



PLAN ID: [REDACTED]

09/17/2025

[REDACTED]
[REDACTED]
[REDACTED]

NOTICE OF ADVERSE BENEFIT DETERMINATION

Dear [REDACTED] and/or [REDACTED]:

Florida Community Care has reviewed your request for
Information: [REDACTED]

- Personal Care: (T1019) Personal Care (15 minute unit)
- Sunday: 9 hour(s) per day
- Monday: 6 hour(s) per day
- Tuesday: 6 hour(s) per day
- Wednesday: 5 hour(s) per day
- Thursday: 4 hour(s) per day
- Friday: 4 hour(s) per day
- Saturday: 4 hour(s) per day
- Total hours per week: 38

which we received on 09/08/2025. After our review, this service has been partially denied as of 09/09/2025.

We made our decision because:
(Check all boxes that apply)

We determined that your requested services are **not medically necessary** because the services do not meet either of the reason(s) checked below: *(See Rule)*

- Meet all of the criteria as defined in Rule 59G-1.010, Florida Administrative Code, for all nursing facility services and mixed services;
OR
- Meet all of the following criteria for all extended state plan services used for the purposes of maintenance therapy and all other home and community-based services:

1. Be individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the patient's needs;
2. Be reflective of the level of service that can be safely furnished, and for which no equally effective and more conservative or less costly treatment is available statewide; and
3. Be furnished in a manner not primarily intended for the convenience of the recipient, the recipient's caretaker, or the provider;

and one of the following:

1. Enable the enrollee to maintain or regain functional capacity; or
2. Enable an enrollee receiving long-term services and supports to have access to the benefits of community living, to achieve person-centered goals, and live and work in the setting of their choice.

The requested **service is not a covered benefit**

Other authority N/A

The facts that we used to make our decision are:

This request for Personal Care (CPT Code: T1019), Frequency: 7 Days./Week - 38 hours a week is partially approved and partially denied. After a complete review of your plan of care and all documents in our possession justifying Personal Care Service hours, I find that you do not require as many Personal Care services as requested. There is no medical necessity to attribute to 38 hours of Personal Care service at this time.

We can approve 14 hours a week of Personal Care based on a calculation of need. Therefore 14 hours are approved and 24 hours are denied, based on medical necessity requirements.

Please work with your case manager to best distribute these hours through the days and week to meet your needs.

You, or someone legally authorized to do so, can ask us for a complete copy of your file, including medical records, a copy of plan review criteria and guidelines, contract provisions, other documents, records, and other information relevant to the adverse benefit determination. These will be provided free of charge.

You may request these documents by contacting: Member Services at 1-833-FCC-PLAN (1-833-322-7526) (TDD/TTY 711), 8AM to 8PM.

Right to Request a Plan Appeal

If you do not agree with this decision, you have the right to request a plan appeal from Florida Community Care. When you ask for a plan appeal, Florida Community Care has a different health care professional review the decision that was made.

How to Ask for a Plan Appeal:

You can ask for a plan appeal in writing or by calling us. Your case manager can help you with this, if you have one. We must receive the request *within 60 days* of the date of this letter. (If you wish to continue your services until a final decision is made on your appeal, we must receive your request sooner. See the "How to Ask for your Services to Continue" section below for details.) Here is where to call or send your request:

Florida Community Care
PO Box 261060
Miami, FL 33126
833-FCC-PLAN (833-322-7526)
FAX: 305-675-6219
Appeals@fcchealthplan.com

Your written request for a plan appeal must include the following information:

- Your name
- Your member number
- Your Medicaid ID number
- A phone number where we can reach you or your legal representative

You may also include the following information if you have it:

- Why you think we should change the decision
- Any medical information to support the request

- Who you would like to help with your plan appeal

Within five days of getting your plan appeal request, we will tell you in writing that we got your plan appeal request unless you ask for an expedited (fast) plan appeal. We will give you an answer to your plan appeal within 30 days of you asking for a plan appeal.

How to Ask for an Expedited (Fast) Plan Appeal if Your Health is At Risk:

You can ask for an “expedited plan appeal” if you think that waiting 30 days for a plan appeal decision resolution could put your life, health, or your ability to attain, maintain, or regain maximum function in danger. You can call or write us (see above), but you need to make sure that you ask us to *expedite* the plan appeal. We may not agree that your plan appeal needs to be expedited, but you will be told of this decision. We will still process your plan appeal under normal time frames. If we determine that we do need to expedite your plan appeal, you will get our plan appeal resolution within 48 hours after we receive your plan appeal request. This is true whether you asked for the plan appeal by phone or in writing.

How to Ask for your Services to Continue:

If you are now getting a service that is scheduled to be reduced, suspended or terminated, you have the right to keep getting those services until a final decision is made in a plan appeal and, if requested, a fair hearing. If your services are continued, there will be no change in your services until a final decision is made in your plan appeal and, if requested, fair hearing.

If your services are continued and our decision is upheld in a plan appeal or fair hearing, we may ask that you pay for the cost of those services. We will not take away your Medicaid benefits. We cannot ask your family or legal representative to pay for the services.

To have your services continue during the plan appeal, you **MUST** file your plan appeal **AND** ask to continue your services within this time frame:

File a request for your services to continue with Florida Community Care no later than 10 days after this letter was mailed **OR** on or before the first day that your services are scheduled to be reduced, suspended, or terminated, whichever is later. You can ask for a plan appeal by phone. **Be sure to tell us if you want your services to continue.**

To have your services continue during the fair hearing, you **MUST** file your fair hearing request **AND** ask for continued services within this time frame:

If you were receiving services during your plan appeal, you can file the request for your services to continue with the Agency for Health Care Administration (Agency) **no later than 10 days** from the date on your Notice of Plan Appeal Resolution OR on or before the first day that your services are scheduled to be reduced, suspended, or terminated, **whichever is later**.

What to Do if You Disagree with the Plan Appeal Decision

You will receive the result of the plan appeal process in a Notice of Plan Appeal Resolution (notice). If you still do not agree with our decision, or if you do not receive your notice on time, you can ask for a fair hearing.

How to Ask for a Fair Hearing:

When you ask for a Medicaid fair hearing, a hearing officer who works for the state reviews the decision that was made. You may ask for a fair hearing any time up to 120 days after you get our Notice of Plan Appeal Resolution. **You must finish your plan appeal process first.**

You may ask for a fair hearing by calling or writing to:

Agency for Health Care Administration
Medicaid Hearing Unit
PO Box 7237
Tallahassee, FL 32314-7237

(877) 254-1055 (*toll-free*)
239-338-2642 (*fax*)
MedicaidHearingUnit@ahca.myflorida.com

After getting your fair hearing request, the Agency will tell you in writing that they got your fair hearing request.

If you have questions, call us at 1-833-FCC-PLAN (1-833-322-7526) (TDD/TTY 711), 8AM to 8PM. For more information on your rights, review the Grievance and Appeal section in your Member Handbook. It can be found online at: FCChealthplan.com.

Sincerely,

Gaspere C. Geraci, MD



Florida Community Care LLC
P.O. Box 261060
Miami, Florida 33126

Medical Director
FCC Care Management Department

This information is available for free in other languages and formats. Please contact our Member Services number at 1-833-322-7526 (TTY: 711), Monday – Friday, 8 a.m. to 8 p.m.

Spanish

Esta información está disponible gratuitamente en otros idiomas y formatos. Comuníquese con nuestro Servicio al Miembros al 1-833-322-7526 (TTY: 711) de lunes a Viernes, de 8 a.m. a 8 p.m.

Haitian Creole

Enfòmasyon sa a disponib gratis nan lòt lang ak fòm. Tanpri kontakte nimewo Sèvis Manm nou an nan 1-833-322-7526 (TTY: 711), lendi rive vandredi, 8 a.m. a 8 p.m.

Notice of Nondiscrimination

Florida Community Care complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Florida Community Care does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Florida Community Care:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
 - Qualified sign language interpreters
 - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
 - Qualified interpreters
 - Information written in other languages

If you need these services, contact Member Services.

If you believe that Florida Community Care has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: Member Services, 833-FCC-PLAN (833-322-7526) or 711 for TTY.

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, Member Services is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, DC 20201
1-800-368-1019, 1-800-537-7697 (TDD)

Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

Written or Oral Translation Services

English: ATTENTION: If you do not speak English, written translation or oral interpretation services, free of charge, are available to you. Call 1-833-322-7526 (TTY: 711).

Español (Spanish): ATENCIÓN: Si no habla inglés, tiene a su disposición servicios de traducción escrita o interpretación oral, gratuitos. Llame al 1-833-322-7526 (TTY: 711).

Kreyòl Ayisyen (Haitian Creole): ATANSYON: Si ou pa pale Anglè, gen sèvis entèpretasyon alekri oswa aloral ki disponib gratis pou ou. Rele 1-833-322-7526 (TTY: 711).

Tiếng Việt (Vietnamese): LƯU Ý: Nếu bạn không nói tiếng Anh, chúng tôi sẽ cung cấp miễn phí cho bạn dịch vụ dịch thuật bằng văn bản hoặc phiên dịch lời nói. Gọi 1-833-322-7526 (TTY: 711).

Português (Portuguese): ATENÇÃO: Se você não fala inglês, há serviços gratuitos de tradução escrita ou interpretação oral à sua disposição. Ligue para 1-833-322-7526 (TTY: 711).

中文 (Chinese) : 注意 : 如果您不会讲英文 , 我们为您提供免费的笔译或口译服务。

请致电 1-833-322-7526 (TTY: 711)。

Zhōngwén (Chinese): Zhùyì: Rúguǒ nín bùhuì jiǎng yīngwén, wǒmen wèi nín tíngōng miǎnfèi de bǐyì huò kǒuyì fúwù. Qǐng zhìdiàn 1-833-322-7526 (TTY: 711).

Français (French): ATTENTION : Si vous ne parlez pas l'anglais, des services gratuits de traduction écrite ou d'interprétation orale sont à votre disposition. Appelez le 1-833-322-7526 (ATS : 711).

Tagalog (Tagalog): Tawag-pansin: Kung hindi ka nagsasalita ng Ingles, available sa iyo ang nakasulat na pagsasalita o oral interpretation services nang walang

bayad. Tawagan ang 1-833-322-7526 (TTY: 711).

Русский (Russian): ВНИМАНИЕ: Если вы не говорите по-английски, то вам доступны бесплатные услуги письменного и устного перевода. Звоните 1-833-322-7526 (TTY: 711)

العربية (Arabic): تنبيه: إذا كنت لا تتحدث الإنجليزية، فستتوفر لك خدمات الترجمة التحريرية أو الشفهية مجاناً. اتصل هاتفياً بالرقم 1-833-322-7526 (TTY: 711)

Italiano (Italian): ATTENZIONE: Se non parla inglese, sono disponibili servizi gratuiti di traduzione scritta o interpretariato orale. Chiamare 1-833-322-7526 (TTY: 711)

Deutsch (German): ACHTUNG! Wenn Sie die englische Sprache nicht beherrschen, stehen Ihnen schriftliche Übersetzungen oder mündliche Dolmetscherdienste kostenlos zur Verfügung. Rufen Sie 1-833-322-7526 (TTY: 711) an.

한국어(Korean): 주의: 영어를 구사하지 못하시면 서면 번역이나 구두 통역 서비스를 무료로 이용하실 수 있습니다. 1-833-322-7526 (TTY: 711)번으로 연락해 주십시오.

Polski (Polish): UWAGA: Jeżeli nie mówisz po angielsku, możesz skorzystać z bezpłatnych pisemnych i ustnych usług tłumaczeniowych. Zadzwoń 1-833-322-7526 (TTY: 711).

ગુજરાતી (Gujarati): ધ્યાન: જો તમે અંગ્રેજી ન બોલતા હો, તો લેખિત અનુવાદ અથવા મૌખિક અર્થઘટન સેવાઓ, વિના મૂલ્યે, તમને ઉપલબ્ધ છે. 1-833-322-7526ને કોલ કરો (TTY: 711).

ภาษาไทย (Thai): โปรดทราบ: หากท่านพูดภาษาอังกฤษไม่ได้ ท่านสามารถใช้บริการแปลเอกสารหรือล่ามแปลภาษาฟรีได้ที่ โทร 1-833-322-7526 (TTY:711)

If you are unable to read this in a smaller font, this information is available to you in other formats or by oral interpretation, free of charge. Call 1-833-322-7526 (TTY: 711).



PLAN ID: [REDACTED]

08/20/2025

[REDACTED]

Notice of Adverse Benefit Determination

Dear [REDACTED]:

Simply Healthcare Plans, Inc. has reviewed your request for CONTINUATION OF T1019 - PERSONAL CARE - 85 HOURS PER WEEK AND S5130 - HOME MAKER - 25 HOURS PER WEEK , which we received on 08/04/2025. After our review, this service has been:

Reduced as of 08/30/2025.

We made our decision because:
(Check all boxes that apply)

We determined that your requested services are **not medically necessary** because the services do not meet either of the reason(s) checked below: (See Rule)

Meet all of the criteria as defined in Rule 59G-1.010(166), F.A.C., for all nursing facility services and mixed services; OR

Meet all of the following criteria for all extended state plan services used for the purposes of maintenance therapy and all other home and community-based services:

1. Be individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the patient's needs;
2. Be reflective of the level of service that can be safely furnished, and for which no equally effective and more conservative or less costly treatment is available statewide; and
3. Be furnished in a manner not primarily intended for the convenience of the recipient, the recipient's caretaker, or the provider:

And one of the following:

1. Enable the enrollee to maintain or regain functional capacity; or
2. Enable an enrollee receiving long-term services and supports to have access to the benefits of community living, to achieve person-centered goals, and live and work in the setting of their choice.

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___ The requested **service is not a covered benefit.**

___ **Other authority**

The facts that we used to make our decision are: We will change some of the care you were getting (REDUCE- S5130- HOMEMAKER-25 HOURS PER WEEK TO 7 HOURS PER WEEK and REDUCE- T1019- PERSONAL CARE- 85 HOURS PER WEEK TO 70 HOURS PER WEEK). We will stop some of your care (TERMINATE: S5135- COMPANION CARE -58 HOURS PER WEEK). We have reviewed your records. You live alone. You are bedbound. You need total care. You need help with all of your daily activities. You need help moving in bed. This is to prevent bed sores. You are otherwise alert. You can use a phone. You have family. You are able to make your needs known. You can be alone. For this reason we are decreasing some of your personal care hours. All of the care you get can help around the home. This is why we are decreasing your homemaker hours. All of the care hours can help keep you company. This is why we are stopping your companion care. We reviewed your care. We looked at what kind of help you need. These changes are being made based on your current needs. With the care approved, you are getting enough care for your needs. You should arrange this care as you wish to be sure your needs are met. This is based on the Florida Medicaid Statewide Medicaid Managed Care Long-term Care Program Coverage Policy, 4.2.1.1 Adult Companion Care, 4.2.1.9 Homemaker Services and 4.2.2.6 Personal Care.(This decision was made by an internal Medical Director who is board certified in Ophthalmology using evidence-based clinical guidelines).A peer-to-peer reconsideration may be requested by your physician/health care provider within 2 days of the adverse determination. A formal appeal must be filed after this time frame. To request a peer to peer please call 833-414-3639.

You, or someone legally authorized to do so, can ask us for a complete copy of your file, including medical records, a copy of plan review criteria and guidelines, contract provisions, other documents, records, and other information relevant to the adverse benefit determination. These will be provided free of charge.

You may request these documents by contacting: **877-440-3738 (TTY 711)** Monday through Friday from 8 a.m. to 7 p.m. Eastern time.

Right to Request a Plan Appeal

If you do not agree with this decision, you have the right to request a plan appeal from Simply. When you ask for a plan appeal, Simply has a different healthcare professional review the decision that was made.

If you want someone else to act for you

You can name a relative, friend, attorney, doctor, or someone else to act as your representative. If you want someone else to act for you, call Member Services at **844-406-2396** for Florida Medicaid, **877-440-3738** for Long-Term Care or **TTY 711**, Monday through Friday from 8 a.m. to 7 p.m. Eastern time to learn how to name your representative. Both you and the

Do you need help with your health care, talking with us, or reading what we send you? Call us toll free at 1-844-406-2396 (TTY 711) for Florida Medicaid or 1-844-405-4298 (TTY 711) for Florida Healthy Kids or 1-877-440-3738 (TTY 711) for Long-Term Care to get this for free in other languages or formats.

¿Necesita ayuda con su cuidado de la salud, para hablar con nosotros o leer lo que le enviamos? Llámenos a la línea gratuita al 1-844-406-2396 (TTY 711) para Florida Medicaid o 1-844-405-4298 (TTY 711) para Florida Healthy Kids o 1-877-440-3738 (TTY 711) para Long-Term Care para recibir esto gratuitamente en otros idiomas o formatos.

Èske ou bezwen èd ak swen sante ou, èd pou pale ak nou, oswa pou li sa nou voye ba ou? Rele nou gratis nan 1-844-406-2396 (TTY 711) pou Florida Medicaid oswa 1-844-405-4298 (TTY 711) pou Florida Healthy Kids oswa 1-877-440-3738 (TTY 711) pou Long-Term Care pou w jwenn sa gratis nan lòt lang oswa nan lòt fòm.

