surveys) are most effective when incorporated into the coach's routines associated with service delivery. Although the components of self-assessment are required annually, it is recommended that they be completed on an ongoing basis, as part of routine responsibilities.

Quality reviews of services should occur on an as-needed, daily, weekly, monthly, quarterly, and annual basis implementing the requirements outlined by the DS Waiver handbook.

As a summary of all required documentation, the following "Timetable for Documentation Requirements" provides a chronological perspective for all requirements. This timetable may be helpful as a reminder to the coach as she assures her paperwork is in place. The following is adapted from the "Time Table for Supported Living Documentation," courtesy of Habilitative Services of North Florida, Inc.

Timetable for Documentation Requirements

Annual Documents:

- **Support Plan** (SP)- Completed by the support coordinator. Current copies must be kept in the individual's record maintained by the supported living provider.

- **Service Authorization**- Form received from the support coordinator providing legal authorization for funding. A copy must be kept in the coach's file on the individual. Services should not begin until the service authorization is received.

- **Functional Community Assessment**- An assessment of the individual's skills and capabilities with regard to living in a community setting. It identifies instruction and assistance that will be needed. The FCA must be completed within 30 days of service provision and updated annually.

- **Implementation Plan**- Developed within 30 days of service authorization and annually thereafter. It's reviewed quarterly and updated as changes are needed/requested. Used to assess the individual's progress toward goals outlined within the support plan. Developed by the coach, it also identifies strategies and approaches for implementation of services.

- **Annual Report**- A written report documenting progress toward support plan goals. Sent to the support coordinator 30 days prior to the support plan end date.

- **Individual Financial Profile** (IFP)- Analysis of the household costs and revenue needed to assure a balanced monthly budget. This profile is needed quarterly if the individual receives a stipend. The IFP is initially developed and sent to the WSC within 10 days of housing selection and before signing a lease.

- **Release of Confidential Information**- Release format to be signed by the person receiving services that allows the coach to share information with others. The form should be specific as to which information can be shared and with whom. This form is usually valid for one year, and can be signed at the time of the annual support plan meeting. The form should be developed by the coach, and may be updated as needed throughout the year and consistent with HIPAA Privacy Rule.

- **Grievance Procedure**- Evidence, usually by signature on a designated form, that the provider's grievance policies and procedures related to what the individual can do if he is not satisfied with services has been explained to the individual. These must be updated annually.

- **Satisfaction Survey**- A survey designed to evaluate the person's satisfaction with supported living services. The survey is developed by the supported living provider and disseminated to persons for whom supported living services are being provided. Copies are maintained in the individual's record and a copy forwarded to the support coordinator for review.

- **Consent to Hold Checkbook/Passbook** (for coaches who provide **fiscal agent services** only)- Evidence the individual or his guardian has given the coach permission to maintain his checkbook. The form is usually signed at the beginning of the support plan year. The need to hold a checkbook or passbook should be reviewed quarterly.

- **Performance Data on District/Regional Projected Service Outcomes** – Goals used to determine, through monitoring and review, the effectiveness of service provision. Outcomes should be measured considering individual skills and circumstances. Topics include evidence the individual:

    - is the lessee or owner of his home;
    - lives with no more than two others with developmental disabilites;
    - demonstrates an increase in abilities, self-sufficiency, and changes in his life consistent with support plan goals;
    - achieves an increased level of community inclusion; and
    - maximizes freedom of choice in all areas of his life, as evidenced by setting personal goals, being informed about service options and making all possible decisions with regard to the conduct of his life.

- **Copy of Lease** – A current copy of the person's lease should be maintained in the record. If the person is purchasing his own home, verification should also be maintained.

Quarterly Documents:

- **Quarterly Meeting Notes**-The supported living coach maintains the results of required **quarterly meetings** with the support coordinator in the individual's record.

- **Housing Survey**-Completed by the coach and made available to the support coordinator at or prior to the quarterly meeting. The housing survey is completed quarterly to update the individual's health and safety status.

- **Checkbook/Passbook/Cash Ledgers**- Reviewed and initialed by supported living coach (if fiscal agent) and WSC.

Monthly Documents:

- **Notation in Checkbooks and in Progress Notes Indicating** that consumer **checkbooks were reconciled with bank statement** (for any consumer who has **bank reconciliation listed on implementation plan**).

- **Copy of Reconciled Bank Statement** (if coach is serving as fiscal agent).

- **Time Intervention/Service Log**- Written documentation of dates, times, and summary of supports provided.

As Needed:

- **Update Demographic, Health, Medical, and Emergency Contact Information**- To be consistent with current situation.

- **Progress Notes** – Completed daily and as needed to document interactions both with the individual and on her behalf (e.g. with other providers, family, etc.). Ongoing progress notes assist in documenting services are being provided as outlined in the implementation plan.

- **Consent Release Forms**- Used for specialized consents not covered by the annual consents or releases.

- **Initial Housing Survey** – Completed during the transition process before the individual moves into his home. It is updated quarterly by the coach and reviewed with the suppport coordinator. (See 'Quarterly'.)

- **Transition Plan** – A guide to support the individual's move into her new home. Copies must be maintained in the record.

Satisfaction Surveys

How can person-directed services be emphasized? In order to accomplish this outcome, a system for evaluating the effectiveness of supports received by each individual is required.

Consistent with requirements established in the DS Waiver handbook, at least annually, each individual will be asked by the coach to complete a survey to examine his satisfaction with the supported living services received. The purpose of the survey is to assist the individual in looking at the quality of his own life. This survey also provides feedback to the provider regarding service delivery. Satisfaction is very individualized, and the survey should reflect those things that are important to the individual and to the fulfillment of choices and desires.

If he needs or wants assistance in completing the survey, friends, family, or neighbors may be asked to provide it. Assistance should be provided based solely on the person's choice and his willingness to participate. Paid staff providing supported living services may not be part of survey activities.

Once the information is obtained from all persons supported by the provider, it's a good idea to analyze the information for patterns and trends. Satisfaction tools are one of the most effective ways for adjusting services to assure they met the needs and desires of the individual – to assure supports are always person-centered and directed.

A number of District/Region offices have developed operating protocols to assist supported living coaches in the development of satisfaction surveys. These protocols complement the requirements and offer providers guidance.

The following sample format, courtesy of Community Circles, Inc., includes the Suncoast Region's Operating Protocol and sample format which highlights some areas for consideration when developing satisfaction surveys:

SUNCOAST REGION
Developmental Disabilities Program
Operating Protocol

SUBJECT: Annual Satisfaction Surveys DATE ISSUED:______________

NUMBER: Section IV-05 REVISED:______________

DEVELOPED BY: ______________________________

TOPIC: Requirements of Supported Living Coaching vendors for annual satisfaction surveys.

PURPOSE: To ensure a standard procedure by which satisfaction surveys are completed annually by supported living customers and reviewed by support coordinators.

PROCEDURE:

- All supported living customers will be asked to complete a satisfaction survey annually.
- The coaching vendor is free to design their own survey form as long as:
  - It is written in indirect and simple language
  - It addresses key areas of satisfaction such as choice, safety, privacy, respect, and supports. A sample survey form is attached.
- While it is the coaching vendors responsibility to assure the individual has the opportunity to complete the survey, direct care staff providing supported living services may not assist in the survey activity for that individual. Direct care staff include coaches, companions, in-home support and personal care assistance providers employed by the vendor company.
- Customers who need assistance in completing the survey should be instructed to request help from family members, friends, neighbors, co-workers, staff employed by other vendors, or their support coordinator.
- Coaching vendors will maintain the results of the survey in the individual's record and a copy will be forwarded to the support coordinator for review.

VENDOR NAME
CUSTOMER SATISFACTION SURVEY

Customer Name: ______________________________

1. Do you feel safe at home and when you are out in the community?
   Yes _____ No ________
   Comments:

2. Do you get to make choices about how you spend your money?
   Yes _____ No ________
   Comments:

3. With the money you have, do you get to go places and do things you like to do?
   Yes _____ No ________
   Comments:

4. Is your coach teaching you things that you want to learn? (Examples: cooking, grocery shopping, paying bills, taking the bus)
   Yes _____ No ________
   Comments:

5. Do you get help when you need it from your supported living staff?
   Yes _____ No ________
   Comments:

6. Does the staff listen to you and treat you with respect?
   Yes _____ No ________
   Comments:

7. Did you get a say in picking the place where you live and who you live with?
   Yes _____ No ________
   Comments:

8. Do you feel you can make a complaint if you are unhappy about something?
   Yes _____ No ________
   Comments:

9. Do you feel your privacy is respected?
   Yes _____ No ________
   Comments:

10. In general, are you satisfied with your supported living services?
    Yes _____ No ________
    Comments:

______________________________	______________________________
Customer's Signature	Form Completed by:
______________________________	______________________________
Date Survey Completed	Relationship to Customer

Dissatisfaction
As discussed earlier in this chapter, observations and discussions with the individual are a powerful tool in determining satisfaction. Supported living coaches should consider that most people are dissatisfied when:

- They are angry or "in trouble" on an ongoing basis;
- Services and supports are not individualized or purposeful;
- No one 'hears' or heeds their preferences or concerns;
- Supports and services do not adjust or change as they do; and
- Others attempt to control their lives.

Coaches should consider any sign of dissatisfaction and explore with the individual and his circle of support. Using information regarding satisfaction, including the results of satisfaction surveys and ongoing reviews, assists the supported living provider with building a system of supports that are responsive to the needs and desires of the individual. This process promotes provider creativity and assures that staff are motivated by a person-centered approach to service delivery.

Annual Quality Reviews

> **"It's hard to play the game, if you don't know what the rules are…"**
>
> Author Unknown.

Understanding what's expected from the funding source is a key element for success for any provider. Although the adage above was designed for persons engaged in organized games, it applies to the supported living provider as well. It simply is not possible to be good at something, if you are unaware of the rules and applicable expectations. Think about any winning sports team. Although skills are valuable, if they aren't applied at the right place and the right time during a game, they're of little value. If they are applied successfully, but without regard to rules and regulations, the game may still be lost.

The following format provides concise information regarding the 'rules' that guide supported living services and the quality enhancement/improvement process.

Who: The Department of Children and Families, Developmental Disabilities Program is obligated through Florida Statute to review the status of all service providers. The Department and the Agency for Health Care Administration (AHCA) have initiated a contract with an independent organization to provide a statewide quality assurance program. Seventy-five percent (75%) of the contract costs are federal funds, and the balance is paid from state funds.

What and When: The statewide quality assurance program provider will review Supported Living Coaching Services and the Core Assurances, as a Medicaid Waiver provider, at least annually. Notification of the impending review will be provided prior to the survey or review dates.

Where: The review will take place at the address listed by the provider of supported living services. Copies of records will need to be available on the day of the review.

How: In order to complete this process, the independent contractor utilizes a Developmental Disabilities Supported Living Coaching Services Monitoring Checklist. This 'Checklist' identifies the standards used to evaluate the provider and identifies critical cites relating to health, safety, and rights; weighted elements that have greater impact on scoring than other cites; and cites which contain 'recoupment of funds' components if it is scored as "not met." The State has the authority to obtain reimbursement for certain funded services, if the requirements are not met. Recoupment means the provider must pay back money already obtained for services, if these items are not validated. These funded services are identified under the cites marked as 'recoupment of funds.'

In addition to the 'Checklist,' the contractor, to guide the determination of performance by the supported living provider, uses a Developmental Services Supported Living Coaching Services Monitoring Protocol. The 'Protocol' includes "probes" associated with each cite. The probes provide guidance to the quality assurance program reviewer in determining whether the cites and standards are met.

The tools used by the statewide quality assurance program are implemented based on a review of records and interviews. A selected sample of records is used to conduct the review. Interviews may be conducted with individuals and families and other service providers.

'Tips for Supporting the Coach in Preparing for an Annual Review' begin on page 8-37 .

In preparing for the annual review, it will be helpful for the supported living coach to understand exactly what is expected. A copy of the 'Monitoring Protocol' for 'Supported Living Coaching Service' and the 'Core Assurances' are available on the Internet. To find these go to http://www.dfmc-florida.org (select: Public Site, select: Provider Resources, select: Review Tools Download). In addition to service specificity, the provider is also responsible for elements contained in the Core Assurances. This tool may also be downloaded from the same address.

Tips for Preparing for the Annual Review

The following are intended to support the provider as he prepares for the annual review. The list is not intended to be all-inclusive and does not necessarily address variations in interpretation from district to district. This information is excerpted from a training package provided courtesy of the Suncoast Region.

Supported living providers are required to have a mechanism for immediately addressing any concerns, preferences, or issues raised by the individual during the survey process.

1. Written Policies and Procedures

- Develop a book of policies and procedures as indicated in Section 3-0 in the Core Assurances.
- Keep policies current.
- Provide evidence policies are being implemented as described.
- Review applicable policies with individuals annually and maintain copies of reviews in person's file.

2. Grievance Logs

- Develop grievance logs containing all elements as indicated in the Core Assurances.
- Enter all complaints and grievances.
- Provide verification of how provider responds to complaints and how they were resolved.
- Do periodic analysis of log - look for trends.
- Document reviews of grievance procedures with the individual annually.

3. Quarterly Home Visits by Support Coordinators and Coaches

- Not optional - required by Florida law.
- Support Coordinator completes a review of the housing survey and provides a signature as acknowledgement review occurred.
- Must be conducted in the person's home.
- Make sure these visits happen. If the support coordinator doesn't initiate them, the coach needs to. Be prepared to show documentation of attempts to get the support coordinator to the home.

4. Consents for Release

- No open-ended consents. Must be time-limited and specific both to whom and what information will be given. Consents must be updated throughout the year as needed and annually.

5. Fiscal Agent

You (or your company) are the fiscal agent for a customer if you control the customer's money in any way. For example:

- You give out spending money.
- You keep the checkbook.
- You are the representative payee for benefits.
- Try not to be a fiscal agent whenever possible. For example:
  - Customer can become their own payee.
  - Checkbook is maintained in the person's home.
- If you are fiscal agent, there must be quarterly reviews of bank statements and checkbooks. Proof should be found in the review of housing survey conducted with the support coordinator, as well as WSC's initials in checkbook register verifying that review occurred.

6. Implementation Plans

- Developed based on the support plan and information from the Functional Community Assessment.
- With permission from the individual, you must have a current support plan or the pages of the support plan related to supported living.
- You must give a copy of the implementation plan to the support coordinator and the individual.
- Attend support plan meetings and assist the person to speak up regarding recommendations for goals. Make sure goals are:
  - Based on what the individual desires
  - Based on what the individual needs
  - Assure the person is comfortable with the plan
- Periodic reviews of progress towards the goals are required. Documentation can be:
  - Charts and graphs (objective) must be clear and easy to understand.
  - Narrative format: Should be both subjective and objective with specific details regarding accomplishments or lack of progress, and recommendations for continuation.
- Includes the supports that are in place to provide for the maintenance of learned skills.

- If customer receives in-home supports and coaching, make sure the implementation plan addresses specific responsibilities to avoid billing duplications.
- Tailor the plan to the individual. Never use the same plan and strategies for everyone.

- Documentation needs to show you are consistently checking progress and making adjustments to training activities accordingly. Evidence of this may be found in:
  - Daily progress notes
  - Data tracking charts/narrative reviews
  - Quarterly home visit documentation (checklists)
  - As the plan changes, document adjustments directly to plan.

7. Quarterly Housing Surveys

- 65B-11 F.A.C. requires the housing survey include a "review of the individual's overall status of health, safety, and well-being." You can document this by:
  - Adding these items to the housing survey form you are using.
  - Include references to all HUD basic housing requirements.

