



CHARLIE CRIST
GOVERNOR

Better Health Care for all Floridians

THOMAS W. ARNOLD
SECRETARY

January 11, 2010

Dear Parent/Legal Guardian:

Our records show that your child is currently receiving private duty nursing or personal care services under the Medicaid home health program. The 2009 Florida Legislature made some changes in the law impacting Medicaid. As a result, Medicaid has changed the authorization requirements for home health services and we wanted to provide you with an update on how the approval process will work.

Private duty nursing services and personal care services require prior approval before Medicaid can pay for services. Your home health agency will apply for approval for services through the Agency's contracted reviewer, currently Keystone Peer Review Organization (KePRO). Your home health agency will need to provide KePRO with a copy of the plan of care and the order from the physician.

Your child will need to be examined by his or her doctor at least every 6 months. This will help to make sure that your child's medical condition is being monitored closely by a doctor. Medicaid will pay for this visit. Your home health agency will need to send proof of this doctor visit to KePRO every 6 months. You can help by reminding your child's doctor that the home health agency will need this documentation in order to continue private duty nursing or personal care services.

Lastly, beginning January 1, 2010, KePRO will need proof of your schedule if you work or go to school. You can help by getting this information from your employer or school now. This information will only need to be updated if there are changes. If you are not able to get a copy of your work or school schedule or if you are self employed you may provide a notarized statement of your schedule to your child's home health agency.

In addition, if you have a medical condition that limits your ability to provide some of your child's care, you must get a statement from your physician that states what the limitations are. We have included some suggested forms with this letter to help you.



You may contact your local Medicaid area office if you have any questions regarding these changes. A list of contact information for the Medicaid area office in each area is also included with this letter.

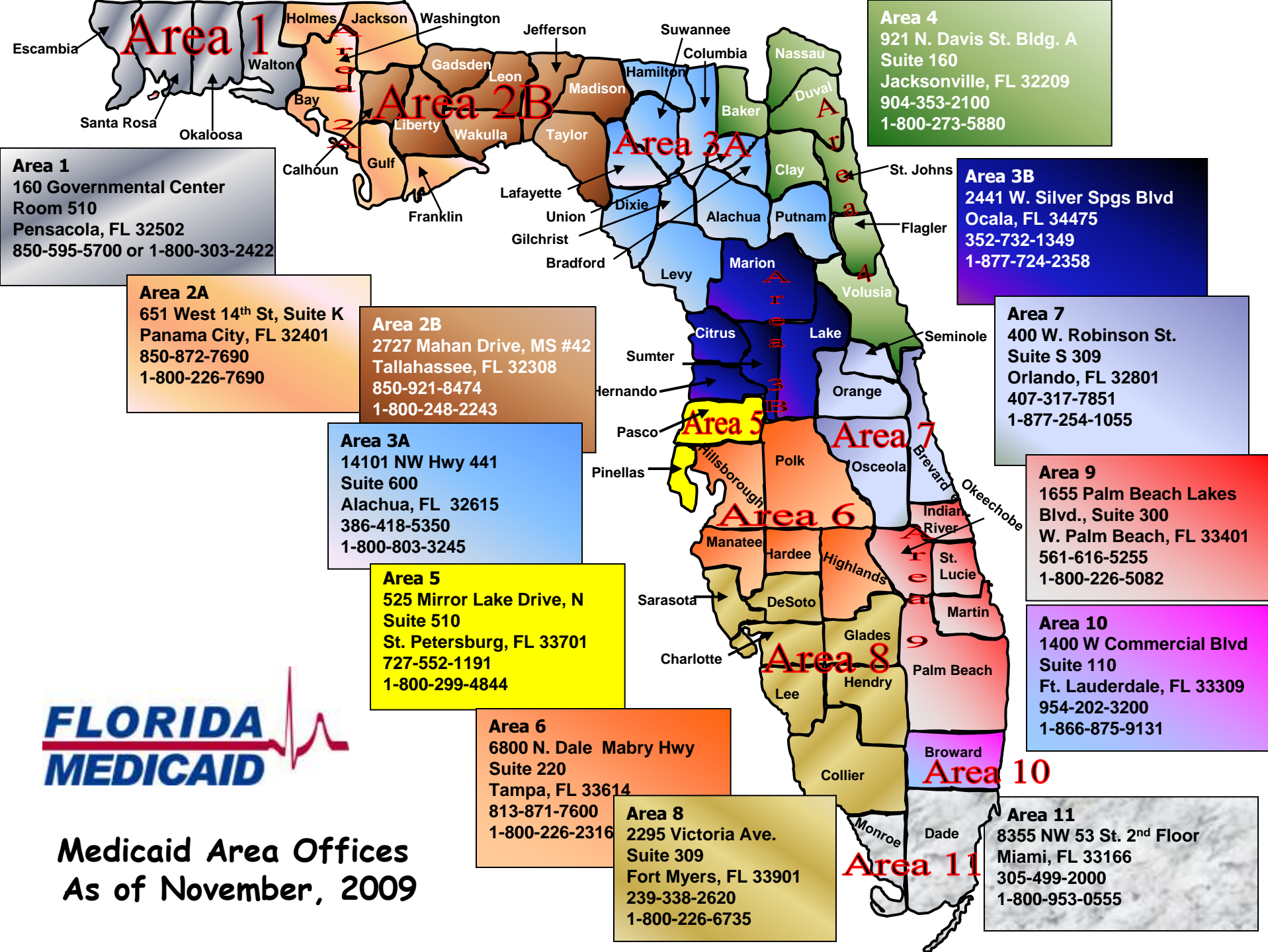
Sincerely,

A handwritten signature in black ink, appearing to read "Beth Kidder". The signature is fluid and cursive, with a large initial "B" and "K".

