



EXCELLENT CARE / ENGLISH

Your Pathway to Understanding

A practical handbook for families, self-advocates, school teams, and hospital teams



Choose a Topic



Explore At Your Pace



Start a Conversation

EXCELLENT CARE

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Start Where You Are.

You do not have to read this handbook from beginning to end. Choose the topic that matches your situation, bring it to a conversation, and write down one next step. The person receiving support belongs at the center of every decision.

Make This Handbook Your Own

Step 1



Step 2



Step 3



Choose a Topic

Use the contents or the starting points below. You do not need to understand every program at once.

Explore At Your Pace

The website's interactive cards are opened here. Read the pathways, compare options, and circle the questions that matter.

Start a Conversation

Bring these pages to a meeting. Ask for plain-language answers, a named contact, and a follow-up date.

Print at actual size on US Letter paper. For two-sided printing, flip on the long edge. All essential information is in these pages; internet access is optional.

The Resource Center's video series is in preparation. Video placeholders have been replaced here with readable diagrams and conversation prompts. The online Resource Center can be used for future updates.

Keep your notes private. Do not record sensitive medical identifiers in a copy you plan to share. Send care records only through the secure process your team provides.

Illustrations show fictional people and situations.

Find a Useful Starting Point

Families & Self-Advocates

Start with admissions, choosing a home, or changing caregiving needs.

School Teams

Start with life after school and turning 18. Confirm the student's individual school exit date.

Hospital Teams

Start with discharge when home is not an option, then the hospital-to-residential handoff.

A Guide, Not a Decision

General education only. This handbook does not provide individual medical or legal advice, determine eligibility, approve funding, or confirm a placement. APD, Medicaid, health plans, clinicians, and receiving providers make the decisions within their roles. Confirm current requirements and availability with the responsible team.

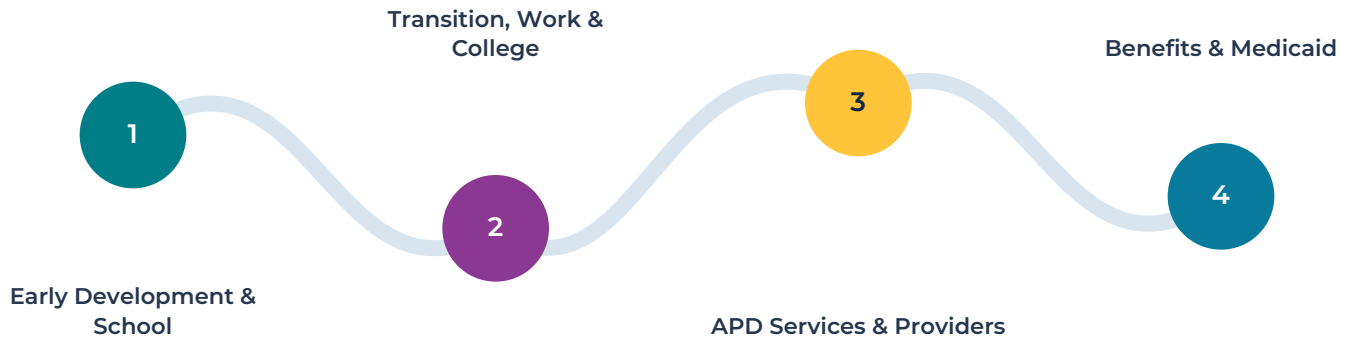
For immediate danger or a medical emergency, call 911. A waiver application is not an emergency-response service.

Edition prepared September 29, 2026. Selected time-sensitive program references checked against official sources. Company program descriptions are adapted from Excellent Care's website; confirm current services directly.

APD RESOURCE ROADMAP

Find The Next Support.

Explore all 12 programs in APD's family resource roadmap, plus its provider directory. Choose a topic; these are options, not steps everyone must follow.



Early Development & School

Screening, education, family support, and learning options.

Early Steps

APD roadmap: ages 0-36 months

Early intervention for infants and toddlers, including developmental screening, therapies, hearing and vision support, and an individualized family support plan.

floridaearlysteps.com/

Florida Public Schools · ESE

APD roadmap: ages 3-22

Exceptional Student Education offers evaluations, accommodations, specialized instruction, and an Individualized Education Program (IEP) through the school district.

www.fldoe.org/academics/exceptional-student-edu/staff/ease-directors.shtml

Family Empowerment Scholarship · Unique Abilities

APD roadmap: ages 3-22

For eligible students with unique abilities, approved scholarship funds may support tuition, tutoring, transportation, learning materials, and other education expenses.

www.stepupforstudents.org/scholarships/unique-abilities/

Florida Diagnostic & Learning Resources System

APD roadmap: ages 3-22

Regional centers help schools and families with evaluations, training, information, and support for students with disabilities.

www.fdlrs.org/

Transition, Work & College

School-to-adult planning, job support, and postsecondary opportunities.

Project 10: Transition Education Network

APD roadmap: ages 12-22

Helps school teams plan transition to adult life through research, technical assistance, and cross-agency collaboration.

project10.info/

APD Unique Abilities Partner Program

APD roadmap: ages 14+

Connects job seekers and employers with disability-employment resources and recognizes businesses that support inclusive hiring.

apd.myflorida.com/unique/

Florida Vocational Rehabilitation

APD roadmap: ages 14+

Offers pre-employment transition services, career exploration, work experiences, job readiness, and employment support.

rehabworks.org/student-youth/student-youth.html

CareerSource Florida

APD roadmap: ages 16+

Connects job seekers with training, career development, youth employment programs, and job matching.

careersourceflorida.com/

Florida Center For Students With Unique Abilities

APD roadmap: ages 18+

Supports eligible postsecondary transition programs and scholarship opportunities for students with intellectual disabilities.

fcsua.org/

APD Services & Providers

Learn about APD services and search its directory of licensed facilities and services.

Agency For Persons With Disabilities (APD)

APD roadmap: ages 3+

Provides information on disability services, waiver pathways, daily living, behavioral and medical supports, and employment across the lifespan.

apd.myflorida.com/

APD Provider Search

directory

Search APD's directory for licensed facilities and services by area; contact providers and APD to confirm fit and availability.

providersearch.apd.myflorida.com/

Benefits & Medicaid

Find public assistance and Medicaid information from the responsible state agencies.

Department of Children and Families (DCF)

all ages

Provides information about public assistance such as food, cash, and Medicaid applications, plus child and family, mental-health, and behavioral-health services.

www.myflfamilies.com/

Agency For Health Care Administration (AHCA)

all ages

Oversees Florida Medicaid and health-care facilities; use AHCA for official Medicaid program and health-plan information.

ahca.myflorida.com/

These summaries are starting points, not eligibility, enrollment, or placement decisions. Program rules and availability can change. APD's roadmap lists the school and youth age bands shown here; ask each agency about current criteria. A provider directory listing does not confirm an opening. Read APD's complete Roadmap to Family Resources .

TOPIC 01 / Planning & decisions

Admissions and Eligibility

Start With The Person, Their Needs, and Their Goals.

Admissions begin with an individualized conversation - not a one-size-fits-all checklist.



Start with the person

Include the person in the conversation. Ask about their preferences, goals, and the support they want.

At a glance



Start With a Conversation

Begin with the person's needs and what matters to them.



Review The Fit

The team reviews care, funding, and space in the home.



Plan Together

Ask who will help with records and the next step.



Prepare the records

Ask the reviewing team which current records are needed and how to share them securely.

Four Parts of An Individualized Review.



The Person

Preferences, communication, routines, relationships, and goals.



Care Needs

Current orders, medications, respiratory support, mobility, and other clinical needs.



The Home

Staffing, accessibility, equipment, emergency preparation, and available capacity.



Authorization

Funding, support coordination, and the services approved for the individual.



Connect on arrival

Introduce the receiving team, confirm the handoff, and help the person settle into the new setting.