Vous avez besoin d'aide pour vos soins de santé, pour communiquer avec nous ou pour lire les documents que nous vous envoyons ? Appelez-nous à notre numéro gratuit 1-844-406-2396 (TTY 711) pour Florida Medicaid ou 1-844-405-4298 (TTY 711) pour Florida Healthy Kids ou 1-877-440-3738 (TTY 711) pour Long-Term Care afin d'obtenir ceci gratuitement dans d'autres langues ou formats.

Ha bisogno di supporto con l'assistenza sanitaria, per parlare con noi oppure leggere ciò che le abbiamo inviato? Ci contatti al numero gratuito 1-844-406-2396 (TTY 711) per Florida Medicaid, 1-844-405-4298 (TTY 711) per Florida Healthy Kids o 1-877-440-3738 (TTY 711) per Long-Term Care per ottenere supporto senza costi aggiuntivi in altre lingue o formati.

Вам нужна помощь с медицинским обслуживанием, консультацией или материалами, которые мы вам прислали? Позвоните нам по бесплатному номеру 1-844-406-2396 (TTY 711) в случае Florida Medicaid, 1-844-405-4298 (TTY 711) в случае Florida Healthy Kids или 1-877-440-3738 (TTY 711) в случае Long-Term Care, чтобы получить эти материалы на другом языке или в другом формате.

ATTENTION: If you speak English, free language assistance services are available to you. Appropriate auxiliary aids and services to provide information in accessible formats are also available free of charge. Call 1-844-406-2396 (TTY 711) for Florida Medicaid or 1-844-405-4298 (TTY 711) for Florida Healthy Kids or 1-877-440-3738 (TTY 711) for Long-Term Care or speak to your provider.



Simply Healthcare Plans, Inc. follows Federal civil rights laws. We don't discriminate against people because of their:

- Race
- National origin
- Disability
- Color
- Age
- Sex or gender identity

That means Simply Healthcare won't exclude you or treat you differently because of these things.

Communicating with you is important

For people with disabilities or who speak a language other than English, Simply Healthcare offers these modifications, auxiliary aids, and services to communicate effectively with us, at no cost to you:

- Qualified sign language interpreters
- Written materials in large print, audio, electronic and other formats
- Help from qualified interpreters in the language you speak
- Written materials in the language you speak

To get these services, call the Member Services number on your ID card. Or you can call our Grievance Coordinator at 1-877-372-7603, ext. 106-121-0301.

Your rights

Do you feel you didn't get these services, or we discriminated against you for reasons listed above? If so, you can file a grievance (complaint). File by mail, email, fax, or phone:

Grievance Coordinator	Phone: 1-844-406-2396 (TTY 711)
Simply Healthcare Plans, Inc.	Fax: 1-866-216-3482
P.O. Box 62429	Email: flmedicaidgrievances@simplyhealthcareplans.com
Virginia Beach, VA 23466-2429	

Need help filing? Call our Grievance Coordinator at the number above. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights:

- **On the web:** <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>
- **By mail:** U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, DC 20201
- **By phone:** 1-800-368-1019 (TTY/TDD 1-800-537-7697)

For a complaint form, visit www.hhs.gov/ocr/office/file/index.html.



Florida Department of Elder Affairs
701B Comprehensive Assessment
Rule: 58-A-1.010, F.A.C.

Provider ID: FCC HealthPlan

Provider Assessor/CM ID: [REDACTED]

Assessor/Case
Manager (CM) Name: [REDACTED]

Signature: [REDACTED]

A. DEMOGRAPHIC SECTION

1. **ASSESSOR/CM: What is the purpose of this assessment?**

- Initial Annual Health Living situation Caregiver Environment Income

2. Social Security number: 5 [REDACTED]

3. Name: a. First: [REDACTED] b. Middle initial: _____

c. Last: [REDACTED]

4. Medicaid number: [REDACTED]

5. Phone number: 3 [REDACTED]

6. Date of birth (mm/dd/yyyy): 0 [REDACTED]

7. Sex: Male Female

8. Race (Mark all that apply): White Black/African American Asian
 American Indian/Alaska Native Native Hawaiian/Pacific Islander Other

9. Ethnicity: Hispanic/Latino Other

10. Primary language: English Spanish Other: _____

11. Does client have limited ability reading, writing, speaking, or understanding English? No Yes

12. Marital status: Married Partnered Single Separated Divorced Widowed

13. **ASSESSOR/CM: Current Physical Location Address** (If type is a facility, enter facility name.)

a. Street: [REDACTED]

b. City: MIAMI c. ZIP code: [REDACTED]

d. Type: Private residence Assisted living facility (ALF) Nursing facility
 Hospital Adult day care Other

e. Name: _____

14. Home Address (If different from current physical location)

a. Street: _____

b. City: _____ c. ZIP code: _____

15. Is client's home address public housing? No Yes

16. Mailing Address (If different from current physical location)

a. Street: _____ b. City: _____

c. State: _____ d. ZIP code: _____

B. MEMORY SECTION

36. Has a doctor or other health care professional told you that you suffer from memory loss, cognitive impairment, any type of dementia, or Alzheimer's disease? No Yes

37. **ASSESSOR/CM: If the client is not answering questions, skip to Question 47 and check:**

38. "I am going to say three words for you to remember. Please repeat the words after I have said them. The words are: sock (something to wear), blue (a color), and bed (a piece of furniture). Now you tell me the three words." **ASSESSOR/CM: Select the number of words correctly repeated after the first attempt:**

Sock Blue Bed Total number of correct words: None One Two Three

"Thank you. I will ask you to repeat these to me again later."

39. Please tell me what year it is: Correct Missed by one year Missed by two to five years
 Missed by five or more years No answer

40. Please tell me what month it is: Correct Missed by one month Missed by two to five months
 Missed by five or more months No answer

41. Please tell me what day (of the week) it is: Correct Incorrect No answer

42. "Let's go back to an earlier question. What were those words I asked you to repeat back to me?"
 Sock Blue Bed

43. **ASSESSOR/CM: Number of words correctly recalled without prompting:** None One Two Three

44. Have any friends or family members expressed concern about your memory? No Yes

45. Have you become concerned about your memory or had problems remembering important things? No (Skip to 47) Yes

46. How often do you have problems remembering things?
 Always Often Sometimes Rarely Don't know

47. **ASSESSOR/CM: In your opinion, are cognitive problems present?** No Yes Don't know

Notes & Summary:

Member's daughter reported that Member has a Dx of Advanced Dementia. Member is alert and disoriented to person, time, and place. The member was unable to answer the questions due to advanced cognitive impairment. Member is also unable to express her necessities.

C. GENERAL HEALTH, SENSORY & COMMUNICATION SECTION

48. How would you rate your overall health at this time? Excellent Very Good Good Fair Poor

49. Compared to a year ago, how would you rate your health?
 Much better Better About the same Worse Much worse

50. How often do you change or limit your activities out of fear of falling?
 Never Occasionally Often All of the time

51. How many times have you fallen in the last six months? # 0

52. How often are there things you want to do but cannot because of physical problems?
 Never Occasionally Often All of the time

53. When you need medical care, how often do you get it?
 Always Most of the time Rarely Only in an emergency Never

54. When you need transportation to medical care, how often do you get it?
 Always Most of the time Rarely Only in an emergency Never

55. Do you drive a car or other motor vehicle? No Yes

56. How often do finances/insurance allow you to obtain health care and medications when you need them?
 Always Most of the time Rarely Only in an emergency Never

57. Have you visited the emergency room (ER) or been admitted to the hospital within the last year?
 No Yes: How many times? ER# Hospital #

58. In the last year were you in a nursing or rehabilitation facility? No Yes

59. Are you usually able to climb two or three stair steps? No Yes Don't know

60. **ASSESSOR/CM: Are there any stairs within the dwelling or leading into/out of the dwelling?** No Yes

61. Are you usually able to carry a full glass of water across a room without spilling it? No Yes Don't know

62. Has a doctor told you that you currently have vision problems? No Yes Blind (If blind, skip to 63)

a. Have you had an eye exam in the past year? No Yes

b. Do you bump into objects (people, doorways) because you don't see them? No Yes

c. Is your vision getting worse than it was last year? No In one eye Slightly worse Much worse

63. Has a doctor told you that you currently have hearing problems? No Yes Deaf (If deaf, skip to 64)

a. Have you had a hearing exam in the past year? No Yes

b. Can you understand words clearly over the telephone? No Yes

c. Is your hearing worse than it was last year? No In one ear Slightly worse Much worse

64. **ASSESSOR/CM: Does client rely on writing, gestures, or signs to communicate?** No Yes

65. **ASSESSOR/CM: Are the client's words formed properly, not slurred or clipped?** No Yes

66. **ASSESSOR/CM: Are any sensory aids or assistive devices currently used?** No Yes
 If yes, please list the type(s) used: Glasses

67. **ASSESSOR/CM: Is there an unmet need for a sensory aid or assistive device?** No Yes
 If yes, please list the type(s) needed: _____

D. ACTIVITIES OF DAILY LIVING SECTION

68. How much assistance do you need with the following tasks?

Task	No assistance needed	Uses assistive device	Needs supervision or prompt	Needs assistance (but not total help)	Needs total assistance (cannot do at all)
a. Bathing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
b. Dressing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
c. Eating	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
d. Using the bathroom	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
e. Transferring	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
f. Walking/Mobility	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>

69. **ASSESSOR/CM: Is there an unmet need for an ADL assistive device?** No Yes

Type(s) needed: _____

70. How much assistance do you have with the following tasks?

Task	No assistance needed	Always has assistance	Has assistance most of the time	Rarely has assistance	Never has assistance
a. Bathing	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Dressing	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Eating	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Using the bathroom	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. Transferring	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f. Walking/Mobility	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Notes & Summary:

Due to cognitive impairment, member require assistance with all of the ADLs. The member recently received a walker, but she is unable to use it because she does not understand how to walk with the assistive device. The member is unable to follow simple commands. The member produces excessive salivation and chokes constantly.

E. INSTRUMENTAL ACTIVITIES OF DAILY LIVING SECTION

71. How much assistance do you need with the following tasks?

Task	No assistance needed	Uses assistive device	Needs supervision or prompt	Needs assistance (but not total help)	Needs total assistance (cannot do at all)
a. Heavy chores	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
b. Light housekeeping	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
c. Using the telephone	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
d. Managing money	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
e. Preparing meals	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
f. Shopping	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
g. Managing medication	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
h. Using transportation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>

72. **ASSESSOR/CM: Is there an unmet need for an IADL assistive device?** No Yes

Type(s) needed: _____

73. How much assistance do you have with the following tasks?

Task	No assistance needed	Always has assistance	Has assistance most of the time	Rarely has assistance	Never has assistance
a. Heavy chores	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Light housekeeping	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Using the telephone	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Managing money	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. Preparing meals	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f. Shopping	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g. Managing medication	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
h. Using transportation	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Notes & Summary:

Member needs assistance with all IADL's. Member's daughter provide assistance with transportation to all medical appointments.

F. HEALTH CONDITIONS & THERAPIES SECTION

74. Have you been told by a physician that you have any of the following health conditions?
ASSESSOR/CM: Indicate whether a problem occurred in the past by marking the first box and when a problem is current by marking the second box. Mark all that apply.

Past	Current	Health Conditions
<input type="checkbox"/>	<input checked="" type="checkbox"/>	Acid reflux/GERD
<input type="checkbox"/>	<input checked="" type="checkbox"/>	Allergies, list: <u>Enviromental</u>
<input type="checkbox"/>	<input type="checkbox"/>	Amputation, site: _____
<input checked="" type="checkbox"/>	<input type="checkbox"/>	Anemia <input checked="" type="checkbox"/> Severe <input type="checkbox"/> Moderate <input type="checkbox"/> Mild
<input type="checkbox"/>	<input checked="" type="checkbox"/>	Arthritis, type: <u>O.A</u>
<input type="checkbox"/>	<input type="checkbox"/>	Bed sore(s) (Decubitus), location: _____
<input type="checkbox"/>	<input checked="" type="checkbox"/>	Blood pressure <input checked="" type="checkbox"/> High <input type="checkbox"/> Low
<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	Broken bones/fractures, location: <u>Left and right arm</u>
<input type="checkbox"/>	<input type="checkbox"/>	Cancer, site: _____
<input type="checkbox"/>	<input type="checkbox"/>	Chlamydia
<input type="checkbox"/>	<input checked="" type="checkbox"/>	Cholesterol <input checked="" type="checkbox"/> High <input type="checkbox"/> Low
<input type="checkbox"/>	<input checked="" type="checkbox"/>	Dehydration
<input type="checkbox"/>	<input type="checkbox"/>	Diabetes <input type="checkbox"/> IDDM <input type="checkbox"/> NIDDM
<input type="checkbox"/>	<input type="checkbox"/>	Dizziness <input type="checkbox"/> Constant <input type="checkbox"/> Frequent <input type="checkbox"/> Occasional <input type="checkbox"/> Rare
<input type="checkbox"/>	<input type="checkbox"/>	Fibromyalgia
<input checked="" type="checkbox"/>	<input type="checkbox"/>	Gallbladder <input checked="" type="checkbox"/> Removal <input type="checkbox"/> Problems
<input type="checkbox"/>	<input type="checkbox"/>	Gonorrhea
<input type="checkbox"/>	<input type="checkbox"/>	Heart problems <input type="checkbox"/> Pacemaker <input type="checkbox"/> CHF <input type="checkbox"/> MI <input type="checkbox"/> Other
<input checked="" type="checkbox"/>	<input type="checkbox"/>	Head, brain, or spinal cord trauma
<input type="checkbox"/>	<input type="checkbox"/>	Herpes
<input type="checkbox"/>	<input type="checkbox"/>	Human Immunodeficiency Virus (HIV)
<input type="checkbox"/>	<input type="checkbox"/>	Human Papilloma Virus (HPV)/ Genital warts
<input type="checkbox"/>	<input checked="" type="checkbox"/>	Incontinence, bladder <input checked="" type="checkbox"/> Constant <input type="checkbox"/> Frequent <input type="checkbox"/> Occasional <input type="checkbox"/> Rare
<input type="checkbox"/>	<input checked="" type="checkbox"/>	Incontinence, bowel <input checked="" type="checkbox"/> Constant <input type="checkbox"/> Frequent <input type="checkbox"/> Occasional <input type="checkbox"/> Rare
<input type="checkbox"/>	<input type="checkbox"/>	Kidney problems or renal disease End stage? <input type="checkbox"/> No <input type="checkbox"/> Yes
<input type="checkbox"/>	<input type="checkbox"/>	Liver problems <input type="checkbox"/> Cirrhosis <input type="checkbox"/> Hepatitis
<input type="checkbox"/>	<input type="checkbox"/>	Lung problems <input type="checkbox"/> Emphysema <input type="checkbox"/> Asthma <input type="checkbox"/> Pneumonia <input type="checkbox"/> COPD
<input type="checkbox"/>	<input type="checkbox"/>	Lupus
<input type="checkbox"/>	<input type="checkbox"/>	Multiple Sclerosis
<input type="checkbox"/>	<input type="checkbox"/>	Muscular Dystrophy
<input type="checkbox"/>	<input checked="" type="checkbox"/>	Osteoporosis
<input type="checkbox"/>	<input type="checkbox"/>	Parkinson's disease
<input type="checkbox"/>	<input type="checkbox"/>	Paralysis <input type="checkbox"/> Full <input type="checkbox"/> Partial <input type="checkbox"/> Local, site: _____
<input type="checkbox"/>	<input type="checkbox"/>	Seizure disorder, type & frequency: _____

F. HEALTH CONDITIONS & THERAPIES SECTION, CONTINUED

Past	Current	Health Conditions
<input type="checkbox"/>	<input type="checkbox"/>	Shingles
<input checked="" type="checkbox"/>	<input type="checkbox"/>	Stroke /CVA
<input type="checkbox"/>	<input type="checkbox"/>	Syphilis
<input type="checkbox"/>	<input type="checkbox"/>	Thyroid problems/Graves/Myxedema <input type="checkbox"/> Hyper <input type="checkbox"/> Hypo
<input type="checkbox"/>	<input type="checkbox"/>	Tumor(s), site: _____
<input checked="" type="checkbox"/>	<input type="checkbox"/>	Ulcer(s), site: Gastric
<input checked="" type="checkbox"/>	<input type="checkbox"/>	Urinary Tract Infection (UTI)
<input type="checkbox"/>	<input checked="" type="checkbox"/>	Other: Macular degeneration, Dementia.

