

Medicaid Covered Services Not Provided by Managed Medical Assistance Plans

This document outlines services not provided by MMA plans, but are available to Medicaid recipients through Medicaid fee-for-service.

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Medicaid Covered Services Not Covered by Health Plans

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Adult Cystic Fibrosis (ACF) Home and Community-Based Services Waiver

❖ **What is the Adult Cystic Fibrosis Waiver?**

The ACF Waiver provides home and community-based services to eligible recipients in order to promote, maintain and optimize the health of individuals to delay or prevent hospitalization or institutionalization.

❖ **What services are covered?**

- Chore
- Community Support Coordination
- Counseling (Individual and Family)
- Dental
- Home-Delivered Meals
- Homemaker
- Massage Therapy
- Nutritional Supplements
- Personal Care
- Personal Emergency Response (Initial Installation, Maintenance, and Monitoring)
- Physical Therapy (Initial and Regular)
- Prescribed Drugs
- Respiratory Therapy
- Respite Care
- Skilled Nursing
- Specialized Medical Equipment and Supplies

❖ **Who is eligible to receive?**

To qualify for the ACF Waiver applicants must be:

- Diagnosed with ACF by a physician
- Be age 18 or older
- Meet level of care requirements as determined by the Department of Elder Affairs

❖ **Who is eligible to provide?**

Providers must be enrolled with Florida Medicaid to render ACF Waiver services.

❖ **How can recipients access?**

Medicaid health plans are not required to provide ACF services. ACF services are reimbursed through the fee-for-service delivery system. However, health plans play an important role in coordinating care for their enrollees, including making appropriate referrals for non-covered services. Health plans should refer enrollees to the Department of Health's Brain and Spinal Cord Injury Program at (800) 342-0778.

For additional information about the ACF Waiver, please visit the [Agency's website](#).

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Applied Behavior Analysis (ABA)

❖ **What is Applied Behavior Analysis?**

Applied behavior analysis (ABA) services provide highly structured interventions with the goal of targeting and decreasing maladaptive behaviors.

❖ **What services are covered?**

The services must be provided as specified in the provider alerts on the Agency's website and the service-specific Medicaid *Coverage and Limitations Handbook* based upon the provider's enrollment type with Florida Medicaid.

- For community behavioral health providers, services include:
 - Evaluation
 - Assessment
 - Treatment plan development and review
 - Therapeutic behavioral on-site, behavior management
 - Therapeutic behavioral on-site, therapeutic support
- For iBudget development disability waiver providers, services include:
 - Behavior analysis assessment
 - Behavior analysis
 - Behavior assistant services
- For early intervention service providers, services include:
 - Screening
 - Evaluation and follow-up evaluation
 - Individual and group early intervention session

❖ **Who is eligible to receive ABA services?**

Medicaid recipients under the age of 21 years who have a diagnosis of autism or autism spectrum disorder

❖ **Who is eligible to provide ABA services?**

Services are provided by qualified providers based upon the criteria established in each of the service-specific handbooks specified above.

❖ **How can recipients access ABA services?**

Medicaid health plans are not required to provide ABA services. ABA services are reimbursed through the fee-for-service delivery system. However, health plans play an important role in coordinating care for their enrollees, including making appropriate referrals for non-covered services. Health plans should refer enrollees to the Agency at (877) 254-1055 to get a list of qualified ABA providers in their area and to provide them with assistance in accessing this service. For additional information about ABA services, please visit the [Agency's website](#). The Agency's website contains more information about service authorization forms, billing instructions, and frequently asked questions.

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Child Health Service Targeted Case Management

❖ **What is Child Health Services Targeted Case Management?**

Child health services targeted case management assists Medicaid recipients in gaining and coordinating access to behavioral health, medical, social, and other supportive services in the community, as specified in Section 1915(g)(1)(2) of the Social Security Act (the Act) and defined in 42 CFR, sections 440.169 and 441.18, or its successive regulation.

❖ **What services are covered?**

Child health service targeted case management includes:

- Assessment
- Linkage
- Monitoring
- Follow-up
- Referral
- Service planning

❖ **Who is eligible to receive?**

Child health services targeted case management is provided to following:

- Recipients under the age of three receiving services from Children's Medical Service
- Recipients under the age of 21 receiving services from the Medical Foster Care program through CMS

❖ **Who is eligible to provide?**

Child health service targeted case management services are provided by:

- Medical foster care provider contractors
- Early Steps local program contractors

❖ **How do recipients access Child Health Services Targeted Case Management?**

Medicaid health plans are not required to provide child health services targeted case management services. Child health services targeted case management services are reimbursed through the fee-for-service delivery system. However, health plans play an important role in coordinating care for their enrollees, including making appropriate referrals for non-covered services. Health plans should refer enrollees to or contact their local Department of Health, Children's Medical Services Area Offices to coordinate needed services.