8. Financial Profile

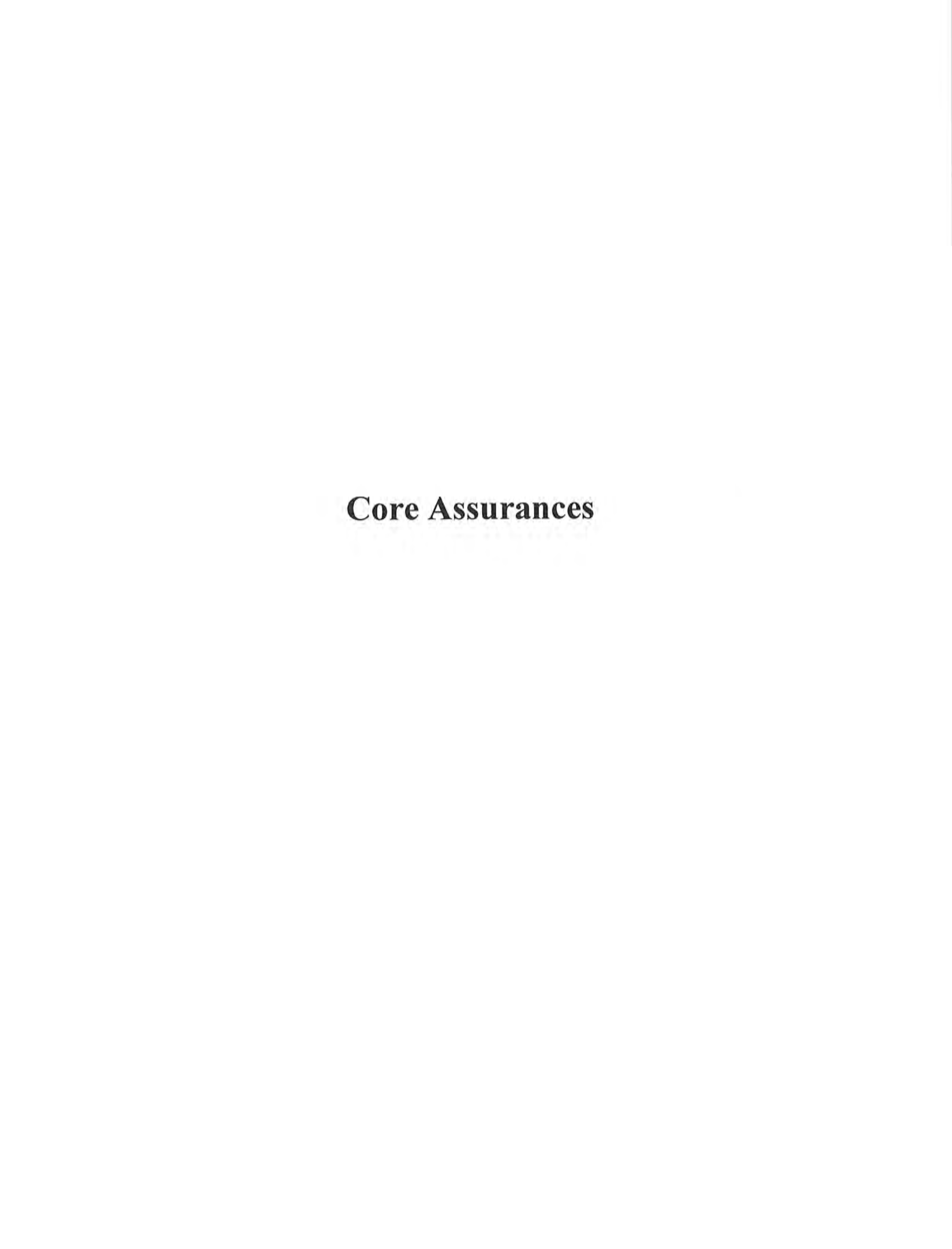
- Make sure it includes current information.
- Double check your math.
- Justifies requests for subsidies or start-up money.
- Must be completed within 10 days of housing selection.

9. Ongoing In-Service Training

- 8 hours per year required for all coaches. Training must be relevant to supported living coaching.
- OK to count "in-house" training (agencies only) time as long as it is:
  - Relevant to supported living coaching and the individuals being supported.
  - Documented as to:
    - # of hours
    - topic - write a brief summary
    - time spent in training
    - who provided the training

10. Annual Reports

- Must give an overall picture - not just a report on instructional methods and goals. Must include progress toward goals identified in the implementation plan. Progress should include objective (fact-based) and subjective information and be submitted to the WSC 30 days prior to the end of the support plan year.



Core Assurances

Developmental Services
Core Assurances
Monitoring Protocol

<table>
<tr><td colspan="2">Cite</td><td>Probes</td></tr>
<tr><td colspan="2">The Core Assurances represent specific administrative and programmatic requirements that are applicable to all Medicaid waiver service providers.

To determine compliance with each Standard from the Core Assurances, elements of performance have been developed to assist the reviewer in determining whether standards have been met. The elements of performance allow the reviewer to tailor the determination of compliance to the unique service under review.</td><td>Minimum Standards: Minimum standards delineate basic requirements that a provider must meet. An overall standard is presented, with supporting elements of performance.

Expanded Practice: Expanded practices represent conditions that exceed minimum expectations. All minimum standards and elements of performance within a section must be met before a provider is eligible for expanded practice scoring in that section.

DR: Code to indicate an element of performance that is subject to Desk Review. Those agency providers who have been identified to undergo a desk review will be requested to supply evidence that demonstrates their compliance with these elements of performance.</td></tr>
<tr><td colspan="3">Alert: Denotes a critical standard or cite relating to health, safety and rights. A deficiency requires a more intense corrective action and follow-up cycle.
"W" Weighted Element: A "W" followed by 2.0 or 4.0 in the Cite column denotes elements that have a greater impact on the monitoring score.
"R" Recoupment: An "R" in the Cite column denotes an element that is subject to recoupment of funds by the State if the element is "Not Met."</td></tr>
<tr><td colspan="3"></td></tr>
<tr><td colspan="3">Standard:
Rights and privileges of individuals are upheld.</td></tr>
<tr><td>1

DR</td><td>The provider has a written policy that identifies the rights and responsibilities of individuals receiving services.</td><td>• Review interactively with the provider their written policy on rights and responsibilities of individuals.</td></tr>
<tr><td>2

W2.0</td><td>There is evidence that the policy identifying individual rights and responsibilities is implemented.</td><td>• Ask the provider how they inform individuals and their families or guardians of their rights and responsibilities and how frequently.
• Ask individuals if they are aware of the providers policy; do they feel that their rights are upheld?
• Look for evidence in records that individuals receive something in writing annually from the provider and that the individual, family or guardian have acknowledged receipt.
• Analyze the results and recommendations from Person-Centered Reviews applicable to the provider to determine if there are any rights related concerns.
• Ask the provider and the provider's staff for examples of how they observe the rights and responsibilities of individuals.
• Ask the provider with multiple employees how they inform and monitor employee observance of individuals' rights and responsibilities.
• Ask the provider and the provider's staff for examples of instances where an individual or their family felt that their rights were not being observed. What was the provider's</td></tr>
</table>

Cite		Probes
		response to these concerns? • If not evident in the policy, ask the provider what other sources of information that they access to identify that their policy is being implemented as designed and that it is effective. • Tour and observe the physical plant and environment. • Observe staff activity and interaction with individuals during facility tour and other onsite activities.
3 W2.0	Individual rights are not restricted in any way. If there is evidence that rights are restricted, the restrictions are made in accordance with state statute and regulation.	• Observe provider/staff interaction with individuals. If there is evidence of rights being restricted, ask the provider or staff to explain why. • Observe the environment for any rights restrictions on individuals. • Observe individuals for problems with behavior. • Ask the provider to give examples of instances where an individual's rights had to be restricted, and what procedures were followed (e.g. court orders). Ask specifically about individuals who may have problems with behavior and how these are addressed. • Inquire about the use of medications, restrictions, and other therapies and treatments to address problems with behavior. • Interactively, with the provider review a sample of records for individuals that had or currently have a restriction on their rights, look for explanation of this restriction in documentation. • Ask individuals if they feel that their rights are restricted by the provider/staff. Talk with individuals about their experiences with the provider. Ask individuals about provider rules or restrictions. • Look for evidence that restrictive (behavioral) programs have been reviewed and approved by the LRC, and that programs are being implemented as written. • Look for evidence that restrictive (behavioral) programs are being monitored and updated and that changes are being reviewed and approved by the LRC. • Determine from provider/staff/individuals whether there are house/facility rules with which individuals must comply, or other routine practices used to manage or alter problem behaviors. (Rules/practices may be written or just understood.) Do these rules/practices pose undue restrictions? • Analyze results and recommendations of Person-Centered Reviews applicable to the provider to determine any related restrictions; whether individuals are provided information on any restrictions.
4 W4.0	The individual(s) is treated with dignity and respect.	• Observe providers interacting with individuals in the service setting. Look for evidence that the provider (or their staff) is sensitive to the rights outlined in cites 4-9.

<table>
<tr><th>Cite</th><th></th><th>Probes</th></tr>
<tr><td>5

W4.0</td><td>The individual's personal privacy is observed.</td><td rowspan="5">• Observe and interview consumers about the subjects covered in cites 4-9.
• Ask individuals/staff/provider how individuals are disciplined or how a problem with behavior is managed.
• Review a sample of records to determine that:
➢ If there are any restrictions on any individual's rights, documentation contains explanation for these restrictions.
➢ If there is a restriction on access to possessions, money, food or freedom of movement, that takes the form of house/facility rules or routine practices, determine if individuals are aware of the rules and if they have agreed to be bound by them. (House Rules are usually written, available to individual/family/staff and may be signed by the individual.) Do the house/facility rules or routine practices unduly restrict rights?
➢ Language used in documentation is respectful.

• Review results and recommendations from Person-Centered Reviews applicable to the provider for any rights related information.
• Look for evidence in provider complaint and satisfaction data to determine if any of these rights have been violated and what steps the provider took to resolve the complaint.</td></tr>
<tr><td>6</td><td>The provider and staff talk to and about the person in a respectful manner.</td></tr>
<tr><td>7</td><td>The individual is included in decisions concerning his or her life.</td></tr>
<tr><td>8

W2.0</td><td>The individual(s) has access to personal possessions, his or her money, food, and freedom of movement.</td></tr>
<tr><td>9</td><td>The provider and staff appear to listen to the person when he/she is speaking.</td></tr>
<tr><td>10</td><td>There is evidence that the provider assists the individual to fully exercise rights and to make informed choices.</td><td>• Ask the provider for examples of how they have assisted individuals to fully exercise their rights and make informed choices.
• Interactively, with the provider, review a record of an individual that the provider has assisted for documentation of this assistance.
• Interactively, with the provider, review a case study or other documentation that would demonstrate this assistance.
• Review results and recommendation from Person-Centered Reviews applicable to the provider for any rights and choice related information.
• Talk with individuals to determine that information on rights and choice is made available to them. Determine if they are satisfied with their choice options and their ability to exercise rights.</td></tr>
<tr><td colspan="3">Note: The following Expanded Practice will be evaluated only when all preceding, required elements of performance for the standard have been met.</td></tr>
<tr><td>11
Expanded Practice</td><td>The provider and staff have knowledge of due process</td><td>• Ask the provider and staff if they know about internal and external complaint and grievance procedures
• Ask the provider if they have knowledge of due process</td></tr>
</table>

Cite		Probes
	procedures and this information is made available to individuals/families/ guardians and provider staff.	options/procedures. • Ask the provider to describe how staff is informed about due process. • Ask the provider and staff to describe how information on due process is made available to individuals and/or their families or guardians. • Determine from individuals whether they have been made aware of these options. Are they assisted to take advantage of these options? • Review Person Centered Review results and recommendations applicable to the provider.
Standard: Individuals have access to environments, including community settings, where services and supports are provided.		
12	Individuals are not denied access to parts of the building or areas where services are delivered due to disability, including administrative offices.	• Review Person Centered Review results and recommendations applicable to the provider for cites 12-14. • Talk with individuals to determine any access issues or concerns. • If applicable, review provider policies and procedures that would include references to issues covered by the ADA, if applicable. • Tour and observe the physical plant for any environmental barriers at sites where services and supports are provided to individuals. • Determine if the provider has a waiver from the Health Department or licensing agency on file for noted environmental barriers.
13	Community involvement is not limited due to an organization's transportation or other barriers.	• Talk with individuals to determine any access issues or concerns. Are they satisfied with the level of community involvement? • Ask the provider about proximity of their location to community centers of activity. • Ask the provider how individuals access (get to) community centers, and community-based activities. • Check complaint and satisfaction data to determine that this is not a problem area for the provider.
14 W2.0	Individuals are provided with opportunities to receive services in the most integrated settings appropriate to their needs	• Talk with individuals to determine if they are satisfied with how and where services are provided. Are they included in decisions for service delivery locations and settings? Do settings appear appropriate to meet individual needs? • Ask the provider about the types of service settings that are offered to individuals for receiving supports and services.

Cite		Probes
	and according to their choice.	• Interactively, with the provider, review records of individuals for examples of the types of service settings that are being offered. • Review complaint and satisfaction data for evidence that provider might be limiting individuals' choices in terms of service settings.
Standard: Individuals are afforded choice of services and supports.		
15 DR	There are written policies and procedures in place to address choice for individuals, including those with a guardian, or for those who have been adjudicated incompetent.	Ask the provider to supply copies of written policies and procedures regarding choices of supports and services being made available to individuals.
16 W2.0	There is evidence that the provider's policies addressing individuals' choice for supports and services are implemented.	• Ask the provider for examples of how they offer choice of supports and services to individuals'. • Ask the provider with staff how they inform and monitor employee observance of individual's rights to choice. • Interactively, with the provider, review a sample of records that demonstrate implementation of the policy and procedures. • If the individual's choices cannot be readily determined, ask the provider how the individual's right to choose is safeguarded. • Talk with individuals about whether choices are offered in supports and services. Were the choices implemented? • Observe provider and consumer interaction if possible. • Analyze the results of Person-Centered Reviews for the provider to determine that they are affording individuals choices for supports and services.
Standard: Individual personal information is kept confidential.		
17 W2.0	Information about the individual is secured and not publicly displayed, except at the choice of the individual.	• Ask the provider about how they maintain the confidentiality of and secure information about individuals they provide with service and supports. • Ask to see provider policies and procedures, if applicable. • For agency providers, ask how staff is informed of policies

Cite		Probes
18	Individual records are secured.	and procedures for maintaining the confidentiality of and securing individuals' information. • Ask the agency provider how they monitor staff compliance with the policy and procedure. • Observe the service setting to determine that policy and procedure are followed relative to maintaining confidentiality and security of information about individuals. Determine whether information about the individual is publicly displayed.
19	Consents for release of information are specific; time limited, signed and dated by the person or authorized representative.	• Ask the provider to supply an example of a consent. If they have versions to cover more than one circumstance, ask to see examples of all. • Interactively, with the provider, review a sample of records that contain release of information consents. ➢ Look for specificity in the release, time limitations, and for signatures and dates. *Note: Providers need not have a signed consent in every consumer file. Consent is only required when information about the consumer is being released. Providers do not need a consent for release of information to send required documentation to the individual's support coordinator.*
Standard: **Suspected abuse, neglect or exploitation is immediately reported in accordance with state law.**		
20 DR	The provider has a written policy to address the immediate reporting of any suspected incidents of abuse or neglect.	• Ask to see the provider's policy on reporting suspected abuse and neglect. • Look for evidence that the policy is reflective of state reporting laws. • Look for evidence that the policy identifies additional contacts that should be made in instances of suspected abuse and neglect

Cite		Probes
21 W4.0	The provider immediately reports any suspected abuse, neglect or exploitation of an individual.	• Ask the agency provider for evidence that staff have been informed of the reporting policy and procedures. • If this is an agency provider, interview staff to determine that they are aware of the provider's policy and procedure, and know whom to call. • Ask the provider to give examples of instances when their reporting policies have had to be put into practice. • Ask the agency staff if they know what to do when they suspect an individual is being abused, neglected or exploited. • Review incident/accident reports for the last six months to determine if patterns exist. • Look for evidence that the provider is reporting suspicion of abuse, neglect or exploitation in consumer records, a log, or in other documentation. • During documentation review, look for any instances where the provider may have had suspicions, but did not or hesitated to make a report. • Is there evidence the provider investigates complaints/accidents/incidents to determine cause and any suspected abuse/neglect? Takes appropriate corrective action per investigation findings? *Note: If Cite 21 is met, and there is evidence that staff is trained in reporting procedures, as applicable, score Cite 21 as MET if there have been no suspected incidents to report.*
22 DR	The provider has a written policy to inform the individual and/or family/guardian about how to report suspected abuse, neglect or exploitation.	• Ask to the see the provider's policy on informing individuals, families or guardians about how to report suspected abuse, neglect or exploitation. • Look for evidence that the policy defines when individuals, families or guardians are to be initially informed and re-informed. • Look for evidence that the policy includes a description of how individuals, families or guardians are to be informed. *Note: It is acceptable if this is a part of the reporting policy.*

23	The provider informs individuals, family and guardians about how to report suspected abuse, neglect or exploitation.	• Ask to see any written information or documentation of training that is given to consumers about reporting abuse, neglect or exploitation.
		  ➢ Recognizing abuse and neglect, and
		  ➢ Preventing abuse, neglect or exploitation.
		• Ask provider and agency staff how individuals, families, and guardians are informed about reporting suspected abuse, neglect or exploitation.
		• Ask consumers, families or guardians if the provider informed them of the phone number to call or any other abuse/neglect reporting procedures.
		• If the provider's policy states that the information is presented in writing and receipt is acknowledged by signature, look for evidence that the provider maintains a copy of this acknowledgement on file.
		• Review results and recommendations from Person-Centered Reviews for the provider.