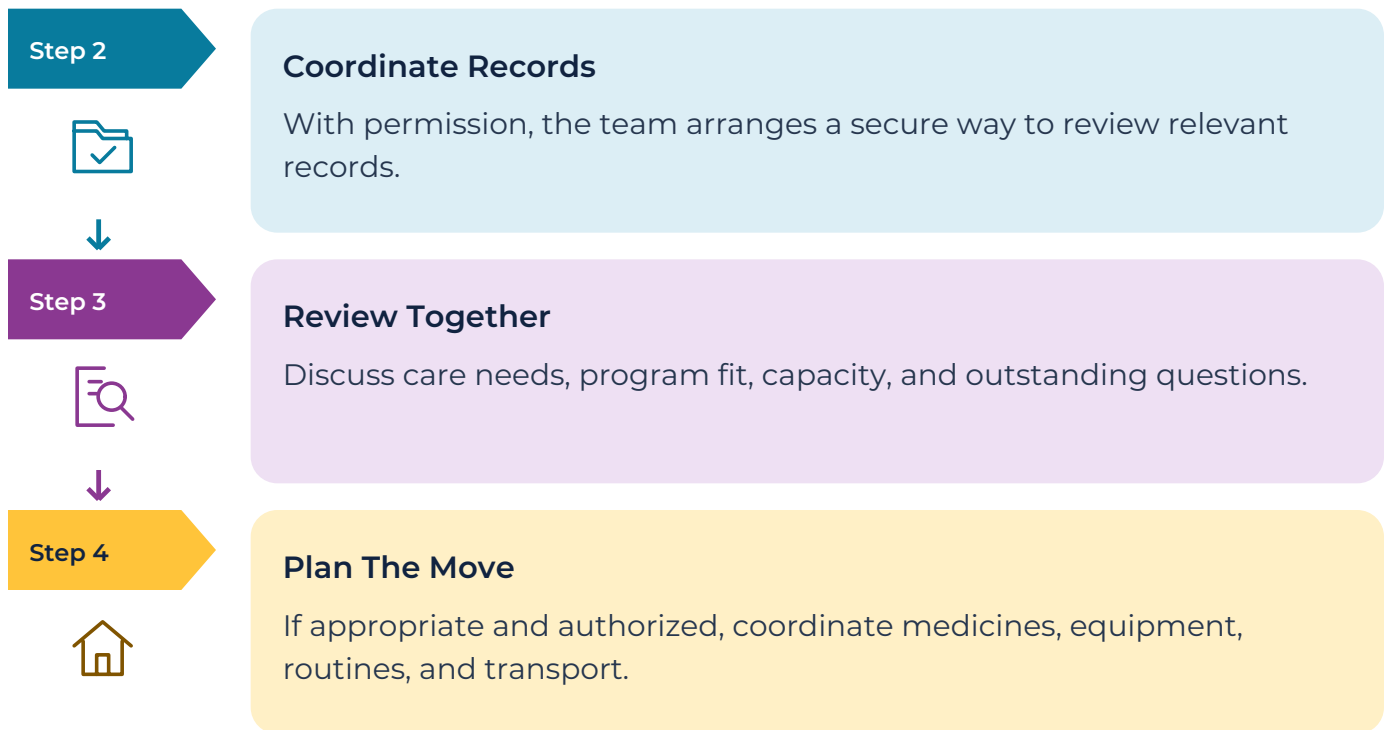
One Step At a Time.

Step 1



Connect

Share contact details and the general reason for your inquiry.



A conversation is a starting point. Admission depends on the complete review, required authorizations, available capacity, and whether the home can safely provide support.

A Few Things Worth Clearing Up.

Who May Be Appropriate For Excellent Care?

Excellent Care supports adults with intellectual and developmental disabilities who need residential assistance. The specialized medical program reviews people with complex medical conditions requiring intensive nursing care. Each person is reviewed individually.

Can a Hospital Or Support Coordinator Make a Referral?

Yes. Families, support coordinators, discharge planners, and other authorized professionals may contact Excellent Care. The team will explain how to coordinate records with appropriate permission.

Where Do Medicaid Waiver Questions Fit?

Funding eligibility and a home's admission review are separate decisions. Our Florida Medicaid waiver guide explains the different steps.

Should We Enter Private Medical Details In The Website Form?

No. Use the form for contact and routing information. The team can arrange an appropriate way to share records.

Sources: [1], [2]



Look up, then verify

Use official sources to find options. Confirm current services, eligibility, and availability with the responsible team.



Continue With The Online Guide

Scan for the current guide and its video section. Video availability and viewing permissions may vary.

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Questions to Take With You



People & Priorities

- Who should be included in the discussion?
- What matters most to the person in everyday life?



Care & Records

- Who holds the current support plan and clinical records?
- Are current medications, orders, and equipment needs documented?



Funding & Next Steps

- Who can clarify funding and service authorizations?
- What timing or transition concerns should the team know?

Notes & next steps

One question I want answered / the next person to contact

TOPIC 02 / Understanding care

Ventilator and Tracheostomy Care

Residential Support Built Around Respiratory Safety.

A specialized home brings clinical coordination, emergency readiness, and everyday life together in one residential setting.



Care belongs in everyday life

Discuss familiar routines, meaningful activities, comfort, and relationships alongside care needs.

At a glance



A Plan For One Person

Care follows the person's clinical orders and needs.



People and Equipment

Ask about trained staff, supplies, and backup plans.



Life Beyond Treatment

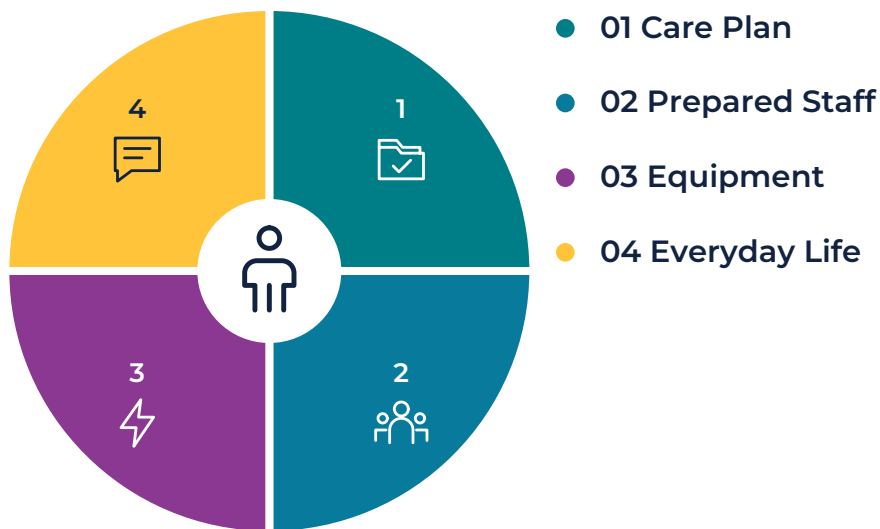
Include comfort, communication, and favorite activities.



Make room for communication

Pictures, gestures, and the person's preferred communication supports can help them express choices.

Four Supports Around One Person.



01



Clinical Direction

Current orders and an individualized plan guide care and the response to changes.

02



Prepared Staff

Ask which professionals are present, how skills are maintained, and how shifts communicate.

03



Equipment Continuity

Ask about supplies, device checks, power, backups where ordered, and transport planning.

04



Everyday Life

Communication, relationships, recreation, and personal routines belong in the plan.



Check equipment readiness

Ask about prescribed equipment, supplies, staff preparation, and the plan for interruptions.

Build Your Questions Around What Matters.



People and Communication

Who will coordinate with physicians, respiratory professionals, nurses, equipment providers, and family?

How are changes and new orders communicated across shifts?



Equipment and Backup Planning

How are supplies, equipment checks, charging, and backup power organized for this person?

What is the plan for appointments, transport, and interruptions?



Individual Care and Everyday Life

How does the plan address airway needs, communication, mobility, comfort, and personal goals?

Who explains the person's warning signs and response plan to staff and family?

A Few Things Worth Clearing Up.

Can An Adult Who Uses a Ventilator Live In a Group Home?

Some adults can, when an appropriately approved specialized medical residence has the staffing, individualized plan, equipment, and emergency systems needed to support that person.

Does a Ventilator Automatically Determine Admission?

No. The review considers the complete clinical, residential, behavioral, equipment, staffing, funding, and safety picture.

How Are Changes In Respiratory Status Handled?

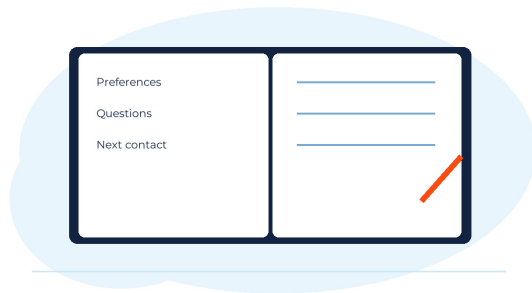
The response follows the person's clinical orders and emergency plan. Ask the team how it documents changes, escalates concerns, and communicates with family.

This family guide helps you ask informed questions. It does not teach tracheostomy procedures or replace individual clinical orders, emergency instructions, or equipment guidance.

Plan For Emergencies Too

For power, transport, supplies, communication, and caregiver backup, use the new emergency-planning review draft.

Sources: [3], [2], [4]



Bring your questions

Write down what matters to the person, what is unclear, and who will follow up.



Continue With The Online Guide

Scan for the current guide and its video section. Video availability and viewing permissions may vary.

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Questions to Take With You



People & Communication

- Which staff are present and what training do they have?
- Who is our contact when needs or orders change?



Orders & Planning

- How are current clinical orders received and reviewed?
- What is the person-specific equipment and emergency plan?