For additional information, please visit the Agency's website at:

[http://portal.flmmis.com/FLPublic/Portals/0/StaticContent/Public/HANDBOOKS/CHS Targeted Case Management Coverage and Limitations Handbook June 2012.pdf](http://portal.flmmis.com/FLPublic/Portals/0/StaticContent/Public/HANDBOOKS/CHS_Targeted_Case_Management_Coverage_and_Limitations_Handbook_June_2012.pdf)

For referral contact information, please visit the Children's Medical Services website at

http://www.floridahealth.gov/AlternateSites/CMS-Kids/home/contact/area_offices.html.

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County Health Department (CHD) Certified Match Program

❖ **What is the Medicaid CHD Certified Match Program?**

The CHD Certified Match program provides reimbursement to CHDs for medically necessary services provided in a school setting to Medicaid eligible students.

❖ **What services are covered under CHD Certified Match?**

- Nursing
- Social work services

❖ **Who is eligible to receive under CHD Certified Match?**

Recipients must meet the following criteria:

- Under the age of 21 years
- Medicaid eligible on the date of service
- Enrolled in a public school

❖ **Who is eligible to provide under CHD Certified Match?**

- County Health Departments
- Practitioners

❖ **How can recipients access CHD Certified Match services?**

Medicaid health plans are not required to provide CHD Certified Match services. CHD Certified Match services are reimbursed through the fee-for-service delivery system. However, health plans play an important role in coordinating care for their enrollees, including making appropriate referrals for non-covered services. Health plans should refer recipients to or contact recipient's local school district.

For additional information about the CHD Certified Match Program, please visit the Agency's website at:

http://portal.flmmis.com/FLPublic/Portals/0/StaticContent/Public/HANDBOOKS/County_Health_DepartmentHB.pdf.

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Developmental Disabilities Individual Budgeting (iBudget) Home and Community-Based Services Waiver

❖ **What is the iBudget Waiver?**

The iBudget Waiver provides home and community-based services to eligible recipients to promote, maintain and optimize the health of individuals in order to delay or prevent institutionalization.

❖ **What services are covered?**

- Adult Day Training
- Adult Dental Services
- Behavior Analysis Services
- Behavior Assistant Services
- Companion
- Consumable Medical Supplies
- Dietitian Services
- Durable Medical Equipment and Supplies
- Environmental Accessibility Adaptations
- Occupational Therapy
- Personal Emergency Response Systems
- Personal Supports
- Physical Therapy
- Private Duty Nursing
- Residential Habilitation
- Residential Nursing Services
- Respiratory Therapy
- Respite Care
- Skilled Nursing
- Specialized Medical Home Care
- Specialized Mental Health Counseling
- Speech Therapy
- Support Coordination
- Supported Employment
- Supported Living Coaching
- Transportation

❖ **Who is eligible to receive?**

To qualify for the iBudget Waiver, applicants must:

- Have one of the developmental disabilities described in Chapter 393, Florida Statutes
- Be age three years or older
- Meet the level of care requirements as determined by the Agency for Persons with Disabilities (APD)

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Developmental Disabilities Individual Budgeting (iBudget) Home and Community-Based Services Waiver (continued)

❖ **Who is eligible to provide?**

Providers enrolled with Florida Medicaid and APD to render iBudget Waiver services.

❖ **How can recipients access iBudget services?**

Medicaid health plans are not required to provide iBudget services. iBudget services are reimbursed through the fee-for-service delivery system. However, health plans play an important role in coordinating care for their enrollees, including making appropriate referrals for non-covered services. Health plans should refer enrollees to APD at (866) 273-2273.

For additional information about the iBudget Waiver, please visit the [Agency's website](#).

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Early Intervention Services (EIS) for Recipients Birth to Three Years of Age

❖ **What is EIS?**

Early Intervention Services are designed to identify, as early as possible, the presence of a developmental delay(s) or a condition(s) that could result in a developmental delay and to provide services to optimize functioning capacity and capabilities.

