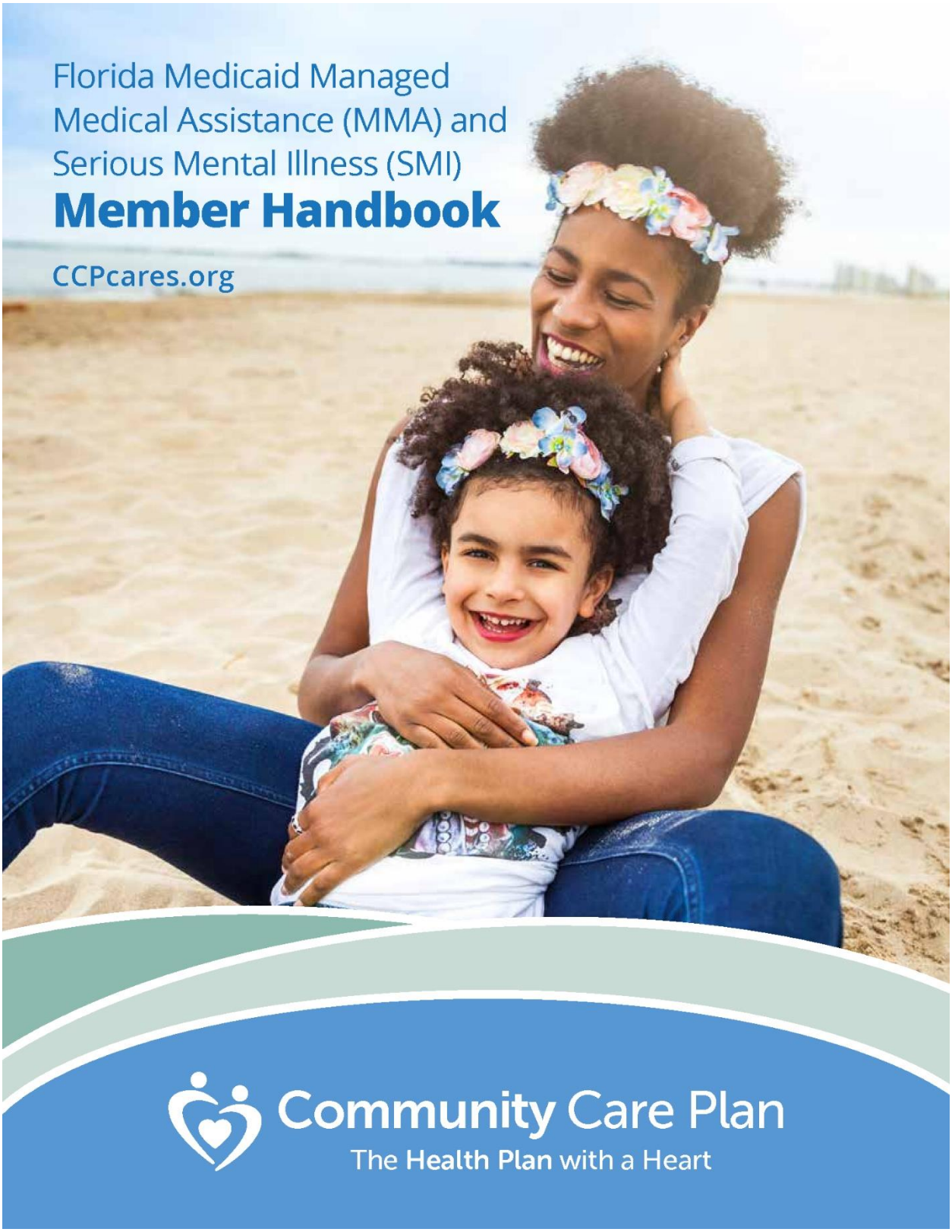
Florida Medicaid Managed
Medical Assistance (MMA) and
Serious Mental Illness (SMI)
Member Handbook
CCPcares.org
Community Care Plan
The Health Plan with a Heart

3/4/25

If you do not speak English, call us at 1-866-899-4828 (TTY/TDD: 711). We have access to interpreter services and can help answer your questions in your language. We can also help you find a health care provider who can talk with you in your language.

Spanish: Si usted no habla inglés, llámenos al 1-866-899-4828 (TTY/TDD: 711). Ofrecemos servicios de interpretación y podemos ayudarle a responder preguntas en su idioma. También podemos ayudarle a encontrar un proveedor de salud que pueda comunicarse con usted en su idioma.

French: **Si vous ne parlez pas anglais**, appelez-nous au 1-866-899-4828 (TTY/TDD: 711). Nous avons accès à des services d'interprétariat pour vous aider à répondre aux questions dans votre langue. Nous pouvons également vous aider à trouver un prestataire de soins de santé qui peut communiquer avec vous dans votre langue.

Haitian Créole: **Si ou pa pale lang Anglè**, rele nou nan 1-866-899-4828 (TTY/TDD: 711). Nou ka jwenn sèvis entèprèt pou ou, epitou nou kapab ede reponn kesyon ou yo nan lang ou pale a. Nou kapab ede ou jwenn yon pwofesyonèl swen sante ki kapab kominike avèk ou nan lang ou pale a.

Italian: **Se non parli inglese** chiamaci al 1-866-899-4828. (TTY/TDD: 711) Disponiamo di servizi di interpretariato e siamo in grado di rispondere alle tue domande nella tua lingua. Possiamo anche aiutarti a trovare un fornitore di servizi sanitari che parli la tua lingua.

Russian: **Если вы не разговариваете по-английски,** позвоните нам по номеру 1-866-899-4828 (TTY/TDD: 711). У нас есть возможность воспользоваться услугами переводчика, и мы поможем вам получить ответы на вопросы на вашем родном языке. Кроме того, мы можем оказать вам помощь в поиске поставщика медицинских услуг, который может общаться с вами на вашем родном языке.

Vietnamese: **Nếu bạn không nói được tiếng Anh**, hãy gọi cho chúng tôi theo số 1-866-899-4828 (TTY/TDD: 711). Chúng tôi có quyền truy cập vào các dịch vụ thông dịch viên và có thể giúp trả lời các câu hỏi của bạn bằng ngôn ngữ của bạn. Chúng tôi cũng có thể giúp bạn tìm một nhà cung cấp dịch vụ chăm sóc sức khỏe có thể nói chuyện với bạn bằng ngôn ngữ của bạn.

Important Contact Information

Community Care Plan (CCP)

Member Services Help Line	1-866-899-4828 Available 24 hours
Member Services Help Line TTY	711 Available 24 hours
Website	www.ccpcares.org
Address	1643 Harrison Parkway Suite H-200 Sunrise, FL 33323

Transportation - Non-Emergency	ModivCare 1-866-306-9358 (Reservations) 1-866-306-9359 (Ride Assistance)
Behavioral Health	Community Care Plan 1-866-899-4828
Vision	iCare Health Solutions 1-877-296-0799
Over The Counter (OTC)	Medline Order online anytime: athome.medline.com/ccpfl 833-660-0908
Pharmacy	Prime Therapeutics 1-800-424-7897
Dental	Your dental plan is assigned to you by Medicaid. Call: • Denta Quest at 1-888-468-5509 • Dental MCNA at 1-855-699-6262 • Liberty at 1-833-276-0850 If you are unsure of what dental plan Medicaid has assigned to you, please call DCF or our Member Services Team at 1-866-899-4828.
To report suspected cases of abuse, neglect, abandonment, or exploitation of children or vulnerable adults	1-800-96-ABUSE (1-800-962-2873) TTY: 711 or 1-800-955-8771 www.myflfamilies.com/services/abuse/abuse-hotline/how-report-abuse

For Medicaid Eligibility	1-866-762-2237 TTY: 711 or 1-800-955-8771 www.myflfamilies.com/medicaid#ME
To report Medicaid Fraud and/or Abuse	1-888-419-3456 https://apps.ahca.myflorida.com/mpi-complaintform/
To file a complaint about a health care facility	1-888-419-3456 http://ahca.myflorida.com/MCHQ/Field_Ops/CAU.shtml
To request a Medicaid Fair Hearing	1-877-254-1055 1-239-338-2642 (fax) MedicaidHearingUnit@ahca.myflorida.com
To file a complaint about Medicaid services	1-877-254-1055 TDD: 1-866-467-4970 http://ahca.myflorida.com/Medicaid/complaints/
To find information for elders	1-800-96-ELDER (1-800-963-5337) www.elderaffairs.org/doea/arc.php
To find out information about domestic violence	1-800-799-SAFE (1-800-799-7233) TTY: 1-800-787-3224 www.thehotline.org/
To find information about health facilities in Florida	https://quality.healthfinder.fl.gov/
To find information about urgent care	Please contact Member Services at 1-866-899-4828 or visit our website www.ccpcares.org
For an emergency	9-1-1 Or go to the nearest emergency room

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Welcome

Welcome to Community Care Plan's Statewide Medicaid Managed Care Plan. Community Care Plan has a contract with the Florida Agency for Health Care Administration (Agency) to provide health care services to people with Medicaid. This is called the Statewide Medicaid Managed Care (SMMC) Program. You are enrolled in our SMMC plan. This means we will offer you Medicaid services. We work with a group of health care providers to help meet your needs.

There are many types of Medicaid services you can receive in the SMMC program. You can receive medical services, like doctor visits, labs, and emergency care, from a **Managed Medical Assistance (MMA)** plan. If you are an elder or adult with disabilities, you can receive nursing facility and home and community-based services in a **Long-Term Care (LTC)** plan. If you have a certain health condition, like AIDS, you can receive care that is designed to meet your needs in a **Specialty** plan.

If your child is enrolled in the Florida KidCare **MediKids** program, most of the information in this handbook applies to you. We will let you know if something does not apply.

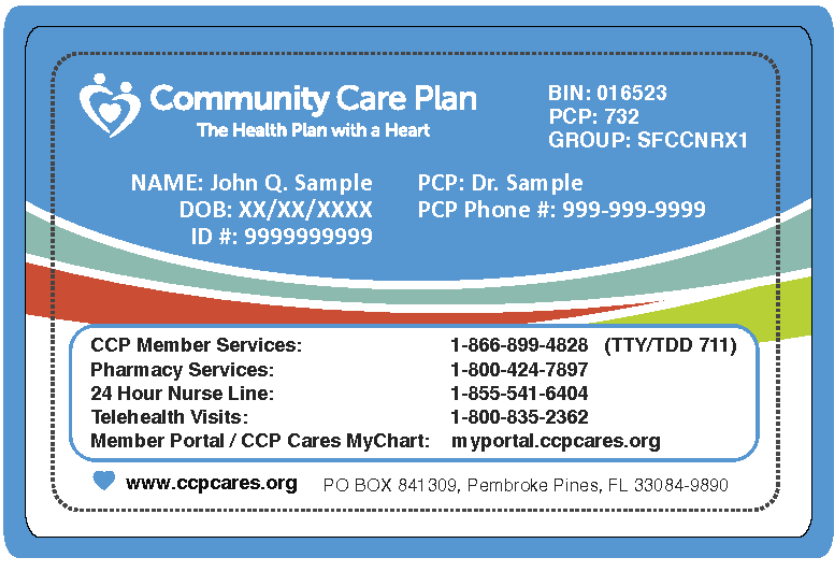
This handbook will be your guide for all health care services available to you. You can ask us any questions or get help making appointments. If you need to speak with us, just call us at 1-866-899-4828.