Cite		Probes
24 W2.0	The registry number is posted and accessible to staff and consumers.	• Ask providers where the phone number for reporting abuse, neglect and exploitation is located for staff and consumer use. • During provider location visits, look for evidence of postings. If not posted, ask provider to show you where it is located, and in the case of agency providers, ask staff to show you the location. • Talk with individuals to determine if they are aware of where the number is posted.
Standard:	**Individuals are assisted in achieving personal goals and desired outcomes.**	
25	The provider is aware of, and has taken responsibility for, coordinating services needed to meet personal goals and needs identified by the individual within the scope of the service.	*NOTE: The support coordinator is not the only provider that is responsible for coordinating services. Every provider performs, or should be performing some level of service coordination even if it is just within the scope of their service.* • Ask the provider and the provider's staff about their approach to working with individuals. • Ask the provider and the provider's staff some general questions about the individuals included in their caseload or enrolled in their service. • Observe if the provider and the provider's staff can supply information from memory about the individuals with whom they work. • Ask the provider and the provider's staff how they develop services and supports for each individual to ensure they directly relate to personal outcomes/goals desired.
26 W2.0	Supports provided are directly related to the individual's desired goals and needs.	Based on the type and scope of the service offered: • Interactively, with the provider, review a sample of records of individuals for evidence of services and supports being offered. Compare consumer goals and outcomes as defined or described in implementation plans, service authorizations, notes from meetings or interactions with individuals, and support coordinators to service logs, goal and outcome tracking forms, progress notes, etc. • Determine if the provider has a process for evaluating the adequacy and frequency of services and supports rendered to individuals. • Interactively, with the provider, look for evidence of timely investigations and attempts to resolve individuals' complaints. • Talk with individuals to determine if they are satisfied with the level of services being offered. Determine if the person is "working on" something that they want to achieve. • Do individuals feel that if they want to change the service in some way that the provider listens to them and works with them to accomplish the change? • Analyze the results of person-centered reviews for the provider to determine that they are assisting individual in achieving personal outcomes in all the areas noted.
27	Supports appear adequate in intensity and frequency to support desired outcomes for the individual.	
28	The provider is performing timely investigations and attempting resolution for any complaints, or inadequate supports for the person, if goals are not being achieved or appropriately supported.	

Cite		Probes
29 W2.0	The provider uses a personal outcome approach to design person-centered supports and services, and to enhance service delivery in order to assist individuals in achieving personal outcomes.	**Support Coordinators**: • Determine through interview and interactive record review with the provider that supports and services that are needed to achieve personal goals and to assure health and safety are aggressively explored and secured by the provider. • Review information submitted from other providers (e.g. Implementation Plans) to determine if services are appropriate to support plan goals, information collected from Personal Outcome Measures interviews and results and recommendations from applicable Person-Centered Reviews. • Talk with individuals to determine if they have input into the service planning and supports offered. Do they feel that the support coordinator responds to their suggestions and concerns? • Review applicable Person Centered Review results and recommendations. **Other Providers**: • Through interview and interactive record review, determine that provider services and supports relate directly and positively to the goals the individual wishes to achieve and to the individual's identified needs. • Through interview, determine that staff at all levels know the individual's personal goals and identified needs. • Through interview and interactive record review, determine that there is evidence of the provider cooperating in the personal outcome assessment process. • Is there evidence that the individual is included in decisions relating to services and supports? That the provider/staff are responsive to individual input and information. • Are supports individualized or "one size fits all"? • Talk with individuals to determine if they have input into the service delivery system and supports offered. Do they feel that the provider/staff respond to their suggestions and concerns? • Review applicable Person Centered Review results and recommendations.
30	The provider has considered a range of different and individualized methods and techniques to be used to achieve the individual's personal goals.	As appropriate to service type, gather data through ➢ Review of provider's self-assessment, ➢ Review of satisfaction survey results, ➢ Review of provider's quality improvement plan, ➢ Review of provider's implementation plans, ➢ Observation of provider operations

Cite		Probes
31	The provider has identified and organized employee work tasks to facilitate the achievement of the individual's personal goals.	• Do services appear to be tailored to individual capabilities and needs? • Look/listen for evidence that staff time and effort is organized—staffing schedules, job descriptions, and organization plans can be sources of evidence • Interview the provider, provider's staff and individuals. **For Support Coordinators:** Look for documentation that a range of service options were discussed with the individual to enhance choice of service delivery to meet desired goals.
32	The Provider participates in discussions related to the individual's record, progress, need for modification to the support or implementation plans, and whether the individuals' needs are being met.	Review results and recommendations from Person-Centered Reviews to determine satisfaction with communication level and responsiveness to need/outcome changes. **For Support Coordinators:** • Ask the support coordinator whether meetings are scheduled to maximize attendance by those invited. • Interactively review a sample of records to determine when these meetings occur and who attends. • Ask the support coordinator how they actively encourage individuals to identify others they wish to invite to support plan meetings. • Through record review of the sample determine if there is a pattern of support plan meetings including only the support coordinator/individual. Is there documentation to support this as a reasonable practice? • Ask the support coordinator how they obtain information on what services are planned for an individual and whether they are successful. **For Other Providers:** • Determine the extent of communication between the provider, individual, family/guardian and other members of the "support planning team," through review of: ➢ Progress notes ➢ Telephone logs ➢ Support plan meeting attendance records • Interview the provider/provider's staff to determine that communication is taking place, through a variety of methods, both within the organization and with outside resources. • Interactively, with the provider, review a sample of records and other documentation to determine whether the provider, if invited, attends support plan and other meetings to discuss the individual's progress and needs. Is there documentation to support this practice? • Determine if and how the provider submits pertinent information, implementation plans, and annual summaries/reports, as appropriate, to the support coordinator. • Talk with individuals to see if they are satisfied with participation of their providers at support planning meetings, and with communication about their supports and services. Are requested changes in services acted upon?
33	The provider works with the consumer/family/guardian when changes in program direction and/or the implementation plan are requested.	

Cite		Probes
34 W2.0	The provider is supporting the individual to expand life experiences through being part of the community and to achieve personal goals by offering opportunities, experiences and relevant training for the individual.	• Analyze Person Centered Review results and recommendations. • Talk with individuals to determine satisfaction with the experiences being provided. • Through interview and document review, determine if the provider advocates for experiences that are meaningful for the individual. Determine if the individual has: ➢ Attempts and successes with developing contacts in the community that are of interest to the person other than paid supports; ➢ Frequent and on-going opportunities to pursue and achieve connections to natural supports, or other generic community supports of interest to the person. • Look/listen for evidence that the provider knows the individual's preferences for community activities. • If the individual has identified increased community participation and integration as a desired outcome, determine if the provider has developed successful strategies to provide this support. • Determine if the provider assists the individual in experiencing various community activities. • Review the schedule for community activities, if available. Determine if activities offered are of interest to the individual and that the schedule provides a variety of community activities. • Determine if community activities are occurring in integrated settings to the maximum extent possible and are desired by the individual. • Determine if there are opportunities for the individual to attend community activities alone rather than only in large groups.
35 W2.0	The provider takes responsibility for addressing individual outcome areas beyond their mission and scope through referral, advocacy or consultation.	• Ask the provider what process they follow when an individual approaches them about an outcome that is beyond their scope of service. • If this is an agency provider, ask for examples of how employees are instructed and guided to handle situations of individual's requesting assistance with outcomes that are not within the scope of supports and services they have been assigned to provide. • Ask to see examples of any written policies, procedures or instructions that the provider has available regarding these types of situations. • Ask the provider to present some examples of implementation of their process, such as records of individuals where this situation has occurred. • For agency/group providers, interview employees to determine their awareness of the steps to take when these situations present. • Analyze the results of Person-Centered Reviews to identify if there is evidence of consistent provider performance in these situations.
36	The provider actively coordinates the dissemination of information to the individual/family/guardian and other providers in order to promote a cohesive planning and support process.	
Note: The following Expanded Practices will be evaluated only when all preceding required elements of performance for the standard have been met.		

Cite		Probes
37 **Expanded Practice**	The provider has a tracking system in place to assure that all individuals are making progress and that effective and timely interventions occur when progress is not made. (Was CA 38)	• Ask the provider to describe how they monitor the progress of the individuals that they serve. • Ask the provider to show you examples of any procedures, forms or reports they use to monitor progress of individuals Look for other evidence that the provider is actively monitoring the progress of individuals
38 **Expanded Practice**	The provider has identified individual and aggregate outcome data for recipients of their service(s) to facilitate the evaluation of supports and services. (Was CA 39)	As appropriate to service type, gather data through ➢ Review of provider's self-assessment, ➢ Review of satisfaction survey results, ➢ Review of provider's quality improvement plan, ➢ Review of provider's implementation plans, ➢ Review any logs or reports that the provider uses to track an individual's progress over time ➢ Observation of provider operations and ➢ Interview of individuals and employees.
39 **Expanded Practice**	The provider uses outcome data to implement a more person-centered service delivery system. (Was CA 40)	
40 **Expanded Practice**	The provider assists the individual with opportunities to meet people who share common interest. (Was CA 41)	• Ask the provider to give examples of individuals they have assisted in the manner described in the standards. • Interactively, with the provider, review a record for at least one of the individuals to determine that the provider is documenting the provision of this type of support and assistance. • Analyze the results of Person-Centered Reviews to identify if there is evidence that the provider consistently assists individuals as described in the standards and takes actions to address applicable recommendations.
41 **Expanded Practice**	The provider assists the individual with opportunities to become involved in activities that can help develop friends and relationships. (Was CA 42)	
42 **Expanded Practice**	The provider assists the individual in developing desired social roles that are of value to the individual. (Was CA 43)	

Cite		Probes
43 **Expanded Practice**	The provider supports the individual to achieve goals that the individual is personally responsible for exploring and developing, e.g. volunteer opportunities, club memberships. (Was CA 44)	
Standard: The provider markets and renders services in a professional and ethical manner.		
44	The provider has a written policy that prohibits solicitation of individuals through the use of fraud, intimidation, undue influence, including offering discounts or special offers that include prizes, free services or other incentives. (Was CA 45)	Interactively, with the provider, review the written policy to determine that it addresses the issues noted in the cites. If the provider does not engage in any marketing activity, the policy should state this and should indicate how this is communicated to and enforced with employees in agency situations. *Note: There are no regulations that prohibit marketing by any type of provider; therefore, all providers must have a policy, even if it simply states that they do not market their services.*
45	The provider has a written policy that prohibits solicitation of an individual currently receiving services from another vendor for the purpose of inducing the individual to switch vendors through the use of fraud, intimidation, or exertion of undue influence on an individual. (Was CA 46)	
46	The provider implements its marketing policy. (Was CA 47)	• Ask the provider if staff receive training on the marketing policy, and how frequently this training occurs and how often it is reinforced. • Talk with individuals receiving the service to determine how provider was selected. • Follow up with questions to the staff to determine their awareness of the provider's marketing policy.
47	There is no indication of non-compliance with acceptable marketing practices. (Was CA 48)	• Determine if any complaints or grievances have been filed against the provider related to marketing issues. • Obtain information from the district, individuals receiving the service and discussions with provider/staff. Continued on next page

Cite		Probes
48	There is no indication that the provider or any employee of a provider is named beneficiary on a Life Insurance Policy for an individual. (NEW 2003)	• Ask the provider about their policies on ethical issues related to financial affairs or arrangements with individuals. • If the provider has this policy in writing, review the policy. • If the provider is an agency, ask the provider how they ensure that employees are informed of the policy and how they are monitored for compliance. • Talk with individuals receiving the service.
49 W2.0	There is no indication that the provider or employees of a provider borrow or use money from an individual or their personal funds. (NEW 2003)	
Standard: Provider procedures facilitate the resolution of grievances.		
50 DR	The Provider has written grievance procedures containing all the required and relevant information that are used to resolve conflicts that may arise between the individual, family, and/or guardian and the provider. (Was CA 49)	• Interactively, with the provider, review procedures for recording, tracking and resolving grievances. The procedures should contain reference to at least the following: ➢ Procedures will be reviewed and signed by individual, family or guardian within 30 days of beginning services and annually thereafter. ➢ Procedures will be communicated in clear, understandable language to the individual, their family or guardian. ➢ Responses to grievances will be provided verbally and in writing at the individual's level of comprehension and in the language understood by the individual. ➢ Procedures include the establishment and maintenance of a log for grievances filed by individuals, families or guardians. ➢ Procedures should specify time frames for responses and grievance resolution. ➢ Procedures should provide for prompt resolution of any conflict.
51	Grievance procedures are annually reviewed and signed by the individual, family and/or guardian, and the provider keeps a copy on file. (Was CA 50)	• Interactively, with the provider, review a sample of individuals' records to determine that a copy of the signed grievance procedure is available. • Ask the provider and staff how they communicate the grievance procedure to individuals, their families or guardians. • Ask if the procedure is available and can be communicated in other languages. • Interview consumers to determine if they know how to make a complaint or file a grievance. Ask whether they have ever presented a grievance to the provider for resolution. • Review any Person Centered Review results or recommendations for information relating to grievances. • Grievance procedures for a new participant to the program are reviewed and signed within 30 days of admission.

Cite		Probes
52	There is evidence that the consumer(s) is satisfied with the grievance resolution. (NEW 2003)	• Explore and investigate one or two resolutions proposed and implemented by the provider. • Interview a sample of consumers, family or guardians registering grievances. • Ask the provider and staff how they communicate response to grievances to individuals, their families or guardians. • Ask if grievance responses can be communicated in other languages. • Ask the provider for an example of a written response to a registered grievance. • If any grievances have been filed, determine that the provider has resolved them within the time frames outlined in the written procedures. • Review any Person Centered Review results or recommendations for information relating to grievances. *Note: If the provider has had no grievances filed, score this element 'Not Applicable.'*
53	The provider maintains a log of grievances filed by individuals, families or guardians. (Was CA 55)	• Review the provider's grievance log and procedures for handling grievances. • Determine if the grievance log contains all of the following elements. If all elements are not included in the log, score this element 'Not Met.' a. The names of the person making the complaint and their relationship to the individual receiving services; b. The date the complaint is received; c. A clear description of the complaint. (Oral complaints will be documented in writing.) d. The date of and the final disposition of each logged complaint. • Randomly select several log entries, if they exist, and ask the provider to pull the individuals' records or grievance file. Review the record for evidence that a copy of the grievance is present or a note is present in the record that a grievance was registered. • Review any Person Centered Review results or recommendations for information relating to grievances. *Note: The provider should have a log established, even if no grievances have been registered, in order to receive a score of 'Met.'*

Standard: The provider has written policies on required topics, and practices appear consistent with the policy.

The elements under this standard are ONLY applicable to group or agency providers, and solo practitioners of Adult Day Training, Non-Residential Support Services, Residential Habilitation, Support Coordination, Supported Employment, and Supported Living Coaching. Score 'Not Applicable' for all other service providers.

Cite		Probes
54	The provider has written policies on the personal outcome process and the use of outcome information for service delivery planning. (Was CA 62)	*Note: Policies referred to under this element may be combined into a single document. Separate documents for each policy topic are not required.* Review the provider's written policies. Policies can state that the provider uses Support Plan goals and individual goals and desired outcomes from Implementation Plans. *Note: Compliance with this element does not require that the provider has received the Personal Outcome Measures training.*
55	The provider implements and follows their policies on the personal outcome process and the use of outcome information in service delivery planning. (New 2003)	• Interview the provider and staff, to determine: ➢ Their awareness of the policy and the purpose ➢ If staff have been instructed on how the policy impacts their work with the consumer ➢ Staffs' responsibility for implementing the policy ➢ How the provider and staff implement the policy through descriptions and specific examples of performance. ➢ If the provider monitors how closely the policy is being followed. • Review results and recommendations from the Person-Centered Reviews applicable to the provider to assist in determining compliance with policy implementation. • Review records, implementation plans, and other documentation to determine if there is evidence to indicate that the provider considers the consumer's desired outcomes and choices in services and support planning. • Interview consumers, family or guardians to determine if they perceive that services and supports are designed to address and achieve desired goals and outcomes.

Cite		Probes
56	The provider has written policies on a person-centered approach to service delivery. (Was CA 63)	Review the provider's written policies. Examples of possible content could include references to: ▪ The provider's philosophy or approach to providing services and supports in a person-centered manner; ▪ A description of how the provider will render person-centered services and supports; ▪ Consumer rights, such as choice, and input on decisions about services, supports and goals ▪ A statement about how staff will be instructed and monitored on rendering person-centered services and supports. ▪ How the provider determines individual's desired goals/outcomes appropriate to service delivery.
57	The provider implements and follows their policies for using a person-centered approach to service delivery. (NEW 2003)	• Interview the provider and staff, to determine: ➢ Their awareness of the policy and the purpose. ➢ If staff has been instructed on how the policy impacts their work with the consumer. ➢ Staffs' responsibility for implementing the policy. ➢ How the provider and staff implement the policy through descriptions and specific examples of performance. ➢ If the provider monitors how closely the policy is being followed. • Interview provider and staff about the approaches they use to render services and supports to individuals. Determine if the provider and staff consider each individual's needs and goals when delivering services and supports and whether services are individualized. • Interview consumers, family or guardians to determine if they perceive that services and supports are designed to address and achieve desired goals and outcomes. • Review results and recommendations from the Person-Centered Reviews applicable to the provider to assist in determining compliance with policy implementation. • When possible, observe the provider's interaction with consumers.