❖ **What services are covered?**

- Screenings
- Evaluations
- Sessions

❖ **Who is eligible to receive EIS?**

Medicaid recipients under the age of three years who are receiving services through the Department of Health Early Steps program, and have one of the following:

- A developmental delay in one or more developmental domains
- An established condition that has a 75 percent or higher probability of resulting in a developmental delay in one or more developmental domains

❖ **Who is eligible to provide EIS?**

EIS providers must be one of the following:

- ◆ Licensed medical professional acting within the scope of practice under state law, who is enrolled as an EIS provider
- ◆ Certified Infant Toddler Developmental Specialists (ITDS)

❖ **How can recipients access EIS?**

Medicaid health plans are not required to provide EIS. EIS are reimbursed through the fee-for-service delivery system. However, health plans play an important role in coordinating care for their enrollees, including making appropriate referrals for non-covered services. Health plans should refer enrollees to the Department of Health (DOH) Early Steps Program at (800) 218-0001.

For additional information about early intervention services, please visit the [Agency's website](#) or [DOH's website](#).

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Familial Dysautonomia (FD) Home and Community-Based Services Waiver

❖ **What is the Familial Dysautonomia Waiver?**

The FD Waiver provides home and community-based services to eligible recipients in order to promote, maintain and optimize the health of individuals to delay or prevent institutionalization.

❖ **What services are covered?**

- Behavioral Science
- Consumable Medical Supplies
- Dental Services
- Durable Medical Equipment
- Non-Residential Support Services
- Respite Services
- Support Coordination

❖ **Who is eligible to receive?**

To qualify for the FD Waiver, the applicant must:

- Be diagnosed with FD by a physician
- Be age three years and older
- Meet level of care requirements as determined by the Department of Elder Affairs

❖ **Who is eligible to provide?**

Providers must be enrolled with Florida Medicaid to render FD Waiver services.

❖ **How can recipients apply for the FD Waiver?**

Medicaid health plans are not required to provide FD services. FD services are reimbursed through the fee-for-service delivery system. However, health plans play an important role in coordinating care for their enrollees, including making appropriate referrals for non-covered services. Health plans should refer enrollees to the Agency at (877) 254-1055.

For additional information about the FD Waiver, please visit the [Agency's website](#).

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Intermediate Care Facility Services for Individuals with Intellectual Disabilities (ICF/IID)

❖ **What is ICF/IID?**

ICF/IID services provide 24-hour medical, habilitative, and health-related services to recipients diagnosed with an intellectual disability or related condition, as specified in Section 1919 of the Social Security Act and defined in 42 CFR, Parts 442 and 483, or its successive regulation.

❖ **What services are covered?**

ICF/IID services include the provision of 365/6 days of the care and services required to attain or maintain the highest practicable physical, mental, and psychosocial well-being of the recipient. Services include, but are not limited to:

- Activity services
- Dental services
- Dietary services (including therapeutic diets)
- Nursing services
- Pharmacy services
- Physician services
- Rehabilitative services (including physical, speech, occupational, and mental health therapies)
- Room/bed and maintenance services
- Routine personal hygiene items
- Social services

❖ **Who is eligible to receive ICF/IID services?**

ICF/IID services are provided to recipients who have a level of need and level of reimbursement determined by the Agency for Persons with Disabilities (APD) within the last six months.

❖ **Who is eligible to provide ICF/IID services?**

ICF/IID services are provided by intermediate care facilities licensed in accordance with Chapter 400, Part VIII, F.S.

❖ **How can recipients access ICF/IID services?**

Medicaid health plans are not required to provide ICF/IID services. ICF/IID services are reimbursed through the fee-for-service delivery system. Medicaid recipients receiving services in an ICF/IID facility are not required to enroll in a health plan (i.e., recipients may choose to continue to receive all of their services through the fee-for-service delivery system). Recipients who are enrolled in a health plan and wish to receive ICF/IID services do not have to dis-enroll from their plan. While health plans are not required to provide ICF/IID services, the plans play an important role in coordinating care for their enrollees, including making appropriate referrals for non-covered services. Plans should refer enrollees to the Agency at (877) 254-1055 to get a list of ICF/IID providers in their area and also to APD to begin the level of need determination process. For additional information about ICF/IID services, please visit the [Agency website](#).

For additional information about the level of need process determined by APD, please visit [APD's website](#).

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Medicaid Certified School Match (MCSM) Program

❖ **What is the MCSM Program?**

The MCSM program provides reimbursement for medically necessary services provided, or arranged for, by a school district. Each Florida school district is responsible for ensuring that recipients with disabilities receive medical services as referenced on the individual education plan (IEP) or individual family support plan (IFSP).