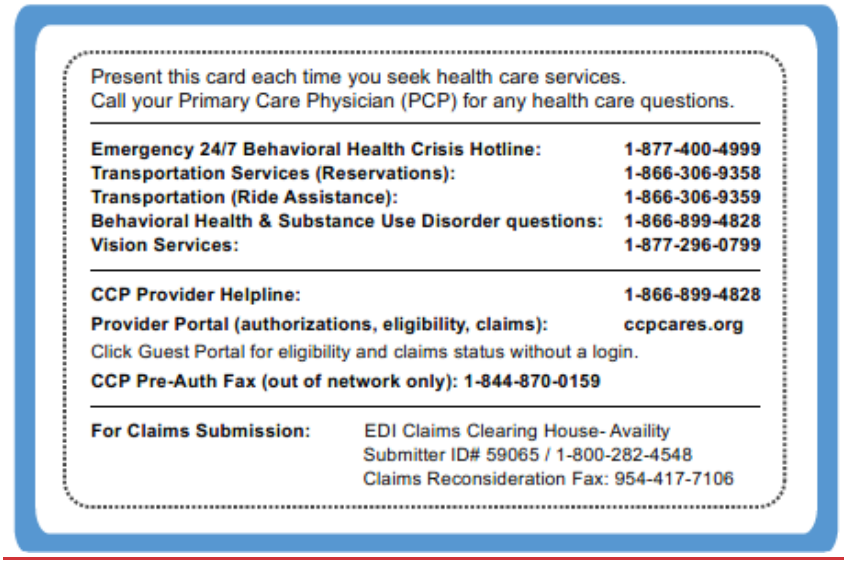
Section 1: Your Plan Identification Card (ID card)

You should have received your ID card in the mail. Call us if you have not received your card or if the information on your card is wrong. Each member of your family in our plan should have their own ID card.

Always carry your ID card and show it each time you go to a health care appointment or the hospital. Never give your ID card to anyone else to use. If your card is lost or stolen, call us so we can give you a new card.

Your ID card will look like this:





Section 2: Your Privacy

Your privacy is important to us. You have rights when it comes to protecting your health information, such as your name, Plan identification number, race, ethnicity, and other things that identify you. We will not share any health information about you that is not allowed by law.

If you have any questions, call Member Services. Our privacy policies and protections are:

Community Care Plan will never give out your history without your written consent. The only people that will have your info will be your doctors and your representative. Community Care Plan staff have been trained to keep your info private.

Section 3: Getting Help from Our Member Services

Our Member Services Department can answer all your questions. We can help you choose or change your Primary Care Provider (PCP for short), find out if a service is covered, get referrals, find a provider, replace a lost ID card, report the birth of a new baby, and explain any changes that might affect you or your family's benefits.

Contacting Member Services

You may call us at 1-866-899-4828, or 711, Monday to Friday, 8:00 a.m. to 7:00 p.m., but not on State approved holidays (like Christmas Day and Thanksgiving Day). When you call, make sure you have your identification card (ID card) with you so we can help you. **(**If you lose your ID card, or if it is stolen, call Member Services.)

Contacting Member Services after Hours

If you call when we are closed, please leave a message. We will call you back the next business day. If you have an urgent question, you may call our 24/7 Nurse Help Line at 1-855-541-6404. Our nurses are available to help you 24 hours a day, 7 days a week.

Section 4: Do You Need Help Communicating?

If you do not speak English, we can help. We have people who help us talk to you in your language. We provide this help for free.

For people with disabilities: If you use a wheelchair, or are blind, or have trouble hearing or understanding, call us if you need extra help. We can tell you if a provider's office is wheelchair accessible or has devices for communication. Also, we have services like:

- Telecommunications Relay Service. This helps people who have trouble hearing or talking to make phone calls. Call 711 and give them our Member Services phone number. It is 1-866-899-4828. They will connect you to us.
- Information and materials in large print, audio (sound); and braille
- Help in making or getting to appointments.
- Names and addresses of providers who specialize in your disability.

All these services are provided free to you.

Section 5: When Your Information Changes

If any of your personal information changes, let us know as soon as possible. You can do so by calling Member Services. We need to be able to reach you about your health care needs.

The Department of Children and Families (DCF) needs to know when your name, address, county, or telephone number changes as well. Call DCF toll free at 1-866-762-2237 (TTY 1-800-955-8771) Monday through Friday from 8 a.m. to 5:30 p.m. You can also go online and make the changes in your Automated Community Connection to Economic Self Sufficiency (MyACCESS) account at https://myaccess.myflfamilies.com/. If you receive Supplemental Security Income (SSI), you must also contact the Social Security Administration (SSA) to report changes. Call SSA toll free at 1-800-772-1213 (TTY 1-800-325-0778), Monday through Friday from 8 a.m. to 7 p.m. You may also contact your local Social Security office or go online and make changes in your Social Security account at https://secure.ssa.gov/RIL/SiView.do.

Section 6: Changes to your Health Plan

If your health plan experiences a significant change that affects you as an enrollee, it is the plan's responsibility to inform you (the enrollee) at least 30 days before the intended effective date of the change.

Section 7: Your Medicaid Eligibility

You must be covered by Medicaid and enrolled in our plan for Community Care Plan to pay for your health care services and health care appointments. This is called having **Medicaid eligibility**. If you receive SSI, you qualify for Medicaid. If you do not receive SSI, you must apply for Medicaid with DCF.

Sometimes things in your life might change, and these changes can affect whether you can still have Medicaid. It is very important to make sure that you have Medicaid before you go to any appointments. Just because you have a Plan ID Card does not mean you still have Medicaid. Do not worry! If you think your Medicaid has changed or if you have any questions about your Medicaid, call Member Services. We can help you check on your coverage.

If you Lose your Medicaid Eligibility

If you lose your Medicaid and get it back within 180 days, you will be enrolled back into our plan.

If you have Medicare

If you have Medicare, continue to use your Medicare ID card when you need medical services (like going to the doctor or the hospital), but also give the provider your Medicaid Plan ID card too.

If you are having a Baby

If you have a baby, he or she will be covered by us on the date of birth. Call Member Services to let us know that your baby has arrived, and we will help make sure your baby is covered and has Medicaid right away.

It is helpful if you let us know you are pregnant **before** your baby is born to make sure your baby has Medicaid. Call DCF toll free at 1-866-762-2237 while you are pregnant. If you need help talking to DCF, call us. DCF will make sure your baby has Medicaid from the day he or she is born. They will give you a Medicaid number for your baby. Let us know the baby's Medicaid number when you get it.

Section 8: Enrollment in Our Plan

Initial Enrollment

When you first join our plan, you have 120 days to try our plan. If you do not like it for any reason, you can enroll in another SMMC plan in the same region. Once those 120 days are over, you are enrolled in our plan for the rest of the year. This is called being **locked-in** to a plan. Every year you have Medicaid and are in the SMMC program, you will have an open enrollment period.

Open Enrollment Period

Each year, you will have 60 days when you can change your plan if you want. This is called your **open enrollment period**. The State's Enrollment Broker will send you a letter to tell you when your open enrollment period is.

You do not have to change plans during your open enrollment period. If you do choose to leave our plan and enroll in a new one, you will start with your new plan at the end of your open enrollment period. Once you are enrolled in the new plan, you are locked-in until your next open enrollment period. You can call the Enrollment Broker at 1-877-711-3662 (TDD 1-866-467-4970).

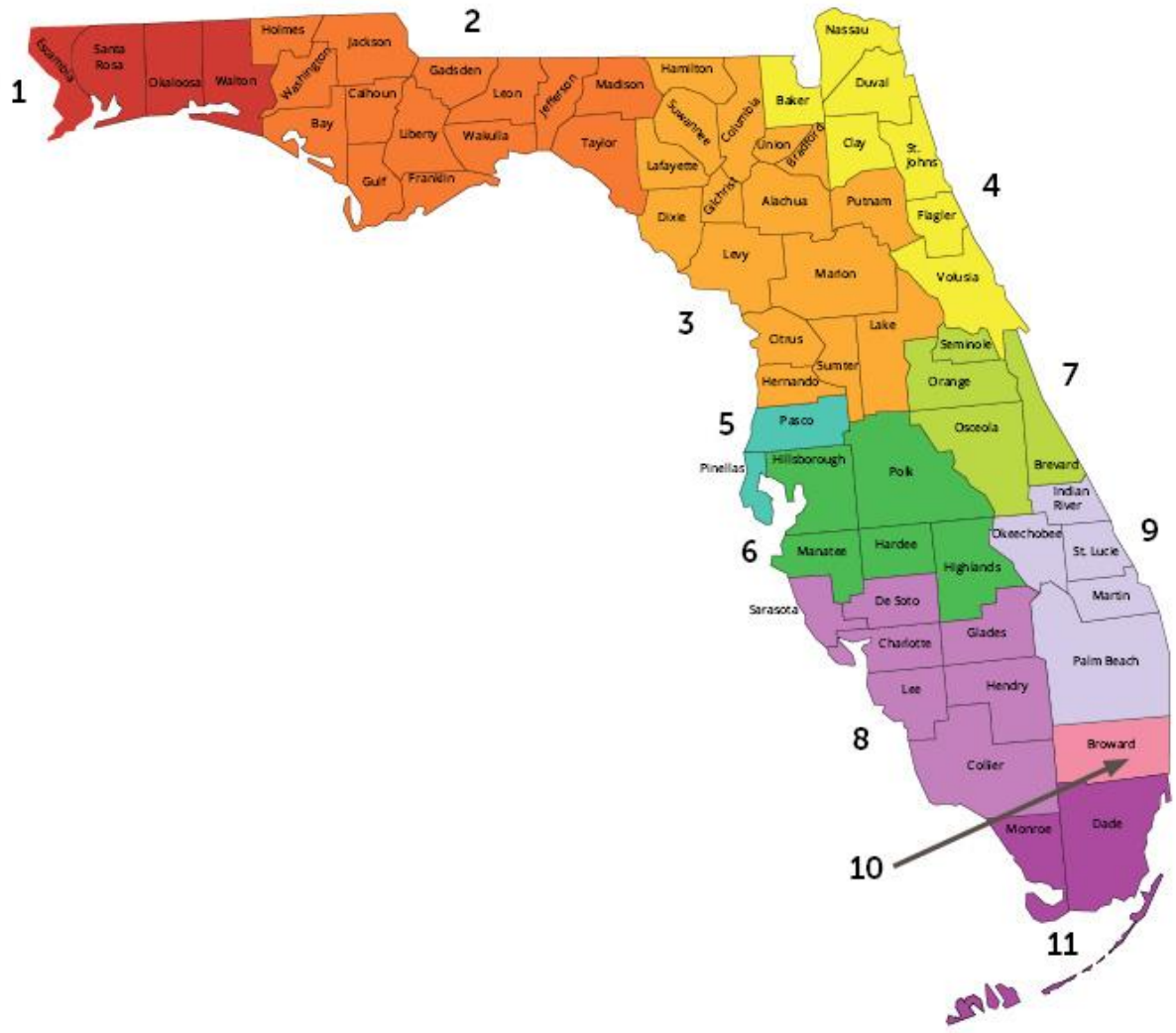
Enrollment in the SMMC Long-Term Care Program

The SMMC Long-Term Care (LTC) program provides nursing facility services and home and community-based care to elders and adults (ages 18 years and older) with disabilities. Home and community-based services help people stay in their homes, with services like help with bathing, dressing, and eating; help with chores; help with shopping; or supervision.

We pay for services that are provided at the nursing facility. If you live in a Medicaid nursing facility full-time, you are probably already in the LTC program. If you don't know, or don't think you are enrolled in the LTC program, call Member Services. We can help you.

The LTC program also provides help for people living in their home. But space is limited for these in-home services, so before you can receive these services, you must speak to someone who will ask you questions about your health. This is called a screening. The Department of Elder Affairs' Aging and Disability Resource Centers (ADRCs) complete these screenings. Once the screening is complete, the ADRC will notify you about your wait list placement or provide you with a list of resources if you are not placed on the wait list. If you are placed on the wait list and a space becomes available for you in the LTC program, the Department of Elder Affairs Comprehensive Assessment and Review for Long-Term Care Services (CARES) program will ask you to provide more information about yourself to make sure you meet other medical criteria to receive services from the LTC program. Once you are enrolled in the LTC program, we will make sure you continue to meet requirements for the program each year.