75. Provide information on the frequency of current therapies or specialty care:

Treatment type:	N/A or None	Monthly	Weekly	Several times a week	Daily	Several times a day
a. Bladder/bowel treatment	<input checked="" type="checkbox"/>	<input type="checkbox"/>				
b. Catheter, type: _____	<input checked="" type="checkbox"/>	<input type="checkbox"/>				
c. Dialysis	<input checked="" type="checkbox"/>	<input type="checkbox"/>				
d. Insulin assistance	<input checked="" type="checkbox"/>	<input type="checkbox"/>				
e. IV Fluids/IV Medications	<input checked="" type="checkbox"/>	<input type="checkbox"/>				
f. Occupational therapy	<input checked="" type="checkbox"/>	<input type="checkbox"/>				
g. Ostomy, site: _____	<input checked="" type="checkbox"/>	<input type="checkbox"/>				
h. Oxygen	<input checked="" type="checkbox"/>	<input type="checkbox"/>				
i. Physical therapy	<input checked="" type="checkbox"/>	<input type="checkbox"/>				
j. Radiation/Chemotherapy	<input checked="" type="checkbox"/>	<input type="checkbox"/>				
k. Respiratory therapy	<input checked="" type="checkbox"/>	<input type="checkbox"/>				
l. Skilled nursing	<input checked="" type="checkbox"/>	<input type="checkbox"/>				
m. Speech therapy	<input checked="" type="checkbox"/>	<input type="checkbox"/>				
n. Suctioning	<input checked="" type="checkbox"/>	<input type="checkbox"/>				
o. Tube feeding	<input checked="" type="checkbox"/>	<input type="checkbox"/>				
p. Wound care/Lesion irrigation	<input checked="" type="checkbox"/>	<input type="checkbox"/>				
q. Other therapy, type: _____	<input checked="" type="checkbox"/>	<input type="checkbox"/>				

Notes & Summary:

Member had a spine surgery in 1990. Member's daughter stated that the Member has macular degeneration. Member had hx of stroke (1985). Member is not receiving any skilled therapy at this time. The member's daughter stated that the bowel and bladder incontinence increased in the last month and required bathing many times a day.

G. MENTAL HEALTH SECTION

ASSESSOR/CM: If the client is not answering questions, skip to Question 81 and check:

76. How satisfied are you with your overall quality of life? Very satisfied Satisfied
 Neither satisfied nor dissatisfied Dissatisfied Very dissatisfied

77. Thinking about how you were this time last year, how do you feel about the way things are now?
 Much better Better About the same Worse Much worse

78. Over the past two weeks, how often have you been bothered by any of the following problems?
(Adapted from the Patient Health Questionnaire PHQ-9, © Pfizer)

	Not at all	Several days	More than half the days	Nearly every day
--	------------	--------------	-------------------------	------------------

a. Little interest or pleasure in doing things	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Feeling down, depressed, or hopeless	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Trouble falling or staying asleep, or sleeping too much	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Feeling tired or having little energy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. Poor appetite or overeating	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f. Feeling bad about yourself – or that you are a failure or have let yourself or your family down	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g. Trouble concentrating on things, such as reading the newspaper or watching television	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
h. Moving or speaking so slowly that other people noticed – Or, the opposite, being so fidgety or restless that you have been moving around a lot more than usual	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
i. Thoughts that you would be better off dead or of hurting yourself in some way*	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**Thoughts of suicide or self-injury, hallucinations, or aggressive behaviors are potentially serious problems that should be reported immediately to a supervisor, primary care physician, emergency care, law enforcement, and/or Adult Protective Services, as appropriate.*

ASSESSOR/CM: If the client answered “Not at all” to a-i above, skip to Question 81.

79. How difficult have these problems made it for you in your daily life activities and interactions with others?
 Not difficult at all Somewhat difficult Very difficult Extremely difficult

80. Are you currently working with a professional to help with this condition? No Yes *(Skip to 81)*

a. Have you or do you plan to discuss these issues with a professional? No Yes *(Skip to 81)*

b. Do you talk about any of these issues with anyone else you know? No Yes

81. Have you been diagnosed with a mental condition or psychiatric disorder by a health professional?

No *(Skip to 82)* Yes: List conditions: **Depression and anxiety**

G. MENTAL HEALTH SECTION, CONTINUED

82. **ASSESSOR/CM:** Indicate whether you noticed problem behaviors or any recurring problems have been reported to you by the client, caregiver, in-home worker, family, or staff, and note the frequency of occurrence in the last month. Provide details in the Notes & Summary section, below.

Problem behaviors	Not at all	Once	Several days	More than half the days	Nearly every day
a. Forgetful or easily confused	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
b. Gets lost or wanders off	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
c. Easily agitated or disruptive	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
d. Sexually inappropriate	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. Threatens or is verbally hostile*	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f. Physically aggressive or violent*	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g. Intentionally injures or harms him/herself*	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
h. Expresses suicidal feelings or plans*	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
i. Hallucinates, hears/sees things that are not there*	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
j. Other:	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**Thoughts of suicide or self-injury, hallucinations, or aggressive behaviors are potentially serious problems that should be reported immediately to a primary care physician, emergency care, law enforcement, and/or Adult Protective Services, as appropriate.*

83. **ASSESSOR/CM:** Does client need supervision? No Yes

Notes & Summary:

Member has a diagnosis of depression and anxiety. Member requires constant supervision due to cognitive impairment. Member has visual hallucinations nearly every day. Member had appointment with her psychiatrist in November 7th, 2024 and prescribed two new medicines, memantine 5 mg and Risperidone 0.25 mg. According to member's daughter, she does not observe any change yet with the new medications in member's behavior due to her anxiety.

H. RESIDENTIAL LIVING ENVIRONMENT SECTION

84. **ASSESSOR/CM:** If information about the client's residence is reported to you, without your observation, check here and all that apply below. If residence issues are directly observed by you, use the list below to observe and check off the specific issue(s) with the potential for safety or accessibility problems.

Check all that apply:

- a. Exterior issues(s): Road Driveway Yard Ramp Windows Roof
- b. Interior issues(s): Doors Stairs Floor Walls Ceiling Lights
- c. Restroom issues(s): Door Handrails Tub Shower Toilet
- d. Utility issue(s): Plumbing Water Electric Gas
- e. Furniture issue(s): Chair Couch Bed Table
- f. Telephone issue(s): Broken No phone Disconnected/No service
- g. Temperature issue(s): Heat Smoke detector Air conditioning
- h. Unsanitary condition(s): Odors Insects Rodents
 Accumulating items or garbage Floors or pathways cluttered

i. Other hazards: _____

85. Is there a pet in your home or yard? No (Skip to 86) Yes

a. Please specify the type and size: _____

b. **ASSESSOR/CM: Pet comments/concerns:** _____

86. **ASSESSOR/CM: Please rate the level of risk in the client's residential living environment:**

- No/low apparent risk from current living conditions.
- Minor risk (One or more aspects are substandard and should be addressed in the following year to avoid potential injury.)
- Moderate risk (Major aspects are substandard and must be addressed in the next few months to remain in home safely.)
- High risk (Serious hazards are present. The client must change dwellings or immediate corrective action must be taken to correct the issues noted above.)

Notes & Summary:

Member continues to live with her daughter and son in law in a single-family house. Member has her own bedroom and bathroom safely equipped for her needs. Member sleeps an in queen bed.

I. NUTRITION SECTION

87. Do you usually eat at least two meals a day? No Yes

88. On a typical day, what types of food do you eat for:

a. Breakfast: cereal with coconut milk, fruit

b. Lunch: Spaghetti, protein, vegetables, beans, rice.

c. Dinner: Fruit

d. Snacks: yogurt

89. Do you eat alone most of the time? No Yes

90. How many cups of water, juice, or other liquid do you drink daily? (If more than eight, Skip to 91) # 3

a. Do you ever limit the amount of fluids you drink? No (Skip to 91) Yes

b. Why and when do you limit the fluids you intake? _____

91. On average, how many servings of fruits and vegetables do you eat every day? (One "serving" is one small piece of fruit or vegetable, about one-half cup of chopped fruit or vegetable, or one-half cup of fruit or vegetable juice.) # 2

92. On average, how many servings of dairy products do you have every day? (One "serving" of dairy is about a slice of cheese, a cup of yogurt, or a cup of milk or dairy substitute.) # 1

93. Estimate your current height and weight: Height: 5 ft. 1 inches Weight: 95 lbs.

94. Have you lost or gained weight in the last few months? Unsure (Skip to 95) No (Skip to 95) Yes

a. How much? Less than five pounds Five to ten pounds Ten pounds or more

b. Was the weight loss/gain on purpose (i.e., dieting or trying to lose/gain weight)? No Yes

95. Are you on a special diet(s) for medical reasons? No (Skip to 96) Yes; check any/all:

Calorie supplement Low fat/cholesterol Low salt/sodium Low sugar/carb Other

a. How long have you been on this diet? _____

b. Why are you on this diet? _____

96. Do you have any problems that make it hard for you to chew or swallow? No Yes; check any/all:

Mouth/tooth/dentures Pain or difficulty swallowing Taste Nausea

Saliva production Other, describe: _____

97. What working appliances do you have for storing/preparing food? None

Refrigerator Microwave Toaster/Oven Stove Other: _____

Notes & Summary:

Member's daughter reported that the Member's appetite is good at this time, however she eats small portions. Member is lactose intolerant and consume coconut milk. Members receives nutritional supplements from the program.

J. MEDICATIONS & SUBSTANCE USE SECTION, CONTINUED

101. Please list the doctors you usually go to for treatment and medications:

Physician name	Phone number	Approx. date of last visit	Reason for last visit:
██████████	██████████	11/05/2024	follow up-PCP

If you have more than ten physicians to record, use the Notes & Summary section or a blank sheet of paper to write the information.

102. What pharmacies or drug stores do you use? Walgreens

103. Are you able to tell the difference between your pills (*i.e., colors, shapes, print*)? No Yes N/A

104. **ASSESSOR/CM: Are the client's medications managed by a facility/caregiver?** No Yes N/A

105. **ASSESSOR/CM: In your opinion, are the client's medications managed properly?** No Yes N/A

106. **ASSESSOR/CM: Should client have a new medication review by a doctor or pharmacist?** No Yes N/A

107. How many days in a typical week do you drink alcohol?

Refused (*Skip to 108*) None (*Skip to 108*) One to two Three to five Six to seven

a. On the days when you have some alcohol, about how many drinks do you usually have?

One to two (*Skip to 108*) Three to five Six or more

b. About how many times in the last month have you had four or more drinks in a day?

None One to two Three to five Six or more

108. Have you used any form of tobacco in the last six months? No (*Skip to 109*) Yes:

a. What type(s)? Chewing tobacco Cigarettes Cigars Snuff Other

b. About how many times do you use tobacco each day?

One to three Four to ten Eleven or more

109. Do you regularly use drugs other than those required for medical reasons (*i.e., controlled substances or "street drugs"*)? Refused (*Skip to 110*) No (*Skip to 110*) Yes, what type(s):

a. About how often do you use these? Rarely Less than twice a month

Less than once a week Several times a week Daily Several times a day

b. How long have you been using that often? Less than a year One or more years

Notes & Summary:

Member's daughter provides assistance with medication management.

K. SOCIAL RESOURCES SECTION

110. If needed, is there someone (besides the primary caregiver) who could help you? No (Skip to 112) Yes

111. Do I have your permission to contact this person, if you need help? No (Skip to 112) Yes

a. Name: _____ b. Relationship to client: _____

c. Phone: _____

About how often do you:	Once a day	Two to six times a week	Once a week	Several times a month	Every few months	A few times a year	Never
112. Talk to friends, relatives, or others (by phone, computer, or other means)?	<input type="checkbox"/>	<input checked="" type="checkbox"/>					
113. Spend time with someone who does not live with you?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>				
114. Participate in activities outside the home that interest you?	<input type="checkbox"/>	<input checked="" type="checkbox"/>					

L. CAREGIVER SECTION

ASSESSOR/CM: If client has no caregiver, stop the assessment here. If client has a caregiver, complete 115-136.

115. **ASSESSOR/CM: HCE Caregiver? If yes, check**

116. Caregiver full name: a. First: [REDACTED]

b. Middle Initial: _____ c. Last: **A** [REDACTED]

117. Caregiver date of birth: (mm/dd/yyyy) [REDACTED]

118. **ASSESSOR/CM: Caregiver identification number** [REDACTED]

119. Caregiver sex: Male Female

120. Caregiver race (Mark all that apply): White Black/African American Asian
 American Indian/ Alaska Native Native Hawaiian/ Pacific Islander Other

121. Caregiver ethnicity: Hispanic or Latino Other

122. Caregiver primary language: English Spanish Other _____

123. Caregiver relationship to client:
 Wife Husband Partner Parent
 Son/In-law Daughter/In-law Other relative Other Non-relative

124. Caregiver address:
a. Street: [REDACTED]
b. City: **Miami** c. State: **FL** d. ZIP code: [REDACTED]

125. Caregiver phone number: [REDACTED]

126. Do you work outside the home? No Yes: Full-time Part-time

127. Do you currently have anyone to assist you with providing care? No (Skip to 129) Yes

L. CAREGIVER SECTION, CONTINUED

128. Do I have your permission to contact this person if for some reason you are unable to provide care for the client? No (*Skip to 129*) Yes, please provide the name and relationship to client:

a. First name: _____ b. Last name: _____

c. Phone: _____ d. Relationship to client: Wife Husband Partner
 Parent Son/In-law Daughter/In-law Other relative Other Non-relative

129. How long have you been providing care for this client?

Less than six months Six to twelve months One to two years Two or more years

130. How many hours per week do you currently spend providing care for the client?

64

131. Do you need training or assistance in performing caregiving tasks? No Yes, please describe:

132. How much of a mental or emotional strain is it on you to provide care for the client?

None Some strain A lot of strain

133. Considering other aspects of your life, please rate the level of difficulty in your:

	No difficulty	Little difficulty	Some difficulty	Moderate difficulty	A lot of difficulty
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a. Relationship with client	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Relationship with family	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Relationships with friends	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Physical health	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. Finances	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f. Functional abilities	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g. Employment	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
h. Time for yourself to do the things you enjoy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>

134. How confident are you that you will have the ability to continue to provide care?

Very confident (*Skip to 135*) Somewhat confident (*Skip to 135*) Not very confident

a. What is the main reason you may be unable to continue to provide care?

135. Assessor/CM: Is the caregiver in crisis? No Yes; check all that apply:

Financial Emotional Physical

L. CAREGIVER SECTION, CONTINUED

136. Ask the caregiver to answer the following about the client. (An answer of "Yes, a change" indicates that there has been a change in the last year caused by thinking and memory problems.)	Yes, a change	No change	Don't know or N/A
a. Problems with judgment (problems making decisions, bad financial decisions, problems with thinking)	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Less interest in hobbies/activities	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Repeats the same things over and over (questions, stories, or statements)	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Trouble learning how to use a tool, appliance, or gadget (TV, radio, microwave, remote control)	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. Forgets the correct month or year	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f. Trouble handling complicated financial affairs (balancing checkbook, income taxes, paying bills)	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g. Trouble remembering appointments	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
h. Daily problems with thinking or memory	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Adapted from the "Eight-item Informant Interview to Differentiate Aging and Dementia," a copyrighted instrument of Washington University, St. Louis, Missouri. Copyright 2005. All rights reserved.

Notes & Summary:

Member's caregiver is her daughter with whom the Member lives. She is very involved in Member's care. Member's daughter stated that she goes out in the mornings to take her grandchildren to school, and she also picks them up from school and she also has to go out to run errands and to attend her medical appointments. Member has cognitive impairment and cannot be left alone.

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WHY ARE WE COLLECTING YOUR SOCIAL SECURITY NUMBER?

We are required to explain that your Social Security number is being collected pursuant to Title 42 Code of Federal Regulations, Section 435.910, to be used for screening and referral to programs or services that may be appropriate for you.

The provision of your Social Security number is voluntary, and your information will remain confidential and protected under penalty of law. We will not use or give out your Social Security number for any other reason unless you have signed a separate consent form that releases us to do so.

Medication Attachment

Generated On: 1/28/2025 12:15:28 PM

Member Name: [REDACTED]

Medication and Dosage	Administration Method	Frequency	Physician	Taken As Prescribed
[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	
[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	
[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	
[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	
[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	
[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	

Caregiver Adequacy Assessment

Reference ID:
Member Name:
Member Phone:

[REDACTED]
[REDACTED]
[REDACTED]

Completed Date: 9/24/2024 3:57:15 PM
Completed By: [REDACTED]
Agency: Florida Community Care

Medicaid ID:

[REDACTED]

Caregiver Name:

[REDACTED]

Relationship to member:

Daughter

Care Manager Name:

[REDACTED]

1. Can the person you care for be safely left alone?

Yes

No

If yes, how many hours per day? _____

PHYSICAL HEALTH

2. At this time, are you able to provide adequate support to the person you care for in the following activities of daily living? (check all that apply)

Bathing

Dressing

Eating

Transferring

Using Bathroom

Assistance with Walking

None

3. At this time, are you able to adequately provide support to the person you care for during the following Instrumental Activities of Daily Living ? (check all that apply)

- Heavy Chores
- Light Housekeeping
- Using the Telephone
- Managing Money
- Preparing Meals
- Shopping
- Managing Medications
- Using Transportation
- None

4. At this time, do you have any medical limitation that may prevent you from meeting the needs of the person you care for?