Everyday Life

- How are routines, communication, and community participation supported?

Notes & next steps

One question I want answered / the next person to contact

TOPIC 03 / Understanding care

Oxygen and Respiratory Support

Respiratory Care That Fits Into Everyday Life.

Individualized plans help connect prescribed treatment, equipment readiness, observation, communication, and community participation.



Care belongs in everyday life

Discuss familiar routines, meaningful activities, comfort, and relationships alongside care needs.

At a glance



Follow The Care Plan

The clinical team explains the prescribed support.



Prepare For Outings

Ask how equipment and supplies travel with the person.



Know Whom to Call

Ask who receives questions and reports of changes.



Plan beyond the home

Discuss how prescribed support, equipment, and assistance will travel with the person.

The Plan Travels With The Person.



Current Orders

Confirm who receives, reviews, and communicates the prescribed plan.



Equipment

Ask how equipment, supplies, batteries, and portable systems are checked.



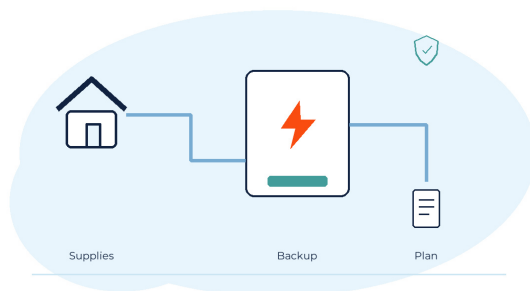
Observations

Know who monitors, documents, and shares relevant changes.



Daily Choices

Discuss comfort, communication, routines, activities, and relationships.



Check equipment readiness

Ask about prescribed equipment, supplies, staff preparation, and the plan for interruptions.

What Needs to Connect?



Bring Care Into The Daily Routine.

Ask how staff coordinate the prescribed therapy, comfort, equipment checks, documentation, and the person's preferred activities.



Prepare For The Whole Trip.

Ask the team about prescribed portable equipment, supplies, power needs, transport, appointments, and the information that should accompany the person.



Know Who to Contact.

Ask who receives new orders, how changes reach every shift, and how the individual emergency plan covers equipment or power interruptions.

A Few Things Worth Clearing Up.

Is Oxygen The Same As a Ventilator?

No. Oxygen therapy supplies extra oxygen. Mechanical ventilation supports breathing. A clinical team explains which support is prescribed for an individual.

Can Families Adjust Oxygen Or Device Settings Themselves?

Follow the prescribing clinician's instructions. This guide does not provide settings, dosing, or directions for changing equipment.

Can Excellent Care Review Respiratory Needs?

The specialized program can review prescribed oxygen, ventilator or tracheostomy support, and other respiratory needs. Suitability depends on an individualized assessment.

Plan For Emergencies Too

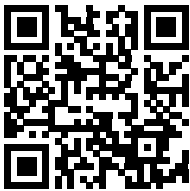
For power, transport, supplies, communication, and caregiver backup, use the new emergency-planning review draft.

Sources: [5], [6]



Agree on the next contact

Record whom to contact, the next action, and when to follow up.



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Questions to Take With You



Orders & Equipment

- Who confirms and updates respiratory orders?
- Who checks equipment and supplies?



Outings & Backup Plans

- What information travels to appointments and the hospital?
- What is the backup plan for interruptions?



Comfort & Communication

- How are changes communicated to clinicians and family?
- How does the plan support the person's comfort and choices?

Notes & next steps

One question I want answered / the next person to contact

TOPIC 04 / Planning & decisions

Choosing a Specialized Medical Group Home

Choosing a Specialized Medical Group Home.

The right questions can reveal how a residence approaches safety, clinical coordination, dignity, communication, and daily life.



Start with the person

Include the person in the conversation. Ask about their preferences, goals, and the support they want.

At a glance



Ask About Care

Find out what the home is approved and staffed to provide.



Picture Everyday Life

Look at choices, routines, privacy, and relationships.



Take Your Questions

Use the same guide when you visit different homes.



Care belongs in everyday life

Discuss familiar routines, meaningful activities, comfort, and relationships alongside care needs.

A Home Should Support The Whole Person.



Licensure and Fit

Ask which services the home is licensed and approved to provide, and how individual fit is assessed.



Staff and Coordination

Ask who is present, when they are available, and how skills and communication are maintained.



Emergency Readiness

Ask about storms, power loss, evacuation, equipment continuity, and individualized response plans.



Everyday Life

Explore choice, privacy, routines, culture, relationships, and community participation.



Family Communication

Identify a main contact and ask how updates, concerns, and care decisions are shared.



The Environment

Notice respect, accessibility, staff interactions, organization, and how personal the home feels.

A Few Things Worth Clearing Up.

Can This Guide Tell Us Whether a Home Is Right For Us?

No. The guide helps you prepare questions. A decision also requires current information, individualized clinical and residential review, appropriate authorizations, and direct discussion with the person and care team.

How Can We Compare Different Homes?

Ask each home the same questions, request specific examples, and include the person's preferences. Follow up on unclear answers before making a decision.

Make Observations Part of The Conversation.

Staff Speak Directly to Residents.

How do you learn and support each person's communication preferences?

The Home Includes Personal Belongings.

What choices can the person make about their room, routines, activities, and relationships?



Look up, then verify

Use official sources to find options. Confirm current services, eligibility, and availability with the responsible team.

Use The Provider Directory As a Starting Point

Editorial draft · WSC and clinical review pending · Sources checked October 2, 2026.

Use the same paper questions for each provider; include the person's own view and keep private details off this site.

- Step 01 Search for options Search APD Provider Search by county, city, or provider name to make a short list. The directory draws from APD iConnect and providers may update their entries; a listing does not show a current opening or prove the setting fits the person.
- Step 02 Ask and verify For each option, ask the person what feels comfortable. Confirm current license information, accessibility, staffing and clinical support, communication, everyday choice, visits, transport, emergency backup, and costs directly with APD and the provider.
- Step 03 Compare each visit Take the same questions on each visit. Record the date, who answered, what remains unclear, and the person's own response. Ask the WSC or discharge team which service approvals or transition steps still need confirmation.

APD Provider Search · APD provider-search information

Sources: [7], [8], [9], [2]



Prepare the records

Ask the reviewing team which current records are needed and how to share them securely.



Continue With The Online Guide

Scan for the current guide and its video section. Video availability and viewing permissions may vary.

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Questions to Take With You



Fit & Clinical Support

- May we review current licensure and service-approval information?
- How do you review a person's clinical and residential needs?
- Which staff are present, and how are their competencies maintained?



Safety & Everyday Life

- What are the equipment, backup-power, and emergency plans?
- What do an ordinary weekday and weekend look like?
- How are choices, privacy, communication, and relationships supported?



Partnership & Next Steps

- Who communicates with family, and how are concerns handled?
- What should we know about funding, available capacity, and next steps?

Notes & next steps

One question I want answered / the next person to contact

TOPIC 05 / Planning & decisions

Hospital-to-Residential Transition

A Coordinated Move Starts Before Discharge Day.

Early communication helps the hospital, family, residential team, clinicians, pharmacy, and equipment providers prepare around the same plan.



Make the next step concrete

Agree on who will do what, when it will happen, and what still needs confirmation.

At a glance



Start Before Moving Day

Talk with the hospital and receiving home early.



Connect The Teams

Ask who is coordinating medicines, equipment, and transport.



Keep Familiar Routines

Share what helps the person feel comfortable and understood.



Connect on arrival

Introduce the receiving team, confirm the handoff, and help the person settle into the new setting.

Before, During, and After The Move.

Step 1



Step 2



Step 3



Step 4



Start The Conversation

Discuss residential fit, permission to share records, funding, and possible barriers early.

Prepare Together

Confirm orders, medicines, equipment, supplies, training, and transport with the responsible teams.

Connect On Arrival

The receiving team checks the handoff and raises any questions through the clinical process.

Keep Communicating

Confirm follow-up appointments, contact people, routines, and how concerns will be shared.



Share the same plan

Keep the person, chosen supporters, and sending and receiving teams connected.

Six Things to Organize Together.



01



Care Information

Current summary, allergies, medication reconciliation, orders, and individualized support plans.

02



Equipment and Supplies

Device details, prescribed settings, vendor contacts, supplies, and backup arrangements.

03



Follow-Up

Appointments, tests, therapies, laboratory needs, and responsible providers.

04

**The Person's Routine**

Communication, comfort, preferences, relationships, and personal goals.

05

**People to Contact**

Decision-makers, family, clinicians, coordinators, and emergency contacts.

06

**Response Plan**

Individual warning signs, escalation instructions, and emergency information.

A Few Things Worth Clearing Up.

Who Decides When Discharge Is Appropriate?