To contact your local ADRC, please visit https://elderaffairs.org/resource-directory/aging-and-disability-resource-centers-adrcs/. They can also help answer any other questions that you have about the LTC program.



Section 9: Leaving Our Plan (Disenrollment)

Leaving a plan is called **disenrolling.** By law, people cannot leave or change plans while they are locked-in except for specific reasons. If you want to leave our plan while you are locked-in, call the State's Enrollment Broker to see if you would be allowed to change plans.

You can leave our plan at any time for the following reasons (also known as **For Cause Disenrollment** reasons[1]):

- We do not cover a service for moral or religious reasons.
- You live in and get your Long-Term Care services from an assisted living facility, adult family care home, or nursing facility provider that was in our network but is no longer in our network.

You can also leave our plan for the following reasons, if you have completed our grievance and appeal process[2]:

- You receive poor quality of care, and the Agency agrees with you after they have looked at your medical records.
- You cannot get the services you need through our plan, but you can get the services you need through another plan.
- Your services were delayed without a good reason.

If you have any questions about whether you can change plans, call Member Services 1-866-899-4828 or the State's Enrollment Broker at 1-877-711-3662 (TDD 1-866-467-4970).

[1] For the full list of For Cause Disenrollment reasons, please see Florida Administrative Rule 59G-8.600: https://www.flrules.org/gateway/RuleNo.asp?title=MANAGED CARE&ID=59G-8.600

[2] To learn how to ask for an appeal, please turn to Section 15, Member Satisfaction, on page 51.

Removal from Our Plan (Involuntary Disenrollment)

The Agency can remove you from our plan (and sometimes the SMMC program entirely) for certain reasons. This is called **involuntary disenrollment**. These reasons include:

- You lose your Medicaid eligibility.
- You move outside of where we operate, or outside the State of Florida
- You knowingly use your Plan ID card incorrectly or let someone else use your Plan ID card.
- You fake or forge prescriptions.
- You or your caregivers behave in a way that makes it hard for us to provide you with care.
- You are in the LTC program and live in an assisted living facility or adult family care home that is not home-like and you will not move into a facility that is home-like[3]

If the Agency removes you from our plan because you broke the law or for your behavior, you cannot come back to the SMMC program.

Section 10: Managing Your Care

If you have a medical condition or illness that requires extra support and coordination, we may assign a case manager to work with you. Your case manager will help you set your healthcare goals, understand the treatment your providers have recommended, and get the services you need. The case manager will work with your other providers and community resources to manage your health care. If we provide you with a case manager and you do not want one, call Member Services to let us know.

Case managers can help you get services that are on your plan of care. Case management members often have several conditions, see several doctors, have a new diagnosis, or need help arranging services the doctor has ordered. CCP case managers assist in coordinating health services and community resources working in collaboration with the social work team to connect you to resources in your community. This can include services like food banks, WIC services, or housing support. If you or a loved one think case management may be able to help, call our Member Services department at 1-866-899-4828 TTY/TDD 711 for more information. You can ask to speak to a Care Coordinator.

If you are in the LTC program, we will assign you a case manager. You must have a case manager if you are in the LTC program. Your case manager is your go-to person and is responsible for **coordinating your care**. This means they are the person who will help you figure out what LTC services you need and how to get them.

[3] This is for Long-Term Care program enrollees only. If you have questions about your facility's compliance with this federal requirement, please call Member Services or your case manager.

If you have a problem with your care, or something in your life changes, let your case manager know and they will help you decide if your services need to change to better support you.

Changing Case Managers

If you want to choose a different case manager, call Member Services. There may be times when we will have to change your case manager. If we need to do this, we will send a letter or notify you via phone call to let you know and we may give you a call.

Important Things to Tell Your Case Manager

If something changes in your life or you don't like a service or provider, let your case manager know. You should tell your case manager if:

- You don't like a service.
- You have concerns about a service provider.
- Your services aren't right.
- You get new health insurance.
- You go to the hospital or emergency room.
- Your caregiver can't help you anymore.
- Your living situation changes.
- Your name, telephone number, address, or county changes

Request to Put Your Services on Hold

If something changes in your life and you need to stop your service(s) for a while, let your case manager know. Your case manager will ask you to fill out and sign a Consent for Voluntary Suspension Form to put your service(s) on hold. You can resume your case management services at any time by calling your case manager or Member Services.

Section 11: Accessing Services

Before you get a service or go to a health care appointment, we must make sure you need the service and that it is medically right for you. This is called **prior authorization.** To do this, we look at your medical history and information from your doctor or other health care providers. Then we will decide if that service can help you. We use rules from the Agency to make these decisions.

Providers in Our Plan

For the most part, you must use doctors, hospitals, and other health care providers that are in our **provider network**. Our provider network is the group of doctors, therapists, hospitals, facilities, and other health care providers that we work with. You can choose from any provider in our provider network. This is called your **freedom of choice**. If you use a health care provider that is not in our network, you may have to pay for that appointment or service**.**

You will find a list of providers that are in our network in our provider directory. If you want a copy of the provider directory, call 1-866-899-4828 to get a copy or visit our website at www.ccpcares.org. To get information about providers in our plan, call 1-866-899-4828. | TTY/TDD 711

If you are in the LTC program, your case manager is the person who will help you choose a service provider who is in our network for each of your services. Once you choose a service provider, they will contact them to begin your services. This is how services are **approved** in the LTC program. Your case manager will work with you, your family, your caregivers, your doctors, and other providers to make sure that your LTC services work with your medical care and other parts of your life.

Providers Not in Our Plan

There are some services that you may be able to get from providers who are not in our provider network. These services are:

- Family planning services and supplies
- Women's preventative health services, such as breast exams, screenings for cervical cancer, and prenatal care
- Treatment of sexually transmitted diseases
- Emergency care

If we cannot find a provider in our provider network for these services, we will help you find another provider that is not in our network. Remember to check with us first before you use a provider that is not in our provider network. If you have questions, call Member Services.

When We Pay for Your Dental Services

Your dental plan will cover most of your dental services, but some services may be covered by Community Care Plan. Contact Member Services at 1-866-899-4828 for help with arranging these services.

What Do I Have to Pay For?

You may have to pay for appointments or services that are not covered**.** A **covered service** is a service we must provide in the Medicaid program. All the services listed in this handbook are covered services. Remember, just because a service is covered, does not mean you will need it. You may have to pay for services if we did not approve it first.

If you get a bill from a provider, call Member Services. Do not pay the bill until you have spoken to us. We will help you.

Services for Children[4]

We must provide all medically necessary services for our members who are ages 0 – 20 years old. This is the law. This is true even if we do not cover a service or the service has a limit. As long as your child's services are medically necessary, services have:

- No dollar limits; or
- No time limits, like hourly or daily limits

Your provider may need to ask us for approval before giving your child the service. Call Member Services if you want to know how to ask for these services.

Services Covered by the Medicaid Fee-for-Service Delivery System, Not Covered Through Community Care Plan

The Medicaid fee-for-service program is responsible for covering the following services, instead of Community Care Plan covering these services:

- County Health Department (CHD) Certified Match Program
- Developmental Disabilities Individual Budgeting (iBudget) Home and Community-Based Services Waiver
- Familial Dysautonomia (FD) Home and Community-Based Services Waiver
- Hemophilia Factor-related Drugs
- Intermediate Care Facility Services for Individuals with Intellectual Disabilities (ICF/IID)
- Medicaid Certified School Match (MCSM) Program
- Model Home and Community-Based Services Waiver
- Newborn Hearing Services
- Prescribed Pediatric Extended Care
- Substance Abuse County Match Program

This Agency webpage provides details about each of the services listed above and how to access these services:
http://ahca.myflorida.com/Medicaid/Policy_and_Quality/Policy/Covered_Services_HCBS_Waivers.shtml.

Moral or Religious Objections

If we do not cover a service because of a religious or moral reason, we will tell you that the service is not covered. In these cases, you must call the State's Enrollment Broker at 1-877-711-3662 (TDD 1-866-467-4970). The Enrollment Broker will help you find a provider for these services.

[4] Also known as "Early and Periodic Screening, Diagnosis, and Treatment" or "EPSDT" requirements.

Section 12: Helpful Information About Your Benefits

Choosing a Primary Care Provider (PCP)

If you have Medicare, please contact the number on your Medicare ID card for information about your PCP.

One of the first things you will need to do when you enroll in our plan is choose a PCP. This can be a doctor, nurse practitioner, or a physician assistant. You will contact your PCP to make an appointment for services such as regular check-ups, shots (immunizations), or when you are sick. Your PCP will also help you get care from other providers or specialists. This is called a **referral**. You can choose your PCP by calling Member Services.

You can choose a different PCP for each family member, or you can choose one PCP for the entire family. If you do not choose a PCP, we will assign a PCP for you and your family.

You can change your PCP at any time. To change your PCP, call Member Services.

Choosing a PCP for Your Child

You can pick a PCP for your baby before your baby is born. We can help you with this by calling Member Services. If you do not pick a PCP by the time your baby is born, we will pick one for you. If you want to change your baby's PCP, call us.

It is important that you select a PCP for your child to make sure they get their well child visits each year. Well child visits are for children 0 – 20 years old. These visits are regular check-ups that help you and your child's PCP know what is going on with your child and These visits can help find problems and keep your child healthy.[5] You do not need a referral for well child visits. Also, there is no charge for well child visits.

Specialist Care and Referrals

Sometimes, you may need to see a provider other than your PCP for medical problems like special conditions, injuries, or illnesses. Talk to your PCP first. Your PCP will refer you to a **specialist**. A specialist is a provider who works in one health care area.

If you have a case manager, make sure you tell your case manager about your **referrals**. The case manager will work with the specialist to get you care.

Second Opinions

You have the right to get a **second opinion** about your care. This means talking to a different provider to see what they have to say about your care. The second provider will give you their point of view. This may help you decide if certain

[5] For more information about the screenings and assessments that are recommended for children, please refer to the "Recommendations for Preventative Pediatric Health Care – Periodicity Schedule" at Periodicity Schedule (aap.org).

services or treatments are best for you. There is no cost to you to get a second opinion.

Your PCP, case manager or Member Services can help find a provider to give you a second opinion. You can pick any of our providers. If you are unable to find a provider with us, we will help you find a provider that is not in our provider network. If you need to see a provider that is not in our provider network for the second opinion, we must approve it before you see them.

Urgent Care

Urgent Care is not Emergency Care. Urgent Care is needed when you have an injury or illness that must be treated within 48 hours. Your health or life are not usually in danger, but you cannot wait to see your PCP, it is after your PCP's office has closed, or you are out of the service area.

If you need Urgent Care after office hours and you cannot reach your PCP, call the 24/7 Nurse Help Line at 1-855-541-6404.

You may also find the closest Urgent Care center to you by calling Member Services at 1-866-899-4828 or going to website www.ccpcares.org and using our provider directory.

Hospital Care

If you need to go to the hospital for an appointment, surgery or overnight stay, your PCP will set it up. We must approve services in the hospital before you go, except for emergencies. We will not pay for hospital services unless we approve them ahead of time or it is an emergency. If you have a case manager, they will work with you and your provider to put services in place when you go home from the hospital.

Emergency Care

You have an **emergency** medical condition when you are so sick or hurt that your life or health is in danger if you do not get medical help right away. Some examples are:

- Broken bones
- Bleeding that will not stop
- You are pregnant, in labor and/or bleeding
- Trouble breathing
- Suddenly unable to see, move, or talk

Emergency services are those services that you get when you are very ill or injured. These services try to keep you alive or to keep you from getting worse. They are usually delivered in an emergency room.