- Yes
- No

If yes explain:

COVERAGE / RELIABILITY

5. Do you have anyone you can rely on should you be unable to provide care?

- Yes
- No

*** IF YES, Please complete a separate Caregiver Assessment for "each" natural support.

6. Are the individuals you utilize for coverage knowledgeable of the needs/requirements of the person you care for?

Yes

No

N/A

MENTAL HEALTH / BURNOUT RISK

7. Do you feel stressed at this time?

Yes

No

8. Do you feel you have enough personal time/privacy/free time?

Yes

No

9. Do you find caregiving to be overwhelming?

Yes

No

10. About how many hours a day do you spend providing care?

8

11. Is your sleep disturbed because you have to provide care?

Yes

No

FINANCIAL

12. Do you work?

Yes

No

If Yes, how many days per week _____ days / week

13. Do you attend school?

Yes

No

If Yes, how many days per week _____ days / week

14. Other activities / responsibilities:

15. Do you feel strained between work and caregiving responsibilities?

Yes

No

N/A

16. Have you had to take time off from work to provide care?

Yes

No

N/A

17. Do you feel that caregiving is a financial strain?

Yes

No

18. Do you have a hard time providing/affording the basic necessities (i.e. heat, electric, etc.)?

Yes

No

N/A

TRANSPORTATION / NECESSITIES

19. Do you drive?

Yes

No

20. Is adequate transportation available and accessible?

Yes

No

KNOWLEDGE

21. Do you feel that you would benefit from trainings in caregiving techniques?

Yes

No

22. Do you feel knowledgeable about the diagnosis of the person you care for?

Yes

No

23. Do you know who to contact or where to go to get more information about the diagnosis?

Yes

No

Is there anything else that would be helpful that hasn't been mentioned?

Yes

No

(If yes please explain)

WILLINGNESS AND CAPABILITY

24. Based on the answers above, do you feel you need additional supports in providing care?

Yes

No

If yes, what kind of supports and how much supports do you feel you need?

25. Based on the answers above, are you capable of continuing to provide assistance?

Yes

No

26. Based on the answers above, are you willing to continue to provide assistance?

Yes

No

27. Assessor Comments:

Member's daughter is very supportive and involved in Member's care.

Member Name:	[REDACTED]	Medicaid ID:	[REDACTED]	Plan of Care Effective Date:	11/1/2023
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Member current residence:	<input checked="" type="checkbox"/> Home	<input type="checkbox"/> Assisted Living Facility (ALF)	<input type="checkbox"/> Adult Family Care Home (AFCH)	<input type="checkbox"/> Nursing facility
Member's choice in residence: (If different from current residence, address achieving this goal in the personal goal section)	<input checked="" type="checkbox"/> Home	<input type="checkbox"/> Assisted Living Facility (ALF)	<input type="checkbox"/> Adult Family Care Home (AFCH)	<input type="checkbox"/> Nursing facility

If member resides in an ALF or attends ADC, does the member have access to a home and community-based setting:	<input type="checkbox"/> Home-like environment	If the member does not have access to one of the previous HCB setting requirements, provide reason and modification needed to promote LIFE.	_____
	<input type="checkbox"/> Community inclusion		_____
	<input type="checkbox"/> Person-centered planning		_____

List available natural supports to assist in member's care: (Specific information regarding assistance provided by natural supports is listed below)	[REDACTED]	List member's Emergency Management Plan	<input type="checkbox"/> Registered with Special Needs Registry Member will remain at home with CG. _____
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Are existing care plans and service providers in place:	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, list care plans and service providers:	CONSUMER DIRECT FOR FLORIDA S5130 Homemaker: 3 HRS/WEEK T1019 Personal Care: 10 HRS/WEEK Sunshine Medical Supplies - CMS	Are services in place adequate to meet member's needs:	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
---	--	--	---	--	--

List advanced directives:	<input type="checkbox"/> Healthcare Surrogate	<input checked="" type="checkbox"/> Healthcare Proxy	<input type="checkbox"/> Power of Attorney	<input type="checkbox"/> Legal Guardian	<input type="checkbox"/> DNR
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List medication oversight strategies:	<input type="checkbox"/> Member oversees own medication; no oversight required <input type="checkbox"/> N/A; member does not take any medications <input checked="" type="checkbox"/> Member requires medication oversight; (see strategies listed below)	
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Review Dates:	10/22/2024			
Type of Visit:	ANNUAL ASSESSMENT			



Plan of Care

Member Name:	[Redacted]	Medicaid ID:	[Redacted]	Plan of Care Effective Date:	11/1/2023
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I have received and read the plan of care. I understand that I have the right to file an appeal or fair hearing if my services have been denied, reduced, terminated, or suspended.

Member/Authorized Rep Signature:	[Redacted]	Date:	10/22/2024	Print Name:	[Redacted]
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I agree with the Plan of Care

List services that Member/Authorized Rep do not agree upon:	
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This Plan of Care prevents the provision of unnecessary or inappropriate services and supports

Member unable to sign and representative not present during visit. Plan of Care mailed to representative for review and signature.

Case Manager Signature:	[Redacted]	Date:	10/22/2024	Print Name:	[Redacted]
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The above Case Manager is responsible for monitoring this Care Plan.



Plan of Care

Member Name:	[REDACTED]	Medicaid ID:	[REDACTED]	Plan of Care Effective Date:	11/1/2023
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Member Assessed Needs / Strengths / Preferences / Self-Care Capabilities	Type of Service / Intervention Services include routine medical and LTC waiver services, regardless of funding source	Amount and Frequency Including units and service schedule	Provider Name Includes: provider, member, family, friend, Medicare, Faith-Based and others	Begin Date	End Date
MEMEBR UNABLE TO MANAGE HOME AND COMMUNITY BASED SERVICES.	CASE MANAGEMENT	MONTHLY AND AS NEEDED	MOLINA LTC CM- [REDACTED]	11/1/2023	10/31/2025
MEMBER HAS FINANCIAL RESTRICTIONS, OTC ASSISTANCE NEEDED.	OTC- OVER THE COUNTER MEDICATION	1 UNIT MONTHLY	NAVARRO/CVS PHARMACY	11/1/2023	10/31/2025
MEMBER IS UNABLE TO DEVELOP AND MANAGE THEIR EMERGENCY PLAN IN THE EVENT OF A NATURAL DISASTER	EMERGENCY PLAN- WTAER, CANNED FOODS, FLASHLIGHTS/BATERRIES, 2 WEEKS SUPPLY OF MEDICATION	ANNUALLY/AS-NEEDED	[REDACTED]	11/1/2023	10/31/2025



Plan of Care

Member Name:	DUNIESKY PADRON JIMENEZ	Medicaid ID:	9516972098	Plan of Care Effective Date:	11/1/2023
Member Assessed Needs / Strengths / Preferences / Self-Care Capabilities	Type of Service / Intervention Services include routine medical and LTC waiver services, regardless of funding source	Amount and Frequency Including units and service schedule	Provider Name Includes: provider, member, family, friend, Medicare, Faith-Based and others	Begin Date	End Date
Member requires assistance with managing chronic health conditions and medication management.(HTN, GERD, UTI, occasional dizziness, legally blind, Hyperlipidemia, Hyperglycemia, Diabetes type II, frequent bladder and	PCP: PRIMARY CARE PHYSICIAN	MONTHLY/AS-NEEDED	[REDACTED]	11/1/2023	10/31/2025
Member requires assistance with managing anxiety, severe depression and medication management.	MEDICAL SPECIALIST (PSYCHIATRIST)	QUARTERLY/AS NEEDED	[REDACTED]	11/1/2023	10/31/2025
Member requires assistance with managing chronic health conditions and medication management. (kidney(both)/pancreas transplantation (2019)).	MEDICAL SPECIALIST (UROLOGIST)	QUARTERLY/AS NEEDED	[REDACTED]	11/1/2023	10/31/2025
Member is unable to drive and requires Transportation to and from medical appointments	TRANSPORTATION SERVICES	AS-NEEDED	[REDACTED]	11/1/2023	10/31/2025



Plan of Care

Member Name:	[REDACTED]	Medicaid ID:	[REDACTED]	Plan of Care Effective Date:	11/1/2023
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Member Assessed Needs / Strengths / Preferences / Self-Care Capabilities	Type of Service / Intervention Services include routine medical and LTC waiver services, regardless of funding source	Amount and Frequency Including units and service schedule	Provider Name Includes: provider, member, family, friend, Medicare, Faith-Based and others	Begin Date	End Date
.EMERGENCY CONTACT, RESPONSIBLE PARTY, FINANCIAL CONTACT AND PARTICIPATE IN CARE PLAN DEVELOPMENT.	ADVANCED DIRECTIVE	AS-NEEDED	[REDACTED]	1/1/2023	10/31/2025
Member requires DME's in order to avoid a fall and maintain stable health	DME - Durable Medical Equipment -CANE, SHOWER CHAIR	DAILY/AS-NEEDED	Services Already in Place	11/1/2023	10/31/2025
Member requires hospitalization to be treated for his health conditions during any emergency.	HOSPITAL ADMISSION	DAILY/AS-NEEDED	[REDACTED]	11/1/2023	10/31/2025
MEMBER IS DIAGNOSED WITH DIABETES.	DISEASE MANAGEMENT	AS NEEDED	MOLINA HEALTHCARE COMMUNITY PLUS	11/1/2023	10/31/2025



Plan of Care

Member Name:	[REDACTED]	Medicaid ID:	[REDACTED]	Plan of Care Effective Date:	11/1/2023
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Member Assessed Needs / Strengths / Preferences / Self-Care Capabilities	Type of Service / Intervention Services include routine medical and LTC waiver services, regardless of funding source	Amount and Frequency Including units and service schedule	Provider Name Includes: provider, member, family, friend, Medicare, Faith-Based and others	Begin Date	End Date
MEMBER IS DIAGNOSED WITH DIABETES- TYPE I	DME -Glucometer, Lancets, and Test Strips	DAILY/AS-NEEDED	Services Already in Place	11/1/2023	10/31/2025
MEMBER REQUIRES OVERSIGHT OF MEDICATIONS	MEDICATION OVERSIGHT	AS NEEDED	[REDACTED]	11/01/2023	10/31/2025
Member is unable to develop and manage an emergency plan in the event of a hurricane or other weather disaster	Emergency Management Plan	As Needed	Member will remain at home with CG.	11/01/2023	10/31/2025
Member needs assistance with bathing and dressing tasks	Personal Care	T1019 - Personal Care 10 hours per week	CONSUMER DIRECT FOR FLORIDA	11/29/2023	10/31/2024

Member Name:	[REDACTED]	Medicaid ID:	[REDACTED]	Plan of Care Effective Date:	11/1/2023
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Member risk factors:	Member suffers from occasional dizziness and is legally blind. Member is at fall risk.	Strategies to minimize risk factors, including back-up plan:	CM will educate on basic fall prevention strategies such as wear shoes, remove clutter, remove loose rugs, increase lighting, use grab bars/handrails.
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Personal Goal Planning

Goal/Objective	Barrier	Intervention	Status
Member is unable to complete housekeeping, shopping, and laundry tasks independently due to limited mobility.	Homemaking S5130 - Homemaker 3 hours per week	CONSUMER DIRECT FOR FLORIDA (877)270-9580	11/29/2023 - 10/31/2024
Member is incontinent and needs consumable medical supplies to maintain hygiene.	Medical Equipment Supply T4535/U2 BLADDER CTRL PADS: 192 UNITS/CASE, 1 CASE/MONTH A4554/U2 UNDERPADS 1 CASE (100 x CASE) EVERY TWO MONTHS	SUNSHINE MEDICAL (786)469-9654	11/01/2023 - 10/31/2024



Plan of Care

Member Name:	[Redacted]	Medicaid ID:	[Redacted]	Plan of Care Effective Date:	11/1/2023
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Goal/Objective	Barrier	Intervention	Status
Member will have no falls in 90 days. Priority- High	Member suffers from occasional dizziness and is legally blind.	CM will educate on basic fall prevention strategies such as wear shoes, remove clutter, remove loose rugs, increase lighting, use grab bars/handrails.	Open



Plan of Care

Member Name:	[Redacted]	Medicaid ID:	[Redacted]	Plan of Care Effective Date:	11/1/2023
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Goal/Objective	Barrier	Intervention	Status

PLAN ID: [REDACTED]

07/18/2025

[REDACTED]
[REDACTED] [REDACTED] [REDACTED]
[REDACTED] [REDACTED]**WRITTEN APPEAL ACKNOWLEDGEMENT**

Dear [REDACTED] [REDACTED] [REDACTED] [REDACTED]:

Florida Community Care received your appeal on 7/16/2025.

You, or someone who is legally authorized, can ask us for a complete copy of your file. This file includes all records, plan review criteria and guidelines, contract provisions and other information for the plan appeal process. This will be given to you free of charge. To ask for these free copies, call the number below.

We may need to ask you for more information to review your appeal. If so, someone will call you soon. At any time during this process, you may send us any needed information. Please feel free to call us. You can also call us at any time to talk about your case.

We will review your appeal and provide a notice of our decision no later than thirty (30) calendar days from 7/16/2025. We may take up to 14 days longer to resolve your appeal. We will do this if you ask us to take longer. We may also take longer if more information is needed, and the delay is in your best interest. If we need more time, we will let you know within 2 days of this decision.

You have the right to keep getting services until a final decision is made. If your services are continued, there will be no change in your services until a final decision is made. This includes your plan appeal and, if requested, fair hearing.

If your services continue and our decision is upheld in a plan appeal or fair hearing, we may ask that you pay for the cost of those services. We will not take away your Medicaid benefits. We cannot ask your family or legal representative to pay for the services.



Florida Community Care LLC
P.O. Box 261060
Miami, Florida 33126

To have your services continue during the plan appeal, you **MUST** file your plan appeal **AND** ask to continue your services within this time frame:

File a request for your services to continue with Florida Community Care no later than 10 days after the Notice of Adverse Benefit Determination was mailed OR on or before the first day that your services are scheduled to be reduced, suspended, or terminated, whichever is later. You can ask for a plan appeal by phone. If you do this, you must then **also** make a request in writing. **Be sure to tell us if you want your services to continue.**

If you need help filling out forms, please call us. We can help with an interpreter that speaks your language. If you have questions, call us at 833-FCC-PLAN or 711 for TTY. For more information on your rights, review Section 17: Member Satisfaction, Complaints, Grievances, and Plan Appeals your Member Handbook. It can be found online at: www.fcchealthplan.com or you can ask Member Services for a printed copy.

Sincerely,

Appeal Department

This information is available for free in other languages and formats. Please contact our Member Services number at 1-833-322-7526 (TTY: 711), Monday – Friday, 8 a.m. to 8 p.m.

Spanish

Esta información está disponible gratuitamente en otros idiomas y formatos. Comuníquese con nuestro Servicio al Miembros al 1-833-322-7526 (TTY: 711) de lunes a Viernes, de 8 a.m. a 8 p.m.

Haitian Creole

Enfòmasyon sa a disponib gratis nan lòt lang ak fòm. Tanpri kontakte nimewo Sèvis Manm nou an nan 1-833-322-7526 (TTY: 711), lendi rive vandredi, 8 a.m. a 8 p.m.

Notice of Nondiscrimination

Florida Community Care complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Florida Community Care does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Florida Community Care:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
 - Qualified sign language interpreters
 - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
 - Qualified interpreters
 - Information written in other languages

If you need these services, contact Member Services.

If you believe that Florida Community Care has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: Member Services, 833-FCC-PLAN (833-322-7526) or 711 for TTY.

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, Member Services is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail

or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, DC 20201
1-800-368-1019, 1-800-537-7697 (TDD)

Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

Written or Oral Translation Services

English: **ATTENTION:** If you do not speak English, written translation or oral interpretation services, free of charge, are available to you. Call 1-833-322-7526 (TTY: 711).

Español (Spanish): **ATENCIÓN:** Si no habla inglés, tiene a su disposición servicios de traducción escrita o interpretación oral, gratuitos. Llame al 1-833-322-7526 (TTY: 711).

Kreyòl Ayisyen (Haitian Creole): **ATANSYON:** Si ou pa pale Anglè, gen sèvis entèpretasyon alekri oswa aloral ki disponib gratis pou ou. Rele 1-833-322-7526 (TTY: 711).

Tiếng Việt (Vietnamese): **LƯU Ý:** Nếu bạn không nói tiếng Anh, chúng tôi sẽ cung cấp miễn phí cho bạn dịch vụ dịch thuật bằng văn bản hoặc phiên dịch lời nói. Gọi 1-833-322-7526 (TTY: 711).

Português (Portuguese): **ATENÇÃO:** Se você não fala inglês, há serviços gratuitos de tradução escrita ou interpretação oral à sua disposição. Ligue para 1-833-322-7526 (TTY: 711).

中文 (Chinese) : **注意 :** 如果您不会讲英文 , 我们为您提供免费的笔译或口译服务 。
请致电 1-833-322-7526 (TTY: 711)。

Zhōngwén (Chinese): **Zhùyì:** Rúguǒ nín bùhuì jiǎng yīngwén, wǒmen wèi nín tígōng miǎnfèi de bǐyì huò kǒuyì fúwù. Qǐng zhìdiàn 1-833-322-7526 (TTY: 711).