❖ **What services are covered under MCSM?**

- Behavioral
- Nursing
- Occupational therapy
- Physical therapy
- Speech-language pathology
- Transportation

❖ **Who is eligible to receive under MCSM?**

Recipients must meet the following criteria:

- Under the age of 21 years
- Considered disabled in accordance with section 393.063, F.S.
- Entitled to school district services under IDEA, Part B or Part C, per section 409.9071, F.S.
- Have services referenced on the IEP or IFSP.

❖ **Who is eligible to provide under MCSM?**

- Charter Schools under contract with school districts
- School Districts
- Special Schools

❖ **How can recipients access MCSM services?**

Medicaid health plans are not required to provide MCSM services. MCSM services are reimbursed through the fee-for-service delivery system. However, health plans play an important role in coordinating care for their enrollees, including making appropriate referrals for non-covered services. Health plans should refer recipients to or contact the recipient's school district.

For additional information about the Medicaid Certified School Match (MCSM) Program, please visit the Agency's website at:

http://portal.flmmis.com/FLPublic/Portals/0/StaticContent/Public/HANDBOOKS/Certified_School_Match_HB.pdf.

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Medical Foster Care

❖ **What is Medical Foster Care?**

Florida Medicaid Medical Foster Care (MFC) services enable specified recipients with complex medical needs to live and receive medical care and support in a home-like environment.

❖ **What services are covered?**

Florida Medicaid reimburses for 365/366 days of continuous medical foster care per year, per recipient. The following are covered services.

- Medical Foster Care services enables recipients with medically complex needs to live and receive all medical care and support in a foster care home.
- Alternative care services when an alternate MFC provider temporarily (less than 30 days) replaces the care rendered by the primary foster home caretaker.
- Recipient absences when a recipient is absent from the MFC provider's residence overnight for up to 15 days during any 90-day period for hospitalization or interim transitional therapeutic visits.

❖ **Who is eligible to receive MFC services?**

Recipients who meet the following criteria:

- Under the age of 21 years
- In the custody of Department of Children & Families (DCF), in a voluntary placement agreement, or in extended foster care, in accordance with section 409.175, F.S.
- Are medically stable
- Require skilled nursing level of care

❖ **Who is eligible to provide MFC services?**

Foster home caretakers who are licensed by DCF in accordance with Rule 65G-2.002, F.A.C., and certified through the Department of Health (DOH).

❖ **How can recipients access MFC services?**

Medicaid health plans are not required to provide MFC services. MFC services are reimbursed through the fee-for-service delivery system. However, health plans play an important role in coordinating care for their enrollees, including making appropriate referrals for non-covered services. Health plans should refer enrollees to their local [DOH Children's Medical Services office](#).

For additional information about the MFC program, please visit the [Agency's website](#) or [DOH's website](#).

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Model Home and Community-Based Services Waiver

❖ **What is the Model Waiver?**

The Model Waiver provides home and community-based services to eligible recipients in order to delay or prevent institutionalization. The Model Waiver also has reserved capacity for children who are currently receiving services in a nursing facility to facilitate their successful transition into the community.

❖ **What services are covered?**

- Assistive Technology and Service Evaluation
- Environmental Accessibility Adaptations
- Respite Care

❖ **Who is eligible to receive?**

To qualify for the Model Waiver applicants must:

- Be diagnosed as having degenerative spinocerebellar disease; or have resided in a skilled nursing facility for at least 60 consecutive days prior to enrollment
- Be under the age of 21 years
- Be determined disabled using criteria established by the Social Security Administration
- Meet level of care requirements as determined by the Department of Health

❖ **Who is eligible to provide?**

Providers enrolled with Florida Medicaid to render Model Waiver services.

❖ **How can recipients access Model Waiver?**

Medicaid health plans are not required to provide Model Waiver services. Model Waiver services are reimbursed through the fee-for-service delivery system. However, health plans play an important role in coordinating care for their enrollees, including making appropriate referrals for non-covered services. Health plans should refer enrollees to the Agency at (877) 254-1055.

For additional information about the Model Waiver, please visit the [Agency's website](#).

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Newborn Hearing Services

❖ **What is a newborn hearing screening?**

The newborn hearing screening is for the purpose of testing all Medicaid eligible newborns for hearing impairment to alleviate the adverse effects of hearing loss on speech and language development, academic performance, and cognitive development. The screening is a test or battery of tests administered to determine the need for an in-depth hearing diagnostic evaluation.