If your condition is severe, call 911 or go to the closest emergency facility right away. You can go to any hospital or emergency facility. If you are not sure if it is an emergency, call your PCP. Your PCP will tell you what to do.

The hospital or facility does not need to be part of our provider network or in our service area. You also do not need to get approval ahead of time to get emergency care or for the services that you receive in an emergency room to treat your condition.

If you have an emergency when you are away from home, get the medical care you need. Be sure to call Member Services when you are able and let us know.

Filling Prescriptions

We cover many different types of medications. We have a list of drugs that we cover called our **Preferred Drug List or PDL**. You can find this list on our website at https://ccpcares.org/Members/Medicaid/Pharmacy or by calling Customer Experience at 1-866- 899-4828.

We cover **brand name** and **generic** drugs. Generic drugs have the same ingredients as brand name drugs, but they are often cost less than brand name drugs. They work the same to improve your health. Sometimes, the pharmacy preferred drug list will pay for you use the brand product over the generic. These brand products are called preferred brand products on the drug list. If a provider writes a prescription for a generic and the drug formulary prefers the brand the pharmacy can assist you with changing the prescription to the brand product.

We have many pharmacies in our provider network. You can fill your prescription at any pharmacy that is in our provider network. Make sure to bring your Plan ID card with you to the pharmacy.

The list of covered drugs may change from time to time, but we will let you know if anything changes.

Specialty Pharmacy Information

The preferred drug list (PDL) contains specialty drugs. Specialty drugs are drugs that cannot be found in the regular pharmacy and come from a “specialty” pharmacy. These drugs usually require prior authorization before you can receive them. Specialty pharmacies are available to you through our pharmacy provider network. Prescriptions for specialty drugs will automatically be enrolled with Prime Rx specialty pharmacy. Prime Rx Specialty pharmacy is one of CCP’s partners in care. Members can change to a different specialty pharmacy by calling Prime Rx Specialty at 1-800-424-7906.

Behavioral Health Services
There are times when you may need to speak to a therapist or counselor, for example, if you are having any of the following feelings or problems:

- Always feeling sad
- Not wanting to do the things that you used to enjoy
- Feeling worthless
- Having trouble sleeping
- Not feeling like eating
- Alcohol or drug abuse
- Trouble in your marriage
- Parenting concerns

We cover many different types of behavioral health services that can help with issues you may be facing. You can call a behavioral health provider for an appointment. You can get help finding a behavioral health provider by:

- Calling Community Care Plan at 1-866-899-4828 | TTY/TDD 711
- Looking at our Provider Directory
- Going to our website at www.ccpcares.org

Someone is there to help you 24 hours a day, 7 days a week.

You do not need a referral from your PCP for behavioral health services.

If you are thinking about hurting yourself or someone else, call 911. You can also go to the nearest emergency room or crisis stabilization center, even if it is outside of our service area. Once you are in a safe place, call your PCP if you can. Follow up with your provider within 24-48 hours. If you get emergency care outside of the service area, we will make plans to transfer you to a hospital or provider that is in our plan's network once you are stable.

Member Reward Programs
We offer reward programs to help keep you healthy and live a healthier life. We call these **healthy behavior programs**. You can earn rewards while for taking care of your health. Our plan offers rewards for completing visits and programs like:

- Completing the "Health Snapshot"
- Well Visits
- Pregnancy and/or Postpartum Care
- Follow-up after a Visit for a Behavioral Health Need
- Tobacco Quit Classes
- Weight Loss
- Alcohol and Substance Abuse Recovery

Please remember that rewards cannot be transferred. If you leave our Plan for more than 180 days, you may not receive your reward. If you have questions or want to learn more, please call us 1-866-899-4828 | TTY/TDD 711. You can also visit: Community Care Plan - Healthy Rewards (ccpcares.org) for everything you need to know..

Chronic Disease Management Programs
We have special programs available that will help you if you have one of these conditions.

We have special programs available that are designed to help you manage more complex diseases and the effects they have on your life and health. CCP chronic disease management staff provides education, support, community resources, and communication with your doctor and other specialists. These programs, for the conditions listed below, are available to you by referral from your health care professional, your case manager, your family, or caregiver, or you can simply ask for them yourself by calling Member Services at 1-866-899-4828 TTY/TDD 711. If you qualify, but change your mind later, you may always choose to stop your participation in the program by calling Member Services or speaking to the Case Manager who is working with you on the program.

- Cancer and Cancer Prevention
- Diabetes and Diabetes Prevention
- Depression and Depression Prevention
- Bipolar Disorder and Bipolar Prevention
- Congestive Heart Failure
- HIV/AIDS
- Hypertension
- Asthma
- Behavioral Health
- Substance Use
- Sickle Cell
- Alzheimer/Dementia
- Schizophrenia

Quality Enhancement Programs
We want you to get quality health care. We offer additional programs that help make the care you receive better. The programs are:

- Case Management/Care Coordination Services – Our program is available to all members. It helps members understand their needs and coordinate services. Please call Member Services at 1-866-899-4828 for help with:
    - Finding a doctor
    - Educational information about your health
    - Information about community resources
    - Making appointments for your wellness care
    - Getting transportation

- Children's Programs – Wellness and Prevention Services
- Domestic Violence – Referral to community agencies
- Pregnancy Prevention – Available to all members
- Prenatal/ Postpartum Pregnancy Program – Our Before Baby & Beyond program helps pregnant CCP members with everything from finding a doctor to birth planning to baby supplies and more. Please call Member Services at 1-866-899-4828 for help with:
    - Finding a doctor for you and your baby
    - Making early prenatal care and postpartum appointments
    - Educational facts and info about caring for your baby, safety, and breastfeeding
    - Getting transportation
    - Baby supplies, food, prenatal classes, housing, and breastfeeding help
    - Making delivery plans
    - Healthy Start Services – Case management and coordination for pregnant woman and infants
    - Nutritional Assessment/Counseling
    - Behavioral Health Programs

You can access these programs by calling Community Care Plan at 1-866-899-4828 and speaking to a Case Manager.

You also have a right to tell us about changes you think we should make.

To get more information about our quality enhancement program or to give us your ideas, call Member Services.

Section 13: Your Plan Benefits: Managed Medical Assistance Services

The table below lists the medical services that are covered by our Plan. Remember, you may need a referral from your PCP or approval from us before you go to an appointment or use a service. Services must be medically necessary for us to pay for them[6].

There may be some services we do not cover but might be covered by Medicaid. There are some services your State has determined are medically appropriate and can be provided in place of a covered service or setting under the State plan. These are called "In Lieu of Services (ILOS)." To find out about these benefits, call the Agency Medicaid Help Line at 1-877-254-1055. If you need a ride to any of these services, we can help you. You can call ModivCare at 1-866-306-9358 to schedule a ride.

[6] You can find the definition for Medical Necessity in the Definitions Policy at https://ahca.myflorida.com/medicaid/rules/adopted-rules-general-policies

If there are changes in covered services or other changes that will affect you, we will notify you in writing at least 30 days before the date the change takes place.

If you have questions about any of the covered medical services, please call Member Services.

Standard Benefits

Service	Description	Coverage/Limitations	Plan OK Needed?
Addictions Receiving Facility Services	Services used to help people who are struggling with drug or alcohol addiction.	We cover as medically necessary and recommended by CCP.	Plan OK needed.
Allergy Services	Services to treat conditions such as sneezing or rashes that are not caused by an illness.	We cover as medically necessary: • Blood or skin allergy testing • Up to 156 doses per year of allergy shots	Plan OK needed.
Ambulance Transportation Services	Ambulance services are for when you need emergency care while being transported to the hospital or special support when being transported between facilities.	We cover as medically necessary.	No plan OK needed.
Ambulatory Surgical Center Services	Surgery and other procedures that are performed in a facility that is not the hospital (outpatient).	We cover as medically necessary.	Plan OK needed.
Anesthesia Services	Services to keep you from feeling pain during surgery or other medical procedures	We cover as medically necessary.	Plan OK needed.

Service	Description	Coverage/Limitations	Plan OK Needed?
Assistive Care Services	Services provided to adults (ages 18 and older) help with activities of daily living and taking medication.	We cover 365/366 days of services per year, as medically necessary.	No plan OK needed when services are rendered in an Assisted Living Facility, Adult family care home, or Residential treatment facility.
Behavioral Health Assessment Services	Services used to detect or diagnose mental illnesses and behavioral health disorders.	We cover, as medically necessary: • One initial assessment per year • One reassessment per year • Up to 150 minutes of brief behavioral health status assessments (no more than 30 minutes in a single day)	No plan OK needed for initial 15 hours.
Behavioral Health Overlay Services	Behavioral health services provided to children (ages 0 – 18) enrolled in a DCF program.	We cover 365/366 days of including therapy, support services and aftercare planning, per year, as medically necessary.	Plan OK needed for certain services.
Behavioral Health Services – Child Welfare	A special mental health program for children enrolled in a DCF program.	We cover as medically necessary and recommended by CCP.	Plan OK needed for certain services.
Cardiovascular Services	Services that treat the heart and circulatory (blood vessels) system.	We cover the following as prescribed by your doctor, when medically necessary: • Cardiac testing • Cardiac surgical procedures • Cardiac devices	Plan OK needed for certain invasive services.

Service	Description	Coverage/Limitations	Plan OK Needed?
Child Health Services Targeted Case Management	Services provided to children (ages 0 - 3) to help them get health care and other services OR Services provided to children (ages 0 – 20) who use medical foster care services.	Your child must be enrolled in the DOH Early Steps program Or your child must be receiving medical foster care services.	No plan OK needed.
Chiropractic Services	Diagnosis and manipulative treatment of misalignments of the joints, especially the spinal column, which may cause other disorders by affecting the nerves, muscles, and organs.	We cover, as medically necessary: • 24 patient visits per year, per member • X-rays	Plan OK needed after 24 visits per year, up to a maximum of 37 visits.
Clinic Services	Health care services provided in a county health department, federally qualified health center, or a rural health clinic.	We cover as medically necessary.	No plan OK needed.
Dialysis Services	Medical care, tests, and other treatments for the kidneys. This service also includes dialysis supplies, and other supplies that help treat the kidneys.	We cover as prescribed by your treating doctor, as medically necessary: • Hemodialysis treatments Peritoneal dialysis treatments	Plan OK needed.

Service	Description	Coverage/Limitations	Plan OK Needed?
Durable Medical Equipment and Medical Supplies Services	Medical equipment is used to manage and treat a condition, illness, or injury. Durable medical equipment is used over and over again, and includes things like wheelchairs, braces, crutches, and other items. Medical supplies are items meant for one-time use and then thrown away.	We cover as medically necessary. Some service and age limits apply. Call 1-866-899-4828 for more information.	Plan OK needed for some Durable Medical Equipment and Medical Supplies Services.
Early Intervention Services	Services to children ages 0 - 3 who have developmental delays and other conditions.	We cover as medically necessary: • One initial evaluation per lifetime, completed by a team • Up to 3 screenings per year • Up to 3 follow-up evaluations per year Up to 2 training or support sessions per week	No plan OK needed.
Emergency Transportation Services	Transportation provided by ambulances or air ambulances (helicopter or airplane) to get you to a hospital because of an emergency.	We cover as medically necessary.	No plan OK needed.