Français (French): **ATTENTION :** Si vous ne parlez pas l'anglais, des services gratuits de traduction écrite ou d'interprétation orale sont à votre disposition. Appelez le 1-833-322-7526 (ATS : 711).

Tagalog (Tagalog): Tawag-pansin: Kung hindi ka nagsasalita ng Ingles, available sa iyo ang nakasulat na pagsasalin o oral interpretation services nang walang bayad. Tawagan ang 1-833-322-7526 (TTY: 711).

Русский (Russian): ВНИМАНИЕ: Если вы не говорите по-английски, то вам доступны бесплатные услуги письменного и устного перевода. Звоните 1-833-322-7526 (TTY: 711)

العربية (Arabic): تنبيه: إذا كنت لا تتحدث الإنجليزية، فستتوفر لك خدمات الترجمة التحريرية أو الشفهية مجانًا. اتصل هاتفياً بالرقم 1-833-322-7526 (TTY: 711).

Italiano (Italian): ATTENZIONE: Se non parla inglese, sono disponibili servizi gratuiti di traduzione scritta o interpretariato orale. Chiamare 1-833-322-7526 (TTY: 711)

Deutsch (German): ACHTUNG! Wenn Sie die englische Sprache nicht beherrschen, stehen Ihnen schriftliche Übersetzungen oder mündliche Dolmetscherdienste kostenlos zur Verfügung. Rufen Sie 1-833-322-7526 (TTY: 711) an.

한국어(Korean): 주의: 영어를 구사하지 못하시면 서면 번역이나 구두 통역 서비스를 무료로 이용하실 수 있습니다. 1-833-322-7526 (TTY: 711)번으로 연락해 주십시오.

Polski (Polish): UWAGA: Jeżeli nie mówisz po angielsku, możesz skorzystać z bezpłatnych pisemnych i ustnych usług tłumaczeniowych. Zadzwoń 1-833-322-7526 (TTY: 711).

ગુજરાતી (Gujarati): ધ્યાન: જો તમે અંગ્રેજી ન બોલતા હો, તો લેખિત અનુવાદ અથવા મૌખિક અર્થઘટન સેવાઓ, વિના મૂલ્યે, તમને ઉપલબ્ધ છે. 1-833-322-7526ને કોલ કરો (TTY: 711).

ภาษาไทย (Thai): โปรดทราบ: หากท่านพูดภาษาอังกฤษไม่ได้ ท่านสามารถใช้บริการแปลเอกสารหรือล่ามแปลภาษาฟรีได้ที่ โทร 1-833-322-7526 (TTY:711)

If you are unable to read this in a smaller font, this information is available to you in other formats or by oral interpretation, free of charge. Call 1-833-322-7526 (TTY: 711).



Florida
community care

Florida Community Care LLC

P.O. Box 261060

Miami, Florida 33126

PLAN ID: [REDACTED]

08/08/2025

[REDACTED]
[REDACTED]
[REDACTED]**NOTICE OF PLAN APPEAL RESOLUTION**

Dear [REDACTED]:

On 07/16/2025 we received your timely plan appeal request regarding Florida Community Care's Notice of Adverse Benefit Determination dated 6/30/2025, NABD Number ACME-16-000156, Denying The Personal Care: Total hours per week: 61 requested for [REDACTED]. 37 hours were continued and 24 hours were denied.

On 08/6/2025, after consideration of the information you provided to Florida Community Care in support of your plan appeal, Florida Community Care hereby Denies your plan appeal. As a result, [REDACTED] will not receive Personal Care: Total hours per week: 61, effective 08/6/2025. You will continue to receive the 37 hours per week you have been receiving.

You, or someone legally authorized to do so, can ask us for a complete copy of your file, including medical records, a copy of plan review criteria and guidelines, contract provisions, other documents, records, and other information considered during the plan appeal process. These will be provided free of charge.

You may request these documents by contacting FCC at 833-FCC-PLAN (833-322-7526).

Right to Request a State Medicaid Fair Hearing

If you do not agree with this decision, you have the right to request a Medicaid fair hearing from the state. When you ask for a fair hearing, a hearing officer who works for the state reviews the decision made during the plan appeal.

How to Ask for a Fair Hearing:

You may ask for a fair hearing any time up to 120 days after you get this Notice of Plan Appeal Resolution. Your case manager can help you with this, if you have one.

You may ask for a fair hearing by calling or writing to:

Agency for Health Care Administration
Medicaid Hearing Unit
P.O. Box 60127
Ft. Myers, FL 33906

(877) 254-1055 (*toll-free*)

239-338-2642 (*fax*)

MedicaidHearingUnit@ahca.myflorida.com

Your written request for a Medicaid fair hearing must include the following information:

- Your name
- Your member number
- Your Medicaid ID number
- A phone number where we can reach you or your authorized representative

You may also include the following information if you have it:

- Why you think we should change the decision
- Any medical information to support the request
- Who you would like to help with your fair hearing

After getting your fair hearing request, the Agency for Health Care Administration (Agency) will tell you in writing that they got your fair hearing request.

How to Ask for your Services to Continue During a Fair Hearing:

If you were receiving services during your plan appeal, file the request for your services to continue with the Agency **no later than 10 days** from the date on this Notice of Plan Appeal Resolution OR on or before the first day that your services are scheduled to be reduced, suspended, or terminated, *whichever is later*.

If your services are continued and our decision is upheld in a fair hearing, we may ask that you pay for the cost of those services. We will not take away your Medicaid benefits. We cannot ask your family or legal representative to pay for the services.

If you have questions, call us at 833-FCC-PLAN (833-322-7526) or 711 for TTY. For more information on your rights, review Section 17: Member Satisfaction –



Florida
community care

Florida Community Care LLC

P.O. Box 261060

Miami, Florida 33126

Complaints, Grievances, and Plan Appeals in your Member Handbook. It can be found online at: www.fcchealthplan.com.

Sincerely,

Angel E. Garrido MD

Angel E. Garrido, M.D
Medical Director

This information is available for free in other languages and formats. Please contact our Member Services number at 1-833-322-7526 (TTY: 711), Monday – Friday, 8 a.m. to 8 p.m.

Spanish

Esta información está disponible gratuitamente en otros idiomas y formatos. Comuníquese con nuestro Servicio al Miembros al 1-833-322-7526 (TTY: 711) de lunes a Viernes, de 8 a.m. a 8 p.m.

Haitian Creole

Enfòmasyon sa a disponib gratis nan lòt lang ak fòm. Tanpri kontakte nimewo Sèvis Manm nou an nan 1-833-322-7526 (TTY: 711), lendi rive vandredi, 8 a.m. a 8 p.m.

Notice of Nondiscrimination

Florida Community Care complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Florida Community Care does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Florida Community Care:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
 - Qualified sign language interpreters
 - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
 - Qualified interpreters
 - Information written in other languages

If you need these services, contact Member Services.

If you believe that Florida Community Care has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: Member Services, 833-FCC-PLAN (833-322-7526) or 711 for TTY.

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, Member Services is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights

Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, DC 20201
1-800-368-1019, 1-800-537-7697 (TDD)

Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

Written or Oral Translation Services

English: ATTENTION: If you do not speak English, written translation or oral interpretation services, free of charge, are available to you. Call 1-833-322-7526 (TTY: 711).

Español (Spanish): ATENCIÓN: Si no habla inglés, tiene a su disposición servicios de traducción escrita o interpretación oral, gratuitos. Llame al 1-833-322-7526 (TTY: 711).

Kreyòl Ayisyen (Haitian Creole): ATANSYON: Si ou pa pale Anglè, gen sèvis entèpretasyon alekri oswa aloral ki disponib gratis pou ou. Rele 1-833-322-7526 (TTY: 711).

Tiếng Việt (Vietnamese): LƯU Ý: Nếu bạn không nói tiếng Anh, chúng tôi sẽ cung cấp miễn phí cho bạn dịch vụ dịch thuật bằng văn bản hoặc phiên dịch lời nói. Gọi 1-833-322-7526 (TTY: 711).

Português (Portuguese): ATENÇÃO: Se você não fala inglês, há serviços gratuitos de tradução escrita ou interpretação oral à sua disposição. Ligue para 1-833-322-7526 (TTY: 711).

中文 (Chinese) : 注意 : 如果您不会讲英文 , 我们为您提供免费的笔译或口译服务 。
请致电 1-833-322-7526 (TTY: 711)。

Zhōngwén (Chinese): Zhùyì: Rúguǒ nín bùhuì jiǎng yīngwén, wǒmen wèi nín tígōng miǎnfèi de bǐyì huò kǒuyì fúwù. Qǐng zhìdiàn 1-833-322-7526 (TTY: 711).

Français (French): ATTENTION : Si vous ne parlez pas l'anglais, des services gratuits de traduction écrite ou d'interprétation orale sont à votre disposition. Appelez le 1-833-322-7526 (ATS : 711).



Tagalog (Tagalog): Tawag-pansin: Kung hindi ka nagsasalita ng Ingles, available sa iyo ang nakasulat na pagsasalin o oral interpretation services nang walang bayad. Tawagan ang 1-833-322-7526 (TTY: 711).

Русский (Russian): ВНИМАНИЕ: Если вы не говорите по-английски, то вам доступны бесплатные услуги письменного и устного перевода. Звоните 1-833-322-7526 (TTY: 711)

العربية (Arabic): تنبيه: إذا كنت لا تتحدث الإنجليزية، فستتوفر لك خدمات الترجمة التحريرية أو الشفهية مجانًا. اتصل هاتفياً بالرقم 1-833-322-7526 (TTY: 711).

Italiano (Italian): ATTENZIONE: Se non parla inglese, sono disponibili servizi gratuiti di traduzione scritta o interpretariato orale. Chiamare 1-833-322-7526 (TTY: 711)

Deutsch (German): ACHTUNG! Wenn Sie die englische Sprache nicht beherrschen, stehen Ihnen schriftliche Übersetzungen oder mündliche Dolmetscherdienste kostenlos zur Verfügung. Rufen Sie 1-833-322-7526 (TTY: 711) an.

한국어(Korean): 주의: 영어를 구사하지 못하시면 서면 번역이나 구두 통역 서비스를 무료로 이용하실 수 있습니다. 1-833-322-7526 (TTY: 711)번으로 연락해 주십시오.

Polski (Polish): UWAGA: Jeżeli nie mówisz po angielsku, możesz skorzystać z bezpłatnych pisemnych i ustnych usług tłumaczeniowych. Zadzwoń 1-833-322-7526 (TTY: 711).

ગુજરાતી (Gujarati): ધ્યાન: જો તમે અંગ્રેજી ન બોલતા હો, તો લેખિત અનુવાદ અથવા મૌખિક અર્થઘટન સેવાઓ, વિના મૂલ્યે, તમને ઉપલબ્ધ છે. 1-833-322-7526ને કોલ કરો (TTY: 711).

ภาษาไทย (Thai): โปรดทราบ: หากท่านพูดภาษาอังกฤษไม่ได้ ท่านสามารถใช้บริการแปลเอกสารหรือสามแปลภาษาฟรีได้ที่ โทร 1-833-322-7526 (TTY:711)

If you are unable to read this in a smaller font, this information is available to you in other formats or by oral interpretation, free of charge. Call 1-833-322-7526 (TTY: 711).

STATE OF FLORIDA
AGENCY FOR HEALTH CARE ADMINISTRATION
OFFICE OF FAIR HEARINGS

[REDACTED],

PETITIONER,

vs.

AHCA Case Nos.: [REDACTED]

Plan ID No.: [REDACTED]
Member ID No.: [REDACTED]

SIMPLY HEALTHCARE PLANS

RESPONDENT.

_____ /

**PETITIONER'S DESIGNATION OF AUTHORIZED REPRESENTATIVE FOR
MEDICAID FAIR HEARING PARTICIPATION**

I. Recipient Information:

Last Name: [REDACTED]

First Name: [REDACTED]

Recipient Medicaid ID: [REDACTED]

Recipient Year of Birth: [REDACTED]

II. Designation:

I wish to designate the person below as my Authorized Representative. I fully understand that this designation will permit my Authorized Representative to file and participate in the Medicaid Fair Hearing on my behalf until conclusion of the hearing and issuance of the Final Order. Also, I consent to the disclosure of my Protected Health Information (PHI) by the Agency for Health Care Administration to my Authorized Representative designated herein for the purposes of filing and participating in the Medicaid Fair Hearing on my behalf.

The address written below will serve as the address of record in the Fair Hearing, unless otherwise indicated.

Authorized Representative: Jocelyn Armand, Legal Services of Greater Miami
Address: 4343 West Flagler Street, Suite 100 Miami, FL 33134

Phone: 305-438-3809
E-mail: JArmand@legalservicesmiami.org
Preferred contact method: E-mail

Fair Hearing Case Numbers: [REDACTED]
[REDACTED]

Recipient Signature:

Recipient Name: [REDACTED]

Date: _____

Respectfully submitted,



Jocelyn J. Armand, Esq.
FL Bar No.:0044264
Attorney for Petitioner
Legal Services of Greater Miami, Inc.
4343 West Flagler Street, Suite 100, Miami, FL 33134
Tel: 305-438-3809
Email: Jarmand@legalservicesmiami.org

CERTIFICATE OF SERVICE

I certify that a copy of this document was e-mailed to Respondent at MedicaidFairHearings@simplyhealthcareplans.com on _____.



Jocelyn Armand



Appointment of Representative (AOR) Form

Member Name

Molina Member ID Number

APPOINTMENT OF REPRESENTATIVE

I agree to name Jocelyn Armand, Esq. (Name and address) to be my representative with a grievance or an appeal for Termination of Companion Care (specific issue).

I approve this person to make or give any request or notice; present or evidence; to obtain information, including, without limitation, the release of past, present or future: HIV test results, alcohol and drug abuse treatment, psychological/psychiatric testing and evaluation information, and any other information regarding medical diagnosis, treatments and/or conditions; and to receive any notice in relation with my pending grievance/appeal.

SIGNATURE (member)

ADDRESS

TELEPHONE NUMBER (AREA CODE)

10/05/2023
DATE

ACCEPTANCE OF APPOINTMENT

I, Jocelyn Armand, hereby agree to the above appointment. I certify that I have not been suspected or prohibited from practice before the Social Security Administration; that I am not as a current or former officer or employee of the United States, disqualified as acting as the claimant's representative; that I will not charge or receive any fee for the representation unless it has been authorized in accordance with the laws and regulations.

Attorney I am a/an

(Attorney, union representative, relative, etc.)



SIGNATURE (Representative)

4343 West Flager Street, Suite 100, Miami, FL 33134
ADDRESS

305-438-3809
TELEPHONE NUMBER (with Area Code)

10/05/2023
DATE



RON DESANTIS
GOVERNOR

JASON WEIDA
SECRETARY

November 25, 2024



FILED

Nov 25, 2024, 8:21 am
OFFICE OF FAIR HEARINGS

ACKNOWLEDGEMENT OF THIRD PARTY MEDICAID FAIR HEARING REQUEST

The Agency for Health Care Administration (“AHCA” or “Agency”) received a request for a Medicaid Fair Hearing on **November 20, 2024**, for:

██████████ c/o Jocelyn Armand
4343 West Flagler St
Suite 100
Miami, FL 33134
Telephone: (305) 438-3809
E-mail: jarmand@legalservicesmiami.org

The hearing request is assigned AHCA Case Number **24-FH3590**.

The parties in this matter are the Medicaid Recipient identified above and the following:

Simply Health Care Plans, Inc.
4200 West Cypress Street
Suite 900
Tampa, Florida 33631
Telephone: (844) 406-2396 (MMA)/ (844) 406-2398 (SPEC)/ (877) 440-3738 (LTC)
Fax: (866) 216-3482
E-mail: MedicaidFairHearings@simplyhealthcareplans.com.

Recipient’s Designation of Mailing Address or E-mail Address

The **e-mail** address provided above for the Recipient or Recipient’s Representative is the Recipient’s address of record for this Fair Hearing. You selected this preferred contact when you requested this Fair Hearing. **Going forward, all information regarding this Fair Hearing will be sent only to the e-mail address above. It is very important to update this address with the Office of Fair Hearings if there is any change.** The Recipient or Recipient’s Representative may request that Fair Hearing information be provided by **mail** instead. It is very important to update any change to the preferred contact with the Office of Fair Hearings. If Recipient or Recipient’s Authorized Representative designates an e-mail address, service at the e-mail address will be presumed to be valid service.

Recipient's Written Designation of Authorized Representative

Any person, including a family member, friend, counsel, or a Recipient's provider, making a Fair Hearing request on behalf of a Recipient, or seeking to represent a Recipient in a Fair Hearing, must file with the Office of Fair Hearings a **written authorization** signed by the Recipient or by a person with legal authority to act on behalf of the Recipient, designating the person as the Recipient's Authorized Representative. To avoid dismissal of the request for Fair Hearing, the Recipient must file their written Designation of Authorized Representative with the Office of Fair Hearings at the address provided below. (See enclosed sample form, "Designation of Authorized Representative for Medicaid Fair Hearing Participation.")