❖ **Who is eligible to receive newborn hearing screening services?**

Newborns are required to either have the screening prior to discharge from the hospital (or birthing center) or a referral must be made for the screening. For home births, the health care provider in attendance is responsible for coordination and referral. Medicaid reimburses newborn hearing screenings for all eligible recipients from birth through 12 months of age.

❖ **Who is eligible to provide newborn hearing screening services?**

Florida law requires licensed hospitals and birthing facilities that provide maternity and newborn care services to provide screening for the detection of hearing loss if the parents or legal guardians do not object to the screening [see Section 383.145, F.S.] All screenings are to be conducted by a licensed audiologist, physician, or specifically trained and supervised individual in newborn hearing screening.

❖ **How can recipients access newborn hearing services?**

Medicaid health plans are not required to provide newborn hearing services. Newborn hearing services are reimbursed through the fee-for-service delivery system. However, the health plan plays an important role in coordinating care for its enrollees, including making appropriate referrals for non-covered services. Plans should refer enrollees to the Agency at (877) 254-1055 to get a list of hearing service providers in their area and to provide them with assistance in accessing this service.

For additional information about newborn hearing screening services, please visit the [Agency's website](#).

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Prescribed Pediatric Extended Care

❖ **What is Prescribed Pediatric Extended Care?**

Prescribed pediatric extended care (PPEC) services provide non-residential short-term, long-term, or intermittent skilled nursing interventions designed to meet the recipients' physiological, developmental, nutritional, and social needs.

❖ **What services are covered?**

- Full Day: Up to 12 hours (minimum of four hours) of basic services per day, per recipient.
- Partial Day: Four hours or less of basic services per day, per recipient.

❖ **Who is eligible to receive PPEC services?**

Recipients who meet the following criteria:

- Under the age of 21 years
- Require skilled nursing level of care
- Are medically stable

❖ **Who is eligible to provide PPEC services?**

A PPEC must be licensed in accordance with Chapter 400, Part VI, F.S., and be in compliance with Rule 59A-13.004, F.A.C.

❖ **How can recipients access PPEC services?**

Medicaid health plans are not required to provide PPEC services. PPEC services are reimbursed through the fee-for-service delivery system. However, health plans play an important role in coordinating care for their enrollees, including making appropriate referrals for non-covered services. Health plans should refer enrollees to the Agency at (877) 254-1055 to get a list of PPEC providers in their area and to provide them with assistance in accessing this service.

For additional information about PPEC services, please visit the [Agency's website](#).

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Program for All-Inclusive Care for Children

❖ **What is Program for All-Inclusive Care for Children?**

The Florida Medicaid PACC provides specialized palliative care support services to provide comfort for children and their families. This program is also referred to as Partners in Care: Together for Kids (PIC: TFK) and is operated by the Department of Health.

❖ **What services are covered?**

- Bereavement support
- Counseling
- Nursing care
- Pain and symptom control
- Personal care
- Play, music and art therapies
- Respite care

❖ **Who is eligible to receive PACC services?**

Recipients who require medically necessary PACC services must meet the following criteria:

- Be under the age of 21 years
- Be diagnosed with a life threatening illness

❖ **Who is eligible to provide PACC services?**

This service is furnished by qualified hospice providers.

❖ **How can recipients access PACC?**

PACC services are only available through the Children's Medical Service (CMS) managed care plan. If an enrollee is interested in receiving PACC services, the enrollee will need to transition into the CMS managed care plan. Health plans play an important role in coordinating care for their enrollees, including making appropriate referrals for non-covered services. Health plans should refer enrollees to the Agency at (877) 254-1055 to learn more about PACC or to the Agency's enrollment broker at (877) 711-3662 if the enrollee or their legal guardian would like to learn more about the services offered through the CMS managed care plan.

For additional information about PACC, please visit the [DOH's website](#).

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Project AIDS Care (PAC) Home and Community-Based Services Waiver

❖ **What is the PAC Waiver?**

The PAC Waiver provides home and community-based services to promote, maintain and optimize the health of persons living with Acquired Immune Deficiency Syndrome (AIDS) in order to delay or prevent institutionalization.

❖ **What services are covered?**

- Case Management
- Chore
- Day Health Care
- Education and Support
- Environmental Accessibility Adaptations
- Home-Delivered Meals
- Homemaker
- Personal Care
- Restorative Massage
- Skilled Nursing
- Specialized Medical Equipment and Supplies
- Specialized Personal Care for Children in Foster Care
- Therapeutic Management of Substance Abuse

❖ **Who is eligible to receive?**

PAC Waiver services are provided to recipients who:

- Have been diagnosed with AIDS by a physician
- Have the presence of AIDS-related opportunistic infection(s)
- Meet level of care requirements as determined by the Department of Elder Affairs

❖ **Who is eligible to provide?**

Providers enrolled with Florida Medicaid to render PAC Waiver services.