Service	Description	Coverage/Limitations	Plan OK Needed?
Evaluation and Management Services	Services for doctor's visits to stay healthy and prevent or treat illness.	We cover as medically necessary: • One adult health screening (check-up) per year • Well child visits are provided based on age and developmental needs • One visit per month for people living in nursing facilities Up to two office visits per month for adults to treat illnesses or conditions	No plan OK needed.
Family Therapy Services	Services for families to have therapy sessions with a mental health professional.	We cover as medically necessary up to 26 hours per year.	No plan OK needed for up to 9 hours.
Gastrointestinal Services	Services to treat conditions, illnesses, or diseases of the stomach or digestion system.	We cover as medically necessary.	Plan OK needed for invasive procedures.
Genitourinary Services	Services to treat conditions, illnesses, or diseases of the genitals or urinary system.	We cover as medically necessary.	Plan OK needed for invasive procedures.
Group Therapy Services	Services for a group of people to have therapy sessions with a mental health professional.	We cover medically necessary up to 39 hours per year.	No plan OK needed for up to 9 hours.

Service	Description	Coverage/Limitations	Plan OK Needed?
Hearing Services	Hearing tests, treatments and supplies that help diagnose or treat problems with your hearing. This includes hearing aids and repairs.	We cover hearing tests and the following as prescribed by your doctor, when medically necessary: • Cochlear implants • One new hearing aid per ear, once every 3 years • Repairs	Plan OK needed for cochlear implants.
Home Health Services	Nursing services and medical assistance provided in your home to help you manage or recover from a medical condition, illness, or injury.	We cover when medically necessary: • Up to 4 visits per day for pregnant recipients and recipients ages 0-20 • Up to 3 visits per day for all other recipients	Plan OK needed.
Hospice Services	Medical care, treatment, and emotional support services for people with terminal illnesses or who are at the end of their lives to help keep them comfortable and pain free. Support services are also available for family members or caregivers	We cover as medically necessary.	Plan OK needed.
Individual Therapy Services	Services for people to have one-to-one therapy sessions with a mental health professional.	We cover as medically necessary up to 26 hours per year.	No plan OK needed.

Service	Description	Coverage/Limitations	Plan OK Needed?
Inpatient Hospital Services	Medical care that you get while you are in the hospital. This can include any tests, medicines, therapies and treatments, visits from doctors and equipment that is used to treat you.	We cover these inpatient hospital services based on age and situation, as medically necessary: • Up to 365/366 days for recipients ages 0-20 • Up to 45 days for all other recipients (extra days are covered for emergencies)	Plan OK needed.
Integumentary Services	Services to diagnose or treat skin conditions, illnesses, or diseases.	We cover as medically necessary.	Plan OK needed for invasive procedures.
Laboratory Services	Services that test blood, urine, saliva, or other items from the body for conditions, illnesses, or diseases.	We cover as medically necessary.	Plan OK needed for genetic testing.
Medical Foster Care Services	Services that help children with health problems who live in foster care homes.	Must be in the custody of the Department of Children and Families.	No plan OK needed.
Medication Assisted Treatment Services	Services used to help people who are struggling with drug addiction	We cover as medically necessary.	No plan OK needed.
Medication Management Services	Services to help people understand and make the best choices for taking medication	We cover as medically necessary.	No plan OK needed.
Mental Health Targeted Case Management	Services to help get medical and behavioral health care for people with mental illnesses	We cover as medically necessary.	No plan OK needed.

Service	Description	Coverage/Limitations	Plan OK Needed?
Neurology Services	Services to diagnose or treat conditions, illnesses or diseases of the brain, spinal cord, or nervous system.	We cover as medically necessary.	Plan OK needed for some procedures.
Non-Emergency Transportation Services	Transportation to and from all your medical appointments. This could be on the bus, a van that can transport disabled people, a taxi, or other kinds of vehicles.	We cover the following services for recipients who have no transportation: • Out-of-state travel • Transfers between hospitals or facilities Escorts when medically necessary	No plan OK needed.
Nursing Facility Services	Medical care or nursing care that you get while living full-time in a nursing facility. This can be a short-term rehabilitation stay or long-term	We cover 365/366 days of services in nursing facilities as medically necessary.	No plan OK needed.
Occupational Therapy Services	Occupational therapy includes treatments that help you do things in your daily life, like writing, feeding yourself, and using items around the house	For children ages 0 - 20 and for adults under the $1,500 outpatient services cap, we cover as medically necessary: • One initial evaluation per year • Up to 210 minutes of treatment per week • One initial wheelchair evaluation per 5 years For people of all ages, we cover, as medically necessary: Follow-up wheelchair evaluations, one at delivery and one 6-months later	Plan OK needed.

Service	Description	Coverage/Limitations	Plan OK Needed?
Oral Surgery Services	Services that provide teeth extractions (removals) and to treat other conditions, illnesses or diseases of the mouth and oral cavity.	We cover as medically necessary.	Plan OK needed for some procedures.
Orthopedic Services	Services to diagnose or treat conditions, illnesses or diseases of the bones or joints.	We cover as medically necessary.	Plan OK needed for Invasive procedures and advanced imaging services (such as MRI or CAT scan).
Outpatient Hospital Services	Medical care that you get while you are in the hospital but are not staying overnight. This can include any tests, medicines, therapies and treatments, visits from doctors and equipment that is used to treat you.	We cover as medically necessary: • Emergency services Non-emergency services cannot cost more than $1,500 per year for recipients ages 21 and over	Plan OK needed for some invasive procedures and overnight hospital observation.
Pain Management Services	Treatments for long-lasting pain that does not get better after other services have been provided	We cover as medically necessary.	Plan OK needed for some invasive procedures.

Service	Description	Coverage/Limitations	Plan OK Needed?
Physical Therapy Services	Physical therapy includes exercises, stretching and other treatments to help your body get stronger and feel better after an injury, illness or because of a medical condition	For children ages 0 - 20 and for adults under the $1,500 outpatient services cap, we cover, as medically necessary: • One initial evaluation per year • Up to 210 minutes of treatment per week • One initial wheelchair evaluation per 5 years For people of all ages, we cover, as medically necessary: • Follow-up wheelchair evaluations, one at delivery and one 6-months later	Plan OK needed except for initial evaluation and re-evaluations.
Podiatry Services	Medical care and other treatments for the feet	We cover as medically necessary: • Up to 24 office visits per year • Foot and nail care • X-rays and other imaging for the foot, ankle, and lower leg Surgery on the foot, ankle, or lower leg	Plan OK needed for invasive surgery.
Prescribed Drug Services	This service is for drugs that are prescribed to you by a doctor or other health care provider	We cover as medically necessary: • Up to a 34-day supply of drugs, per prescription Refills, as prescribed	Plan OK needed for some medications. No copay for covered medications.
Private Duty Nursing Services	Nursing services provided in the home to people ages 0 to 20 who need constant care.	We cover up to 24 hours per day, as medically necessary.	Plan OK needed.

Service	Description	Coverage/Limitations	Plan OK Needed?
Psychological Testing Services	Tests used to detect or diagnose problems with memory, IQ, or other areas.	We cover, as medically necessary, 10 hours of psychological testing per year.	No Plan OK needed.
Psychosocial Rehabilitation Services	Services to assist people re-enter everyday life. They include help with basic activities such as cooking, managing money and performing household chores.	We cover up to 480 hours per year, as medically necessary.	No Plan OK needed for up to 240 hours.
Radiology and Nuclear Medicine Services	Services that include imaging such as x-rays, MRIs, or CAT scans. They also include portable x-rays.	We cover as medically necessary.	Plan OK needed for advanced imaging such as MRI or CAT scans. No Plan OK needed for x-rays.
Regional Perinatal Intensive Care Center Services	Services provided to pregnant women and newborns in hospitals that have special care centers to handle serious conditions.	We cover as medically necessary.	No Plan OK needed.
Reproductive Services	Services for women who are pregnant or want to become pregnant. They also include family planning services that provide birth control drugs and supplies to help you plan the size of your family.	We cover family planning services, as medically necessary. You can get these services and supplies from any Medicaid provider; they do not have to be a part of our Plan. These services are free. These services are voluntary and confidential, even if you are under 18 years old.	No plan OK needed.

Service	Description	Coverage/Limitations	Plan OK Needed?
Respiratory Services	Services that treat conditions, illnesses or diseases of the lungs or respiratory system.	We cover as medically necessary: • Respiratory testing • Respiratory surgical procedures Respiratory device management	Plan OK needed for some invasive procedures and devices.
Specialty Psychiatric Hospitals	In lieu of Inpatient Psychiatric Hospital	We cover as medically necessary and recommended by CCP.	No plan OK needed.
Specialized Therapeutic Services	Services provided to children ages 0-20 with mental illnesses or substance use disorders.	We cover, as medically necessary: • Assessments • Foster care services • Group home services	Plan OK needed.
Speech-Language Pathology Services	Services that include tests and treatments help you talk or swallow better.	For children ages 0-20, we cover, as medically necessary: • Communication devices and services • Up to 210 minutes of treatment per week • One initial evaluation per year For adults, we cover, as medically necessary: • One communication evaluation per 5 years	Plan OK needed except for initial evaluation and re-evaluations
Statewide Inpatient Psychiatric Program Services	Services for children with severe mental illnesses that need treatment in the hospital.	As medically necessary for children ages 0-20.	Plan OK needed.
Transplant Services	Services that include all surgery and pre- and post-surgical care.	We cover as medically necessary.	Plan OK needed.

Service	Description	Coverage/Limitations	Plan OK Needed?
Visual Aid Services	Visual Aids are items such as glasses, contact lenses and prosthetic (fake) eyes.	We cover as medically necessary when prescribed by your doctor: • Two pairs of eyeglasses for children ages 0-20 • One frame every two years and two lenses every 365 days for adults ages 21 and older • Contact lenses • Prosthetic eyes	Please call iCare at 1-877-296-0799 for OK.
Visual Care Services	Services that test and treat conditions, illnesses, and diseases of the eyes.	We cover as medically necessary.	Please call iCare at 1-877-296-0799 for OK.

Expanded Benefits

Expanded benefits are extra goods or services we provide to you, free of charge. Call Member Services to ask about getting expanded benefits.

Service	Description and How to Use	Coverage/ Limitations	Plan OK Needed?
24/7 Access to Virtual Lactation & Pregnancy Support	Mobile app with 24/7 access to a live doula or lactation counselor. Call CCP Member Services or your Care Coordinator.	Must be pregnant or have had a baby in the past twelve (12) months.	Plan OK needed.
Acupuncture	Acupuncture	Must be 21 + years old.	Plan OK needed. Must get a referral from a plan Pain Specialist or Cancer doctor.
Additional PCP Visits for Adults	Visits to your primary care doctor for any reason.	No limits.	No Plan OK needed.
Adult Hearing Aid Services	Assessment for a Hearing Aid	One (1) every 2 years. Must be 21+ years old.	No Plan OK needed.

Service	Description and How to Use	Coverage/ Limitations	Plan OK Needed?
Adult Visual Aid Services	Vision aids are things like glasses or contact lenses. Call iCare at 1-877-296-0799.	Contact Lenses: 6-month supply. Frames: One (1) set of frames each year. Both include one (1) yearly eye exam.	No Plan OK needed.
Assessment/Evaluation Services – Behavioral	Evaluation and assessment for behavioral health. Call CCP Member Services.	One (1) every year. Must be 21+ years old	Plan OK needed.
Behavioral Health Day Services/ Day Treatment	Behavior Health Day Treatment	Maximum of 10 extra units per year of day treatment; one day per week up to 52 days per year of day care services. Must be 21+ years old	Plan OK needed.
Behavioral Health Medical Services (Drug Screening)	Alcohol or drug testing specimen. Call CCP Member Services.	Must be 21+ years old	No Plan OK needed.
Behavioral Health Medical Services (Medication Management)	Help with special medications for substance use disorder. Call CCP Member Services.	Must be 21+ years old	No Plan OK needed.
Behavioral Health Medical Services (Verbal Interaction)	Spoken communication for Mental Health/ Behavioral Health Medical Services, and Substance Abuse. Call CCP Member Services.	Must be 21+ years old	No Plan OK needed.
Behavioral Health Screening Services	Behavioral Health Screening Services. Call CCP Member Services.	Must be 21+ years old	No Plan OK needed.