Cite		Probes
58 DR	The provider has written policies on promoting health, safety and well-being of individuals. (Was CA 64)	Review the provider's written policies. Examples of <u>possible</u> content could include references to: ▪ Training staff on identifying and reporting incidents, ▪ Maintaining an incident log, ▪ Reporting incidents or unusual occurrences to the District, ▪ Monitoring incidents to identify if improvements are needed, ▪ Environmental and personal safety related issues ▪ Healthy-living related issues, ▪ How emergencies such as fire or disasters would be handled, and ▪ How illnesses or injuries will be handled.
59	The provider implements and follows their policies on promoting health, safety and well-being of individuals. (NEW 2003)	• Interview the provider and staff, to determine: ➢ Their awareness of the policy and the purpose ➢ If staff have been instructed on how the policy impacts their work with the consumer ➢ Staffs' responsibility for implementing the policy ➢ How the provider and staff implement the policy through descriptions and specific examples of performance. ➢ If the provider monitors how closely the policy is being followed. • Review the provider's records of incidents. • Review incident information supplied by the Districts • Talk with individuals to determine if they are aware of policies, e.g. what to do in case of fire, illness, injury. • Review results and recommendations from the Person-Centered Reviews applicable to the provider to assist in determining compliance with policy implementation.

Cite		Probes
60	The provider has written policies on the safe administration and handling of medication, that includes staff training.	Review the provider's written policies. Examples of <u>possible</u> content could include references to: ▪ Provider and staff do not administer or handle consumer medications. ▪ Identified staff is only allowed to administer or handle medications. ▪ Description of provider and staff training curriculum and the time frames when training takes place and who conducts the training for the agency. ▪ Description of how medications will be handled and stored. ▪ Description of how medication administration will be documented. ▪ How consumers are informed about the provider's position on, or responsibilities related to administering and handling medications.
61	The provider implements and follows their policies on the safe administration and handling of medication, including those related to staff training. (NEW 2003)	• Interview the provider and staff, to determine: ➢ Their awareness of the policy and the purpose. ➢ If staff has been instructed on how the policy impacts their work with the consumer. ➢ Staffs' responsibility for implementing the policy. ➢ How the provider and staff implement the policy through descriptions and specific examples of performance. ➢ If the provider monitors how closely the policy is being followed. ➢ Provider/staff are trained to administer medication, as applicable. ➢ Provider/staff administer medication per requirements in policy/procedures. • Review results and recommendations from the Person-Centered Reviews applicable to the provider to assist in determining compliance with policy implementation.

Cite		Probes
62	The provider has written policies on transitioning of individuals. (Was CA 66)	Review the provider's written policies. Content should at a minimum include references to: • Planning activities that will occur to promote a smooth transition to and from the setting or service. • Expected communication before and after the transition. • How records and other information will be shared and transferred.
63	The provider implements and follows their policies on transitioning of individuals. (NEW 2003)	• Interview the provider and staff, to determine: ➢ Their awareness of the policy and the purpose. ➢ If staff have been instructed on how the policy impacts their work with the consumer. ➢ Staffs' responsibility for implementing the policy. ➢ How the provider and staff implement the policy through descriptions and specific examples of performance. ➢ If the provider monitors how closely the policy is being followed. • Review records and talk with individuals who have recently transitioned into the program to determine if policy was implemented. Could transition have been improved? • Review results and recommendations from the Person-Centered Reviews applicable to the provider to assist in determining compliance with policy implementation.
64	The provider has written policies on staff training, orientation, and in-service. (Was CA 67)	Review the provider's written policies. Examples of possible content could include: ▪ Solo provider will attend all required orientation and training as required by the District for enrollment. ▪ Solo provider will request and maintain a record of attendance and course content for all training programs attended. ▪ Solo provider will describe how they intend to enhance or maintain their skills in rendering services and supports ▪ Agency providers describe the orientation for new employees. ▪ Agency providers describe initial and in-service training for staff and when this training takes place. ▪ How training will be documented and filed. ▪ Solo/Agency providers will address how on-going training will be obtained. *Note: This element applies to solo as well as agency providers.*

Cite		Probes
65	The provider implements and follows their policies on staff training, orientation and in-service. (NEW 2003)	Interview the provider and staff, to determine: • Their awareness of the policy and the purpose. • If staff has been instructed on how the policy impacts their work with the consumer. • Staffs' responsibility for implementing the policy. • How the provider and staff implement the policy through descriptions and specific examples of performance. • If the provider monitors how closely the policy is being followed. • There is evidence in training records that the policy is implemented.
66	The provider has written policies on self-assessment. (Was CA 68)	Review the provider's written policies. Examples of <u>possible</u> content could include references to: ▪ What the provider will focus on in the self-assessment (refer to elements under Standard 3.1). ▪ The materials or resources that will be used in the process. ▪ When the provider will conduct the self-assessment ▪ What the provider will do with self-assessment results ▪ The involvement of individuals and families in the self- assessment process.
67	The provider implements and follows their policies on self-assessment. (NEW 2003)	Interview the provider and staff, to determine: • Their awareness of the policy and the purpose. • If staff has been instructed on how the policy impacts their work with the consumer. • Staffs' responsibility for implementing the policy. • How the provider and staff implement the policy through descriptions and specific examples of performance. • If the provider monitors how closely the policy is being followed.
68	If the provider is an agency or group provider, there is an available table of organization, including board of directors (when applicable), directors, supervisors, support staff and all other employees. (Was CA 69)	• Ask the provider for the table of organization. ➢ Determine that the Table of Organization is current. ➢ Determine if the Table of Organization appears adequate to support individuals' achievement of personal goals and needs. *Note: Score this element as 'Not Applicable' for solo providers.*

Standard: The provider completes a self-assessment to determine the effectiveness of services being offered and compliance with established requirements

The elements under this standard are ONLY applicable to group or agency providers, and solo practitioners of Adult Day Training, Non-Residential Support Services, Residential Habilitation, Support Coordination, Supported Employment, and Supported Living Coaching. Score 'Not Applicable' for all other service providers.

Cite		Probes
69 DR	The provider conducts a self-assessment at least annually. (Was CA 71)	• Ask the provider to describe how they conduct their self-assessment (e.g., tools used, criteria they apply, what point in the year) • Examine the provider's self-assessment procedures, tools and results • At a minimum, the provider's self-assessment will include a combination of: ➢ Record review ➢ Interviews to determine the extent to which provider actions support the achievement of personal goals identified by individuals receiving services; and ➢ Annual individual satisfaction surveys.
70	The assessment examines the provider's compliance with requirements found in the Medicaid Waiver Agreement and Assurances, and applicable rules and regulations. (Was CA 72)	Examine the provider's self-assessment procedures, tools and results to determine if all of the following are addressed: • The self-assessment includes a determination of the extent to which the provider is developing and maintaining person-centered processes that assist individuals to achieve personal outcomes particularly in the areas of personal goals, choice, social inclusion, relationships, rights, dignity and respect, health, environment, security and satisfaction. • The self-assessment examines how well the provider knows and supports outcomes desired by individuals. • The self-assessment process solicits input and involvement from individuals receiving the services, their parents or guardians, and volunteers. • The self-assessment process determines at what level the provider: ➢ Promotes personal dignity and respect; ➢ Allows for celebration of successes; ➢ Uses positive approaches in all service and support activities. ➢ Promotes continuity and security for each individual. The self-assessment examines whether Core Assurance and Service-specific requirements found in the Medicaid Waiver Agreement, DS Waiver Services Florida Medicaid Coverage and Limitations handbook are being met.
71 W2.0	The provider's self-assessment is effective in determining the need for improvement. (NEW 2003)	• Ask the provider if they have learned anything from conducting a self-assessment, and what they have done with that knowledge (e.g., formulated QIP, addressed staffing issues). • Are areas requiring improvement identified?
72 W2.0 DR	A Quality Improvement Plan (QIP) is developed and implemented to address areas needing improvement. (Was CA 73)	Review the QIP to determine • Whether assignments, responsibilities, and time frames for correction have been identified. • There is evidence that the QIP is reviewed periodically (e.g., quarterly) to determine if assignments and timeframes have been met. • The QIP is updated to reflect changes needed to keep the plan current. • Strategies in the plan are modified if they are not working. • Progress that has been made.
73	Satisfaction survey results	• Ask the provider to discuss their satisfaction survey results

Cite		Probes
W2.0 DR	"needing improvement" are incorporated into the provider Quality Improvement Plan.	and what has been done with these results. • Ask the provider to give examples of quality improvement plans or efforts that were established or implemented relating to the satisfaction survey results. • Talk with individuals to determine if the provider has satisfactorily addressed comments related to service improvement.

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10.04.01; rev. 10.25.01; rev. 10.26.01; rev. 10.31.01; rev 11.01.01; rev 11-13-01; rev.09.05.02; rev.01.03.03;rev.02.03.03; 02.04.03; 02.25.03

Supported Living Coaching Services Monitoring Protocol

Developmental Services

Supported Living Coaching Services

Monitoring Protocol

Supported living coaching services provide training and assistance, in a variety of activities, to support individuals who live in their own homes or apartments. These services may include assistance with locating appropriate housing, the acquisition, retention or improvement of skills related to activities of daily living such as personal hygiene and grooming, household chores, meal preparation, shopping, personal finances and the social and adaptive skills necessary to enable individuals to reside on their own.

Supported living services mean the provision of supports necessary for an adult who has a developmental disability to establish, live in and maintain a household of their choosing in the community. This includes supported living coaching and other supports.

Cite		Probes
Explanation of Monitoring Tool Symbols/Codes ☼ Alert: Denotes a critical standard or cite relating to health, safety and rights. A deficiency requires a more intense corrective action and follow-up cycle. "W" Weighted Element: A "W" followed by 2.0 or 4.0 in the Cite column denotes elements that have a greater impact on the monitoring score. "R" Recoupment: An "R" in the Cite column denotes an element that is subject to recoupment of funds by the State if the element is "Not Met."		
Standard: The provider successfully supports the individual to live in his or her own home. *For the following elements of performance associated with this standard:* ***Review results of the Person-Centered Reviews, information available from individuals receiving the service and available documentation.*** *The purpose of this section is to determine provider performance and the quality of supports in this area. Do not score an element as met solely based on the presence of the documentation.*		
1 W2.0	The provider develops an individualized implementation plan (IP) for all consumers.	Ask the provider to describe the implementation planning process, including: ➢ Who is typically involved? ➢ When does it usually take place? ➢ What happens with the IP once it is developed? ➢ How does the provider monitor that IP's are being completed within state defined timeframes? Review results and recommendations from Person-Centered Reviews for cites 1-9. *Note: The Supported Living Supports Strategy Guide can be used, but it MUST BE supplemented with all the required elements for the Implementation Plan.*

Cite		Probes
2 W2.0	An individualized implementation plan (IP) is developed under the direction of the consumer. (Was SLC 1)	• Review results and recommendations from Person-Centered Reviews applicable to the provider for cites 2-7 • Ask the provider how each consumer has been involved in the development of their implementation plan. • Talk with individual to determine their level of participation in the IP process. Do services reflect interests and goals that they have? • Interactively with the provider, review a sample of implementation plans. During review, ➢ Explore with the provider what other sources of information about an individual influence the implementation plan. ➢ Determine if there is consumer sign-off on the plan or any changes to the plan to indicate acceptance. ➢ Review monthly summaries to determine if updates are being made to the IP. • Talk to consumers, family or guardians about the progress that is being made in achieving goals. • Ask individual about their participation in the IP process. • Are they satisfied with their goals and supports received? • Have they talked about changes?
3	The IP identifies goal(s) and needs from the individual's support plan and other pertinent sources appropriate to the individual. (Was SLC 2)	• Ask the provider about their process for ensuring their implementation plan is effective and contains information related to these standards. (The IP may contain information from other sources, but at a minimum must contain goals from the support plan.) • The IP identifies training programs and activities to accomplish desired goals and identified needs. • Ask individuals about training and activities in which they are involved. Do they feel these are beneficial? Are they interested in the training and activities?

Cite		Probes
4	The IP identifies strategies and methods to assist the individual in meeting goal(s) as well as the data collection system to be used to assess success and achievement. (Was SLC 3)	• Look for evidence of provider-developed implementation plan forms or other structures put in place to ensure that data is captured consistently and in such a way that it can be analyzed over time. • Determine if the provider evaluates the strategies or methods for effectiveness and how frequently. • Ask the provider how they determine strategies and methods that will assist individuals in meeting goals.
5 W2.0	The IP is reviewed periodically to determine whether progress is being made and is updated to reflect new interest, goals, needs, or strategies to promote meaningful progress. (Was SLC 4)	• Ask the provider to describe how they monitor the progress of the individuals that they serve • Look for evidence that the provider is actively monitoring the progress of individuals. • Look for evidence of IP updates being made based on an individual achieving goals or not. • Review IP and provider's policies, as applicable to determine if plans are reviewed at stated time frames, and changes documented per stated procedures.
6	The provider is tracking and acting on an individual's progress or lack of progress.	Review service log entries and the annual report to determine whether progress is noted. Determine whether: • Activities, supports and contacts are detailed; • Follow-up is performed if indicated; • Progress statements contain objective (data/fact based) as well as subjective information; • Recommendations for changes in approach are made when progress is not being made.

<table>
<tr><th>Cite</th><th></th><th>Probes</th></tr>
<tr><td>7</td><td>The provider has taken action on the results reported through the Person-Centered Review process. (NEW 2003)</td><td>Sample size is at least two person-centered reviews in those instances when more than one has been conducted. 100% of the sample equals a designation of 'Met.'

• Determine if any Person-Centered Reviews have been conducted with consumers receiving services and supports from this provider.
• Ask the provider if they have received Person-Centered Review results and what action they have taken based on the results.
• Interactively, with the provider, review records and documentation for individuals that have taken part in the person-centered review process. Determine if there is any documented evidence that the provider has acted on the recommendations in the report.
• Talk with individuals who participated in the person centered review to determine whether changes were discussed with them and have been made. Are they satisfied with the service changes?

Note: If there have been no person-centered reviews conducted with individuals for which this provider renders services and supports, score this cite as 'Not Applicable.'
Note: The provider may address the recommendations in a manner other than that identified in the report.</td></tr>
<tr><td>8</td><td>The provider assists individuals in completing a functional community assessment prior to his or her move to a supported living arrangement. (Was SLC 5)</td><td rowspan="2">Functional Community Assessment is the basis for identifying the types of training, assistance and the intensity of support rendered by the provider. It is a tool designed to assist the provider in becoming familiar with the individual and his/her capabilities and needs. This assessment addresses all areas of daily life including relationships, medical and health concerns, personal care, household and money management, community mobility, recreation and leisure.
• Ask the provider to describe their process for completing and updating the functional community assessment, including when this activity typically occurs.
• Interactively, with the provider, review a sample of these assessments to determine when they are completed and when they are updated.
• Talk with individuals to determine their level of participation in this process.</td></tr>
<tr><td>9</td><td>The provider assists individuals in updating the functional community assessment annually. (Was SLC 6)</td></tr>
</table>

Cite		Probes
10	The provider forwards a copy of the completed initial Housing Survey to the individual's support coordinator within 10 working days of the selection. (Was SLC 7)	*The Housing Survey is the basis for surveying a prospective home to ensure that it is safe.* *Note: The quarterly update to the Housing survey should be presented in a face-to-face meeting between the supported living coach, the individual and the support coordinator. The individual may invite others to attend. The meeting should cover the individual's financial status, supported living services and the individual's health, safety and well-being.* • Ask the provider to describe the process for completing and updating the Housing Survey for individuals. • Determine when this activity occurs, what is included in the completion and updating process in terms of review. • Determine if and when the provider submits the initial, and reviews and submits the revised Housing Survey to an individual's support coordinator. • Interactively, with the provider, review a sample of records of individuals that have a completed Housing Survey, and look for dates of completion and submission to support coordinators. • Determine whether surveys appear to appropriately reflect the individual's living situation. • Look for evidence of updates to the Housing survey • Look for documentation (date, reviewer signature, etc.) that the quarterly reviews took place, the survey was reviewed, and who was in attendance. • Discuss with individuals their level of participation in this process.
11 W2.0	The provider updates the Housing Survey quarterly and has it available for review by the waiver support coordinator at the time of the coordinator's quarterly home visit. (Was SLC 8)	
12 W2.0	The provider's quarterly updates to the support coordinator include a review of the individual's overall status of health, safety and well-being. (Was SLC 9)	

Cite		Probes
13	The provider assists individuals in completing the Financial Profile and submitting it to the waiver support coordinator no more than 10 days following the selection of housing by the individual. (Was SLC 10)	*The Financial Profile is an analysis of the household costs and revenue sources associated with maintaining a balanced monthly budget for the individual. The analysis will substantiate the need for a monthly subsidy or initial start-up costs, and should be a source of information for determining strategies for assisting the person in money management.* *Note: The quarterly update to the financial profile should be presented in a face-to-face meeting between the supported living coach, the individual and the support coordinator. The individual may invite others to attend. The meeting should cover the individual's financial status, supported living services and the individual's health, safety and well-being.* • *Ask the provider to describe the process for completing a financial profile for an individual, including when this activity usually takes place.* • *Interactively, with the provider, review a sample of records to determine that the financial profile is included as part of the individual's Implementation Plan.* • *Determine whether surveys appear to have been updated and whether they appropriately reflect the individual's financial situation.* • *Look for evidence of updates to the Financial Profile.* • *Look for documentation (date, reviewer signature, etc.) that the quarterly reviews took place, the financial profile was reviewed, and who attended.* • *Discuss with individuals their level of participation in this process.* *Note: If the financial profile indicates a need for a one time or recurring subsidy, the profile must be submitted to the waiver support coordinator and approved by the District before the individual signs a lease.*

Cite		Probes
14	Providers acting as fiscal agents for the individual must provide bank statements and other financial to the support coordinator for review at the time of the quarterly meeting. (NEW 2003)	Look for documentation that a review of the bank statements takes place at the time of the quarterly review with the support coordinator. • Discuss with the provider what other financial documents are reviewed. (e.g. mortgage or rent payments, utilities, etc.) • Determine whether the provider has signed written consent to act as the fiscal agent. • Talk with individuals to determine their satisfaction with this support. • Review results and recommendations from person-centered reviews. *Note: If the provider is not acting as fiscal agent, score this cite as 'Not Applicable.'*
15 W2.0	Provider assists individuals to be fiscally responsible in their decision making and to assure that affordable choices are made. (Was SLC 11)	• Ask the provider to describe, using specific examples, how they assist individuals in being fiscally responsible. • Individuals with resource limitations are counseled by the coach on the benefits of sharing cost with a roommate and other cost saving means • Check provider documentation to determine that this assistance is being noted. • Talk with individuals to determine the level of support in this area. • Review results and recommendations from Person-Centered Reviews.
16	As appropriate to the individual's goals, needs, and interests, services are provided in the individual's place of residence or in the community. (Was SLC 12)	Review results and recommendations from Person-Centered Reviews to assist in scoring cites 16-17. • Ask the provider where they typically provide supported living coaching services. • Determine whether the services and activities are based on the individual's interest, choice or related goal or need, and not the convenience of the provider. • Talk with individuals to determine where services are provided and whether they have input into service location.