The hospital and treating professionals determine medical readiness. Residential admission also requires the receiving provider's individual review and the necessary authorizations.

What Can Families Contribute?

Share what helps the person feel comfortable, how they communicate, their usual routines, and changes you notice. Ask the team to explain anything that is unclear.

What If Information Or Equipment Is Missing?

Raise it with the hospital and receiving team before the proposed move so they can identify the responsible person and next step.

Plan For Emergencies Too

For power, transport, supplies, communication, and caregiver backup, use the new emergency-planning review draft.

Sources: [10], [11]



Care belongs in everyday life

Discuss familiar routines, meaningful activities, comfort, and relationships alongside care needs.



Continue With The Online Guide

Scan for the current guide and its video section. Video availability and viewing permissions may vary.

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Questions to Take With You



Care Handoff

- Has the receiving team reviewed current orders and instructions?
- Are medicines, nutrition, equipment, and supplies coordinated?



Travel & Arrival

- Is transport arranged around the person's needs?
- Do the person and family know what to expect on arrival?



Continuity & Follow-Up

- Do receiving staff understand communication, routines, and the response plan?
- Are follow-up appointments and contacts confirmed?

Notes & next steps

One question I want answered / the next person to contact

TOPIC 06 / Funding & Medicaid

Florida Medicaid Waiver Programs

Waiver Options, Explained With Care.

You do not have to learn the system all at once. Start with the plain-language overview, then use the visual guides to find the questions and official resources that matter to your family.



Ask for an individual review

Describe the person's needs and circumstances. The responsible agency or team makes the determination.

At a glance



Apply and Ask

APD can explain the application and the person's status.



Know Your Program

Eligibility, enrollment, and service approval are separate steps.



Plan The Support

Ask a coordinator which services are approved for the person.

In plain language: Home and Community-Based Services (HCBS) programs can help eligible people receive authorized care and support in their own home, a family home, or a community residence instead of an institution. Florida offers more than one way to organize those services.

You Are Not Expected to Know Every Term.

Many families first encounter words like “waiver,” “support plan,” and “individual budget” during a stressful transition. It is okay to take one step at a time and ask the same question more than once.

Three Program Names You May Hear.

iBudget Florida

APD's HCBS waiver for eligible people with developmental disabilities. A support coordinator helps identify needs and organize authorized social, medical, behavioral, therapeutic, and residential services.

Good question to ask

Which services can be authorized in my family member's support plan and budget?

Excellent Care connection

iBudget is Excellent Care's primary funding source for eligible, authorized residential services.

Consumer-Directed Care Plus (CDC+)

CDC+ gives an enrolled person more responsibility and flexibility to manage an approved monthly budget, choose workers, and organize supports. A trained CDC+ consultant provides guidance, and a representative may help.

Good question to ask

Do we want the responsibility of hiring, scheduling, and managing providers?

Remember

CDC+ is an option within iBudget, not a separate shortcut into waiver eligibility.

IDD Comprehensive Managed Care (ICMC)

AHCA describes ICMC as a statewide Medicaid program that combines regular Medicaid healthcare with additional home and community-based services. Participants work with a Florida Community Care case manager.

Good question to ask

Is ICMC available and appropriate for the person's current Medicaid and support needs?

What APD highlights

Enrollment has no cost, participants may disenroll, and one case manager helps coordinate services.



Prepare the records

Ask the reviewing team which current records are needed and how to share them securely.

From Questions to Authorized Support.

Step 1 / 5

Gather Records

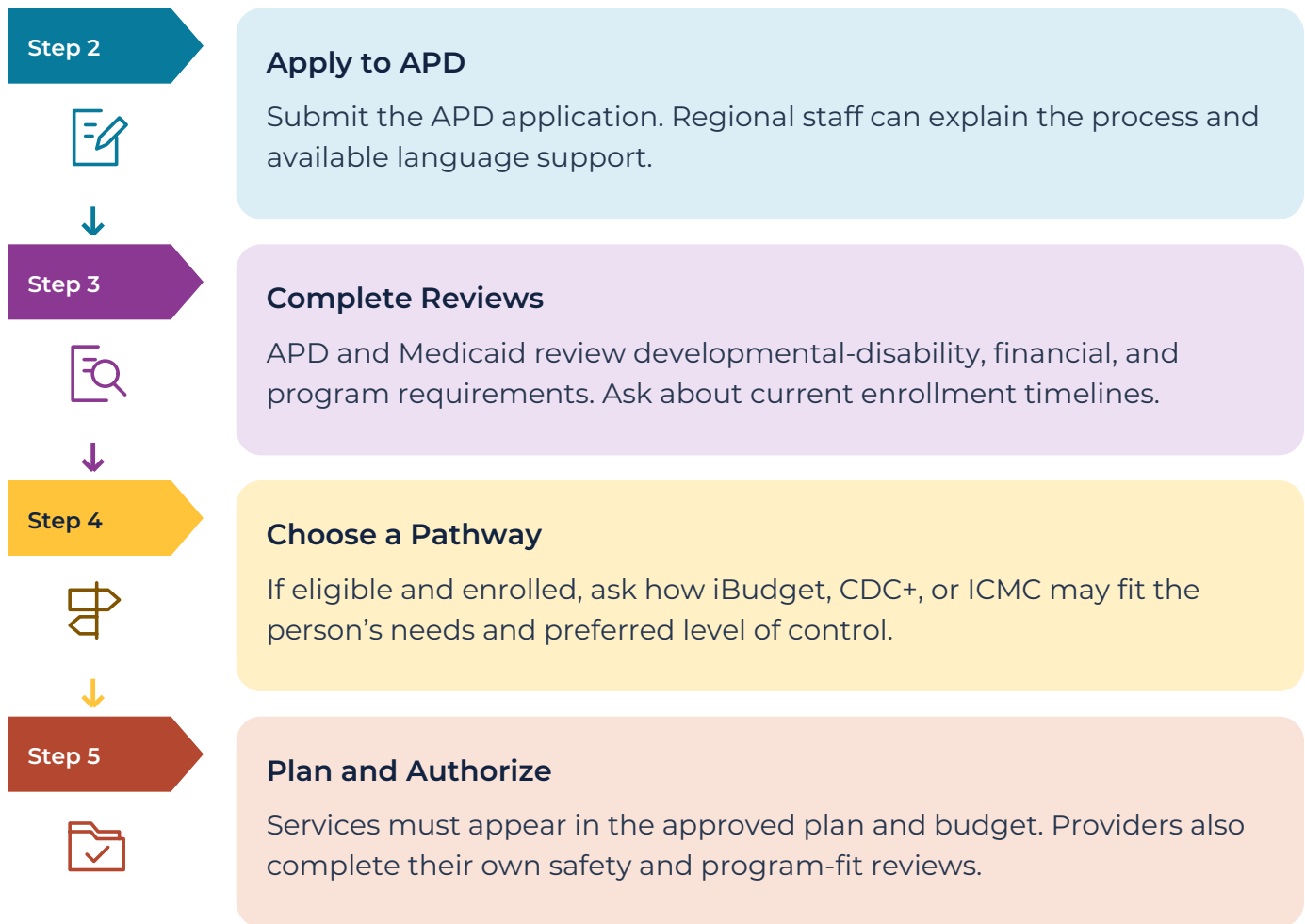
Collect medical, psychological, school, genetic, and adaptive-functioning records that document the disability and when it began.

Step 1



Gather Records

Collect medical, psychological, school, genetic, and adaptive-functioning records that document the disability and when it began.



Choose The Statement That Feels Closest.

Begin With The APD Application.

Gather records that show the qualifying developmental disability and that it began before age 18. If records are incomplete, APD says staff can help families identify needed information.

Ask What Comes After The Eligibility Decision.

APD eligibility and waiver enrollment are separate steps. Ask your APD contact about current enrollment status, timelines, Medicaid requirements, and who will help coordinate the next step.

Review The Current Plan Before Requesting Changes.

Ask the support coordinator or case manager which services are authorized now, what assessments or physician orders are needed, and whether iBudget, CDC+, or ICMC best matches the person's goals.

Who May Qualify For APD Services?

Florida law defines the developmental disabilities APD serves. The condition generally must begin before age 18, create a substantial limitation, and be expected to continue indefinitely. A diagnosis alone does not automatically establish every program requirement.

i Intellectual Disability

A lifelong condition that affects learning, problem-solving, and everyday skills, such as communication and self-care. The amount and type of support a person needs can vary.

Sources: [13]

i Autism (APD Criteria Apply)

A developmental disability that can affect communication, interaction, learning, and behavior. Strengths and support needs vary widely. APD uses its own eligibility criteria.

Sources: [14], [15]



Cerebral Palsy

A group of conditions that affect movement, balance, and posture because of differences or injury in the developing brain. Some people need mobility or daily-living support; others need less assistance.