Service	Description and How to Use	Coverage/ Limitations	Plan OK Needed?
Breast Pump	Device used by lactating mothers to pump breast milk	One Breast Pump every four (4) years	No Plan OK needed.
Breast Pump-Hospital Grade	An electronic pump used by hospitals for lactating mothers to pump breast milk	One Breast Pump (Rental Only) every year	Plan OK needed.
Cellular Phone Services	Free cell phone with minutes and texting. Call CCP Member Services.	Ages 21+ years old	Plan OK needed.
Chiropractic Services	Chiropractor visits	Thirteen (13) extra chiropractic visits per year. Ages 21+ years old	Plan OK needed. Must get a referral from a plan Pain Specialist or Cancer doctor.
Computerized Cognitive Behavioral Therapy	Health Behavior assessment or re-assessment	Ages 21+ years old	Plan OK needed.
Doula Services	Doulas are a non-medical person who supports pregnant women, before, during and after pregnancy. Call CCP Member Services or your Care Coordinator.	Unlimited for Pregnant women	No Plan OK needed.

Service	Description and How to Use	Coverage/ Limitations	Plan OK Needed?
Financial Literacy	Life coaching for money management & budgeting. Teens can also learn about saving money. Financial investment guidance, financial counseling, financial consultation, advice, tax consultation and a 25% discount on tax preparation and credit repair. See the benefits information on www.CCPcares.org to learn more.	Ages 13+ years old Community Care Plan knows that money can impact your health. We want to help. We have teamed up with KOFE: Knowledge of Financial Education to help improve the financial health of our members. You now have access to resources and tools about things like money, spending, credit, credit cards, and more. You can also call the toll-free number to talk to a financial coach. You have all the tools you need to reach your financial goals!	No Plan OK needed.
Fitness Membership	Gym or fitness allowance. Call CCP Member Services.	Ages 18+ years old	Plan OK needed.
Food Assistance	Meals delivered to your home. Call CCP Member Services.	28 meals per year. Ages 18+ years old.	Plan OK needed.
Glucose Monitoring	Device that measures blood sugar	No limits with OK	Plan OK needed.
Home Delivered Meals (Pregnant)	Meals delivered to your home if you are pregnant. Call CCP Member Service or your Care Coordinator.	2 meals per day for up to 28 days.	Plan OK needed.
Healthy Meal Delivery After Birth	Meals delivered to your home after you have a baby. Call CCP Member Services or your Care Coordinator.	2 meals per day for up to 28 days.	Plan OK needed.

Service	Description and How to Use	Coverage/ Limitations	Plan OK Needed?
Home Delivered Meals – Disaster Preparedness/ Relief	Home delivered meals before or after a natural disaster. Call CCP Member Services.	One (1) per year	Plan OK needed.
Home Delivered Meals – Post-Facility Discharge (Hospital or Nursing Facility)	Home delivered meals after going home from a hospital or nursing home stay. Call CCP Member Services.	Ten (10) meals one (1) time per year. Must be 21+ years old.	Plan OK needed.
Home Visit by a Clinical Social Worker	Services of a clinical social worker in home health or hospice setting. Call CCP Member Services.	48 visits per year	Plan OK needed.
Hospital Bed	Durable Medical Equipment	One (1) Hospital Bed every five (5) years	Plan OK needed.
Housing Assistance	Help paying for any housing related needs. Call CCP Member Services.	$250 once per lifetime. Must be 18+ years old.	Plan OK needed.
Intensive Outpatient Treatment – Behavioral	Outpatient for alcohol and/or drug treatment. Call CCP Member Services.	Unlimited if at an in-network facility. Ages 21+ years old	Plan OK needed.
Massage Therapy	Therapeutic massage	Two (2) hours per month. Must be 21 + years old.	Plan OK needed. Must get a referral from a plan Pain Specialist or Cancer doctor.

Service	Description and How to Use	Coverage/ Limitations	Plan OK Needed?
Maternal OUD/SUD Peer Support	Support from someone who has overcome opioid or substance use. Call CCP Member Services or your Care Coordinator.	Limited to pregnant women.	Plan OK needed.
Maternity New Mom Package	Portable Crib & Monitor. Call CCP Member Services or your Care Coordinator.	Must take a safe sleep class. Limited to pregnant women	Plan OK needed.
Meals – Non-Emergency Transportation Daytrips	For non-emergency care when you must travel a long distance. Call CCP Member Services.	$150 per stay. Limited to 21+ years old	Plan OK needed.
Medically Related Home Care Services/Homemaker	Carpet cleaning. Call CCP Member Services or your Care Coordinator.	Two (2) times per year. The member must have a diagnosis of asthma. Ages 21+ years old.	Plan OK needed.
Member Support including Companionship	Companionship visits and support. Visit www.CCPcares.org/Papa to learn more.	60 hours per rolling 12 months For Pregnant women and new moms up to 12 months after your baby is born.	Plan OK needed.
Newborn Circumcision	Circumcision for male infants at the initial hospitalization visit, in the physician's office, or participating outpatient facility.	One per lifetime within the first 12 weeks after birth.	No Plan OK needed.
Non-emergency Transportation – Non-Medical Purposes - up to 25 miles	Fees for tolls, parking and other for non-medical travel. Call CCP Member Services.	Ages 21+ years old	Plan OK needed.
Nutritional Counseling	Provides you with information on the right type of foods to eat based on your health needs. Call CCP Member Services.	Unlimited with in-network provider. Ages 21+ years old	Plan OK needed.

Service	Description and How to Use	Coverage/ Limitations	Plan OK Needed?
Occupational Therapy Evaluation for Adults	Evaluation for occupational therapy treatments	One per year. Ages 21+ years old	No Plan OK needed.
Over The Counter Benefit	Over the counter (OTC) medicines and medical supplies to improve health. Order online anytime at athome.medline.com/ccpfl. Call 833-660-0908 (TTY:711) OTC Benefit Service reps can help you Monday–Friday, 8 am–8 pm EST. Fill out the order form in the back of the catalog. Mail it to the address on the form. It may take up to 4 weeks to process mailed orders. Have your member ID ready when you order.	$50 per household per month.	No Plan OK needed.
Phone Application for Pregnant Women	Access to remote case management via cell phone application. Call your Care Coordinator.	For high-risk pregnancies only	Plan OK needed.
Physical Therapy for Adults	Evaluation for physical therapy treatments	One evaluation per year. Must be 21+ years old	No Plan OK needed
Prenatal Services	Visits to ensure that you and your baby are healthy during and after your pregnancy	14 visits for low-risk pregnancies 18 visits for high-risk pregnancies	No Plan OK needed
Psychosocial Rehabilitation	Psychosocial rehabilitation treatments	Unlimited with OK	Plan OK needed.

Service	Description and How to Use	Coverage/ Limitations	Plan OK Needed?
Respiratory Therapy for Adults	Respiratory therapy includes treatments to help you breathe easier when being treated for a respiratory illness or condition. Call CCP Member Services.	One (1) per year, visits after evaluation will vary based on need. Must be 21+ years old	Plan OK needed.
Social Media Safety Classes	Free classes for kids and parents to keep yourself safe online. Call CCP Member Services.	Must be 14+ years old	Plan OK needed.
Speech Therapy for Adults	Speech therapy includes treatments to help you talk or swallow better. Call CCP Member Services.	One (1) per year. Visits after evaluation will vary based on need.	Plan OK needed.
Substance Abuse Treatment or Detoxification Services (Outpatient)	Treatment for substance use or detoxification in an outpatient setting	15 days per month.	Plan OK needed.
Swimming Lessons (Drowning Prevention)	Swimming lessons for kids. Call CCP Member Services.	Covered up to $200 per year. This is limited to 1,000 members per year. Ages 3 to 18 years old.	Plan OK needed.
Targeted Case Management	Targeted Case Management. Call CCP Member Services.	Must be 21+ years old	Plan OK needed.
Therapeutic Behavioral On-Site Services	Treatment programs to stabilize symptoms of behavioral health conditions. Call CCP Member Services.	Must be 21+ years old	Plan OK needed.
Therapy - Art	Uses music, dance, or art therapies, not for recreation, to treat behavioral health conditions.	Ages 7-21 years old	Plan OK needed.

Service	Description and How to Use	Coverage/ Limitations	Plan OK Needed?
Therapy – Equine	Uses horses to treat a variety of conditions	Ten (10) sessions. Ages 7-21 years old	Plan OK needed.
Therapy – Pet	Uses animals to help people recover from or cope with health problems or mental disorders.	Must be 7+ years old	Plan OK needed.
Therapy/ Psychotherapy (Group)	Group therapy for behavioral health conditions	No limits. Must be 21+ years old.	No Plan OK needed.
Therapy/ Psychotherapy (Individual/Family)	Individual or Family therapy for behavioral health issues. Call CCP Member Services.	Two (2) additional visits per year. Must be 21+ years old	Plan OK needed.
Tutoring K-12	On-demand 24/7 tutoring services. See the benefits information on www.CCPcares.org to learn more.	2 hours per week. Ages 5-19 years old	Plan OK needed.
Tutoring, Vocational Training & Job Readiness	On-demand 24/7 tutoring for GED preparation. See the benefits information on www.CCPcares.org to learn more.	2 hours per week Must not have a High School diploma or GED certificate Ages 18+ years old	Plan OK needed.
Waived Copayments	All services including behavioral health	Ages 21+ years old	No Plan OK needed.

Expanded Benefits for SMI Members ONLY

Service	Description and How to Use	Coverage/ Limitations	Plan OK Needed?
Caregiver Support	Training and Educational Support for Caregivers of members living with serious mental illness. Call CCP Member Services.	No limits for caregivers of members over six (6) years old.	Plan OK needed.
Individual Therapy Sessions for Caregivers	Visits with a behavioral health provider for caregivers of a member with Serious mental illness. Call CCP Member Services.	12 sessions per year. For caregivers of members ages six (6) years old.	Plan OK needed.
Legal Guardianship	To help pay legal fees for services such as a power of attorney when their mental health condition makes the member unable to make decisions for themselves. Call CCP Member Services.	$500 per lifetime Ages 6+ years old.	Plan OK needed.
Member Support including Companionship	Companionship visits and support. Visit www.CCPcares.org/Papa to learn more.	60 hours per rolling 12 months. Ages 13+ years old.	Plan OK needed.
Medication Assisted Treatment Services	Methadone administration for the treatment of substance use.	Must be given by a licensed program or provider. Ages 6+ years old	No Plan OK needed.
Peer Support Counseling	Group counseling sessions with people who have successfully managed behavioral health conditions. Call CCP Member Services.	12 sessions per year of individual or group sessions.	Plan OK needed.

In Lieu of Services (ILOS)

Service	Description	Coverage/Limitations	Plan OK Needed?
Ambulatory Detoxification Services	Services provided to people who are withdrawing from drugs or alcohol.	We cover as medically necessary and recommended by CCP.	Plan OK needed.
Community-Based Wrap-Around Services	Services provided by a mental health team to children who are at risk of going into a mental health treatment facility.	We cover as medically necessary.	Plan OK needed.
Crisis Stabilization Unit Services	Emergency mental health services that are performed in a facility that is not a regular hospital.	We cover as medically necessary and recommended by CCP. 15 days per month	Plan OK needed.
Detox or Addictions Receiving Facilities	In lieu of Inpatient Detox Hospital	We cover as medically necessary and recommended by CCP. • 15 days per month	Plan OK needed.
Drop-In Center Services	Services provided in a center that helps homeless people get treatment or housing.	We cover as medically necessary.	No plan OK needed.
Family Training and Counseling for Child Development	Services to support a family during their child's mental health treatment.	We cover as medically necessary and recommended by CCP.	No plan OK needed.
Psychiatric Specialty Hospital Services	Emergency mental health services that are performed in a facility that is not a regular hospital.	We cover as medically necessary and recommended by CCP.	Plan OK needed.
Infant Mental Health Pre and Post Testing Services	Testing services by a mental health professional with special training in infants and young children.	We cover as medically necessary and recommended by CCP.	No plan OK needed.