Submission of Documents to Office of Fair Hearings

You may obtain any information regarding this fair hearing or submit any relevant documents to the following address:

**Agency for Health Care Administration
Office of Fair Hearings
2727 Mahan Drive
Mail Stop #11
Tallahassee, FL 32308
Telephone: (850) 412-3649
Fax: (850) 487-1423
E-mail: OfficeOfFairHearings@ahca.myflorida.com.**

A Hearing Officer will be assigned by the Office of Fair Hearings to preside over this hearing request. The Hearing Officer will provide additional written instructions regarding this hearing request.

This hearing request is subject to, and will be conducted pursuant to, Rule 59G-1.100, Florida Administrative Code. You may review this Rule at the following link: <http://ahca.myflorida.com/medicaid/review/Rules.shtml>.

Enclosures:

Notice of Nondiscrimination Policy

Designation of Authorized Representative for Medicaid Fair Hearing Participation (Sample)

COPIES FURNISHED TO (w/ Enclosure):

**[REDACTED] c/o Jocelyn Armand
4343 West Flagler St
Suite 100
Miami, FL 33134
jarmand@legalservicesmiami.org**

**Simply Health Care Plans, Inc.
MedicaidFairHearings@simplyhealthcareplans.com**

**AHCA Medicaid Hearing Unit
MedicaidHearingUnit@ahca.myflorida.com**

Notice of Nondiscrimination Policy

The Agency for Health Care Administration (“AHCA”) is committed to providing all people with an equal opportunity to participate in its programs, services, and activities. AHCA complies with applicable Federal civil rights laws and does not exclude people or treat them differently in admission to, access to, or employment in its programs, services, or activities on the basis of race, color, national origin, age, disability, or sex. Communication aids and services, such as: qualified sign language interpreters, qualified foreign language interpreters, and written information in alternative formats (i.e.: Braille, large print, foreign language, etc.) are provided free of charge, in accordance with federal law, when necessary to ensure equal opportunity and effective communication.

This Notice is provided as required by Title II of the Americans with Disabilities Act of 1990, Section 504 of the Rehabilitation Act, and Section 1557 of the Affordable Care Act and implementing regulations. This Notice is available, upon request, in alternative formats. Individuals who require free communication aids and services to effectively participate in AHCA’s programs, services, and activities are invited to make their requests to the Civil Rights Compliance Coordinator at the contact information listed below. If you believe that AHCA has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex you can file a grievance in person, by mail, or by telephone with:

Civil Rights Compliance Coordinator
2727 Mahan Drive, Mail Stop #3
Tallahassee, FL 32308
Voice: (850) 412-3661
TTY: (800) 955-8771



Spanish ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-(888) 419-3456 (TTY: 1-800-955-8771).

French Creole Atansyon: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-(888) 419-3456 (TTY: 1-800-955-8771).

Vietnamese CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-(888) 419-3456 (TTY: 1-800-955-8771).

Portuguese ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 1-(888) 419-3456 (TTY: 1-800-955-8771).

Chinese 注意 : 如果您使用繁體中文, 您可以免費獲得語言援助服務。請致電 1-(888) 419-3456 (TTY: 1-800-955-8771)

French ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-(888) 419-3456 (ATS: 1-800-955-8771).

Tagalog PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-(888) 419-3456 (TTY: 1-800-955-8771).

Russian ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-(888) 419-3456 (телетайп: 1-800-955-8771).

Arabic

ملحوظة: إذا كنت تتحدث العربية، فإن خدمات المساعدة اللغوية متاحة لك بالمجان. اتصل برقم 1-(888) 419-3456 (التحويلة: 1-800-955-8771)

Italian ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-(888) 419-3456 (TTY: 1-800-955-8771).

German ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-(888) 419-3456 (TTY: 1-800-955-8771).

Korean 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-(888) 419-3456 (TTY: 1-800-955-8771) 번으로 전화해 주십시오.

Polish UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-(888) 419-3456 (TTY: 1-800-955-8771).

Gujarati નોંધ: જો તમે ગુજરાતી બોલતા હો, તો નિ:શુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. ફોન કરો 1-(888) 419-3456 (TTY: 1-800-955-8771).

Thai เรียบ: ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร 1-(888) 419-3456 (TTY: 1-800-955-8771).

NOTE: This sample designates a Medicaid Recipient's Authorized Representative for a Fair Hearing. It also allows the Agency for Health Care Administration to disclose Protected Health Information (PHI) about the Recipient to the Authorized Representative. To designate an Authorized Representative to file or represent a Medicaid Recipient in a Fair Hearing, complete and submit this sample to the Office of Fair Hearings at the address provided in the sample instructions below. Designation of an Authorized Representative does not require use of this sample; any writing that meets the requirements of Rule 59G-1.100, Florida Administrative Code, for designation of an Authorized Representative may be used.

**DESIGNATION OF AUTHORIZED REPRESENTATIVE FOR
MEDICAID FAIR HEARING PARTICIPATION (SAMPLE)**

For instructions for filling out this form, please see reverse side.

Recipient Information

Last: _____ **First:** _____ **Middle Initial:** _____

Recipient Medicaid ID: _____ **Recipient Year of Birth:** _____

I wish to designate the person below as my Authorized Representative. I fully understand that this designation will permit my Authorized Representative to file and participate in the Medicaid Fair Hearing on my behalf until conclusion of the hearing and issuance of the Final Order. Also, I consent to the disclosure of my Protected Health Information (PHI) by the Agency for Health Care Administration to my Authorized Representative designated herein for the purposes of filing and participating in the Medicaid Fair Hearing on my behalf. **The address written below will serve as the address of record in the Fair Hearing, unless otherwise indicated.**

Authorized Representative: _____
(Print Name)

Address: _____

Phone: _____

E-mail: _____

Please select your preferred contact (select only one): E-mail: **OR** USPS Mail:

If no box is selected, or if both boxes are selected, your default preferred contact will be USPS mail.

Fair Hearing Case Number: 24-FH3590

Recipient or Legal Representative:

(Print Name)

(Signature)

(Date)

Instructions

Recipient Information:

Last: Enter the legal last name of the recipient.

First: Enter the legal first name of the recipient.

Middle Initial: Enter the first letter of the legal middle name of the recipient.

Recipient Medicaid ID: Enter the Medicaid ID of the recipient.

Recipient Year of Birth: Enter the year of birth for the recipient.

Authorized Representative Information:

Authorized Representative: Enter the legal name of the representative.

Address: Enter the mailing address of the representative.

Phone: Enter the phone number of the representative.

E-mail: Enter the e-mail address of the representative.

Preferred Contact: Indicate whether the representative's preferred contact is e-mail or USPS mail. Select only one box. If no box is selected, or if both boxes are selected, your default preferred contact will be mail.

Fair Hearing Case Information:

Fair Hearing Case Number: Enter the case number for the fair hearing.

Final Instructions:

The sample must be signed and dated by the recipient and submitted using one of the methods below.

E-mail	Fax	Mail
OfficeOfFairHearings@ahca.myflorida.com	(850) 487-1423	Agency for Health Care Administration 2727 Mahan Drive Mail Stop #11 Tallahassee, FL 32308



RON DESANTIS
GOVERNOR

JASON WEIDA
SECRETARY

el 25 de noviembre de 2024

ACUSE DE RECIBO DE SOLICITUD DE AUDIENCIA IMPARCIAL DE MEDICAID DE TERCEROS

La Agencia para la Administración de la Atención de Salud (“AHCA” o “Agencia”) recibió una solicitud para una Audiencia Imparcial de Medicaid el **20 de noviembre de 2024** para:

██████████ c/o Jocelyn Armand
4343 West Flagler St
Suite 100
Miami, FL 33134
Teléfono: (305) 438-3809
Correo Electrónico: jarmand@legalservicesmiami.org

La solicitud de audiencia está asignada al Número de Caso AHCA **24-FH3590**.

Las partes en este asunto son el Beneficiario de Medicaid identificado anteriormente y el siguiente:

Simply Health Care Plans, Inc.
4200 West Cypress Street
Suite 900
Tampa, Florida 33631
Teléfono: (844) 406-2396 (MMA)/ (844) 406-2398 (SPEC)/ (877) 440-3738 (LTC)
Fax: (866) 216-3482
Correo Electrónico: MedicaidFairHearings@simplyhealthcareplans.com.

Designación de la dirección postal o dirección de correo electrónico por parte del beneficiario

La dirección **electronica** proporcionada anteriormente por el Beneficiario o el Representante del Beneficiario constituye la dirección de registro del Beneficiario para esta Audiencia imparcial. Usted estableció que prefiere esta forma de contacto cuando solicitó esta Audiencia imparcial. **En adelante, toda la información sobre esta Audiencia imparcial se enviará solo a la dirección electronica especificada arriba. Es sumamente importante que actualice esta dirección en la Oficina de Audiencias Imparciales en caso de llevarse a cabo algún cambio.** El Beneficiario o el Representante del Beneficiario pueden solicitar que la información de la Audiencia imparcial se proporcione por **correo postal**. Es sumamente importante que actualicen cualquier cambio en la forma que usted prefiere que se lo contacte en la Oficina de Audiencias

Imparciales. Si el Beneficiario o el Representante autorizado por el beneficiario designa una dirección de correo electrónico, se considerará que es un servicio activo y válido para recibir notificaciones.

Designación por Escrito del Representante Autorizado del Beneficiario

Cualquier persona, **incluyendo un miembro de la familia, amigo, abogado o un proveedor del Beneficiario**, que está solicitando una audiencia imparcial en nombre de un Beneficiario, o desea representar a un Beneficiario en una audiencia imparcial, debe presentar en la Oficina de Audiencias Imparciales una **autorización por escrito** firmada por el Beneficiario o por la persona con autoridad legal para actuar en nombre del Beneficiario, donde designa a la persona como el representante autorizado del Beneficiario. Para evitar el rechazo de la solicitud de audiencia imparcial, el Beneficiario debe presentar su designación por escrito del representante autorizado con la Oficina de Audiencias Imparciales en la dirección que se indica a continuación. (Ver el ejemplo de formulario adjunto, “Designación de Representante Autorizado para la Participación en la Audiencia Imparcial de Medicaid”).

Presentación de Documentos a la Oficina de Audiencias Imparciales

Usted puede obtener cualquier información concerniente a esta audiencia imparcial o presentar cualquier documento pertinente a la siguiente dirección:

Agency for Health Care Administration

Office of Fair Hearings

2727 Mahan Drive

Mail Stop #11

Tallahassee, FL 32308

Teléfono: (850) 412-3649

Fax: (850) 487-1423

Correo Electrónico: OfficeOfFairHearings@ahca.myflorida.com.

Un Funcionario de Audiencia será asignado por la Oficina de Audiencias Imparciales para presidir en esta solicitud de audiencia. El Funcionario de Audiencia proporcionará instrucciones adicionales por escrito en lo que concierne a esta solicitud de audiencia.

Esta solicitud de audiencia está sujeta, y se llevará a cabo de conformidad con, la Regla 59G-1.100, Código Administrativo de Florida. Usted puede revisar esta Regla en el siguiente enlace: <http://ahca.myflorida.com/medicaid/review/Rules.shtml>.

Anexos:

Aviso de Política de No Discriminación

Designación del Representante Autorizado para la Participación en la Audiencia Imparcial de Medicaid (ejemplo)

cc (con Anexos):

**[REDACTED] c/o Jocelyn Armand
4343 West Flagler St
Suite 100
Miami, FL 33134
jarmand@legalservicesmiami.org**

**Simply
MedicaidFairHearings@simplyhealthcareplans.com**

**Unidad de Audiencia de Medicaid de AHCA
MedicaidHearingUnit@ahca.myflorida.com**

NOTA: Este formulario designa a un Representante Autorizado del Beneficiario de Medicaid para la Audiencia Imparcial. Asimismo, le permite a la Agency for Health Care Administration (Dependencia de la Administración del Cuidados Médicos) a divulgar la Información de Salud Protegida (PHI, por sus siglas en inglés) sobre el Beneficiario al Representante Autorizado. Para designar a un Representante Autorizado para presentar o representar a un beneficiario de Medicaid en una Audiencia imparcial, complete y envíe este formulario a la Oficina de Audiencias Imparciales en la dirección que se proporciona en las instrucciones de este formulario (a continuación). La designación de un Representante autorizado no requiere el uso de este formulario; se puede utilizar cualquier escrito que cumpla con los requisitos de la Norma 59G-1.100 del Código Administrativo de la Florida en materia de designación de un Representante autorizado.

DESIGNACIÓN DE REPRESENTANTE AUTORIZADO PARA LA PARTICIPACIÓN EN LA AUDIENCIA IMPARCIAL DE MEDICAID (SOLICITUD)

Para obtener instrucciones sobre cómo completar este formulario, consulte el reverso.

Información del beneficiario

Apellido: _____ **Nombre:** _____ **Inicial del 2do nombre:** _____

Id. del beneficiario de Medicaid: _____ **Fecha de nacimiento del beneficiario:** _____

Deseo designar a la persona que se nombra a continuación mi Representante Autorizado. Comprendo plenamente que esta designación le permitirá a mi Representante autorizado presentar y participar en la Audiencia imparcial de Medicaid en mi nombre hasta que finalice la audiencia y se emita la Resolución final. Asimismo, doy mi consentimiento para que la Dependencia de Administración de Atención Médica divulgue mi Información de Salud Protegida (PHI, por sus siglas en inglés) a mi Representante Autorizado que se designó en este documento a fin de que presente y participe en la Audiencia imparcial de Medicaid en mi nombre. **El domicilio que aparece escrito a continuación constituirá el domicilio de registro para la audiencia Imparcial, a menos que se indique lo contrario.**

Representante autorizado: _____
(Nombre en letra de molde)

Domicilio: _____

Teléfono: _____

Correo electrónico: _____

Por favor, seleccione la forma de contacto que prefiere:

Correo electrónico: **O** **Correo USPS (Servicios Postales de Estados Unidos):**

Si no se selecciona ninguna casilla, o si se seleccionan ambas casillas, su contacto preferido predeterminado será el correo de USPS.

Número de Caso de Audiencia Imparcial: 24-FH3590

Beneficiario o representante legal:

(Nombre en letra de molde)

(Firma)

(Fecha)

INTRUCCIONES

Información del beneficiario

Apellido: escriba el apellido legal del beneficiario.

Nombre: escriba el nombre legal del beneficiario.

Inicial del segundo nombre: escriba la primera letra del segundo nombre legal del beneficiario.

Id. de Medicaid del beneficiario: escriba la Id. de Medicaid del beneficiario.

Año de nacimiento del beneficiario: escriba el año de nacimiento del beneficiario.

Información del representante autorizado:

Representante autorizado: escriba el nombre legal del representante.

Domicilio: escriba el domicilio postal del representante.

Teléfono: escriba el número de teléfono del representante.

Correo electrónico: Escriba el correo electrónico del representante.

Forma de contacto que se prefiere: Indique si el representante prefiere ser contactado por correo electrónico o por correo USPS. Seleccione solo una casilla. Si no se selecciona ninguna casilla, o si se seleccionan ambas casillas, su contacto preferido predeterminado será el correo de USPS.

Número de caso de audiencia imparcial:

Número de caso de audiencia imparcial: escriba del número de caso de la audiencia imparcial.

Instrucciones finales:

El beneficiario debe firmar y fechar esta solicitud y enviarla por medio de algunas de las vías que mencionan a continuación.

Correo electrónico	Fax	Correo
OfficeOfFairHearings@ahca.myflorida.com	(850) 487-1423	Agency for Health Care Administration 2727 Mahan Drive Mail Stop #11 Tallahassee, FL 32308



FILED

Aug 10, 2023, 8:50 am
OFFICE OF FAIR HEARINGS

**STATE OF FLORIDA
AGENCY FOR HEALTH CARE ADMINISTRATION
OFFICE OF FAIR HEARINGS**

[REDACTED],

PETITIONER,

AHCA Case No.: 23-FH1065

Plan ID No.: L [REDACTED]

vs.

MOLINA HEALTH CARE OF FLORIDA, INC.,

RESPONDENT.

_____ /

FINAL ORDER

Pursuant to notice, the undersigned convened a telephonic Fair Hearing on the instant case on May 30, 2023, at 10:03 a.m. and June 28, 2023, at 1:04 p.m. Eastern Standard Time ("EST").

APPEARANCES

For the Petitioner:

[REDACTED]

Petitioner's Authorized Representative

For the Respondent:

Melissa Hedrick
Counsel for Respondent
Molina Health Care of Florida, Inc.

STATEMENT OF ISSUE

The issue is whether Petitioner proved by a preponderance of the evidence that Respondent's denial of additional personal care services was incorrect.

PRELIMINARY STATEMENT

All parties appeared telephonically. [REDACTED]),
Petitioner's Authorized Representative and daughter-in-law, appeared for the Fair Hearing to

provide testimony on behalf of the Petitioner. [REDACTED]), Petitioner's daughter-in-law, appeared for the Fair Hearing as a witness for Petitioner.