Sources: [16]



Spina Bifida Cystica Or Myelomeningocele

A condition present at birth in which the spine does not close completely. Myelomeningocele involves the spinal cord and nerves and can affect leg movement, bladder control, and bowel function.

Sources: [17]



Down Syndrome

A genetic condition involving extra material from chromosome 21. It affects development and learning and may also involve heart, hearing, or other health needs. Each person's abilities and support needs are different.

Sources: [18]



Prader-Willi Syndrome

A genetic condition that can affect muscle tone, growth, learning, and appetite. Feeding difficulties may occur in infancy; strong, persistent hunger often develops later. Support needs change with age.

Sources: [19]



Phelan-McDermid Syndrome

A genetic condition that can affect development, speech, learning, and muscle tone. Some people also have seizures or autism-related traits. Abilities and support needs vary from person to person.

Sources: [20]



Tatton-Brown-Rahman Syndrome

A rare genetic condition that can affect learning and development and is often associated with above-average growth. Low muscle tone, loose joints, or other health needs may also occur.

Sources: [21]



Children Ages 3-5 At High Risk For a Developmental Disability

This is an APD review category, not a diagnosis. Children ages 3-5 may be considered when records show developmental delays or certain other risk factors. APD reviews the supporting information.

Sources: [22]

A caring reminder: Families do not have to determine eligibility on their own. APD makes the official decision and can explain what documentation is needed for the person's specific diagnosis or circumstances.



Start with the person

Include the person in the conversation. Ask about their preferences, goals, and the support they want.

Eight Service Families, Centered On One Person.



01



Life Skills and Employment

Learning everyday skills or getting support to find and keep a job.

02



Supplies and Equipment

Approved supplies, equipment, or changes that make a home easier to use.

03



Personal Supports and Respite

Help with daily activities. Respite has age and living-arrangement rules.

04



Residential Services

Support in a home, with the level of care approved for the person.

05



Support Coordination

A coordinator helps connect the person's needs, plan, and services.

06



Therapy, Nursing, and Wellness

Authorized clinical support, such as nursing or respiratory therapy.

07



Transportation

Approved rides to community waiver services when other support is unavailable.

08



Adult Dental

Eligible dental care not otherwise covered by the Medicaid State Plan.

Services depend on the person's needs, program rules, and approval in their plan and budget.

Residential and Medical Supports

Florida's official list includes residential habilitation, residential nursing, skilled nursing, private duty nursing, respiratory therapy, and Specialized Medical Home Care. APD describes Specialized Medical Home Care as providing up to 24-hour nursing services and medical supervision in qualifying licensed group homes.

Answers Without The Jargon.

Does APD Eligibility Mean Waiver Services Begin Immediately?

No. APD eligibility, Medicaid eligibility, program enrollment, service planning, and individual service authorization are separate decisions. Ask APD about the person's current status and timeline.

Can The Waiver Help Pay For a Group Home?

iBudget includes residential services, but the person must be eligible and enrolled, and the specific residential service must be approved in the support plan and budget. A provider must also determine that it can safely meet the person's needs.

Is CDC+ a Separate Waiver?

No. APD describes CDC+ as a self-directed option within iBudget. It gives the participant more control, along with more day-to-day responsibility for managing workers and an approved budget.

Can a Family Choose Every Service On The List?

No. The list shows services the program can offer. Actual services depend on assessed need, coverage criteria, medical necessity when required, available funding, and formal authorization.

Can Excellent Care Determine Medicaid Or Waiver Eligibility?

No. APD and the responsible Medicaid agencies make those decisions. Excellent Care can explain its residential programs and help a family organize questions for the official team.

Getting APD Services: a Practical Checklist

Editorial draft · specialist review pending · Sources checked October 2, 2026.

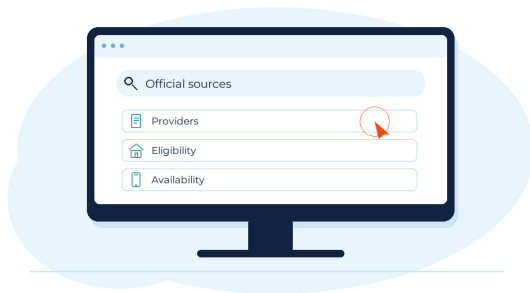
Use these four steps to prepare for and follow up on a conversation with APD.

- Step 01 Ask APD Ask APD which application form and supporting records fit the person; use APD's current quick guide rather than guessing that every document is required.
- Step 02 Keep records Keep copies of the application, confirmation, written notices, contact names, and dates. Ask which agency decides each next step.
- Step 03 Read the notice If APD assigns a pre-enrollment category, read the letter and report significant changes to the regional office. Pre-enrollment is not the same as waiver enrollment.
- Step 04 Confirm approvals If the person is enrolled in a waiver, ask which requested services are in the support plan and individually authorized. Eligibility, enrollment, and service authorization are separate decisions.

Contact Log (Keep This Paper Copy Private)

APD application and quick guides · APD pre-enrollment

Sources: [12], [13], [14], [15], [16], [17], [18], [19], [20], [21], [22], [23], [24], [25], [26], [27], [28]



Look up, then verify

Use official sources to find options. Confirm current services, eligibility, and availability with the responsible team.



Continue With The Online Guide

Scan for the current guide and its video section. Video availability and viewing permissions may vary.

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Notes & next steps

One question I want answered / the next person to contact

Questions to Take With You



Where Things Stand

- Which program is the person currently eligible for or enrolled in?
- Who is our primary contact for planning and service authorization?



Needs & Authorizations

- Which services are already approved, and which require a new assessment?
- What records or physician orders are still needed?
- How would residential, nursing, respiratory, equipment, and transportation needs be included?



Timing & Changes

- What are the current enrollment or review timelines?
- Who should we call if the person's health or living situation changes?

Notes & next steps

One question I want answered / the next person to contact

TOPIC 07 / Funding & Medicaid

Crisis Waiver

Support When Needs Become Urgent.

Understanding Crisis Waiver Enrollment



Talk about changing support

Explain which care tasks or hours are becoming difficult and what help is still available.

Is someone in immediate danger? Call 911 for a life-threatening emergency. Do not wait for a waiver review. This handbook does not provide emergency response.

At a glance



Tell APD What Changed

Explain the urgent risk and why current help is not enough.



Keep Useful Records

Ask what evidence is needed and how to send it.



Confirm The Next Step

APD reviews the request. A request does not guarantee enrollment.

A sudden change can leave a family unsure where to turn. Crisis enrollment is a way for APD to consider urgent access to waiver services when specific criteria are met. It is not a separate waiver or a guarantee of immediate services.

**Ask for an individual review**

Describe the person's needs and circumstances. The responsible agency or team makes the determination.

Three Situations APD May Review.

A Safe Place to Live Is At Risk.

The person is homeless, in a shelter, or in an unsafe living arrangement. APD looks at the immediate health and safety risks and available alternatives.

What to explain

Where the person is staying, when that arrangement may end, and why available support cannot keep them safe.

Examples of evidence

A shelter record, eviction notice, or a dated statement describing temporary or unsafe housing.

Behavior Creates An Immediate, Serious Safety Risk.

Without immediate waiver services, behavior may threaten life or cause injury requiring emergency medical care. APD considers the severity, frequency, and supports already attempted.

What to explain

Specific incidents and dates, injuries, what support was tried, and why it has not been enough.

Examples of evidence

Incident reports, medical treatment records, behavior assessments, or an existing safety plan from a professional.

The Caregiver Can No Longer Provide Safe Care.

Illness, injury, advanced age, or extreme duress prevents the caregiver from meeting the person's health and safety needs. APD also reviews whether another caregiver can help.

What to explain

What changed, which daily care tasks can no longer be provided, and why other caregivers are unavailable.

Examples of evidence

A physician's statement about the caregiver's medical limitations and a signed explanation of other circumstances.

More than one situation may apply. Explain the full picture to APD. The agency considers severity, immediate risk, available supports, and the intensity of services needed.

How to Request a Crisis Review.

Step 1



Step 2



Step 3



Contact APD

Tell your regional office that circumstances are urgent and you want to request crisis enrollment.

Explain The Change

Describe the immediate risk, dates, current supports, and why those supports no longer meet the need.

Share Evidence

Send relevant records through APD's approved process. Ask which documents are still needed.

Step 4**Confirm Follow-Up**

Keep your receipt and copies. Ask who is reviewing the request and when to check back.

Applying For The First Time?

APD's online system now includes a Crisis Application section. Follow its prompts along with the initial APD application.

Already In Pre-Enrollment?

Report the change to your APD worker or regional office. The online crisis option also serves active APD clients who are not receiving iBudget services.

APD must establish the applicable disability, level-of-care, and waiver requirements. If the person already receives iBudget services, contact the waiver support coordinator and APD about changing needs.