Service	Description	Coverage/Limitations	Plan OK Needed?
Intensive Outpatient Mental Health	In lieu of inpatient hospital services	We cover as medically necessary and recommended by CCP.	Plan OK needed.
Mental Health Partial Hospitalization Program Services	Treatment provided for more than 3 hours per day, several days per week, for people who are recovering from mental illness	We cover as medically necessary and recommended by CCP.	Plan OK needed.
Mobile Crisis Assessment and Intervention Services	A team of health care professionals who provide emergency mental health services, usually in people's homes	We cover as medically necessary and recommended by CCP.	No plan OK needed.
Multisystemic Therapy Services	An intensive service focused on the family for children at risk of residential mental health treatment	We cover as medically necessary and recommended by CCP.	No plan OK needed.
Partial Hospitalization Services	Services for people leaving a hospital for mental health treatment	We cover as medically necessary and recommended by CCP.	Plan OK needed.
Self-Help/Peer Services	Services to help people who are in recovery from an addiction or mental illness	We cover as medically necessary and recommended by CCP.	No plan OK needed.
Substance Abuse Intensive Outpatient Program Services	Treatment provided for more than 3 hours per day, several days per week, for people who are recovering from substance use disorders.	We cover as medically necessary and recommended by CCP.	Plan OK needed.

Service	Description	Coverage/Limitations	Plan OK Needed?
Substance Abuse Short-term Residential Treatment (SRT)	In lieu of Inpatient Detoxification Hospital Care	Max of 15 days per event, 3 times in calendar year	Plan OK needed.

Nursing Facility Transition Assistance Benefit

Community Care Plan (CCP) offers a Nursing Facility Transition benefit to help families of children living in a nursing facility to bring their child home. The benefit will provide assistance to the children and their families to help overcome barriers preventing the child from living at home with their family.

This benefit is available for individuals currently residing in a nursing facility and are either under 21 years old or under 30 years of age and have been living in a nursing facility before turning 21 years old.

The Nursing Facility Transition benefit may include the following:

- Home renovations
- Purchase of a generator to provide power medical equipment during outages
- Home additions to give the child space for all necessary medical equipment and care needs
- Addition of an accessible bathroom
- Adaptations to or purchase of a vehicle equipped to meet the child's transportation needs
- Deposits to help with the transition (like rental security deposits or move-in fees)
- Home repairs or services to ensure a healthy living space
- Funding to help with moving costs

Eligible members may receive up to $50,000 to assist with the transition home. This benefit is a once in a lifetime.

You should talk to your case manager if you think this benefit can help. They can tell you more and help you figure out what to do next.

If you need assistance with contacting your case manager, please call Member Services at 1-866-899-4828 Monday through Friday from 8 a.m. to 7 p.m. Eastern time.

Pathways to Prosperity

The Pathways to Prosperity program help people who may have barriers to employment, economic self-sufficiency, and independence get access to care coordination and case management services. These "Hope Navigators" can people help with health-related

social needs, such as housing assistance, access to food, job training, and education support. Members can call the HOPE Florida program at 1-833-GET-HOPE.

Pathways to Purpose

The Pathways to Purpose program help seniors (over age 60) get access to care coordination and case management services. “Hope Navigators” work to equip seniors and their caregivers with assistance in identifying and overcoming barriers to identify needs and develop a path to purpose to ensure our seniors have an enhanced quality of life. To get connected to a Hope Navigator, call 1-833-GET-HOPE or email information@elderaffairs.org

Do you want to HELP? Become a HOPE Hero. Individuals can get involved in Hope Florida – A Pathway to Purpose by becoming a Hope Hero! Hope Heroes volunteer their time and services to help members in their community. Seniors helping others creates a clear pathway to purpose and enhances everyone’s quality of life. Once you sign up, a Hope Florida Coordinator will reach out to you to learn more about your personal volunteer goals and to pair you with a volunteer opportunity.

Section 14: Cost Sharing for Services

Cost sharing means the portion of costs for certain covered services that is your responsibility to pay. Cost sharing can include coinsurance, copayments, and deductibles. If you have questions about your cost sharing requirements, please contact Member Services.

Section 15: Member Satisfaction

Complaints, Grievances, and Plan Appeals

We want you to be happy with us and the care you receive from our providers. Let us know right away if at any time you are not happy with anything about us or our providers. This includes if you do not agree with a decision we have made.

	What You Can Do:	What We Will Do:
If you are not happy with us or our providers, you can file a **Complaint**	You can: • Call us at any time. at 1-866-899-4828	We will: • Try to solve your issue within 1 business day.
If you are not happy with us or our providers, you can file a **Grievance**	You can: • Write to us or call us at any time. • Call us to ask for more time to solve your grievance if you think more time will help. Community Care Plan 1643 Harrison Parkway Suite H-200 Sunrise, FL 33323 Attention: Grievance & Appeals 1-866-899-4828	We will: • Review your grievance and send you a letter with our decision within 30 days. If we need more time to solve your grievance, we will: • Send you a letter with our reason and tell you about your rights if you disagree.
If you do not agree with a decision we made about your services, you can ask for an **Appeal**	You can: • Write to us, or call us and follow up in writing, within 60 days of our decision about your services. • Ask for your services to continue within 10 days of receiving our letter, if needed. Some rules may apply. Community Care Plan 1643 Harrison Parkway Suite H-200 Sunrise, FL 33323 Attention: Grievance & Appeals 1-866-899-4828	We will: • Send you a letter within 5 business days to tell you we received your appeal. • Help you complete any forms. • Review your appeal and send you a letter within 30 days to answer you.

	What You Can Do:	What We Will Do:
If you think waiting for 30 days will put your health in danger, you can ask for an **Expedited or "Fast" Appeal**	You can: • Write to us or call us within 60 days of our decision about your services. Community Care Plan 1643 Harrison Parkway Suite H-200 Sunrise, FL 33323 Attention: Grievance & Appeals 1-866-899-4828	We will: • Give you an answer within 48 hours after we receive your request. • Call you the same day if we do not agree that you need a fast appeal and send you a letter within 2 days.
If you do not agree with our appeal decision, you can ask for a **Medicaid Fair Hearing****	You can: • Write to the Agency for Health Care Administration Office of Fair Hearings. • Ask us for a copy of your medical record. • Ask for your services to continue within 10 days of receiving our letter, if needed. Some rules may apply. *********You must finish the appeal process before you can have a Medicaid Fair Hearing.*	We will: • Provide you with transportation to the Medicaid Fair Hearing, if needed. • Restart your services if the State agrees with you. If you continued your services, we may ask you to pay for the services if the final decision is not in your favor.

Fast Plan Appeal

If we deny your request for a fast appeal, we will transfer your appeal into the regular appeal time frame of 30 days. If you disagree with our decision not to give you a fast appeal, you can call us to file a grievance.

Medicaid Fair Hearings (for Medicaid Members)
You may ask for a fair hearing at any time up to 120 days after you get a Notice of Plan Appeal Resolution by calling or writing to:

Agency for Health Care Administration
Medicaid Fair Hearing Unit
P.O. Box 60127
Ft. Myers, FL 33906
1-877-254-1055 (toll-free)
1-239-338-2642 (fax)
MedicaidFairHearingUnit@ahca.myflorida.com

If you request a fair hearing in writing, please include the following information:

- Your name
- Your member number
- Your Medicaid ID number
- A phone number where you or your representative can be reached

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

- Why you think the decision should be changed
- The service(s) you think you need
- 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 will tell you in writing that they got your fair hearing request. A hearing officer who works for the State will review the decision we made.

If you are a Title XXI MediKids member, you are not allowed to have a Medicaid Fair Hearing.

Review by the State (for MediKids Members)
When you ask for a review, a hearing officer who works for the State reviews the decision made during the Plan appeal. You may ask for a review by the State any time up to 30 days after you get the notice. **You must finish your appeal process first.**

You may ask for a review by the State by calling or writing to:

Agency for Health Care Administration
P.O. Box 60127
Ft. Myers, FL 33906
1-877 254-1055 (toll-free)
1-239-338-2642 (fax)
MedicaidHearingUnit@ahca.myflorida.com

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

Continuation of Benefits for Medicaid Members
If you are now getting a service that is going to be reduced, suspended, or terminated, you have the right to keep getting those services until a final decision is made for your **Plan appeal or Medicaid fair hearing**. If your services are continued, there will be no change in your services until a final decision is made.

If your services are continued, and our decision is not in your favor, we may ask you to 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 your appeal or fair hearing, you must file your appeal and ask to continue services within this timeframe, whichever is later:

- 10 days after you receive a Notice of Adverse Benefits Determination (NABD), or
- On or before the first day that your services will be reduced, suspended, or terminated

Section 16: Your Member Rights
As a recipient of Medicaid and a member in a Plan, you also have certain rights. You have the right to:

- Be treated with courtesy and respect
- Always have your dignity and privacy considered and respected
- Receive a quick and useful response to your questions and requests
- Know who is providing medical services and who is responsible for your care
- Know what member services are available, including whether an interpreter is available if you do not speak English
- Know what rules and laws apply to your conduct
- Be given easy to follow information about your diagnosis, and openly discuss the treatment you need, choices of treatments and alternatives, risks, and how these treatments will help you
- Participate in making choices with your provider about your health care, including the right to say no to any treatment, except as otherwise provided by law
- Be given full information about other ways to help pay for your health care
- Know if the provider or facility accepts the Medicare assignment rate
- To be told prior to getting a service how much it may cost you
- Get a copy of a bill and have the charges explained to you
- Get medical treatment or special help for people with disabilities, regardless of race, national origin, religion, handicap, or source of payment
- Receive treatment for any health emergency that will get worse if you do not get treatment
- Know if medical treatment is for experimental research and to say yes or no to participating in such research
- Make a complaint when your rights are not respected

- Ask for another doctor when you do not agree with your doctor (second medical opinion)
- Get a copy of your medical record and ask to have information added or corrected in your record, if needed
- Have your medical records kept private and shared only when required by law or with your approval
- Decide how you want medical decisions made if you can't make them yourself (advanced directive)
- To file a grievance about any matter other than a Plan's decision about your services.
- To appeal a Plan's decision about your services
- Receive services from a provider that is not part of our Plan (out-of-network) if we cannot find a provider for you that is part of our Plan
- Speak freely about your health care and concerns without any bad results
- Freely exercise your rights without the Plan or its network providers treating you badly
- Get care without fear of any form of restraint or seclusion being used as a means of coercion, discipline, convenience, or retaliation
- Receive information on beneficiary and plan information
- Obtain available and accessible services covered under the Plan (includes In Lieu of Services (ILOS))

Section 17: Your Member Responsibilities

As a recipient of Medicaid and a member in a Plan, you also have certain responsibilities. You have the responsibility to:

- Give accurate information about your health to your Plan and providers
- Tell your provider about unexpected changes in your health condition
- Talk to your provider to make sure you understand a course of action and what is expected of you
- Listen to your provider, follow instructions for care, and ask questions
- Keep your appointments, and notify your provider if you will not be able to keep an appointment
- Be responsible for your actions if treatment is refused or if you do not follow the health care provider's instructions
- Make sure payment is made for non-covered services you receive
- Follow health care facility conduct rules and regulations
- Treat health care staff and case manager with respect
- Tell us if you have problems with any health care staff
- Use the emergency room only for real emergencies
- Notify your case manager if you have a change in information (address, phone number, etc.)