Cite		Probes
17 W2.0	As appropriate to the individuals' goals, needs, and interests, the supported living coach works with other providers and an individual's waiver support coordinator to avoid activity duplication. (Was SLC 13)	• Ask the provider to describe, using specific examples, how they coordinate coaching services and supports with other providers. • Review claims and other documentation to determine if services unnecessarily duplicate or overlap. (e.g. supported living coach and in-home support staff should not perform same functions.) • Determine if the provider has routine contact individuals' support coordinators and other providers. • Check provider documentation to determine that this contact is being noted. • Talk with individuals receiving the service to determine how supports are delivered.
Standard: The provider and all employees of the provider are qualified to provide Supported Living services.		
18 ☼ W4.0	Level two background screenings are complete for all direct service employees. (Was SLC 14)	Review available personnel files or records to ascertain compliance. Check for: • Notarized affidavit of good moral character; • Proof of local background check • Documentation of finger prints submitted to FDLE for screening and screening reports on file; • Criminal records that include possible disqualifiers have been resolved through court disposition.
19☼ W4.0	All employees undergo background re-screening every 5 years. (Was SLC 14)	• Review available personnel files or records to very that employees undergo background re-screening at least every 5 years. • Look for evidence of completion and submission of an FDLE Form, identified as either attachment 3 or 4. *Note: Fingerprint cards are not required on resubmission.*

Cite		Probes
20	Independent providers and employees of agencies who render services have a bachelor's degree from an accredited college or university with a major in nursing, education, or social, behavioral or rehabilitative science. (Was SLC 15)	*In lieu of a bachelor's degree, a person rendering these services has an associate's degree from and accredited college or university with a major in nursing, education or social, behavioral or rehabilitative science and two years of experience. Experience in one of the previously mentioned fields can substitute on a year-for-year basis for the required college education.* • Ask the independent vendor about their qualifications and experience. • Ask to see a copy of the provider's resume and personnel file. Review file for documentation of qualifications. • If possible, query the district before the visit, to check the enrollment file references. • Determine if the provider participates in at least one monitoring review per year and has been certified by the district. (Certification usually occurs at the time of enrollment.) Review a sample of agency staff personnel files. • Check job descriptions, to determine that the provider is requiring these qualifications. • Check job applications completed by the employee and/or resumes of employees for required experience. • Determine if the provider participates in at least one monitoring review per year and has been certified by the district. (Certification usually occurs at the time of enrollment.)

Standard: The provider and the provider's staff meet training requirements for delivery of Supported Living services.

For all the following elements of performance associated with this standard: Review district requirements for mandatory meetings and training documentation.. Review provider's training records to determine if documentation is maintained and at a minimum includes: The topic of the training; length of the training session; Training dates; Participants' signature; Instructor's name; Objectives and/or a syllabus.

NOTE: The District is not the sole source for a provider to find training programs and activities referred to in the Core Assurances. Providers may develop their own curriculum for their staff, or providers and their staff may attend a program offered through another provider.

Cite		Probes
21	Agency employees and independent providers are required to attend at least 12 hours of pre-service training prior to assuming job responsibilities. (Was SLC 16)	• Ask the provider to describe the type of training that is required for Supported Living Coaching and how they arrange for this training for themselves or employees. • Review personnel files and other provider training records for evidence that required training has taken place or is scheduled. • Determine that services are not being rendered to individuals before the provider or providers' staffs have had the required training. • Ask agency employees to describe the training they have received and when the training occurred, or when it will occur in the case of retraining.
22 W2.0	Agency employees and independent providers have eight (8) hours of annual in-service training. (Was SLC 17)	• Ask the provider to describe the type of training that is required for Supported Living Coaching and how they arrange for this training for themselves or employees. • Review personnel files and other provider training records for evidence that required training has taken place or is scheduled. • Determine that services are not being rendered to individuals before the provider or providers' staffs have had the required training. • Ask agency employees to describe the training they have received and when the training occurred, or when it will occur in the case of retraining.
23	Agency employee and independent provider training consists of, at a minimum, a detailed review of the most current (now using the 1997 publication), *A Guide to Supported Living in Florida*, an overview of affordable housing options and home modifications, and Rule 65B-11, Florida Administrative Code. (Was SLC 18)	• Ask the provider to describe the type of training that is required for Supported Living Coaching and how they arrange for this training for themselves or employees. • Review personnel files and other provider training records for evidence that required training has taken place or is scheduled. • Determine that services are not being rendered to individuals before the provider or providers' staffs have had the required training. • Ask agency employees to describe the training they have received and when the training occurred, or when it will occur in the case of retraining.

Cite		Probes
24	Proof of current training and certification in Cardiopulmonary Resuscitation (CPR) is available for all independent providers or agency staff. (NEW 2003)	• Independent vendors and agency staff complete this training within 30 days of initially providing services. • Review provider, or a sample of agency staff personnel files and/or training records for evidence of required training. Training documentation must be maintained on file. • Determine if the provider or agency staff receive retraining according to the CPR requirements established by the sponsoring organization or requirement. • Review CPR certificates or CPR training documentation to determine expiration date and need for updated training. *Note: A certified trainer must provide CPR training.*
25	Proof of current training in AIDS and infection control is available for all independent providers and agency staff. (Was SLC 19)	• Independent vendors and agency staff complete this training within 30 days of initially providing services. • Determine if the independent vendor and agency staff receives retraining according to the requirements established by the sponsoring organization or regulation. • Review personnel files and other provider training records for evidence of required training. • Infection control may be a separate training or included and documented as part of the AIDS training as "universal precautions". *Note: American Red Cross First Aid Training does not meet the requirements for HIV/AIDS training.*

<table>
<tr><th>Cite</th><th></th><th>Probes</th></tr>
<tr><td>26</td><td>The provider attends mandatory meetings and training scheduled by the District and/or Department. (Was SLC 21)</td><td>Ask the provider if they are aware of District and Department mandatory meeting and training schedules. Ask the provider if they can produce any notices, announcements or agendas received about meetings or training.
Ask the provider what District and Department meetings or training they have attended during the review period.
Ask the provider for any evidence they have to verify attending the meeting or training.
Look for evidence in documents supplied by the provider of attendance at District and Department meetings, such as notes in personnel files or other records.
Note: If the District has not sponsored any mandatory meetings, score this cite as 'Not Applicable.'</td></tr>
<tr><td>27

W2.0</td><td>Independent providers and agency staff receive training on responsibilities and procedures for maintaining health, safety and well-being of individuals served. (Was SLC 24)</td><td>Ask the provider and/or their staff about what types of training programs they have and continue to attend.

Training on health, safety and well-being of individuals <u>could include</u> such topics as:
Fire safety for the environment;
Evacuation procedures in the event of natural or other disasters;
Training on what to do in the event of personal health emergencies involving consumers;
Traffic/transportation safety;
Basic infection control training, e.g., hand washing before and after all contact with consumers.</td></tr>
</table>

Cite		Probes
28 W2.0	Independent providers and agency staff receive training on medication administration and on supervising individuals in the self-administration of medication. (Was SLC 25)	Determine if: • The provider has a policy related to their own and/or staff training on medication administration or supervision of self-administration of medication. • The provider and/or staff receive training on medication administration or supervision of self-administration of medications, when applicable to their job responsibilities and the needs of individuals in the program. • Determine if medication administration training includes evidence of a return demonstration by an RN of the training by the provider and staff. • Determine if the training includes recognizing adverse drug reactions, drug-to-drug interactions or food and drug interactions. • Determine if training is provided by a qualified trainer (physician, registered nurse); the curriculum used is developed or approved by an RN or other appropriate entity (e.g. district). *Note: A provider's policy on medication administration may be that their program does not administer or supervise self-administration of medications and all staff are made aware of this position and trained on this policy.*
29	Independent providers and agency staff receive training on required documentation for service(s) rendered.	Look for evidence that the provider and/or staff have received training on the type and format of documentation that is required for the services and supports that they render. Examples of this training could include: • The proper format and content of a progress note, • Recording data related to an individual's progress towards achieving goals, • Documenting the activities that individuals participate in during their time with the provider. • Instruction on documentation that is required for reimbursement and monitoring purposes. • Development of an Individual Implementation Plan and supporting documentation requirements.

Cite		Probes
30	Independent providers and agency staff receive training on responsibilities under the Core Assurances. (Was SLC 27)	Look for evidence that the provider and/or staff have been familiarized with and have had some training related to the Core Assurances section of their Waiver Services Agreement and the DS Waiver Services Florida Medicaid Coverage and Limitations handbook. Examples of this training could include instruction on: • The rights of individuals in the program and how the provider respects these rights; • Maintaining confidentiality of consumer information; • Offering individual's choice of services and supports; • Recognizing and reporting of suspected abuse, neglect or exploitation; • Assisting individuals in achieving personal goals and desired outcomes; • Rendering services in an ethical manner.

Cite		Probes
31	Independent providers and agency staff receive training on responsibilities under the requirements of specific services offered. (Was SLC 27)	Look for evidence that the provider and/or staff have been familiarized with and have had training related to the service specific sections of their Waiver Services Agreement and the DS Waiver Services Florida Medicaid Coverage and Limitations handbook. Examples of this training could include instruction on: • Implementation plan development and monitoring; • Specifics of rendering services and supports; • Service limitations; • Service documentation requirements • Billing for services; and • Outcomes established for service delivery.

Cite		Probes
32	Independent providers and agency staff receive training on use of personal outcomes to establish a person-centered approach to service delivery. (Was SLC 28)	Look for evidence that the provider and/or staff have received training on using desired outcomes for individuals as the guide for rendering services and supports. Examples of this training could include instruction on: • Designing training programs that address the consumers goals from the Support Plan; • Involving the consumer and/or family in the development of the implementation plan; • Designing services and supports from the standpoint of the outcome that is desired by the individual and/or family. • Training in Personal Outcome Measures or another person centered planning approach. • Individualizing service delivery methods. Refer also to the providers policy in this area to determine training specified. *Note: This does not mean that the provider must have received the official Personal Outcome Measures training (with the exception of Support Coordinators). Other person-centered approaches are acceptable.*

Cite		Probes
33 W2.0	Independent providers and agency staff receive other training specific to the needs or characteristics of the individual as required to successfully provide services and supports. (Was SLC 29)	Look for evidence that the provider and/or staff assigned to render services and supports to individuals have received some orientation to an individual and their unique characteristics and needs. The family or guardian, a physician or nurse, other providers or people who are in regular contact with and understand the unique characteristics and needs of the individual can provide this orientation. Examples of this training could include instruction on: • Communicating with the individual; • Repositioning requirements for the individual; • Instruction on a behavior program, if applicable to the individual; • Specific training to implement a training program tailored to an individual's goals. This training may be one-on-one in nature, and therefore documentation may not take the form of an agenda, or curriculum with handouts and outline. Look for evidence in the consumers record, such as in progress notes or other provider documentation for this evidence.
34	Proof of required training in recognition of abuse and neglect and the required reporting procedures is available for all independent vendors and agency staff. (New 2003)	• Review personnel files and other provider training records for evidence of required training. • If applicable, ask staff about the in-service training that they have received. • Training should include prevention, detection and reporting requirements.

Cite		Probes
Standard: Services are provided at an intensity and duration necessary for successful support of the individuals served.		
35	Services are rendered at a time and place mutually agreed to by the individual and the provider. (Was SLC 31)	• Ask the provider to supply evidence that they work with the individual to identify service times. • Review the provider's satisfaction survey to determine if this is an area that is covered and if the provider has any results. • If the provider collects complaint data, ask to see the data and determine if any complaints have been reported relative to service times. • Ask the individual if the time and location of the service is consistent with their needs and expectations. • Determine from discussions with the provider and with individuals that alternative times for supported living coaching are being offered • Review results and recommendations of person centered reviews applicable to the provider to determine whether choices are optimized.
36 W2.0	Providers have an on-call system that allows individuals' access to services for emergency assistance 24 hours-per-day, 7 days a week. (Was SLC 32)	• Ask the provider to describe their on-call and back-up systems. • Determine that telephone access to the provider or the backup provider is available without toll charges to the individual. • Determine if independent provider's backup providers are certified and enrolled Medicaid providers and certified as a supported living provider pursuant to rule 65B-11, Florida Administrative Code. • Determine through discussion with individuals that provider accessibility meets their expectations. Do they have difficulty reaching the provider? Are they satisfied with the amount of access? • Review results and recommendations of person centered reviews. *NOTE: Score Cite 37 as 'Not Applicable' when evaluating an Agency.*
37	Independent providers must specify a backup person to provide supports in the event he or she is unavailable. (Was SLC 33)	

Cite		Probes
38	Supported living coaching services are provided only to adults (age 18 or over) who rent or own their own homes or apartments in the community. (Was SLC 34)	• Check demographic data in the provider's files for age, and a copy of the individual's lease. • Review individual's lease if available in the provider's files. *The individual receiving supported living services must appear on the lease either singularly, with a roommate or a guarantor.* • Look for evidence or ask individuals whom they pay monthly for rent. • Providers, or their immediate family are not the individual's landlord, nor do they have any interest in the ownership of the housing unit.
39 W2.0	Individuals receiving supported living coaching services live where and with whom they choose. (Was SLC 36)	• Interactively, with the provider, review progress note documentation to determine how the individual made living arrangement decisions. • Speak with any individual(s) about their living arrangements and if they were involved in the decision and if the arrangements are desirable. • Review results and recommendations from person centered reviews to examine choice, living options/decisions and satisfaction with community integration. • Review results of the annual satisfaction survey.
40 W2.0	Individuals receiving supported living services have control over the household and its daily routines. (Was SLC 38)	
41	Services are made available to individuals within 90 days prior to moving or to individuals who are in the process of looking for a place of their own. (Was SLC 39)	• Ask the provider to describe, using specific examples, when supported living coaching services are typically made available to individuals. • Interactively, with the provider, review records and documentation to determine when services are made available to individuals that are moving or looking for alternative living arrangements. • Determine that these services are only rendered 90 days prior to an individual's move from residential habilitation. • Talk with individuals about services and review person centered reviews applicable to the provider.
42	Supported living coaching services are not provided to individuals who live in family homes, foster homes, or group homes, except for the 90 days prior to the individual moving into their own homes or apartments. (Was SLC 40)	

Cite		Probes
43	Waiver program providers and employees of waiver providers who provide incidental transportation comply with all program requirements. (Was SLC 41)	*Note: Incidental transportation is considered that which is outside of the transportation for disadvantaged program.* • Determine if the provider transports individuals. ➢ If transportation is provided in personal cars and/or agency vehicles check for current vehicle registration and proof of insurance coverage. ➢ Check for provider and employee valid and current driver's license as applicable. ➢ Ask the provider about their system to assure vehicle safety. ➢ The district should be notified of any traffic violations immediately, with the exception of parking tickets.