15 Calendar Days

Florida law sets this eligibility-decision timeframe after APD receives a complete application for an applicant deemed to be in crisis. It is not a promise that services start within 15 days. Ask APD to confirm the complete-application date and explain any delay.

**Prepare the records**

Ask the reviewing team which current records are needed and how to share them securely.

Build a Clear Picture For APD.



A Short Written Explanation

Describe what changed, when it changed, the immediate risks, and the help needed. Include which alternatives were tried and why they are unavailable or insufficient. A letter can support your request; it does not replace APD's application requirements.



Records That Support The Request

Choose documents that relate to the crisis situation above. APD's guidance asks for current records, generally from the last 12 months, and may require additional information. Ask how to proceed if a record is missing.



A Contact and Follow-Up Record

Keep the date submitted, confirmation number, name of the APD contact, and copies of what you sent. Report significant changes promptly.

Keep private information private. Send personal and medical documents only through the official process APD directs you to use. Do not put them in Excellent Care's general contact form.

Know What a Review Can Mean.

Does Meeting Crisis Criteria Guarantee Enrollment?

No. Enrollment depends on APD's determination, the applicable program requirements, and available funding. A crisis request does not guarantee placement in a particular home.

What If APD Denies The Request?

Ask for the written decision and review the appeal instructions and deadlines in that notice. Disability Rights Florida may be able to explain your rights or offer assistance.

Can Excellent Care Approve a Crisis Request?

No. APD makes crisis and waiver enrollment decisions. Excellent Care can discuss its residential programs, but its referral form is not an APD crisis application.

Connect With The Official Team.

APD Southern

Miami-Dade & Monroe
(305) 810-1016

APD Southeast

Broward & nearby
counties
(561) 822-4596

APD Information

Not sure where to start?
1-866-273-2273

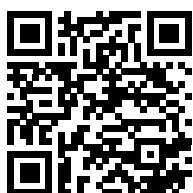
Confirm the office serving your county through APD. These are program contacts, not emergency lines.

Sources: [29], [30], [31], [32], [33], [34], [35], [12], [36]



Agree on the next contact

Record whom to contact, the next action, and when to follow up.



Continue With The Online Guide

Scan for the current guide and its video section. Video availability and viewing permissions may vary.

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TOPIC 08 / Planning & decisions

Life After School

Planning For 22 and Beyond.

Leaving school is a change in support, not an end to possibility. Start with the young person's interests, choices, and idea of a good day.



Make the next step concrete

Agree on who will do what, when it will happen, and what still needs confirmation.



Explore meaningful activities

Ask about work, learning, community participation, and the supports needed to try them.

Different Ages. Connected Plans.

Step 1



Start Early / Build The Transition Team.

Florida's school transition planning begins at age 12. Use the Individualized Education Program (IEP) to connect learning with adult goals. Invite the student to lead in the way that works for them. A question to ask What does the student want life after school to include? Who can help Student, family, school social worker, and IEP/ESE team.

Step 2**Explore Work & Learning / Try Possibilities Before School Ends.**

Ask Florida Vocational Rehabilitation about student services, including Pre-Employment Transition Services for eligible students ages 14-21. Explore work experience, further learning, transportation, and community activities. A question to ask What can we try now, and who will help arrange it? Who can help School transition staff and a Vocational Rehabilitation counselor.

**Step 3****Around Age 18 / Review Benefits and Decision Support.**

SSI uses adult disability rules for an age-18 review. Separately, discuss healthcare, consent, and any help the young adult wants with decisions. These changes do not all happen on the school's timeline. A question to ask Which benefits and permissions need a separate review? Who can help Social Security, the healthcare team, and a qualified legal adviser when needed.

**Step 4****Before The Final School Day / Make The Next Week Real.**

Confirm the individual exit date and diploma arrangements with the school. Map an ordinary week: daytime activities, transport, care, relationships, and backup support. Ask which adult services are actually approved and ready. A question to ask Who is responsible for each part of the first week after school? Who can help School team, APD or the waiver support coordinator, and chosen adult-service providers.

Do not wait for a 22nd birthday to start. School eligibility and exit dates vary. School services do not automatically transfer into APD, Medicaid, or adult programs.



Look up, then verify

Use official sources to find options. Confirm current services, eligibility, and availability with the responsible team.

Work, Benefits, and The Next Step

Editorial draft · employment and benefits specialist review pending · Sources checked October 2, 2026.

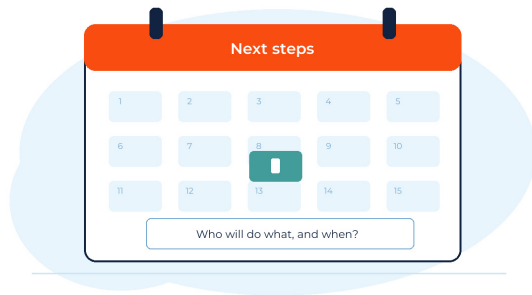
Compare options on a printed copy; note the person's goals, questions, contacts, and next step.

The Person's Goals

- Topic 01 Explore work Ask the person what work they want to try. APD's 2017 job-coach brochure describes help with a work plan, résumé, applications, interviews, employer contacts, and transportation coordination. Confirm what a current coach will actually provide.
- Topic 02 Plan daily supports Plan the route to work, hours, communication, support on the job, and a backup ride before the first day. Ask who to call if the job or support changes.
- Topic 03 Check benefits Before earnings change, ask a qualified benefits counselor about the person's actual SSI/SSDI, Medicaid, and reporting situation. Social Security's Find Help tool identifies providers and benefits-counseling resources; this page cannot predict benefit amounts.
- Topic 04 Explore learning For school-to-adult planning, browse Project 10 publications with the student and school team. Explore FCSUA's inclusive college program finder and confirm each program's current admissions, supports, and costs.

APD job-coach brochure (2017 PDF) · Social Security: Find Help · Project 10 transition publications · FCSUA inclusive college program finder

Sources: [37], [38], [39], [40], [41], [42], [43]



Make the next step concrete

Agree on who will do what, when it will happen, and what still needs confirmation.



Continue With The Online Guide

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Questions to Take With You



Goals & School

- What matters most to the student after school?
- What is the confirmed school exit date?



Services & Daily Life

- Which adult services are approved, and which are pending?
- What will daytime activities, care, and transport look like?



Contacts & Next Steps

- Who will coordinate the school-to-adult handoff?
- When will we review progress and the backup plan?

Notes & next steps

One question I want answered / the next person to contact

Go Further When You Are Ready.

**Florida Department of Education:
School Transition**

[41] Sources

**Florida Vocational Rehabilitation:
Student Services**

[42] Sources

Social Security: SSI Redeterminations

[43] Sources

Keep Exploring

Turning 18: Choices & Support

TOPIC 11

Florida Medicaid Waiver Programs

TOPIC 06

TOPIC 09 / Planning & decisions

When Home Is Not An Option

Leaving The Hospital, With a Plan.

It is okay to say clearly what care is - and is not - available. Bring the person's wishes and the real barriers to the hospital social worker or case manager as early as possible.



Make the next step concrete

Agree on who will do what, when it will happen, and what still needs confirmation.



Share the same plan

Keep the person, chosen supporters, and sending and receiving teams connected.

What Is Making The Next Step Difficult?

01



No Available Caregiver / Explain The Gap Without Blame.

Describe which tasks, hours, and supervision are unavailable. A relative may be unable or unwilling to provide care; the team needs an accurate picture, not an assumed caregiver.

A question to ask

Can we document the care gap and hold a discharge-planning meeting?

Who can help

Hospital social worker, case manager, patient, and chosen support people.

02



Care Needs Are Too Complex / Match The Setting to The Actual Needs.

Ask the clinical team to describe nursing, respiratory, behavioral, equipment, and accessibility needs. Ask which receiving providers can review those needs and what support would be required.

A question to ask

Has a potential receiving team reviewed the current care needs?

Who can help

Treating clinicians, discharge staff, and potential receiving providers.

03



Funding Or Placement Is Unclear / Separate The Questions That Need Answers.

Clinical fit, an available opening, and payment approval are separate issues. Ask who is contacting the health plan, APD, and any current waiver support coordinator. Record what is pending and the next follow-up date.

A question to ask

What is pending, who owns each step, and when will we hear back?

Who can help

Case management, the health plan, APD, and the waiver support coordinator when involved.



Prepare the records

Ask the reviewing team which current records are needed and how to share them securely.

A hospital stay, a family's inability to provide care, or a referral does not automatically secure a waiver, a residential opening, or payment. If the proposed discharge feels unsafe, explain the specific concern promptly and ask the hospital about its review and escalation process.

Sources: [44], [34]



Agree on the next contact

Record whom to contact, the next action, and when to follow up.