Melissa Hedrick, Counsel for Molina Health Care of Florida, Inc. ("Molina"), appeared for the Fair Hearing convened on June 28, 2023, as representative for Respondent. Kathia Matos ("Ms. Matos"), Utilization Management Director, appeared for both hearings as a witness for Respondent. Caridad Bello, Government Contract Specialist, appeared for both hearings as a witness for Respondent. Yuneisy Cruz, Director for Health Care Services for the Long Term Care Program, appeared for both hearings as a witness for Respondent. Dr. Gabriel Novoa ("Dr. Novoa"), Medical Director for Molina, appeared for the Fair Hearing as a witness for Respondent.

The following appeared as observers: Linda Latson, Registered Nurse Specialist and Fair Hearing Liaison for the Agency for Health Care Administration ("Agency" or "AHCA"), appeared at the Fair Hearing convened on May 30, 2023. Doris Rivera, Medical Health Care Program Analyst for the Agency, appeared at the Fair Hearing convened on June 28, 2023.

Prior to the Fair Hearing, Petitioner sent to the Office of Fair Hearings and Respondent the following items:

1. a twenty-one (21)-page evidence packet, which appears in the Office of Fair Hearings' case management system as file title "Fair Hearing Request [Petitioner].pdf.pdf;"

2. six (6) photos with 2 corresponding email cover pages, which appear in the Office of Fair Hearings' case management system as file titles "23-FH1065 and 23-FH1066 Photo Evidence.pdf¹" and "23-FH1065 & 23-FH1066 Photo Evidence(2).pdf²;"
3. two (2) video files with 2 corresponding email cover pages, which appear in the Office of Fair Hearings' case management system as file titles "23-FH1065 and 23-FH1066 - Email with Video(2).pdf.pdf³," "[Petitioner] - Video of Petitioner scratching her skull.MOV⁴," "23-FH1065 and 23-FH1066 - Email Video Close up.pdf⁵," and "[Petitioner] - Petitioner's close-up video scratching her skull.mov⁶;"
4. a one-hundred and thirty-four (134)-page evidence packet, which appears in the Office of Fair Hearings' case management system as file titles "23-FH1065 & 23-FH1066 Emailed Correspondence.pdf⁷," "23-FH1065 & 23-FH1066 Evidence Part 1.pdf⁸," "23-FH1065 & 23-FH1066 Evidence Part 2.pdf⁹," and "23-FH1065 & 23-FH1066 Evidence Part 3.pdf¹⁰."

¹ This file was received on May 22, 2023, and contains one (1) still image identified as "Picture of Petitioner with Clothespin."

² This file was received on May 22, 2023, and contains five (5) still images identified collectively as "Pictures of Petitioner's skull showing damage to herself."

³ This email was received on May 22, 2023, related to the corresponding video file identified as "[Petitioner] – Video of Petitioner Scratching her Skull.MOV."

⁴ This file was received on May 22, 2023, and contains the video file identified as "[Petitioner] - Video of Petitioner Scratching her Skull."

⁵ This email was received on May 22, 2023, related to the corresponding video file identified as "[Petitioner] – Petitioner's close-up video scratching her skull.mov."

⁶ This file was received on May 22, 2023, and contains the video file identified as "[Petitioner] - Petitioner's close-up video scratching her skull.mov."

⁷ This file contains pages 1 – 13 of PCE 4.

⁸ This file contains pages 14 – 55 of PCE 4.

⁹ This file contains pages 56 – 102 of PCE 4.

¹⁰ This file contains pages 103 – 134 of PCE 4.

Absent an objection from Respondent, the undersigned admitted into evidence the twenty-one (21)-page evidence packet as Petitioner’s Composite Exhibit 1 (“PCE 1”), the six (6) photos with corresponding email cover pages as Petitioner’s Composite Exhibit 2 (“PCE 2”), the two (2) video files with corresponding email cover pages as Petitioner’s Composite Exhibit 3 (“PCE 3”), and the one-hundred and thirty-four (134)-page evidence packet as Petitioner’s Composite Exhibit 4 (“PCE 4”).

Prior to the hearing, Respondent sent to the Office of Fair Hearings and Petitioner an eighty-nine (89)-page evidence packet. The evidence packet appears in the Office of Fair Hearings’ case management system as “MFH Package Office 23FH1065_ 23FH1066_1.pdf¹¹,” “MFH Package Office 23FH1065_ 23FH1066_2.pdf¹²,” “MFH Package Office 23FH1065_ 23FH1066_3.pdf¹³,” “MFH Package Office 23FH1065_ 23FH1066_4.pdf¹⁴,” “MFH Package Office 23FH1065_ 23FH1066_5.pdf¹⁵,” “MFH Package Office 23FH1065_ 23FH1066_6.pdf¹⁶,” and “MFH Package Office 23FH1065_ 23FH1066_7.pdf¹⁷.” The undersigned overruled Petitioner’s objection and admitted the eighty-nine (89)-page packet into evidence as Respondent’s Composite Exhibit 1 (“RCE 1”).

FINDINGS OF FACT

¹¹ This file contains pages 1 – 10 of RCE 1.

¹² This file contains pages 11 – 21 of RCE 1.

¹³ This file contains pages 22 – 33 of RCE 1.

¹⁴ This file contains pages 34 – 44 of RCE 1.

¹⁵ This file contained pages 45 – 52 of RCE 1.

¹⁶ This file contains pages 53 – 63 of RCE 1.

¹⁷ This file contains pages 64 – 89 of RCE 1.

1. Petitioner is an enrolled member of Molina’s Long-term Care (“LTC”) program. *See* RCE 1 at pages 1, 3. Molina is a managed care organization contracted by the Agency to provide services to eligible Medicaid recipients in the state of Florida.

2. As of the date of the Fair Hearing, Petitioner is eighty-three (83) years old. *Id.* at 22. Petitioner lives alone in the community. *Id.* at 23. According to Petitioner’s Florida Department of Elder Affairs: 701B Comprehensive Assessment (“701B”), dated April 25, 2023, Petitioner has the following health conditions: dementia, depression, arthritis, dehydration, constant dizziness, constant bladder incontinence, occasional bowel incontinence, osteoporosis, renal mass, right and left knee replacement, irritable bowel syndrome, and a past diagnosis of kidney cancer. *Id.* at 28 – 31. As testified by [REDACTED], Petitioner is diagnosed with Alzheimer's. *See infra* ¶ 13.

3. As provided in the 701B, Petitioner’s needs for activities of daily living (“ADLs”) are as follows: Petitioner needs assistance (but not total help) for all ADLs. *Id.* at 24. Petitioner uses an assistive device for walking/mobility. *Id.* In regard to her instrumental activities of daily living (“IADLs”), Petitioner needs total assistance (cannot do at all) with all IADLs. *Id.* at 27.

4. By letter dated May 1, 2023, Petitioner’s primary care physician, [REDACTED], recommended support due to Petitioner’s health status. The letter stated:

The present is to certify that [Petitioner] is not able to stay home alone due to her condition like Dementia, [a]bnormal gait and mobility, progressive [m]uscle weakness and depends in a wheelchair which increases the risk of falling frequently. She has sufficient criteria to solicitate additional hours in her daily care.

...
See PCE 1 at page 6.

5. By letter dated May 3, 2023, Petitioner’s psychiatrist, [REDACTED], recommended additional services for Petitioner. The letter stated:

I am writing this letter on behalf of [Petitioner] who is a patient under my care. [Petitioner] suffers, and is being treated, for depression and anxiety. She is prescribed Lexapro daily, Seroquel 3 times a day, and Remeron at bedtime. [Petitioner] has other health issues that also affect her ability to function. She certainly would need, and benefit from; assistance to carry out her activities of daily life.

...
See PCE 1 at page 7.

6. In a Notice of Adverse Determination (“NABD”) dated May 2, 2023, Respondent reduced Petitioner’s personal care services. The NABD explained the basis of the reduction as follows:

We determined that your requested services are not medically necessary because the services do not meet either of the reasons checked below: *(See Rule)*

- ...
- Meet all of the following criteria for all extended state plan services used for the purposes of maintenance therapy and all other home and community-based services:
 1. Be individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the patient’s needs;
 2. Be reflective of the level of service that can be safely furnished, and for which no equally effective and more conservative or less costly treatment is available statewide; and
 3. Be furnished in a manner not primarily intended for the convenience of the recipient, the recipient’s caretaker, or the provider;

- and one of the following:
1. Enable the enrollee to maintain or regain functional capacity; or
 2. Enable an enrollee receiving long-term services and supports to have access to the benefits of community living, to achieve person-centered goals, and live and work in the setting of their choice.

The facts that we used to make our decision are: This decision was based on medical necessity (as defined by Agency for Health Care Administration's Medical Necessity as defined in Rule 59G-4, 192 and reflects the application of Molina Clinical Policy (332)

The reason why the request was not approved is: There is a reduction Effective 05/12/2023 of personal care services from 32 hours to 19 hours per week by the Medical Director because the additional services are not medically necessary. You are already receiving other services that should meet your needs. You are going to continue to receive a total of 40 hours of Home Care. This determination by the Medical Director has been made based on medical necessity (as defined by Florida law) and reflects the application of Molina Healthcare's approved review criteria and guidelines.

...

See RCE 1 at 65 – 66.

7. In a Notice of Adverse Determination (“NABD”) dated May 2, 2023, Respondent reduced

Petitioner’s homemaker services. The NABD explained the basis of the reduction as follows:

We determined that your requested services are **not medically necessary** because the services do not meet either of the reason(s) checked below: *(See Rule)*

...

- Meet all of the following criteria for all extended state plan services used for the purposes of maintenance therapy and all other home and community-based services:
 1. Be individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the patient’s needs;
 2. Be reflective of the level of service that can be safely furnished, and for which no equally effective and more conservative or less costly treatment is available statewide; and
 3. Be furnished in a manner not primarily intended for the convenience of the recipient, the recipient’s caretaker, or the provider;

and one of the following:

1. Enable the enrollee to maintain or regain functional capacity; or
2. Enable an enrollee receiving long-term services and supports to have access to the benefits of community living, to achieve person-centered goals, and live and work in the setting of their choice.

The facts that we used to make our decision are: This decision was based on medical necessity (as defined by Agency for Health Care Administration's Medical Necessity as defined in Rule 59G-4, 192 and reflects the application of Molina Clinical Policy (332)

The reason why the request was not approved is: There is a reduction Effective 05/12/2023 of homemaker services from 10 hours to 7 hours per week by the Medical Director because the additional services are not medically necessary. You

are already receiving other services that should meet your needs. You are going to continue to receive a total of 40 hours of Home Care. This determination by the Medical Director has been made based on medical necessity (as defined by Florida law) and reflects the application of Molina Healthcare's approved review criteria and guidelines.

...

Id. at 74 – 75.

8. At Fair Hearing, Petitioner's Authorized Representative and Respondent clarified that no reduction of personal care services or homemaker services took place. Petitioner's thirty-two (32) hours per week of personal care services and ten (10) hours per week of homemaker services remained as originally approved, in consideration of Petitioner's new request for an additional thirty-eight (38) hours per week of personal care services. Respondent subsequently approved ten (10) of the thirty-eight (38) hours requested.

9. Petitioner requested a plan appeal for the denial of additional twenty-eight (28) hours per week of personal care services. Respondent issued a Notice of Plan Appeal Resolution ("NPAR") dated May 3, 2023, upholding the denial of personal care services. The NPAR explained as follows, in pertinent part:

We made our decision based on the Florida Agency for Health Care Administration's Long-Term Care (LTC) Program Policy (Rule 59G-4.192) and the Molina Clinical Policy for Medical Necessity (332). It shows rules that you must meet to show medical necessity (need). Part of the rules is having an evaluation (test) to find out what you need. These tests are done the first time a member needs a test. They are also done annually (every year) and when there is a significant (big) change in the member's care. A significant (big) change may involve a change in the member's state of health or the person taking care of them. Your recent test does not show a significant (big) change in your care. The extra notes sent by [REDACTED], does not mention a significant (big) change in your care to show you need a change to your plan of care. You are already receiving services that should meet your needs. For this reason, the extra 28 hours of Personal Care Services is not approved. Please talk to your doctor and/or Case Manager about your options.

While we are denying the extra 28 hours of Personal Care Services, you will still receive 42 hours of Personal Care Services and 14 hours of Homemaker Services per week.

...

Id. at 83.

10. On May 5, 2023, the Office of Fair Hearings received Fair Hearing requests on behalf of Petitioner to challenge the denial of additional personal care services in AHCA Case Number 23-FH1065 and the denial of additional homemaker services in AHCA Case Number 23-FH1066. On May 15, 2023, the undersigned issued a notice, to all parties of record, consolidating both cases and an Order Scheduling Fair Hearing by Telephone and Prehearing Instructions (“Scheduling Order”), setting the hearing for May 30, 2023, at 10:00 a.m. EST.

11. Accordingly, as of the date of the Fair Hearing, Petitioner is authorized to receive the following Florida Medicaid LTC services: forty-two (42) hours per week of personal care services, fourteen (14) hours per week of homemaker services, fourteen (14) hours per week of adult companion care services, and seven (7) home delivered meals, weekly. *Id.* at 51 – 52, 89.

12. On May 30, 2023, the Fair Hearing convened with the Petitioner’s Authorized Representative and Respondent in attendance. On the record, Petitioner’s Authorized Representative withdrew the Fair Hearing request for case 23-FH1066 regarding additional homemaker services. As the Fair Hearing request for case 23-FH1066 was withdrawn, the undersigned deconsolidated the cases, proceeding solely as to the remaining issue under case 23-FH1065 regarding additional personal care services.

13. [REDACTED] testified at the Fair Hearing to the following:

- a. Petitioner cannot think clearly, cook, dress herself, shower, or go outside on her own. Petitioner is incontinent, cannot prepare meals, and cannot administer her

own medication. [REDACTED] argues that Petitioner's condition has worsened and cannot be left at home alone, but is alone after 3 p.m. every day when the home health aide leaves. The home health aide's schedule is from 7 a.m. to 3 p.m. [REDACTED] argues that Petitioner has had a recent diagnosis of Alzheimer's which [REDACTED] contends was not considered in Respondent's decision.

- b. Petitioner's husband passed away in April 2023. Petitioner lived with him at their home where he provided supervision and companionship. After his passing, [REDACTED] [REDACTED] contacted Molina and requested additional hours for her health.
- c. Another private caretaker was hired by Petitioner's family to care for Petitioner in the times the home health aide is not present.
- d. Petitioner does not have a primary caregiver. [REDACTED] does not provide personal care for Petitioner. [REDACTED] role involves preparing medications, arranging doctor visits, and grocery shopping for Petitioner. [REDACTED] [REDACTED] does not have employment outside of the home and has a family of her own.

14. Ms. Matos testified at the Fair Hearing to the following:

- a. The service hours provided are based on medical necessity. The responses within the 701B and LTC supplemental assessment for Petitioner's ADLs and IADLs were used to make a determination on medical necessity. See RCE 1 at 46 – 47. Petitioner is approved for forty-two (42) hours of personal care services and fourteen (14) hours of homemaker services, weekly. *Id.* at 51 – 52, 83.

- b. Based on the fact that Petitioner’s husband passed away, Petitioner requested thirty-eight (38) additional personal care hours per week. In consideration of this event, Molina approved ten (10) hours per day of personal care services to meet Petitioner’s needs and accommodate for the transition of care, denying the remaining twenty-eight (28) hours per week. *Id.* at 83. Ms. Matos asserts that in review of the request, Molina considered the member’s clinical condition, ADLs and IADLs, cognition level, and caregiver status. Ms. Matos argues that Molina did not identify any changes in Petitioner’s needs for assistance. *Id.* at 3 – 19, 22 – 38, 41 – 45, 46 – 47.
- c. Ms. Matos asserts that the passing of Petitioner’s husband was not considered as a “significant change” directly affecting Petitioner’s care because he was an informal support, not a participating caregiver listed on the 701B. *Id.* at 3-4, 46.
- d. Molina is aware of Petitioner’s dementia diagnosis. *Id.* at 5. The LTC supplemental assessment was completed with Petitioner and [REDACTED]. *Id.* at 46 – 47. The 701B lists Petitioner’s primary caregiver and daughter-in-law as [REDACTED] *Id.* at 36. [REDACTED] is listed as Petitioner’s informal support/caregiver in the care plan signed by [REDACTED]. *Id.* at 48 – 52.

CONCLUSIONS OF LAW

15. The Agency’s Office of Fair Hearings has jurisdiction over the subject matter of this proceeding and the parties pursuant to Fla. Stat. § 409.285(2)(2019). This order is the final administrative decision of AHCA under Fla. Stat. § 409.285(2)(a).

16. This hearing was held as a *de novo* proceeding pursuant to Fla. Admin. Code R. 59G-1.100(17)(b).

17. Because Petitioner is requesting a new service, Fla. Admin Code R. 59G-1.100(17)(g) assigns the burden of proof to Petitioner. The standard of proof in an administrative hearing is a preponderance of the evidence. The preponderance of the evidence standard requires proof by “the greater weight of the evidence” (Black’s Law Dictionary at 1201, 7th Ed.)