Cite		Probes
Standard: The provider maintains sufficient reimbursement and monitoring documentation to verify service delivery and to evaluate each individual's services and supports. *Note: Score based on the presence or absence of required documentation.*		
44 R	Provider has at a minimum, a copy of the service log for the period being reviewed. (Was SLC 42)	Review a sample of provider records to determine that • Copies of service logs are available and contain times and dates that service was rendered with a detailed list of the activities performed on each visit. ➢ Progress notes including documentation of activities, supports and contacts with the individual, other providers and agencies with dates and times, ➢ A summary of support provided during the contact, ➢ Any follow-up needed, and ➢ Progress toward achieving Support Plan goals. **Cite 44 is subject to recoupment as reimbursement documentation if not available.**

Cite		Probes
45 R	Provider has at a minimum, an individual implementation plan, and/or transition plan (if applicable). (Was SLC 43)	Interactively, with the provider, review a sample of implementation plans to determine they contain, at a minimum: • Name, address and contact information of the individual served; • Goal(s) from the support plan that the service will address. • Strategies employed to assist the individual in meeting the support plan goal(s). • System to be used for data collection and assessing the individual's progress in achieving the support plan goal(s). • For SLC, include the frequency of the supported living service. • How home, health and community safety needs will be addressed and the supports required to meet these needs. • The method for accessing the provider 24-hours per-day, 7-days per-week for emergency assistance. • A description of how natural and generic supports will be used to assist in supporting the individual. • A financial profile that includes strategies for assisting the person in money management, when requested by the individual or guardian, and the amount approved for the supported living subsidy (the financial profile is critical in determining whether or not the housing selected by the individual is within their financial means and will identify the need for monthly subsidy which must be approved by the District). Additionally, the implementation plan may include training objectives appropriate to the individual's programs and services. **Cite 45 is subject to recoupment as monitoring documentation if not available.**

Cite		Probes
46 R	The IP is developed, at a minimum, within 30 days of new service initiation (implementation plan complete and copy sent to support coordinator at time of first billing), or within 30 calendar days of service authorization effective date when services are being continued. (NEW 2003)	• Review records to compare service authorization data with IP development time frames. • How does the provider monitor that IP are being completed within stated time frames? • Review records to determine that support coordinator supplied with a copy of the plan at the time of initiation and when significant updates are made to the plan. **Cite 46 is subject to recoupment as reimbursement documentation if not available within 30 days of the effective date of the authorization.**
47 W2.0	Provider has at a minimum, an annual written report summarizing the individual's progress toward achieving the goal(s) from the support plan. (Was SLC 44)	• Interactively, with the provider, review a sample of records to determine if they contain an annual, written report that indicates the individual's progress toward their support plan goal(s) for the year. • The annual report should reflect progress statements made in the service log and other supporting documentation. Reports should include ➢ Objective (fact-based) information reflecting the results of training and supports provided to the individual over the course of the year, ➢ Subjective information (opinions), and ➢ Recommendations. • Look for evidence that the Annual Report was sent to the support coordinator and provided to the individual/family 30 days prior to the end of the support plan year.
48	Provider has at a minimum a copy of the annual satisfaction survey maintained in the individual's record. (Was SLC 45)	Interactively, with the provider, review a sample of records or other files and reports to determine if they contain a copy of the completed satisfaction survey and resulting quality improvement measures that have been put in place as a result of the survey. *Note: Staff providing direct supported living services to the individual may not assist in the survey activity for that individual. A family member, guardian, support coordinator or another person should be enlisted to assist the individual.*

Cite		Probes
49	The provider forwards a copy of the annual satisfaction survey to the waiver support coordinator. (Was SLC 45)	Look for evidence that the provider has forwarded satisfaction survey results to the waiver support coordinator. This could be a note and date on the copy of the survey that is maintained in the individual's file or a sentence in the progress notes.
50 W2.0	Provider has at a minimum, documentation of a quarterly meeting in which the individual, the waiver support coordinator and the supported living coach review supported living services. (Was SLC 46)	Interactively, with the provider, review records of individuals for evidence of quarterly meetings with the support coordinator. Quarterly meetings with the individual and support coordinator should cover at least the following topics: • Financial statement and bank record review, when applicable • Housing survey and any updates • Updates to demographic, health, medical, and emergency information. *Note: It is the responsibility of the support coordinator to set up the quarterly meeting at a time convenient for all participants. If no meeting was set, look for evidence that the supported living provider attempted to satisfy this requirement. They are an active, not passive partner in this.*
51	When the provider is acting as fiscal agent for the individual, provider has at a minimum, progress notes in the service log indicating that the supported living coach and waiver support coordinator review bank statements and financial records quarterly. (Was SLC 47)	Interactively, with the provider, review records of individuals for evidence of quarterly meetings with the support coordinator. Quarterly meetings with the individual and support coordinator should cover at least the following topics: • Financial statement and bank record review, when applicable • Housing survey and any updates • Updates to demographic, health, medical, and emergency information. *Note: It is the responsibility of the support coordinator to set up the quarterly meeting at a time convenient for all participants. If no meeting was set, look for evidence that the supported living provider attempted to satisfy this requirement. They are an active, not passive partner in this.*

Cite		Probes
52 R	Provider has at a minimum, an initial Housing Survey containing quarterly updates of the individual's health and safety status. (Was SLC 48)	Interactively, with the provider, review records of individuals for evidence of an initial Housing Survey and quarterly updates. **Cite 52 is subject to recoupment as monitoring documentation if not available.**
53	Provider makes available an initial Housing Survey with quarterly updates to the waiver support coordinator. (Was SLC 49)	*Note: The Housing Survey and updates can be provided at the quarterly meetings between the SLC and WSC or it can be provided to the WSC prior to the quarterly meeting.* Interactively, with the provider, review a sample of individual records to determine there is evidence of a meeting or transmission of the Housing survey and updates to the WSC contained in the service log/progress notes.
54	Provider has at a minimum, up-to-date information regarding the demographic, health, medical and emergency information, and a complete copy of the current support plan, if approved by the individual/guardian, for each individual served. (Was SLC 50)	Interactively, with the provider, review a sample of individual records to determine they contain ➢ Current demographic, health, medical and emergency information, and ➢ A complete copy of the current support plan (if permitted by the individual/guardian). Determine from provider how often information is updated. Is there evidence that the provider shares the individual's updated information with their waiver support coordinator?

Cite		Probes
Standard: Provider bills for services as authorized.		
55 R	Supported living coaching services are limited to the amount, duration and scope of the services described in the individual's support plan and current approved cost plan. (Was SLC 30)	• Interactively, with the provider, review daily service logs and monthly progress notes. • Compare services provided against the service authorization for the sample under review. • Verify that service authorizations are on file for each individual. • Review claims information and compare against authorization and billing. **Cite 55 is subject to recoupment if the provider is rendering the service without an authorization, or is billing for more than the authorized service levels.**
56 R	Provider does not bill separately for transportation that is required during a supported living activity. (Was SLC 52)	• Interactively, with the provider, review a sample of claims submitted for payment. • Compare the sampled claims with service records for individuals and claims information. • Ask the provider to describe and discuss billing policies and procedures. • Ask the provider if they have had any difficulty with denied claims. **Cite 56 is subject to recoupment for any amount billed separately for transportation that was included in the supported living rate.**
57 R	The provider bills for supported living coaching as defined and specified in the DS Waiver Services Medicaid Coverage handbook. (NEW 2003)	Supported Living Coaching services are training services expected to enhance skills and achieve individual outcomes. **Cite 58 is subject to recoupment for any individual when there is evidence that the individual is not receiving this service as defined. (e.g. No evidence of training services or meaningful support for the individual, and services were billed.)**

Cite		Probes
Standard: The provider meets Projected Service Outcomes established for service delivery.		
58	The provider has established a systematic method of data collection for outcome data. (Was SLC 54)	• Ask the provider to discuss the goals and projected outcomes that they are monitoring. • Ask the provider what data they are collecting and how they collect the data (e.g, record review, specially developed forms completed by employees, consumer satisfaction surveys, etc.) • Ask for samples of the tools or other evidence that confirms data is being collected and monitored. • Ask the provider to describe how it is determined they are meeting the goals and projected outcomes. • If the provider has any data or reports that they produce and maintain related to the goals and projected outcomes, ask to see these reports and identify how long the provider has been tracking this data.
59	There is evidence that the data is reviewed periodically and that corrective measures are put in place if the data indicators that the goal is not being achieved. (Was SLC 55)	• Ask the provider how it is determined they are achieving projected outcomes. • Ask the provider how frequently they perform this monitoring. • Ask the provider if they have identified any areas in need of improvement and what corrective actions they have taken. • Look for evidence that the provider is collecting and monitoring data according to the time frames they have defined.

Cite		Probes
60 W2.0	Individuals in supported living are the lessee or owner of the home in which they reside. (NEW 2003)	**For elements 60-65, document findings in comments as # met/total sample. 100% of the sample equals a designation of 'Met.'** Outcomes should be measured considering individual skills and circumstances. Determine achievement of projected service outcomes at the time of the review using the following: ➢ Results and recommendations from person centered review applicable to the provider. ➢ Information from sample records and documentation reviewed. ➢ Results gathered from other review information ➢ Discussion with individual's receiving services ➢ Review the provider's data or reports on the service outcomes. ➢ Ask the provider if they have calculated a rate of achievement for this outcome. ➢ Check leases for individual's signatures or the provider's data on lease and mortgage information. ➢ Ask the provider what they are doing with the information when it reveals a need for improvement.
61 W2.0	The provider achieves a satisfactory or better rating, based upon the results of annual individual satisfaction surveys. (NEW 2003)	• Review the provider's data or reports on the service outcomes. • Ask the provider if they have calculated a rate of achievement for this outcome. • Ask the provider what they are doing with the information when it reveals a need for improvement.
62 W2.0	Individuals in supported living live in homes occupied by no more than two other beneficiaries with developmental disabilities and in areas in which persons with disabilities account for no more than 10% of the houses or 10% of the units in an apartment complex, unless otherwise waived by the Department. (NEW 2003)	• Review the provider's data or reports on the service outcomes. • Ask the provider if they have calculated a rate of achievement for this outcome. • Ask the provider what they are doing with the information when it reveals a need for improvement.

Cite		Probes
63 W2.0	Individuals who use the supports and services of the provider demonstrate an increase in abilities, self-sufficiency, and changes in their lives consistent with their Support Plan goal(s). (NEW 2003)	Indicators may include achievement of goals on the Support Plan and Implementation Plan, results of Satisfaction Surveys and Personal Outcome Assessments. • Review service logs and annual reports. • Review the provider's data or reports on the service outcomes. • Ask the provider if they have calculated a rate of achievement for this outcome. • Ask the provider what they are doing with the information when it reveals a need for improvement.
64 W2.0	Individuals who use the services of the provider achieve an increased level of community inclusion or community involvement. (NEW 2003)	Indicators may be: ➢ Evidence of building and/or maintaining natural support systems, ➢ Establishing or increasing community connections, and/or ➢ Exercising rights and privileges as fully participating members of the community. • Review service logs and annual reports. • Review the provider's data or reports on the service outcomes. • Ask the provider if they have calculated a rate of achievement for this outcome. • Ask the provider what they are doing with the information when it reveals a need for improvement.
65 W2.0	Individuals who use the services of the provider maximize freedom of choice in all areas of their lives as evidenced by setting personal goals, being fully informed about service options and making all possible decisions with regard to the conduct of their lives. (NEW 2003)	• Review the provider's data or reports on the service outcomes. • Ask the provider if they have calculated a rate of achievement for this outcome. • Ask the provider what they are doing with the information when it reveals a need for improvement.
Standard: Personal funds are appropriately maintained and are accounted for accurately.		
66 W2.0	Separate checking or savings accounts are maintained for individual's personal funds. (Was SLC 56)	Determine if the provider acts as a fiscal agent, manages, stores and/or retains funds belonging to an individual. If yes, determine if the conditions outlined in cites 69-76 are

<table>
<tr><th>Cite</th><th></th><th>Probes</th></tr>
<tr><td>67

W2.0</td><td>If a single trust account is maintained for personal funds of all individuals, there is separate accounting for each individual. (Was SLC 57)</td><td rowspan="4">being met.

Talk with individuals concerning their fund management and satisfaction with this support.

Review results and recommendations from person centered reviews applicable to the provider.
Review provider policies and procedures on managing, storing or retaining funds belonging to an individual.
Interactively, with the provider, review records of individuals for which the provider is managing, storing or retaining personal funds. Look for written permission from the individual or guardian.
Determine if any complaints or grievances have been filed against the provider relative to the handling of an individual's personal funds.
When available, analyze results of person-centered reviews to identify if providers are consistently following the process outlined in the standard and sub-standards when managing, storing or retaining an individual's personal funds.</td></tr>
<tr><td>68

W2.0</td><td>Account(s) is reconciled monthly to the account total as noted on the bank statement. (Was SLC 58)</td></tr>
<tr><td>69</td><td>Account statements and reconciliation records are retained for review. (Was SLC 59)</td></tr>
<tr><td>70

W2.0</td><td>Individual and provider funds are not commingled. (Was SLC 60)</td></tr>
<tr><td>71

W2.0</td><td>The provider has written consent to manage funds or act as fiscal agent. (NEW 2003)</td><td>Determine from records that the provider maintains on file a written consent to manage funds signed by the individual, if competent, or their guardian.</td></tr>
</table>

<table>
<tr><th>Cite</th><th></th><th>Probes</th></tr>
<tr><td colspan="3">If the provider is not rendering services to individuals that have problems with behavior such as those that follow, score the elements in this section Not Applicable.
<u>Types of Problems with Behavior:</u>
Actions of the individual which, without behavioral, physical, or chemical intervention
1. Have resulted in self-inflicted, detectable, external or internal damage requiring medical attention or are expected to increase in frequency, duration, or intensity resulting in self-inflicted, external or internal damage requiring medical attention.
2. Have occurred or are expected to occur with sufficient frequency, duration or magnitude that a life-threatening situation might result, including excessive eating or drinking, vomiting, ruminating, eating non-nutritive substances, refusing to eat, holding one's breath, or swallowing excessive amounts of air.
3. Have resulted in external or internal damage to other people that require medical attention or are expected to increase in frequency, duration or intensity resulting in external or internal damage to other persons that requires medical attention.
4. Have resulted or are expected to result in major property damage or destruction.
5. Have resulted or are expected to result in arrest and confinement by law enforcement personnel</td></tr>
<tr><td colspan="3">Standard: Behavioral Services result in objective and measurable improvements in behavior that are consistent with the individual's outcomes.</td></tr>
<tr><td>72</td><td>When rendering services and supports to individuals identified as having problems with behavior, the provider is assisted by a qualified professional or professionals who meet the requirements in the Medicaid Handbook for the type of service the professional is providing.</td><td>If individuals in the program experience problems with behaviors, determine from the provider what qualified behavioral professional assists them with services for this individual.

Determine if the behavioral professional is
• An employee of the provider, review personnel files.
• On contract or an adjunct to the service under review, request that qualifications be available during the time of the review.

Ask to speak with the certified or licensed professional(s) responsible for developing interventions or supports for the individual(s). If psychotropic medications are used, then a licensed physician must be involved. For other services (e.g., counseling) refer to the Medicaid Waiver Handbook for provider qualifications.

Look for evidence that the prescribing professional is monitoring the individual</td></tr>
<tr><td>73</td><td>Behavior Service goal(s) are consistent with and relate directly to the individual's personal outcomes/goals.</td><td>Review the person's support plan, if available, service authorization information, the implementation plan and the individual's behavioral plan (intervention/treatment/therapy plan) to determine if a clear connection exists between behavioral supports and services and the persons stated personal outcomes/goals.</td></tr>
</table>

Cite		Probes
74	The individual has a written, individual plan developed by a certified or licensed professional that clearly identifies what will change as a result of intervention, the intervention(s) to be used and how progress will be measured.	Review record(s) of individuals that the provider or staff has identified as having problems with behaviors. Is a behavior plan present, and who developed the plan? Review the individual's records and the behavior services plan to determine: • The problem with behavior is described in writing and in objective measurable terms. • There is evidence that interventions, treatments and therapies were based on the results of an assessment of the problem with behavior by the behavior service professional. • There is documentation that interventions account for medical problems, significant life changes, or other factors that might worsen the problem with the behavior. • If the individual was evaluated by a physician or other medical professional to rule out potential medical problems that might account for the problem with behavior. *Note: The plan may be written by someone other than the behavior service professional, but must be approved by the professional.*
75 W2.0	Written consent to use the plan was obtained from the individual or guardian.	• Review records and other documentation to determine that signed consent is on file. If consent was not obtained, look for documentation of the reason. • Talk with individuals receiving the service. Are they aware of the plan and interventions? Are they in agreement with the need for intervention and approaches used?
76	Implementers (provider staff) of the plan are able to carry out the plan as written.	• Ask staff to describe the procedures and the circumstances under which they are used • Observe the actual use of the procedure or intervention if possible. • Interview the individual for their understanding of implementation of the plan. • Review personnel and training records to verify staff training on the program.