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Questions to Take With You



Person & Care Needs

- What does the person want, and what care is needed?
- Which care tasks or hours cannot be covered at home?



Options & Review

- Which providers have reviewed the current needs?
- What funding, service, or placement approvals are pending?



Coordination & Follow-Up

- Who is coordinating the plan and the next meeting?
- How do we raise an unresolved safety concern?

Notes & next steps

One question I want answered / the next person to contact

Go Further When You Are Ready.

Federal Hospital Discharge-Planning Requirements

[44] Sources

APD: Crisis Review Information

[34] Sources

Keep Exploring

Hospital-to-Residential Transition

TOPIC 05

Crisis Waiver

TOPIC 07

TOPIC 10 / Planning & decisions

When a Caregiver Cannot Continue

A Change In Care Needs a Shared Plan.

Needing more help is not a failure. Describe what has changed, what support remains, and what the person needs to stay safe and connected.



Talk about changing support

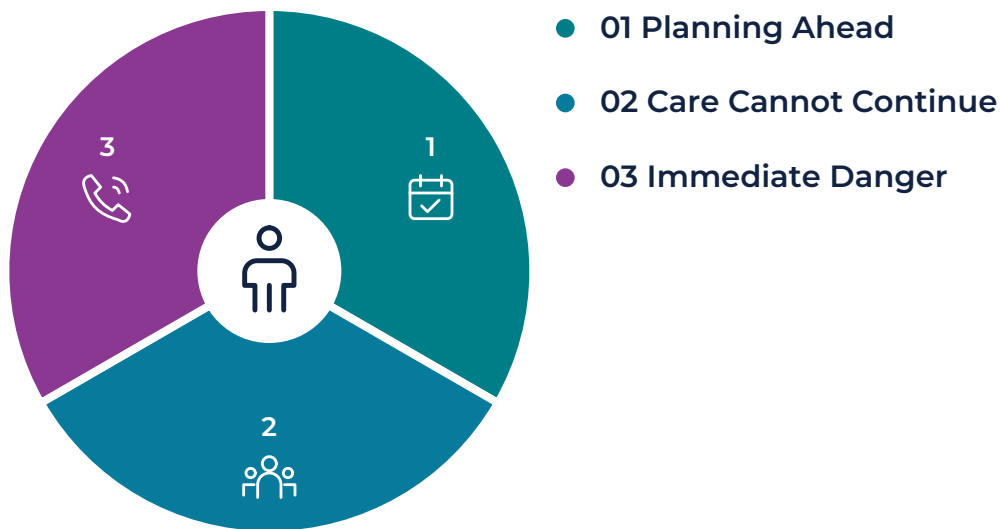
Explain which care tasks or hours are becoming difficult and what help is still available.



Care belongs in everyday life

Discuss familiar routines, meaningful activities, comfort, and relationships alongside care needs.

How Soon Is Help Needed?



01



Build a Backup Before It Is Needed.

Write down daily support needs, familiar routines, and people to contact. Ask about respite, in-home supports, and longer-term options. Check eligibility, approval, and availability rather than assuming a service is ready.

A question to ask

What is our backup if the main caregiver becomes unavailable?

Who can help

The person, chosen supporters, APD, and any current support coordinator.

02



Report The Change With Concrete Examples.

Explain the caregiver's health or capacity, which tasks cannot be done, and what alternatives have been tried. Ask APD whether a crisis review may be appropriate. APD decides whether its requirements are met.

A question to ask

What documentation is needed, and how do we submit it securely?

Who can help

APD and, for someone already receiving iBudget services, the waiver support coordinator.

03



Use Emergency Help For An Emergency.

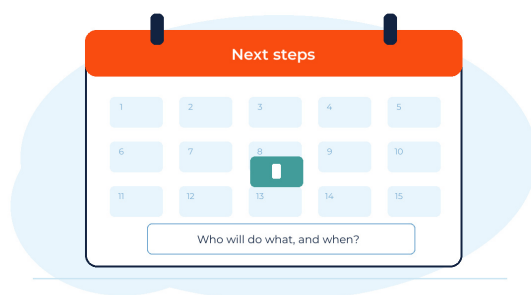
If someone is in immediate danger or has a medical emergency, call 911. A waiver request is not an emergency-response service. Once immediate safety is addressed, involve the care team in planning the next supports.

A question to ask

Who can help coordinate support after the immediate emergency?

Who can help

Emergency services now; the care team and APD for follow-up planning.



Make the next step concrete

Agree on who will do what, when it will happen, and what still needs confirmation.

Caregiver strain deserves attention, but it does not automatically qualify someone for crisis enrollment. APD reviews the circumstances and program requirements. Do not wait for a crisis to report changing needs.

Sources: [31], [34]



Agree on the next contact

Record whom to contact, the next action, and when to follow up.



Continue With The Online Guide

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Questions to Take With You



What Has Changed

- Which care tasks or hours are no longer manageable?
- What support is still available, and from whom?



Options & Documentation

- Which supports could help now or in the future?
- What records does APD need to review the change?



Backup & Follow-Up

- Who will we call if the caregiver becomes unavailable?
- What is the next action, contact, and follow-up date?

Notes & next steps

One question I want answered / the next person to contact

Go Further When You Are Ready.

APD: Caregiver-Related Crisis Criteria

[31] Sources

APD: Crisis Review Information

[34] Sources

Keep Exploring

Crisis Waiver

TOPIC 07

When Home Is Not An Option

TOPIC 09

TOPIC 11 / Planning & decisions

Turning 18: Choices & Support

Support The Person. Respect Their Voice.

A disability diagnosis alone does not remove a person's right to make decisions. Start by asking what the young adult wants help with and how information can be made easier to understand.

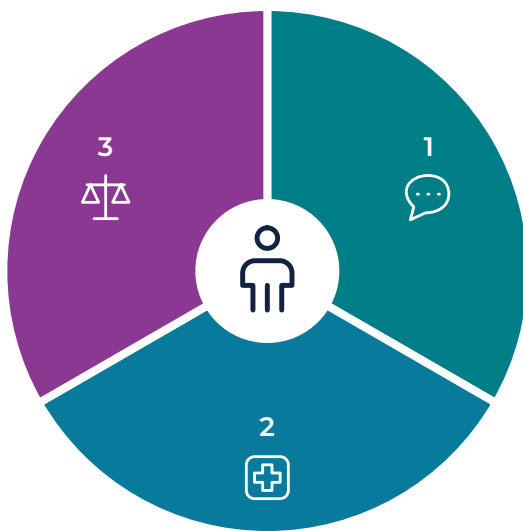
**Start with the person**

Include the person in the conversation. Ask about their preferences, goals, and the support they want.

**Help the person understand choices**

Use clear language, pictures, and enough time. Ask whom the person wants involved.

Different Supports Do Different Jobs.



- 01 Help Understanding Choices
- 02 Health & Information
- 03 Formal Decision Authority

01



Help Understanding Choices / The Person Stays At The Center.

Supported decision-making can include trusted people, plain-language explanations, pictures, and extra time. Support helps the person understand and communicate choices; it is not the same as someone taking over decisions.

A question to ask

What helps this person understand and express a choice?

Who can help

The young adult, chosen supporters, and an advocate if wanted.

02



Health & Information / Ask What Permission Is Needed.

Access to records, permission to discuss care, and authority to make a healthcare decision are not interchangeable. Ask the provider what consent or documentation applies. Get legal advice before choosing a formal arrangement.

A question to ask

What may supporters do, and what still requires the adult's consent?

Who can help

The healthcare team and a qualified Florida legal adviser.

03



Formal Decision Authority / Understand The Scope Before Acting.

Powers of attorney, healthcare arrangements, guardian advocacy, and guardianship have different requirements and limits. A qualified adviser can explain alternatives and any court process. Do not assume a parent automatically keeps all decision-making authority at 18.

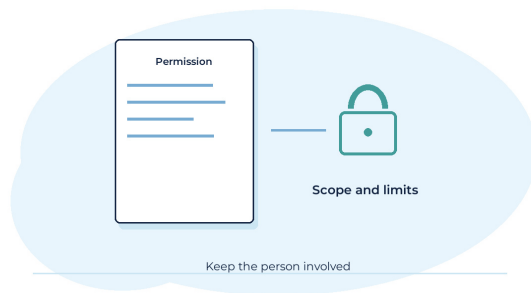
A question to ask

What is the least restrictive support that fits this person's needs?

Who can help

The adult, a disability-rights advocate, and a qualified legal adviser.

This guide explains conversation topics, not which legal arrangement to choose. Authority depends on applicable law and valid documents or court orders. For time-sensitive consent questions, ask the healthcare team to involve its appropriate legal or ethics support.



Clarify permissions

Ask what permission or authority is needed for records, care discussions, and decisions.