Beth Kidder, Chief
Bureau of Medicaid Services

BK/cad

Enclosures: Medicaid Area Office Contact List
AHCA Physician Visit Documentation Form
Parent/Legal Guardian Physician Statement
Parent/Legal Guardian Statement of Work Schedule (from employer)
Parent/Legal Guardian Statement of School Schedule (from academic institution)
Parent/Legal Guardian Statement of Work/School Schedule



Area 4
 921 N. Davis St. Bldg. A
 Suite 160
 Jacksonville, FL 32209
 904-353-2100
 1-800-273-5880

Area 1
 160 Governmental Center
 Room 510
 Pensacola, FL 32502
 850-595-5700 or 1-800-303-2422

Area 3B
 2441 W. Silver Spgs Blvd
 Ocala, FL 34475
 352-732-1349
 1-877-724-2358

Area 2A
 651 West 14th St, Suite K
 Panama City, FL 32401
 850-872-7690
 1-800-226-7690

Area 2B
 2727 Mahan Drive, MS #42
 Tallahassee, FL 32308
 850-921-8474
 1-800-248-2243

Area 7
 400 W. Robinson St.
 Suite S 309
 Orlando, FL 32801
 407-317-7851
 1-877-254-1055

Area 3A
 14101 NW Hwy 441
 Suite 600
 Alachua, FL 32615
 386-418-5350
 1-800-803-3245

Area 9
 1655 Palm Beach Lakes
 Blvd., Suite 300
 W. Palm Beach, FL 33401
 561-616-5255
 1-800-226-5082

Area 5
 525 Mirror Lake Drive, N
 Suite 510
 St. Petersburg, FL 33701
 727-552-1191
 1-800-299-4844

Area 10
 1400 W Commercial Blvd
 Suite 110
 Ft. Lauderdale, FL 33309
 954-202-3200
 1-866-875-9131

Area 6
 6800 N. Dale Mabry Hwy
 Suite 220
 Tampa, FL 33614
 813-871-7600
 1-800-226-2316

Area 8
 2295 Victoria Ave.
 Suite 309
 Fort Myers, FL 33901
 239-338-2620
 1-800-226-6735

Area 11
 8355 NW 53 St. 2nd Floor
 Miami, FL 33166
 305-499-2000
 1-800-953-0555



**Medicaid Area Offices
 As of November, 2009**



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Physician Visit Documentation Form
*(To be completed by the **recipient's** physician)*

Date: _____

Medicaid Recipient Name: _____

Physician Name: _____

Physician Address: _____

Physician Telephone Number: _____

Diagnosis(es): _____

Please describe the patient's ongoing need for home health services:

Signature of Physician: _____

National Provider Identifier: _____





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Parent/Legal Guardian Medical Limitations

Date: _____

Patient Name: _____

Physician Name: _____

Physician Address: _____

Physician Telephone Number: _____

Please describe any medical limitation or disability that the above named individual may have that would limit their ability to participate in the care of a patient with complex medical needs (e.g. lifting restrictions, developmental disorder, bed rest for pregnancy, etc.):

If limitation/disability is temporary, please document the expected timeframe for resolution.

Signature of Physician: _____

National Provider Identifier: _____





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Work Schedule Statement from Employer

(NOTE: this form must be completed by a supervisor)

Parent/Legal Guardian Name: _____

Name of Employer: _____

Address: _____

Work Schedule:

Monday: _____

Tuesday: _____

Wednesday: _____

Thursday: _____

Friday: _____

Saturday: _____

Sunday: _____

If employee works a variable work schedule, please indicate the number of hours per week, this employee works: _____

Supervisor Name: _____

Title: _____

Telephone Number: _____

Signature: _____

Date: _____





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Parent/Legal Guardian School Schedule

(NOTE: this form must be completed by a school advisor or representative)

Parent/Legal Guardian Name: _____

Name of School: _____

Address: _____

Semester: Fall Spring Summer Year: _____

Class Schedule (Include days of the week and hours each day): _____

Name of School Representative: _____

Title: _____

Telephone Number: _____

Signature: _____

Date: _____





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Parent/Legal Guardian Statement of Work Schedule
(NOTE: *this form must be notarized*)

Parent/Legal Guardian Name: _____

Statement of Work Schedule

Name of Employer: _____

Address: _____

Telephone Number: _____

Work Schedule (Include days of the week and hours each day): _____

The information above is true and valid to the best of my knowledge.

Parent/Legal Guardian Signature: _____

Date: _____

Notary Signature: _____

Notary Printed Name: _____

Notary Address: _____

Notary Telephone Number: _____

Date: _____