Cite		Probes
77 W2.0	A system is in place to assure that procedures are carried out as designed.	• Review behavior service plan to determine if a plan to monitor implementation is available. • Review provider or behavioral professional documentation to determine if monitoring occurs as planned. • If there are problems with implementation, are these addressed and corrected?
78 W2.0	There is evidence of progress or lack thereof in reducing the problem with behavior.	Review available and required documentation to determine whether progress in being made, or if lack of progress, that there is a plan for the continuation, modification or termination of services. Documentation available for review to determine whether progress is being made should include: • Data collected on plan implementation. Are the data collected as required in the plan? • Data displays (graphed). Review to determine progress and currency of graphing. • Progress should be verified in writing as a progress note or summary. *Note: Some measurable progress must be demonstrated or predicted or the current array of services must be seriously questioned.*
79	Emergency procedures (e.g., reactive strategies, crisis management procedures) used by the provider for problems with behavior are developed and implemented under the guidance of certified or licensed behavioral services professionals.	• Determine if a written procedure is available. Is the procedure individualized? • Review any procedures that the provider has for emergency or crisis management. *(Note: The provider may have general procedures, as well as individualized. Reviewers should look at both.)* • Determine who developed the emergency or crisis management procedure, and if it is approved by the LRC or the District. • Determine if the procedure identifies: ➢ How staff will be trained; ➢ What documentation must be kept and submitted upon use of the emergency procedure.

Cite		Probes
80	Staff are able to use the procedure when and as designed	• Review personnel and training records to determine whether staff has been trained in the use of these procedures. (Certain procedures such as ACT or TEAM require periodic retraining or certification.) • Determine whether only trained staff is allowed to use these procedures. • Talk with individuals and staff to determine their awareness of, and familiarity with these procedures.
81	Records are kept on the use of the emergency procedure and occurrences of the problem behavior.	Request to see reports on use of emergency procedures. Verify the following: • Daily reports on the employment of physical, chemical, or mechanical restraints by those specialist authorized in the use of such restraints are made to the chief administrator of the program. • A monthly summary including the type of restraint, the duration of usage and the reasons therefore will be submitted to the district administrator and the district local advocacy committee. *(Note: Reports may be sent to the District Developmental Disabilities Program Office for routing to District Administrator.)* • Review the agency procedure for reporting the use of emergence interventions. • Determine if the use of emergency interventions was properly reported. Review documented number of restraints reported to the Local Review Committee. *Note to reviewer: If emergency or crisis procedures have not been used, score this element Not Applicable.*

Personal Outcome Measures (POMs)

Outcome-based person-centered performance measures are a successful tool in program evaluation. The Council on Quality and Leadership redefined quality as responsiveness to people rather than compliance with organizational processes. The use of Personal Outcome Measures is helpful in both supporting and assessing the individual's success during her experience in supported living.

Training on the use of 'Personal Outcome Measures,' designed by the Council, is required by the statewide quality assurance program for all support coordinators. Training on person-centered planning, which may include a discussion on outcomes, is required for supported living coaches. This process includes twenty-five individualized outcome statements, which provide the WSC, as well as the individual receiving services, a method for addressing organizational performance within the context of individual outcomes.

The WSC uses the outcomes, based upon a solid relationship with the individual, for understanding the effectiveness of service delivery; and the individual can use the outcomes to assess her satisfaction with the same. The WSC reviews POMs with each individual on an annual basis.

Personal Outcomes Measures assist the supported living coaching provider in becoming person-centered, focusing on what matters most to each individual. Interviews related to POM are conducted with a sampling of consumers during the annual quality reviews by the statewide quality assurance program. The results of these reviews are shared with the WSC for follow-up. The WSC is responsible for discussing any issues related to the delivery of supported living coaching with the coach.

As a proactive measure the coach may consider using POM as a method for gathering information and assessing progress.

Effective Use of Personal Outcome Measures:

As a component to...

- Assessing satisfaction with services and supports.
- Information gathering for the support plan and annual report.
- Measuring gaps in service delivery.
- Identifying patterns and trends.
- Understanding how well the processes facilitated personal goals.
- Identifying the issues that matter most to people, determining personal priorities.

Chapter Eight: Enhancing Quality

The Council developed personal outcomes over a ten year period, using data collection and interviews with over 2,000 individuals with developmental disabilities. Personal outcomes are organized by categories of people's expectations of the services and supports they receive. These categories and outcome measures refer to the major expectations that people have in their lives. Within each category, individuals have opportunities to identify their own meaning for a particular outcome.

The Personal Outcome Measures are as follows:

IDENTITY

1. People choose personal goals.
2. People choose where and with whom they live.
3. People choose where they work.
4. People have intimate relationships.
5. People are satisfied with services.
6. People are satisfied with their personal life situations.

AUTONOMY

7. People choose their daily routine.
8. People have time, space, and opportunity for privacy.
9. People decide when to share personal information.
10. People use their environments.

AFFILIATION

11. People live in integrated environments.
12. People participate in the life of the community.
13. People interact with other members of the community.
14. People perform different social roles.
15. People have friends.
16. People are respected.

ATTAINMENT

17. People choose services.
18. People realize personal goals.

SAFEGUARDS

19. People are connected to natural support networks.
20. People are safe.

RIGHTS

21. People exercise rights.
22. People are treated fairly.

HEALTH AND WELLNESS

23. People have the best possible health.
24. People are free from abuse and neglect.
25. People experience continuity and security.

Chapter Summary

In supported living, quality must occur on several levels: The person's goals for supported living, as envisioned and described in the support plan, must be met to his satisfaction; the supported living coach must continuously assess her own degree of success and effectiveness, as well as that of any services and supports; and finally, the supported living agency must commit to a culture of excellence.

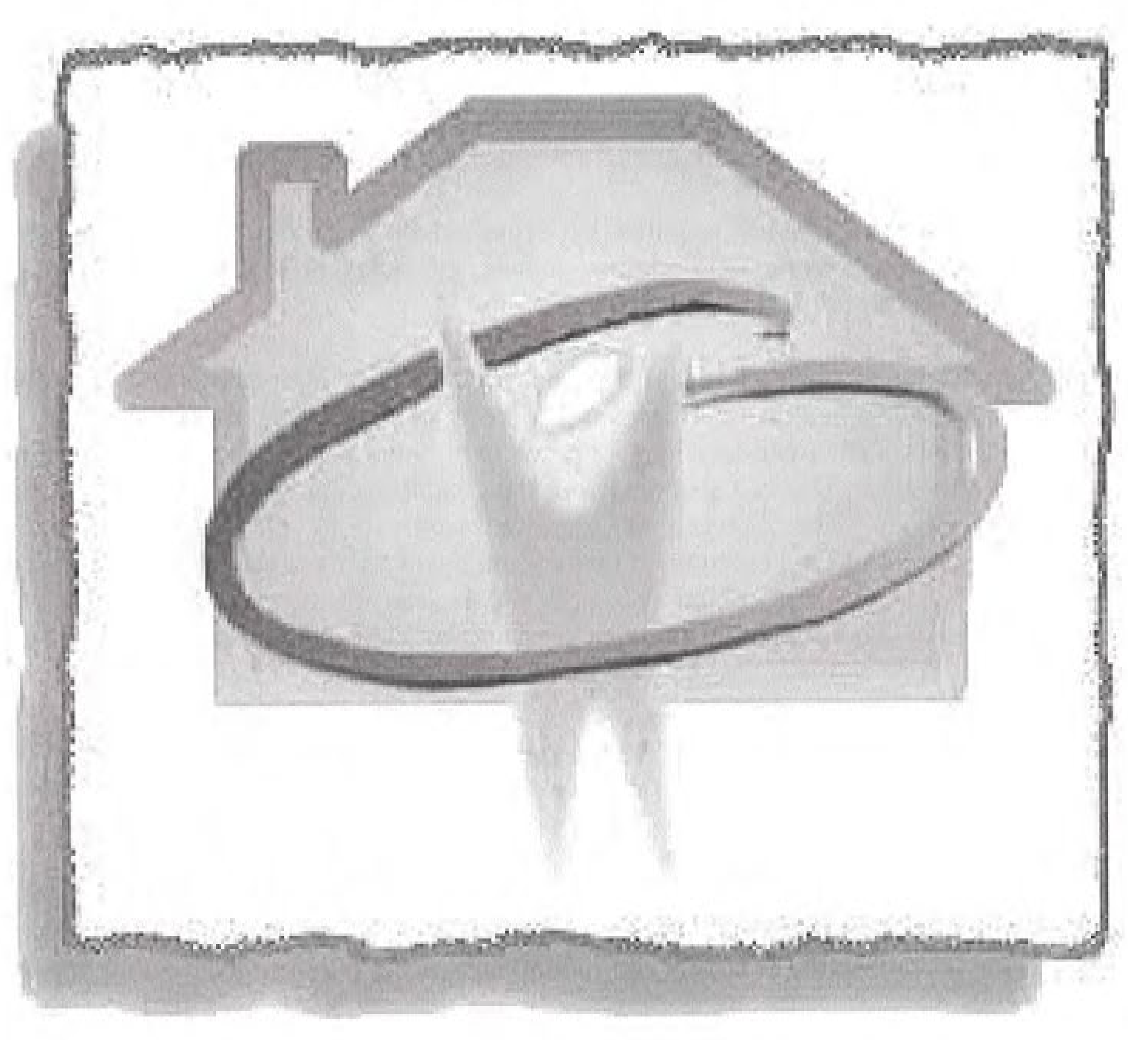
When all three levels are met with quality, people's lives are forever changed. For the individual, the coach, staff, and agency owners, continued success becomes as infinite a possibility as the capacity to dream, and each dream can be fully realized. "The sky's the limit!"

The 'Supported Living Process' graphic that follows illustrates the continuous flow of supported living services. Supported living involves on-going persistence in planning, documenting, and enhancing quality service. When each aspect of the process is carefully implemented, and pursued with dedication and diligence, a cycle of continuing success can be achieved.

The Supported Living Process:

Produced for the Florida Developmental Disabilities Council
By Program Design, Inc. 5/03

GLOSSARY



GLOSSARY

Chapter 393 of Florida Statutes - defines supported living as "a category of individually determined services designed and coordinated in such a manner as to provide assistance to adult clients who require ongoing supports to live as independently as possible in their own homes, to be integrated into the community, and to participate in community life to the fullest extent possible."

Chapter 65B-11 Florida Statutes – Florida Administrative Code (FAC) which defines procedures for the provision of supported living services.

Abuse, Neglect and Exploitation –the infliction of physical pain, injury, or mental anguish, or the deprivation of services by caretakers which are necessary to maintain the health and welfare of an adult. A situation in which an adult is unable to provide or obtain the services which are necessary to maintain the his health or welfare.

Abuse Reporting – Florida law requires that every citizen who knows or has reasonable cause to suspect that a vulnerable adult is abused, neglected or exploited immediately report such suspicions to the 24 hour registry.

Advanced Directives (AD) – a legal document that allows competent people to give instructions regarding health care they would like to receive when they would not be competent to make their own decisions. The written component of the AD is called an instructional directive. The AD also describes the conditions that must occur for the AD to be implemented. The AD can designate someone to be the health care agent (surrogate) in the event the person is no longer competent. This is called Durable Power of Attorney. A special case of an AD, which describes the conditions in which life supports would or would not be provided to an incompetent person, is called a Living Will.

Agency on Healthcare Administration (AHCA) –the state agency responsible for administration of the Florida Medicaid program. Web address: http://www.fdhc.state.fl.us

Annual Satisfaction Survey – a document completed annually by persons receiving supported living services that addresses satisfaction with the supported living provider. The provider is responsible to assure the individual has the opportunity to complete the survey.

Annual Report – completed by the supported living provider, the annual report summarizes the person's progress toward achievement of the goal (s) from the support plan. The annual report shall include objective (fact based) information reflecting the results of training and supports provided to the individual over the course of the year, was well as subjective information (opinions) and recommendations.

Certification – the process used to determine an individual is eligible to provide supported living services. Provider must meet the following requirements: a bachelor's degree form an accredited college or university with a major in nursing, education or a social behavioral or rehabilitative science; or have an associates degree from an accredited college or university with a major in nursing, education or a social behavioral or rehabilitative science and two year of experience.

Circle of Support – a group assembled at the request of the individual, who provides support and direction in the development and implementation of the support plan. The group includes the person and/or the person's spokesperson, family, friends, associates, and may include some human service workers.

Community - local, non-segregated settings where people live, work and pursue leisure interests. For persons with disabilities, community is characterized by generic resources utilized by other people without disabilities and settings which promote direct personal interaction with others.

Core Assurances –the document that specifies administrative and programmatic requirements for Developmental Services Home and Community Based Services Waiver and Developmental Disabilities Program Medicaid Waiver providers.

Cost Plan – the format used by the Waiver Support Coordinator listing all services requested by the individual on the support plan, regardless of funding source, and the anticipated cost of each waiver service. The District/Region must approve the cost plan prior to service provision. Each time a individual's support plan is amended to increase or add services, the cost plan too must be amended and approved, as described above, for the service to be initiated. A support plan and cost plan must be updated for each individual at least annually, during the annual support planning process to reflect current needs and situations. Cost plan forms are available from the District/Region.

Best Practices – a standard established to achieve, review and analyze what works best for people. It's focused on person-centered practices.

Density – a guideline which establishes parameters for supporting individuals in community living. It specifies that persons with disabilities can utilize no more than ten percent of the housing in a city block, subdivision, neighborhood, apartment or condo complex , or mobile home park. The purpose for this is to avoid the development of neighborhoods which are segregated.

Demographic Information – up-to-date information on the person's current living situation and phone numbers along with any emergency contact information. This is usually maintained in the record maintained by the supported living coach.

Department of Children and Families (DCF) –an authorized department (within the state of Florida) by AHCA to operate and oversee the Medicaid Waiver in accordance with the Interagency Agreement for Medicaid.

Developmental Disabilities Program – The Program responsible for the administration of support and services for persons diagnosed with developmental disabilities. This includes the Developmental Disabilities Program office (central office) located in Tallahassee and the Developmental Disabilities District/Regional offices located throughout the state.

Developmental Services Waiver Services Florida Medicaid Coverage and Limitations -a Handbook used by Medicaid Waiver providers as a reference. The Handbook lists all waiver services offered under the Developmental Services Home and Community Based Services Waiver, provider qualifications and training requirements, projected service outcomes, service descriptions, service limitations, documentation requirements, place of service and special considerations for service delivery. The handbook also contains Procedure Codes, the Waiver Services Agreement, the Core Assurances, and Contact Directories for AHCA area and DCF District offices. The website address at time of publication is www.fdhc.state.fl.us/Medicaid/dev_serv/.

Disaster Preparedness Plan –a plan tailored to each individual's location, situation and need. This plan gives the person security in knowing what to do for any major natural or human disasters such as hurricanes, tornadoes, floods, riots and other large-scale emergencies.

Do Not Resuscitate (DNR) orders – is a written directive from a person or his doctor that he should not be revived if he experiences cardiac arrest or stops breathing. Instead, the person desires a natural death without invasive medical procedures. This usually occurs when the person experiences inevitable fatal illness and does not wish to prolong his suffering.

Fiscal Agent –Persons serving as a representative payee for receipt of third party benefits, cosigner on bank accounts, maintaining physical possession of banking records or otherwise controls the individual's finances.

Functional Community Assessment (FCA) –the basis for identifying the types of instruction and the intensity of support rendered by the provider. FCA is a tool designed to assist the provider in becoming familiar with the individual and his or her capabilities and needs. This assessment addresses all areas of daily life including relationships, medical and health concerns, personal care, household and money management, community mobility, recreation and leisure. This is completed with the person prior to their move into a supported living arrangement.

Grievance Logs - logs maintained for review by the provider to include the name of the person making the complaint and their relationship to the individual receiving services;

date the complaint is received; a clear description of the complaint; and the date of the final disposition of each logged complaint.

Guardian –a legally designated person in the individual life that ensures protection of rights as well as health and safety. Guardians make decisions on behalf of the individual, consistent with the levels of decision making identified in the court order. decisions in each person's life.

Health History – a written summary of the person's overall health, including ongoing health concerns and documentation of follow up for these concerns.

Home - a place where one lives or resides; an environment offering security and happiness; a valued place regarded as a refuge or place of origin.

Housing Survey - the basis for surveying a prospective home to ensure that it is safe. This survey must be updated quarterly by the supported living coach and made available for review by the support coordinator at the time of the support coordinator's quarterly home visit. These updates include a review of the person's overall health, safety and well-being status.

Implementation Plan - a required document developed by the supported living coach that provides a clear picture of those things the individual and the coach have agreed to work toward for the coming year. It serves as a job description how services will be provided to meet the goals identified on the support plan.

Individual Financial Profile - a document completed by the supported living coach which analysis of the household costs and revenue sources associated with maintaining a balanced monthly budget. The analysis will substantiate the need for a monthly subsidy or initial start-up costs, and should be a source of information for determining strategies for assisting the person in money management.