❖ **How can recipients apply for the PAC Waiver?**

Medicaid health plans are not required to provide PAC services. PAC services are reimbursed through the fee-for-service delivery system. However, health plans play an important role in coordinating care for their enrollees, including making appropriate referrals for non-covered services. Health plans should refer enrollees to the Agency at (877) 254-1055.

For additional information about the PAC Waiver, please visit the [Agency's website](#).

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Substance Abuse County Match Program

❖ **What are Substance Abuse County Match program services?**

This program enables eligible counties to receive federal matching funds for four Medicaid funded substance abuse services.

❖ **What services are covered?**

Substance abuse county match services include the provision of diagnostic, screening, preventive, and rehabilitative services to identify recipients at risk for substance use disorders and to maintain recovery when treatment is successfully completed, as specified and defined in 42 CFR, section 440.130. Services include:

- Comprehensive aftercare
- Group peer recovery support
- Individual peer recovery support
- Intervention

❖ **Who is eligible to receive?**

Substance abuse county match program services are provided to recipients who have been screened and deemed in need of the program's services.

❖ **Who is eligible to provide?**

Under this program the county contracts with providers to offer these services. The county reimburses the providers directly and in full, and then submits claims to Medicaid for reimbursement of the federally funded portion. This process requires the participating county to enroll in Medicaid as a Community Behavioral Health Services provider (provider type 05).

Substance abuse county match services are provided by:

- Licensed practitioners, within their scope of practice
- Community behavioral health agencies

❖ **How can recipients access substance abuse county match program services?**

Medicaid health plans are not required to provide substance abuse county match services. Substance abuse county match services are reimbursed through the fee-for-service delivery system. However, health plans play an important role in coordinating care for their enrollees, including making appropriate referrals for non-covered services. Health plans should provide the enrollees with the appropriate referral information.

The [Agency's website](#) contains resources for recipients and providers about substance abuse county match program services including the certified match agreement, cost and descriptions, recommended components, certification of expenditures, and service process guide.

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Traumatic Brain Injury and Spinal Cord Injury (TBI/SCI) Home and Community-Based Services Waiver

❖ What is the TBI/SCI Waiver?

The TBI/SCI Waiver provides home and community-based services to eligible recipients to promote, maintain and optimize the health of individuals in order to delay or prevent institutionalization.

❖ What services are covered?

- Assistive Technologies
- Attendant Care
- Behavioral Programming
- Community Support Coordination
- Companion Services
- Consumable Medical Supplies
- Emergency Alert Response System (Initial Installation, Monitoring, and Maintenance)
- Environmental Accessibility Adaptations
- Life Skill Training
- Occupational Therapy
- Personal Adjustment Counseling
- Personal Care Services
- Physical Therapy
- Rehabilitation Engineering Evaluation
- Residential Habilitation
- Transition Case Management
- Transition Environmental Accessibility Adaptations

❖ Who is eligible to receive?

To qualify for the TBI/SCI Waiver, the applicant must:

- Be age 18 years or older
- Be diagnosed with a traumatic brain or spinal cord injury, or both, as defined in Chapter 381.745, Florida Statutes
- Be medically stable, which is defined as the absence of any of the following:
 - ♦ An active, life threatening condition (e.g., sepsis, respiratory, or other condition requiring system therapeutic measures)
 - ♦ Intravenous drip to control or support blood pressure
 - ♦ Intracranial pressure or arterial monitoring
- Meet level of care requirements as determined by the Department of Elder Affairs

❖ Who is eligible to provide?

Providers enrolled with Florida Medicaid to render TBI/SCI Waiver services.

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Traumatic Brain Injury and Spinal Cord Injury (TBI/SCI) Home and Community-Based Services Waiver (continued)

❖ **How can recipients apply for the TBI/SCI Waiver?**

Medicaid Health plans are not required to provide TBI/SCI services. TBI/SCI services are reimbursed through the fee-for-service delivery system. However, health plans play an important role in coordinating care for their enrollees, including making appropriate referrals for non-covered services. Health plans should refer enrollees to the Department of Health's Brain and Spinal Cord Injury Program at (800) 342-0778.

For additional information about the TBI/SCI Waiver, please visit the [Agency's website](#).