- Have a plan for emergencies and access this plan if necessary for your safety
- Report fraud, abuse, and overpayment

Section 18: Other Important Information

Indian Health Care Provider (IHCP) Protection

Indians are exempt from all cost sharing for services furnished or received by an IHCP or referral under contract health services.

Emergency Disaster Plan

Disasters can happen at any time. To protect yourself and your family, it is important to be prepared. There are three steps to preparing for a disaster: 1) Be informed; 2) Make a Plan; and 3) Get a Kit. For help with your emergency disaster plan, call Member Services or your case manager. The Florida Division of Emergency Management can also help you with your plan. You can call them at 1-850-413-9969 or visit their website at www.floridadisaster.org.

Tips on How to Prevent Medicaid Fraud and Abuse:

- DO NOT share personal information, including your Medicaid number, with anyone other than your trusted providers.
- Be cautious of anyone offering you money, free or low-cost medical services, or gifts in exchange for your Medicaid information.
- Be careful with door-to-door visits or calls you did not ask for.
- Be careful with links included in texts or emails you did not ask for, or on social media platforms.

Fraud/Abuse/Overpayment in the Medicaid Program

To report suspected fraud and/or abuse in Florida Medicaid, call the Consumer Complaint Hotline toll-free at 1-888-419-3456 or complete a Medicaid Fraud and Abuse Complaint Form, which is available online at:

https://apps.ahca.myflorida.com/mpi-complaintform/

You can also report fraud and abuse to us directly by contacting the plans Compliance Officer at 1-954-622-3482 or by writing to:

Community Care Plan
ATT: Compliance officer
1643 Harrison Parkway
Suite 200
Sunrise, FL 33323

Abuse/Neglect/Exploitation of People
You should never be treated badly. It is never okay for someone to hit you or make you feel afraid. You can talk to your PCP or case manager about your feelings.

If you feel that you are being mistreated or neglected, you can call the Abuse Hotline at 1-800-96-ABUSE (1-800-962-2873) or for TTY/TDD 711.

You can also call the hotline if you know of someone else that is being mistreated.

Domestic Violence is also abuse. Here are some safety tips:

- If you are hurt, call your PCP
- If you need emergency care, call 911 or go to the nearest hospital. For more information, see the section called EMERGENCY CARE
- Have a plan to get to a safe place (a friend's or relative's home)
- Pack a small bag, give it to a friend to keep for you

If you have questions or need help, please call the National Domestic Violence Hotline toll free at 1-800-799-7233 (TTY 1-800-787-3224).

Advance Directives
An **advance directive** is a written or spoken statement about how you want medical decisions made if you can't make them yourself. Some people make advance directives when they get very sick or are at the end of their lives. Other people make advance directives when they are healthy. You can change your mind and these documents at any time. We can help you get and understand these documents. They do not change your right to quality health care benefits. The only purpose is to let others know what you want if you can't speak for yourself.

1. A Living Will
2. Health Care Surrogate Designation
3. An Anatomical (organ or tissue) Donation

You can download an advanced directive form from this website: https://quality.healthfinder.fl.gov/report-guides/advance-directives.

Make sure that someone, like your PCP, lawyer, family member, or case manager knows that you have an advance directive and where it is located.

If there are any changes in the law about advance directives, we will let you know within 90 days. You don't have to have an advance directive if you do not want one.

If your provider is not following your advance directive, you can file a complaint with Member Services at 1-866-899-4828 or the Agency by calling 1-888-419-3456.

Getting More Information

You have a right to ask for information. Call Member Services or talk to your case manager about what kinds of information you can receive for free. Some examples are:

- Your member record
- A description of how we operate
- How we make sure we keep getting better at what we do (Quality Improvement Program)
- How we measure the quality of our services (Performance Measures)

You can also visit our website: https://ccpcares.org/Members/Medicaid

Section 19: Additional Resources

Floridahealthfinder.gov

The Agency is committed to its mission of providing "Better Health Care for All Floridians". The Agency has created a website www.FloridaHealthFinder.gov where you can view information about Florida home health agencies, nursing facilities, assisted living facilities, ambulatory surgery centers and hospitals. You can find the following types of information on the website:

- Up-to-date licensure information
- Inspection reports
- Legal actions
- Health outcomes
- Pricing
- Performance measures
- Consumer education brochures
- Living wills
- Quality performance ratings, including member satisfaction survey results

The Agency collects information from all Plans on different performance measures about the quality of care provided by the Plans. The measures allow the public to understand how well Plans meet the needs of their members. To see the Plan report cards, please visit https://quality.healthfinder.fl.gov/Facility-Provider/Medicaid-ReportCard?&type=-13.

Elder Housing Unit

The Elder Housing Unit provides information and technical assistance to elders and community leaders about affordable housing and assisted living choices. The Florida Department of Elder Affairs maintains a website for information about assisted living facilities, adult family care homes, adult day care centers and nursing facilities at https://elderaffairs.org/programs-services/housing-options/ as well as links to additional Federal and State resources.

MediKids Information

For information on MediKids coverage, please visit:
http://ahca.myflorida.com/medicaid/Policy_and_Quality/Policy/program_policy/FLKidCare/MediKids.shtml

Aging and Disability Resource Center

You can also find additional information and assistance on State and federal benefits, local programs and services, legal and crime prevention services, income planning or educational opportunities by contacting the Aging and Disability Resource Center.

Independent Consumer Support Program

The Florida Department of Elder Affairs also offers an Independent Consumer Support Program (ICSP). The ICSP works with the Statewide Long-Term Care Ombudsman Program, the ADRC and the Agency to ensure that LTC members have many ways to get information and help when needed. For more information, please call the Elder Helpline at 1-800-96-ELDER (1-800-963-5337) or visit https://elderaffairs.org/programs-services/medicaid-long-term-care-services/statewide-medicaid-managed-care-long-term-care-program/.

Section 20: Forms
Examples:

Living Will
Declaration made this _____ day of , (20 __), I _____,

Willfully and voluntarily make known my desire that my dying not be artificially prolonged under the circumstances set forth below, and I do hereby declare that, if at any time I am incapacitated and:

_____ (initial) I have a terminal condition, or

_____ (initial) I have an end-stage condition, or

_____ (initial) I am in a persistent vegetative state, and if my primary physician and

another consulting physician have determined that there is no reasonable medical probability of my recovery from such a condition, I direct that life-prolonging procedures be withheld or withdrawn when the application of such procedures would serve only to prolong artificially the process of dying and that I be permitted to die naturally with only the administration of medication, or the performance of any medical procedure deemed necessary to provide me with comfort care or to alleviate pain.

It is my intention that this declaration be honored by my family and physician as the final expression of my legal right to refuse medical or surgical treatment and to accept the consequences for such refusal.

In the event that I have been determined to be unable to provide express and informed consent regarding the withholding, withdrawal, or continuation of life-prolonging procedures, I wish to designate, as my surrogate to carry out the provisions of this declaration:

Name: _____,

Address: _____,

_____,

Phone: _____,

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

Additional Instructions (optional):

Witness Signatures:

Signature: _____,

Print Name: _____,

Address: _____,

Date: _____,

Signature: _____,

Print Name: _____,

Address: _____,

Date: _____,

Designation of Health Care Surrogate for Minors

I/We, _____(name/names), the (check the box that applies,)

[ ] natural guardian(s) as defined in s. 744.301(1), Florida Statutes; [ ] legal custodian(s).

[ ] legal guardian(s) of the following minor(s):

_____,

_____,

_____,

Name: _____,

Address: _____,

_____,

Phone: _____,

If my/our designated health care surrogate for a minor is not willing, able, or reasonably available to perform his or her duties, I/we designate the following person as my/our alternate health care surrogate for a minor:

Name: _____,

Address: _____,

_____,

Phone: _____,

I/We authorize and request all physicians, hospitals, or other providers of medical services to follow the instructions of my/our surrogate or alternate surrogate, as the case may be, at any time and under any circumstances whatsoever, with regard to medical treatment and surgical and diagnostic procedures for a minor, provided the medical care and treatment of any minor is on the advice of a licensed physician.

I/We fully understand that this designation will permit my/our designee to make health care decisions for a minor and to provide, withhold, or withdraw consent on my/our behalf, to apply for public benefits to defray the cost of health care, and to authorize the admission or transfer of a minor to or from a healthcare facility.

I/We will notify and send a copy of this document to the following person(s) other than my/our surrogate, so that they may know the identity of my/our surrogate:

Name: _____,

Signed: _____,

Date: _____,

WITNESSES:

Name: _____,

Date: _____,

Name: _____,

Date: _____,

Donor Form (Anatomical Donation)

Advance Directive Wallet Card

Designation of Health Care Surrogate

I, _____, designate as my health care surrogate under S. 765.202, Florida Statutes:

Name: _____,

Address: _____,

_____,

Phone: _____,

If my health care surrogate is not willing, able, or reasonably available to perform his or her duties, I designate as my alternate health care surrogate:

Name: _____,

Address: _____,

_____,

Phone: _____,

INSTRUCTIONS FOR HEALTH CARE

I authorize my health care surrogate to: (Initials required in blank spaces below.)

_____ Receive any of my health information, whether oral or recorded in any form or medium, that:

1. Is created or received by a health care provider, health care facility, health plan, public health, employer, life insurer, school or university, or health care clearinghouse; and

2. Relates to my past, present, or future physical or mental health or condition; the provision of health care to me; or the past, present, or future payment for the provision of health care to me.

I further authorize my health care surrogate to:

_____ Make all health care decisions for me, which means he or she has the authority to:

1. Provide informed consent, refusal of consent, or withdrawal of consent to any and all of my healthcare, including life-prolonging procedures.
2. Apply on my behalf for private, public, government, or veteran's benefits to defray the cost of health care.
3. Access my health information reasonably necessary for the health care surrogate to make decisions involving my health care and to apply for benefits for me.
4. Decide to make an anatomical gift pursuant to part V of chapter 765, Florida Statutes.

Specific instructions and restrictions:

_____

_____

_____

While I have decision making capacity, my wishes are controlling, and my physician and health care providers must clearly communicate to me the treatment plan or any change to the treatment plan prior to its implementation. To the extent that I am capable of understanding, my health care surrogate shall keep me reasonably informed of all decisions that he or she has made on my behalf and matters concerning me.

This health care surrogate designation is not affected by my subsequent incapacity except as provided in Chapter 765, Florida Statutes.

Pursuant to section 765.104, Florida Statutes, I understand that I may, at any time while I retain my capacity, revoke, or amend this designation by:

1. Signing a written and dated instrument which expresses my intent to amend or revoke this designation;

2. Physically destroying this designation through my own action or by that of another person in my presence and under my direction;

3. Verbally expressing my intention to amend or revoke this designation; or

4. Signing a new designation that is materially different from this designation.

My health care surrogate's authority becomes effective when my primary physician determines that I am unable to make my own health care decisions unless I initial either or both of the following boxes:

If I initial this box [ ] my health care surrogate's authority to receive my health information takes effect immediately.

If I initial this box [ ] my health care surrogate's authority to make health care decisions for me takes effect immediately. Pursuant to section 765.204(3), Florida States, any instructions of health care decisions I make, either verbally or in writing, while I possess capacity shall supersede any instructions or health care decisions made by my surrogate that are in material conflict with those made by me.

Signatures: Sign and date the form here:

Date: _____,

Sign your name: _____,

Address: _____,

Print your name: _____,

City: _____

State: _____,

Donor Form (Anatomical Donation)
Visit Donate Life Florida to learn about organ donation and sign up:

www.donatelifeflorida.org/register/

Advance Directive Wallet Card
For an Advance Directive card for your wallet, visit:

www.aha.org/system/files/2018-01/piiw-walletcard.pdf

Non-Discrimination Notice

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