Informed Choices - a voluntary, well-considered decision made on the basis of options, information, and understanding. The decision-making process should result in a free and informed decision by the individual about whether or not he or she desires supports and services, and which services she needs.

Instruction - methods, approaches, and strategies used by the coach to guide the person toward attainment of personal goals.

Invoice for Service - billing completed by the supported living coach for reimbursement of services indicating the number of hours spent with the individual.

Level Two Background Screening - must be completed for all supported living coaches. This process includes:

- **Affidavit** of good moral character;
- **Local background check**;

- **Finger prints** submitted to FDLE (Florida Department of Law Enforcement) for screening;
- **3 verified** personal **references** and;
- **Re-screening** performed every 5 years.

Medicaid Waiver – was initiated in 1993 as a means of adding federal funds to state general revenue funding. Currently funds the majority of services for individuals with developmental disabilities statewide.

Medication Administration Record (MAR) – a person specific document on which medication administration or self-administration is recorded.

Personal Outcome Measures (POM's) –process used with the individual, to assess the attainment of outcomes they consider most important in their lives. This process includes getting to know the person and the significant people in his life, determining the presence or absence of personal outcomes, and the supports necessary to achieve the outcomes desired. This process may also involve record reviews, on-site visits to service providers and additional interviews with the provider's staff.

PRN – Pro re nata (Latin), meaning as the occasion arises. A term usually associated with certain medications to indicate they are administered, according to need, as the situation/health status requires.

Progress Notes – narrative documentation by the supported living coach of activities, supports and contacts with the individual, other providers and agencies progress notes include dates and times, and a summary of support provided during the contact, any follow up needed and progress toward achieving support plan goals.

Quality Improvement Plan –(QIP) a plan of proposed, corrective actions developed by the provider, that address the improvements needed for services sited below standard by the Department or their authorized agent. Those providers deemed non-compliant with these Assurances and /or requirements found in the Developmental Services Waiver Services Florida Medicaid Coverage and Limitations handbook, submit written QIPs, as required in their written monitoring report, and identified through a self-assessment.

Release/Consent Form – a document signed by the person indicating that specified organizations or individuals are allowed to share personal information about the individual with each other.

Representative Payee - when the Social Security Administration (SSA) has reason to believe that the individual is not able to utilize the funds on his or her behalf, it may designate another to receive the payments on the person's behalf. These individuals,

public or private agency is known as a "representative payee". They are obliged to apply payments for the use and benefit of the recipient.

Self-assessment – an annual evaluation completed by the provider to review organizational capabilities required to meet the personal goals and the service requirements identified in the Medicaid Waiver Services Agreement, the Developmental Services Waiver Services Florida Medicaid Coverage and Limitations handbook. This self-assessment also reviews the provider's policies and procedures by identifying the extent to which they are consistent with their daily practices and the objectives stated in the Medicaid Waiver Services Agreement.

Service Authorization Forms – an approved form sent to a Medicaid Waiver provider from the waiver support coordinator authorizing the provision of specific services or supports to an individual. Without this form the provider cannot be assured reimbursement. This authorization is contingent upon the enrolled consumer remaining eligible for Medicaid during the month of service. Upon the loss of Medicaid Eligibility the service authorization is null and void.

Service Logs – time intervention log indicating the frequency of the supported living services.

Significant Event Report – a format which provides the department with timely notice and awareness of events which may require direct intervention. These events are categorized by 'critical' and non-critical. Procedures for use are provided by District/Regional Program.

Statewide Quality Assurance Program – a contracted provider which performs quality assurance activities for the Developmental Services Home and Community-Based Waiver (HCBS) program that include person-centered and provider reviews at least annually.

Support Plan –an individualized plan of supports and services designed to meet the needs of the person. The plan is based on the preferences, interests, talents, attributes and needs of the individual. The individual or parent, legal guardian or guardian advocate, shall be consulted in the development of the plan and shall receive a copy of the plan and any revisions made to the plan. Each plan includes the least restrictive, and most cost-beneficial environment for accomplishment of the objectives for individual progress and a specification of all services authorized. The plan shall include provisions for the most appropriate level of care. The ultimate goal of each plan is to enable the individual to live a dignified life in the least restrictive setting, appropriate to the individual's needs. The support plan must be completed in a format provided by the Department and according to the instructions provided by the Developmental Disabilities Program.

Supported Living - the provision of supports necessary for persons with developmental disability to establish, live in and maintain a household of their choosing in the community.

Supported Living Coaching – a certified provider who provides assistance, in a variety of activities, to support persons who live in their own homes.

Third Party Benefits – includes Social Security (SSI, SSA) and Veterans benefits, food stamps, and Medicaid, to persons eligible for financial assistance.

Time Intervention Report – please see service logs.

Training – strategies that identifies the sequence and approach to learning. Typically "training" occurs at a set time and set place and promotes the acquisition of skills.

Transition Planning – a written guide or plan which is developed as the result of collaboration of the circle of support. It assures a shared vision, and mutual understanding of the supports needed to assure a successful move and; ensures that the needed supports and services are in place to promote the person's comfort and safety

Waiver Support Coordinator – a Medicaid Waiver provider who provides oversight, service and support coordination. The WSC advocates, identifies, develops, coordinates and accesses supports and services on behalf of the individual, or assisting the individual or family to access supports and services on their own. The waiver support coordinator is responsible for assessing a beneficiaries' needs, preferences and future goals (outcomes). The WSC assists the individual in developing a support plan and a cost plan.

WEBSITE LINKS

WEBSITE LINKS

Abilities of Florida	www.abletrust.org/abilities-of-fl/abilities-of-fl.html
Able Trust	www.abletrust.org
ABLEDATA, Information on Assistive Technology	www.abledata.com
Access Unlimited – Accessible Vehicles for People with Disabilities	www.accessunlimited.com
Accessible Travel Source - Providing Access Information for Mature and Disabled Travelers	www.access-able.com
Advocacy Center for Persons with Disabilities	www.advocacycenter.org
Agency for Health Care Administration	www.fdhc.state.fl.us
Alcohol, Drug Abuse & Mental Health Program	www.state.fl.us/cf_web/adm
American Association of People with Disabilities	www.aapd-dc.org/
American Association on Mental Retardation	www.aamr.org
Assistive Technology Educational Network of Florida	www.fimcvi.org/assistivetechnology.htm
APSE - Association for Persons in Supported Employment	www.apse.org/
Attainment Company, Products for Persons with Disabilities	www.attainmentcompany.com
Autism Network International	www.ani.autistics.org/
Autism Resources	www.autism-info.com
Autism Society Chapters	www.autism-society.org/society/asa-south-east.html
Autism Society of Greater Orlando	www.greaterorlando.org
Autism Treatment Center of America	www.son-rise.org
Best Buddies International	www.bestbuddies.org
Canine Companions for Independence	www.caninecompanions.org
CARD – FSU	www.autism.fsu.edu

CARD – University of Florida	www.card.ufl.edu
CARD – University of Miami	www.psy.miami.edu/card
Center for Autism & Related Disabilities – University of Central Florida	www.ucf-card.org
Center for Autism & Related Disabilities – University of South Florida	http://card-usf.fmhi.usf.edu/
Center for Independent Living	www.cil.gulf.net
Centers for Disease Control Recommended Immunizations Schedules	www.cdc.gov/nip
Cerebral Palsy Learning Tutorial	www.med.virginia.edu/cmc/tutorials/cp/cp.htm
Children's Medical Services	www.doh.state.fl.us/cms/default.html
Code of Federal Regulations	www.access.gpo.gov
Commission for the Transportation Disadvantaged/Florida	www.dot.state.fl.us/ctd
Council for Exceptional Children	www.cec.sped.org
Council on Quality and Leadership in Supports for People with Disabilities	www.thecouncil.org/
Department of Aging & Mental Health, USF	www.fmhi.usf.edu/amh/statement.html
Department of Children and Families	www.state.fl.us/cf_web
Department of Education	www.firn.edu/doe
Department of Elder Affairs	www.state.fl.us/doea
Department of Health	www.doh.state.fl.us
Department of Health and Human Services -Health Care Financing Administration	www.hcfa.gov
Department of Justice ADA Home Page	www.usdoj.gov
Developmental Disabilities Council/Florida (DDC)	www.fddc.org
Developmental Disabilities Program, Dept. of Children and Families	www5.myflorida.com/cf_web/myflorida2/healthhuman/ddp

Diagnostic & Learning Resources System	www.fdlrs.brevard.klz.fl.us/fdlrs/index.html
Disability Advocacy Worldwide (TASH)	www.tash.org
Disability Resources on the Internet	www.disabilityresources.org
Disability Solutions - A Resource for Families and Others Interested in Down Syndrome and Related Disabilities	www.disabilitysolutions.org
Division of Blind Services	www.state.fl.us/dbs
Division of Vocational Rehabilitation	www.myflorida.com/doe/vr
Dolphin Research Center - Swim with Dolphins	www.dolphins.org/drc-prog.htm
Down Syndrome Association of Jacksonville	www.down-town.org
Easter Seals	www.easter-seals.org/cgi-bin/pubsitclist.pl
Easter Seals Society/Florida	www.flseals.com
Epilepsy Foundation of Northeast Florida	www.floridaepilepsy.org/northeast.htm
Family & Advocates Partnership for Education	www.fape.org
Family C.A.F.E.	www.familycafe.net
Family Care Council	www.fccflorida.org
Flairs Network	www.flairs.org
Florida Association of the Deaf	www.fladeaf.org
Florida Alliance for Assistive Services and Technology	http://faast.org/
Florida Alliance of Information and Referral Services	www.flairs.org
Florida Commission on Community Services	www.fccs.org
Florida Council for Community Mental Health	www.fccmh.org
Florida Housing Coalition	www.flhousing.org

Florida Independent Living Centers	www.FLAILC.org
Florida Kidcare	www.floridakidcare.org
Florida School for the Deaf & Blind	www.k12.fl.us
Florida Spinal Cord Injury Resource Center	www.fscirc.com
Florida Statutes	www.leg.state.fl.us
Florida Outreach Project	www.neurosci90.health.ufl.edu/fop/Default.html
FRAXA Research Foundation	www.fraxa.org
Goodwill Industries	www.goodwillindustries.org/html/fl.html
Gulf Coast Chapter, Autism Society of America	www.web.tampabay.rr.com/autism
Health Care Financing Administration	www.hcfa.gov
Housing Coalition/Florida	www.flhousing.org
IDEA Practices –idealinks	www.ideapractices.org/idealinks.htm#assistivetech
Infinitec Inc., Assistive Technology	www.infinitec.org/index.html
Information Resource Network/Florida (FIRN)	www.firn.edu
Institute for Child Health Policy	www.ichp.edu
Job Accommodation Network (JAN)	www.janweb.icdi.wvu.edu
Learning Disabilities Information & Resources	www.ldonline.org
Mailman Center for Child Development	www.pediatrics.med.miami.edu/pediatrics/peds.htm
Manasota Autism Society	www.saraweb.com/MAS/indexswf.html
Miami Lighthouse for the Blind	www.miamilighthouse@the–directory.com
MUMS - National Parent-to-Parent Network	www.netnet.net/mums/
National Family Caregivers Association	www.nfcacares.org
National Home of Your Own Alliance	www.alliance.unh.edu
National Parent Network on Disabilities	www.npnd.org
National Program Office on Self-Determination	www.self-determination.org

National Resource Library on Information Related to Youth With Chronic or Disabling Conditions	www.cyfc.umn.edu/NRL/index.html
North American Riding for the Handicapped Association, Inc.	www.narha.org
Online Asperger Syndrome Information & Support (OASIS)	www.udel.edu/bkirby/asperger
Our-Kids - Devoted to Raising Special Kids with Special Needs	www.our-kids.org/default.html
Parenting Special Needs	www.specialchildren.about.com/parenting/specialchildren
Parents Helping Parents	www.php.com
Pen Pals for Individuals with Developmental Disabilities	www.penafriend.com
Physical Rehabilitation Network	www.voicepaper.com
Prader-Willi Syndrome Association	www.pwsausa.org
Prader-Willi Syndrome Association (Florida)	www.Members.aol.com/delchert/pwsa2.htm
R.C. Phillips Research and Education Unit	www.ufgenetics.org/philips.htm
Respect of Florida	www.respectofflorida.org
Respite National Locator Service	www.chtop.com/locator.htm
Southern Movement for Independence	www.southernmovement.org.
Spina Bifida Association of America	www.sbaa.org
Statewide Advocacy Council (SAC)	www.state.fl.us/cf_web/hrac
Statewide Advocacy Network on Disabilities	www.members.aol.com/_ht_a/standweb1/default.htm
The Fathers Network - Support for Fathers and Families Raising Children with Special Health Care Needs and Developmental Disabilities	www.fathersnetwork.org
The Kennedy Krieger Institute - A Comprehensive Resource for Children with Disabilities	www.kennedykrieger.org
The Sibling Support Project	www.chmc.org/departmt/sibsupp

United Cerebral Palsy	www.ucpa.org
University of Florida Brain Institute	www.uflbi.ufl.edu
Volusia Autism	www.geocities.com/HotSprigs/Villa/4454
World Association of Persons with (dis)Abilities (WAPD)	www.wapd.org

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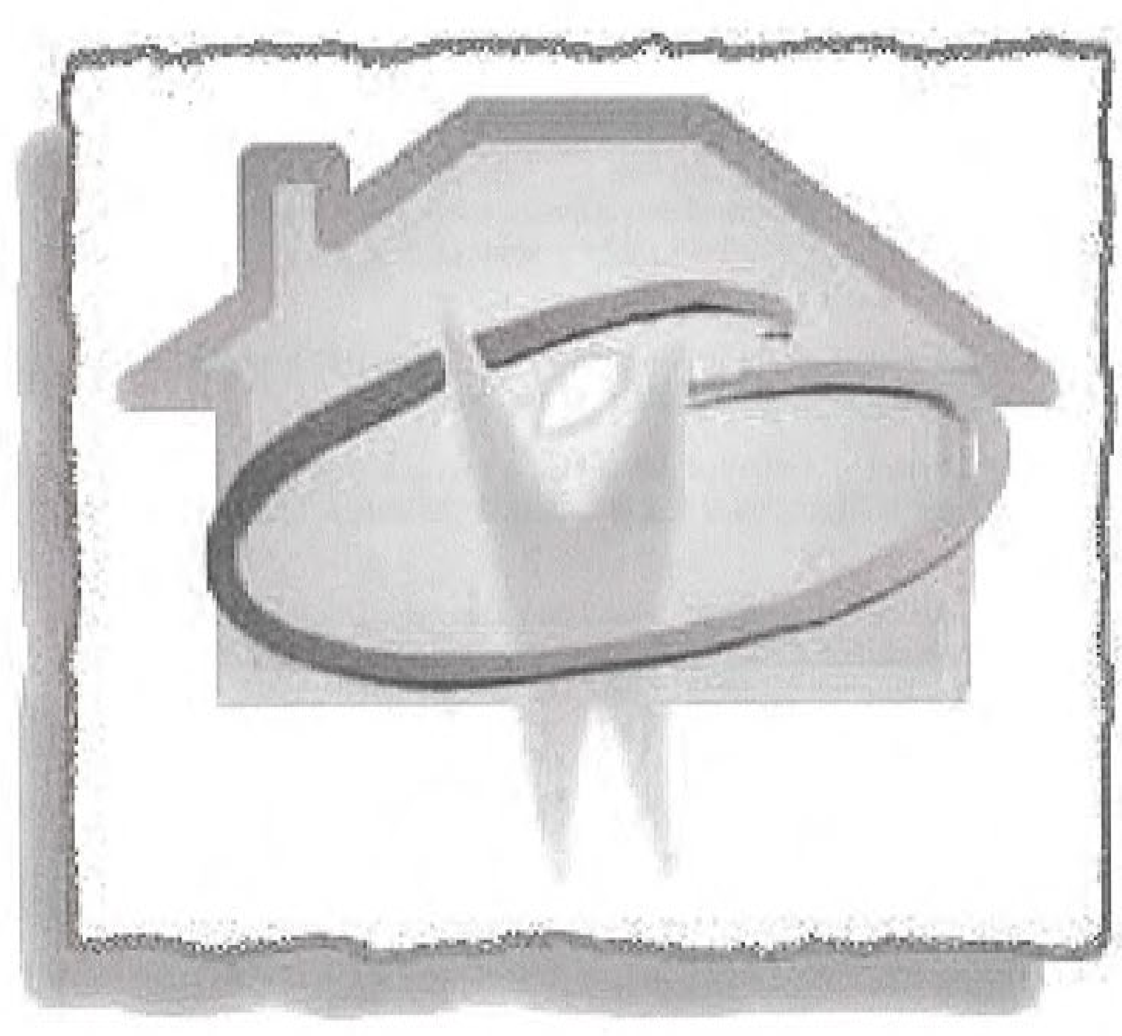

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