18. The Florida Medicaid Statewide Managed Care Long-term Care Program Coverage Policy (March 2017) (“LTC Policy”), incorporated by reference in Fla. Admin. Code R. 59G-4.192, governs Long-Term Care services available under Florida Medicaid. *Id.* at 106 – 127. The LTC Policy provides the following, in pertinent part:

1.1 Description and Program Goal

Under the Statewide Medicaid Managed Care Long-Term Care (LTC) program, managed care plans (LTC plans) are required to provide an array of home and community-based services that enable enrollees to live in the community and to avoid institutionalization.

...

1.3 Definitions

The following definitions are applicable to this policy. For additional definitions that are applicable to all sections of Rule Division 59G, F.A.C., please refer to the Florida Medicaid definitions policy.

1.3.1 Activities of Daily Living (ADLs)

ADLs include:

- Bathing
- Dressing
- Eating (oral feedings and fluid intake)
- Maintaining continence (examples include taking care of a catheter or colostomy bag or changing a disposable incontinence product when the recipient is unable to control bowel or bladder functions)
- Toileting
- Transferring

...

1.3.5 701-B Comprehensive Assessment

An individualized, complete assessment of an individual's medical, developmental, behavioral, social, financial, and environmental status. The assessment is conducted by a trained individual employed by the Department of Elder Affairs Comprehensive Assessment and Review for Long-Term Care Services (CARES) program or the LTC plan, to determine eligibility for the LTC program based on the need for a nursing facility level of care.

...

1.3.9 Instrumental Activities of Daily Living (IADLs)

When necessary for the recipient to function independently, including:

- Grocery shopping
- Laundry
- Light housework
- Meal preparation
- Money Management
- Personal hygiene
- Transportation
- Using the telephone to take care of essential tasks (examples include paying bills and setting up medical appointments)

...

1.3.14 Medically Necessary or Medical Necessity

For the purposes of this policy, the service must meet either of the following criteria:

- a) Nursing facility services and mixed services must meet the medical necessity criteria defined in Rule 59G-1.010, F.A.C.
- b) All other LTC supportive services must meet all of the following:
 - Be individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the patient's needs
 - Be reflective of the level of service that can be safely furnished, and for which no equally effective and more conservative or less costly treatment is available statewide
 - Be furnished in a manner not primarily intended for the convenience of the recipient, the recipient's caretaker, or the provider

And, one of the following:

- Enable the enrollee to maintain or regain functional capacity; or
- Enable the enrollee to have access to the benefits of community living, to achieve person-centered goals, and to live and work in the setting of his or her choice.

...

1.3.16 Natural Supports

Unpaid supports that are provided voluntarily to the individual in lieu of home and community-based services and supports.

...

4.0 Coverage Information

4.1 General Criteria

Florida Medicaid LTC plans cover services that meet all of the following:

- Are determined medically necessary, as defined in this rule
- Do not duplicate another service
- Meet the criteria as specified in this policy

4.2 Specific Criteria

Florida Medicaid LTC plans cover services that meet all of the following:

- Consistent with the type, amount, duration, frequency, and scope of services specified in an enrollee’s authorized plan of care
- Provided in accordance with a goal in the enrollee’s plan of care
- Intended to enable the enrollee to reside in the most appropriate and least restrictive setting

...

4.2.2 Mixed Services

Mixed services may exceed State Plan limits on those services in accordance with this policy. The Long-term Care benefit includes coverage of the following mixed services:

...

4.2.2.6 Personal Care

In accordance with Rule 59G-4.215, F.A.C., for enrollees under the age of 21 years. To provide assistance with ADLs and IADLs, including assistance with preparation of meals, and housekeeping chores which are incidental to the care furnished or are essential to the health and welfare of the enrollee. The scope and nature of these services do not otherwise differ from personal care services furnished to persons under the age of 21 years.

19. The Florida Medicaid Definitions Policy (August 2017) (“Definitions Policy”), incorporated by reference in Fla. Admin. Code R. 59G-1.010, defines “Medically Necessary” or “Medical Necessity” as follows:

2.83 Medically Necessary or Medical Necessity

The medical or allied care, goods, or services furnished or ordered must meet the following conditions:

- Be necessary to protect life, to prevent significant illness or significant disability, or to alleviate pain
- Be individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the patient’s needs

- Be consistent with generally accepted professional medical standards as determined by the Medicaid program, and not experimental or investigational
- Be reflective of the level of service that can be safely furnished, and for which no equally effective and more conservative or less costly treatment is available statewide
- Be furnished in a manner not primarily intended for the convenience of the recipient, the recipient’s caretaker, or the provider

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

20. The Agency’s Florida Medicaid **Personal Care Services Coverage Policy** (November 2016) (“PC Policy”) has been incorporated, by reference, into Rule **59G-4.215, F.A.C.** The PC Policy provides as follows:

1.1 Description

Florida Medicaid personal care services provide medically necessary assistance, in the home or in the community, with activities of daily living (ADL) and age appropriate instrumental activities of daily living (IADL) to enable recipients to accomplish tasks they would normally be able to do for themselves if they did not have a medical condition or disability.

...

1.1.2 Statewide Medicaid Managed Care Plans

Florida Medicaid managed care plans must comply with the coverage requirements outlined in this policy, unless otherwise specified in the AHCA contract with the Florida Medicaid managed care plan. The provision of services to recipients enrolled in a Florida Medicaid managed care plan must not be subject to more stringent coverage limits than specified in Florida Medicaid policies.

...

4.0 Coverage Information

4.1 General Criteria

Florida Medicaid reimburses for services that meet all of the following:

- Are determined medically necessary
- Do not duplicate another service
- Meet the criteria as specified in this policy

4.2 Specific Criteria

Florida Medicaid reimburses for up to 24 hours of personal care services per day, per recipient, in order to provide assistance with ADLs and age appropriate IADLs when the recipient meets the following criteria:

- Has a medical condition or disability that substantially limits their ability to perform ADLs or IADLs and do not have a parent or legal guardian able to provide the required care
- Is under the care of a physician and has a physician's order for personal care services
- Requires more extensive and continual care than can be provided through a home health visit
- Requires services that can be safely provided in their home or the community

...

5.1 General Non-Covered Criteria

Services related to this policy are not reimbursed when any of the following apply:

- The service does not meet the medical necessity criteria listed in section 1.0.
- The recipient does not meet the eligibility requirements listed in section 2.0.
- The service unnecessarily duplicates another provider's service.

5.2 Specific Non-Covered Criteria

Florida Medicaid does not reimburse for the following:

- A skill level other than what is prescribed in the physician order and approved plan of care (POC)
- Assistance with homework
- Babysitting
- Care, grooming, or feeding of pets and animals
- Certification of the POC by a physician
- Companion sitting or leisure activities
- Escort services
- Housekeeping (except light housekeeping to make the environment safe), homemaker, and chore services
- Nursing assessments related to the POC
- Professional development training or supervision of home health staff or other home health personnel
- Respite care to facilitate the parent or legal guardian attending to personal matters
- Services funded under section 110 of the Rehabilitation Act of 1973 or under the provisions of the Individuals with Disabilities Educational Act
- Services furnished by relatives as defined in section 429.02(18), F.S., household members, or any person with custodial or legal responsibility for the recipient. (Except when a recipient is enrolled in the Consumer-Directed Care Plus program)
- Services provided in any of the following locations:
 - Hospitals

- Intermediate care facility for individuals with intellectual disabilities – Nursing facilities
- Prescribed pediatric extended care centers
- Residential facilities or assisted living facilities when the services duplicate those provided by the facility
- Services rendered prior to the development and approval of the POC
- Travel time to or from the recipient’s place of residence
- Yard work, gardening, or home maintenance work

Florida Medicaid may reimburse for some services listed in this section through a different service benefit.

...

7.0 Authorization

7.1 General Criteria

The authorization information described below is applicable to the fee-for-service delivery system. For more information on general authorization requirements, please refer to Florida Medicaid’s General Policies on authorization requirements.

...

Personal Care Task	General Time Allowances
Bathing	
Full-body Bath: Tub, shower or sponge/bed bath.	Up to 30 minutes. May rotate with partial bath based on recipient’s needs
Partial Bath: A sponge bath includes, at a minimum, bathing of the face, hands, and perineum.	15–20 minutes per partial bath
Dressing	
Laying out clothing, handing and retrieving clothing, putting clothes on and taking them off, including handling fasteners, zippers, and buttons.	15 minutes
Application of prosthetic devices or application of therapeutic stockings.	May add 15 minutes for applying hose and/or Prosthesis
Grooming and Skin Care	

Brushing teeth, denture care, shaving, washing and drying face and hands. Applying lotion to non-broken skin.	15–30 minutes
Shampoo and comb hair, basic hair care, basic nail care.	15 minutes
Positioning	
Moving recipient to and from a lying position, turning side to side, and positioning recipient in bed.	10 minutes/every 2 hours when medically indicated
Transfers	
Moving recipient into and out of a bed, chair, or wheelchair. May include the use of assistive devices.	15 minutes/every 2 hours when medically indicated
Toileting and Maintaining Continence	
Includes transfer on or off the toilet, bedside commode, urinal, or bedpan. Includes cleaning the perineum and cleaning after an incontinent episode. Includes taking care of a catheter or colostomy bag or changing a disposable incontinence product.	15–45 minutes
Eating	
Taking in food by any method. Extra time may be allowed for preparing a special diet.	30 minutes per meal
Delegated Medical Monitoring and Activities	
Non-skilled medical tasks that are delegated to the aide by the RN, in accordance with Florida laws and practice acts. The tasks include, but are not limited to, assisting recipient with pre-poured medications, monitoring vital signs, and measurement of intake/output.	15–30 minutes day for all monitoring tasks performed

PC Policy at pages 3 – 8, and 10.

21. In the instant case, Petitioner requested an additional thirty-eight (38) hours per week of personal care services. See ¶ 8, 9. Respondent approved ten (10) additional hours per week of personal care services while denying the remaining twenty-eight (28) hours. See ¶¶ 8, 9, 14.

Respondent determined that the additional twenty-eight (28) hours per week of personal care services were in excess of Petitioner's needs. See ¶ 9. Petitioner has burden of proof to show by a preponderance of evidence that the Respondent's determination was incorrect. See ¶ 17.

22. Section 4.1 of the LTC Policy provides that Florida Medicaid LTC plans cover services that: (a) are determined medically necessary, as defined in the LTC Policy; (b) do not duplicate another service; and (c) meet the criteria as specified in the LTC Policy. See ¶ 18. The Definitions Policy requires that the requested personal care services must "[b]e individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the patient's needs." See ¶ 19. Under Florida's Medicaid program, personal care services are "[t]o provide assistance with ADLs and IADLs, including assistance with preparation of meals, and housekeeping chores which are incidental to the care furnished or are essential to the health and welfare of the enrollee." See ¶ 18.

23. As previously recognized, Petitioner suffers from multiple medical problems and needs significant support with her ADLs and IADLs. See ¶¶ 2, 3, 13. The record demonstrates that Petitioner needs assistance (but not total help) for all ADLs. See ¶ 3. Petitioner also needs total assistance (cannot do at all) with all IADLs. See ¶ 3. [REDACTED] also testified that Petitioner's condition has worsened and is left alone after 3 p.m. when the home health aide leaves. See ¶ 13. Ms. Matos and [REDACTED] both testified that an additional thirty-eight (38) hours of personal care services were requested following the passing of Petitioner's husband. See ¶ 13, 14. According to Ms. Matos' testimony, the 701B and LTC supplemental assessment were used to make a determination on medical necessity. See ¶ 14. In review of the request, Ms. Matos explained that Respondent considered the member's clinical condition, ADLs

and IADLs, cognition level, and caregiver status from a new 701B and LTC supplemental assessment, both dated on April 25, 2023. See ¶ 14.

24. [REDACTED] testified that Petitioner lived with her husband who provided supervision and companionship. See ¶ 13. The record does not reflect that Petitioner's husband assisted Petitioner with her ADLs and IADLs. See RCE 1 at 3 – 4, 7 – 8, 17 – 19, 46. Ms. Matos explained that Respondent did not consider the passing of Petitioner's husband as a "significant change" in Petitioner's care and is not listed on the 701B because he was an informal support, not a participating caregiver. See ¶ 14. As such, the record does not support a loss of care with respect to Petitioner's ADLs and IADLs due to his absence. Additionally, [REDACTED] testified that another private caretaker was hired to care for Petitioner in the time periods the home health aide is not present. See ¶ 13. The record is not consistent in regard to [REDACTED] role as Petitioner's caregiver. [REDACTED] provides assistance to Petitioner with only some IADLs on a limited basis. To illustrate, although her name is listed as caregiver on the 701B and care plan, [REDACTED] testified that her role only involves preparing medications, arranging doctor visits, and grocery shopping for Petitioner. See ¶ 13. The LTC Policy provides that natural supports are "[u]npaid supports that are provided voluntarily to the individual in lieu of home and community-based services and supports." See ¶ 18. The Definitions Policy also provides that medically necessary services "be furnished in a manner not primarily intended for the convenience of the recipient, the recipient's caretaker, or the provider." See ¶ 19. All in all, it appears from the record that [REDACTED] and Petitioner's husband served roles as natural supports in regard to Petitioner's care, not as primary caregivers. Accordingly, the undersigned has to agree with Respondent that the absence of a natural support, who did

not assist with ADLs and IADLs, did not significantly affect the needs of Petitioner's personal care in this case. See ¶ 14.

25. Briefly, Petitioner argued that Respondent did not consider a diagnosis of Alzheimer's in their determination. The 701B includes the dementia diagnosis and was considered in review of the service request. See ¶ 2, 14. [REDACTED] testified that Petitioner's health condition has worsened, but Petitioner did not introduce evidence to demonstrate which specific needs are unmet due to this condition even with the increase of personal care hours. See ¶ 13. Thus, the undersigned does not find this as a credible argument for support of the additional personal care hours.

26. Further, in the letter introduced from Petitioner's primary care physician, [REDACTED] it indicates that Petitioner's medical conditions, including dementia and wheelchair bound status, make her a fall risk in need of additional support. See ¶ 4. Petitioner's psychiatrist, [REDACTED], also wrote a letter in support of the request for services stating "[Petitioner] suffers, and is being treated, for depression and anxiety... She certainly would need, and benefit from, assistance to carry out her activities of daily life." See ¶ 5. The LTC Policy states that the fact that a provider has prescribed or recommended medical services does not, alone, make such services medically necessary. See ¶ 18. As such, although both letters present credible insight into Petitioner's functional capacity from a medical standpoint, these recommendations in themselves do not make the requested services medically necessary. Even assuming arguendo that these physicians' letters had that footing, neither identify any observed unmet needs for the medical conditions raised that the additional services could be allocated to address. See ¶ 4, 5. Aside from these letters from both physicians, the undersigned has not found much supporting

evidentiary value in Petitioner’s exhibits in addressing the unmet needs to “provide assistance with ADLs and IADLs” beyond what was already considered in the 701B and LTC supplemental assessment. Nonetheless, as previously discussed, the record does not support a finding for additional unmet needs individualized, specific, and consistent with Petitioner’s current medical conditions. See ¶ 23 – 25. Accordingly, the undersigned does not find that Petitioner demonstrated that an additional twenty-eight (28) hours of personal care services are not in excess of Petitioner’s needs. Therefore, the additional twenty-eight (28) hours per week of personal care services were not shown to be medically necessary.

27. All in all, upon consideration of the testimony provided, evidence submitted, and applicable policies, the undersigned finds that Petitioner did not prove by a preponderance of the evidence that Respondent’s denial of personal care services was incorrect.

IT IS THEREFORE ORDERED AND ADJUDGED THAT:

Respondent’s denial of additional personal care services is **AFFIRMED**. Petitioner’s appeal based on Respondent’s denial of personal care services is **DENIED**.

DONE AND ORDERED this 10th day of August, 2023 in Tallahassee, Leon County, Florida.

 Kimberly Roche
23-FH1065
2023.08.10 08:44:15
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KIMBERLY ROCHE, Hearing Officer
Agency for Health Care Administration
Office of Fair Hearings
2727 Mahan Drive, Mail Stop # 11
Tallahassee, FL 32308-5407

NOTICE OF A RIGHT TO JUDICIAL REVIEW

A PARTY WHO IS ADVERSELY AFFECTED BY THIS FINAL ORDER IS ENTITLED TO JUDICIAL REVIEW, WHICH SHALL BE INSTITUTED BY FILING THE ORIGINAL NOTICE OF APPEAL WITH THE AGENCY CLERK OF AHCA, AND A COPY, ALONG WITH THE FILING FEE PRESCRIBED BY LAW, WITH THE DISTRICT COURT OF APPEAL IN THE APPELLATE DISTRICT WHERE THE AGENCY MAINTAINS ITS HEADQUARTERS OR WHERE A PARTY RESIDES. REVIEW PROCEEDINGS SHALL BE CONDUCTED IN ACCORDANCE WITH THE FLORIDA APPELLATE RULES. THE NOTICE OF APPEAL MUST BE FILED WITHIN 30 DAYS OF THE RENDITION OF THE ORDER TO BE REVIEWED.

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