Compare Decision Supports At 18

Compare options on a printed copy; note the person's goals, questions, contacts, and next step.

Editorial draft · Florida legal and transition review pending · Sources checked October 2, 2026.

- **Topic The person's voice** Ask the young adult how they want information, who they trust, and which decisions they want help with. Different arrangements have different legal scope; no single option fits everyone.
- **Topic Legal scope** Florida Statutes § 709.2209 describes a supported decisionmaking agreement as authority to receive information and communicate for the person without authority to bind or act for them. This is not a durable power of attorney. Ask a qualified Florida adviser how this and other options apply.
- **Topic School transition** At a transition meeting, ask the school team which rights or records change at 18, how the student will participate, and what college, work, health, and community supports to explore.
- **Topic Programs and resources** Project 10 has publications on age of majority and transition planning. FCSUA lists inclusive postsecondary programs; confirm each program's current requirements and supports.

Florida Statutes § 709.2209 · Project 10 transition publications · FCSUA inclusive college program finder

Sources: [33], [39], [40], [45], [46], [43]



Look up, then verify

Use official sources to find options. Confirm current services, eligibility, and availability with the responsible team.



Continue With The Online Guide

Scan for the current guide and its video section. Video availability and viewing permissions may vary.

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Questions to Take With You



Voice & Support

- What decisions does the young adult want help with?
- Who does the person trust, and how do they communicate?



Consent & Documents

- Which permissions or documents need review at 18?
- What does each document allow, and what are its limits?



Benefits & Advice

- Which benefits need an adult-eligibility review?
- Who can explain less restrictive support options?

Notes & next steps

One question I want answered / the next person to contact

Go Further When You Are Ready.

Disability Rights Florida: Supported Decision-Making

[45] Sources

Disability Rights Florida: Guardianship and Alternatives

[46] Sources

Social Security: SSI Redeterminations

[43] Sources

Keep Exploring

Life After School

TOPIC 08

Admissions and Eligibility

TOPIC 01

A Few Words You May Hear

APD

Florida's Agency for Persons with Disabilities.

Eligibility

Meeting a program's requirements. This is not the same as enrollment or an approved service.

Authorization

Approval for a specific service, within the applicable plan and program rules.

Support Coordinator / Case Manager

A person who helps connect needs, plans, providers, and follow-up.

IEP

Individualized Education Program: the student's school plan.

Care Handoff

The transfer of relevant information and responsibilities between care teams.

Sources & Useful Contacts

The handbook adapts all 11 Resource Center topics. Source numbers refer to the links listed below. Agency pages may be in English; ask the agency for language assistance when needed. Rules and availability can change.

[1] Watch on YouTube

youtu.be/qxMwPaiXoQs

[2] Florida APD residential services

apd.myflorida.com/providers/residential.htm

[3] Watch on YouTube

youtu.be/hIX6iVpzxLU

[4] MedlinePlus tracheostomy information

medlineplus.gov/trachealdisorders.html

[5] Watch on YouTube

youtu.be/TnRdYl_drcM

[6] MedlinePlus oxygen therapy

medlineplus.gov/oxygentherapy.html

[7] Watch on YouTube

youtu.be/SGBW_B0ckFM

[8] APD Provider Search

providersearch.apd.myflorida.com/

[9] APD provider-search information

apd.myflorida.com/resources/providersearch.htm

[10] Watch on YouTube

youtu.be/9fGJ8gPndIM

[11] AHRQ discharge planning

www.ahrq.gov/patient-safety/patients-families/engagingfamilies/strategy4/index.html

[12] Visit APD's application information

apd.myflorida.com/services/apply.htm

[13] Read more: MedlinePlus

medlineplus.gov/ency/article/001523.htm

[14] Read more: CDC

www.cdc.gov/autism/about/index.html

[15] APD documentation guidance

apd.myflorida.com/services/autism.htm

[16] Read more: CDC

www.cdc.gov/cerebral-palsy/about/index.html

[17] Read more: CDC

www.cdc.gov/spina-bifida/about/index.html

[18] Read more: MedlinePlus

medlineplus.gov/genetics/condition/down-syndrome/

[19] Read more: MedlinePlus

medlineplus.gov/genetics/condition/prader-willi-syndrome/

[20] Read more: MedlinePlus

medlineplus.gov/genetics/condition/22q133-deletion-syndrome/

[21] Read more: GeneReviews

www.ncbi.nlm.nih.gov/sites/books/NBK581652/

[22] APD documentation guidance

apd.myflorida.com/services/age35.htm

[23] Source: APD's eight service families

apd.myflorida.com/medicaid/ibudget/ibudgetservices.htm

[24] APD pre-enrollment

apd.myflorida.com/services/preenrollment.htm

[25] APD Medicaid Waiver Services

apd.myflorida.com/services/medicaid.htm

[26] APD iBudget Florida

apd.myflorida.com/medicaid/ibudget/

[27] Florida DD Resources

fddresources.qlarant.com/medicaid-waivers/

[28] AHCA: ICMC

ahca.myflorida.com/icmc-program.html

[29] APD housing documentation guidance

apd.myflorida.com/services/homeless.htm

[30] APD safety documentation guidance

apd.myflorida.com/services/dangertoself.htm

[31] APD caregiver documentation guidance

apd.myflorida.com/services/caregiver.htm

[32] Open APD's application system

applynow.apd.myflorida.com/

[33] Source: Florida Statutes, section 393.065

leg.state.fl.us - Florida Statutes 393.065

[34] APD crisis guidance

apd.myflorida.com/services/crisisguide.htm

[35] APD's quick guide

apd.myflorida.com/services/docs/QuickGuideCrisis.pdf

[36] Disability Rights Florida

disabilityrightsflorida.org/

[37] APD job-coach brochure (2017 PDF)

apd.myflorida.com/brochures/What%20to%20Expect%20From%20Your%20Job%20Coach.B2017.pdf

[38] Social Security: Find Help

choosework.ssa.gov/findhelp

[39] Project 10 transition publications

project10.info/DPage.php?ID=77

[40] FCSUA inclusive college program finder

www.fcsua.org/findfpctp/

[41] Florida Department of Education: school transition

www.fldoe.org/academics/exceptional-student-edu/secondary-transition.shtml

[42] Florida Vocational Rehabilitation: student services

www.rehabworks.org/student-youth/student-youth.html

[43] Social Security: SSI redeterminations

www.ssa.gov/ssi/text-redets-ussi.htm

[44] Federal hospital discharge-planning requirements

www.ecfr.gov/current/title-42/chapter-IV/subchapter-G/part-482/subpart-C/section-482.43

[45] Disability Rights Florida: supported decision-making

disabilityrightsflorida.org/disability-topics/disability_topic_info/faqs_about_supported_decision_making

[46] Disability Rights Florida: guardianship and alternatives

transition.disabilityrightsflorida.org/guardianship-and-guardianship-alternatives/

[47] Early Steps

floridaearlysteps.com/

[48] Florida public schools · ESE

www.fldoe.org/academics/exceptional-student-edu/staff/ease-directors.shtml

[49] Family Empowerment Scholarship · Unique Abilities

www.stepupforstudents.org/scholarships/unique-abilities/

[50] Florida Diagnostic & Learning Resources System

www.fdlrs.org/

[51] Project 10: Transition Education Network

project10.info/

[52] APD Unique Abilities Partner Program

apd.myflorida.com/unique/

[53] Florida Vocational Rehabilitation

rehabworks.org/student-youth/student-youth.html

[54] CareerSource Florida

careersourceflorida.com/

[55] Florida Center for Students with Unique Abilities

fcsua.org/

[56] Agency for Persons with Disabilities (APD)

apd.myflorida.com/

[57] Department of Children and Families (DCF)

www.myflfamilies.com/

[58] Agency for Health Care Administration (AHCA)

ahca.myflorida.com/

[59] Read APD's complete Roadmap to Family Resources

apd.myflorida.com/resources.htm

Notes & Next Steps

Keep your notes private. Do not record sensitive medical identifiers in a copy you plan to share. Send care records only through the secure process your team provides.

Next Action

Notes & next steps

One question I want answered / the next person to contact

Contact / person responsible: _____

Follow-up date: _____

Next Action

Notes & next steps

One question I want answered / the next person to contact

Contact / person responsible: _____

Follow-up date: _____

One Next Step Is Enough.

You can return to these pages whenever your questions or circumstances change. Keep the person's preferences, safety, and everyday life in the conversation.



Online Resource Center

excellentcare.org/resources/

The Resource Center's video series is in preparation. Video placeholders have been replaced here with readable diagrams and conversation prompts. The online Resource Center can be used for future updates.

General education only. This handbook does not provide individual medical or legal advice, determine eligibility, approve funding, or confirm a placement. APD, Medicaid, health plans, clinicians, and receiving providers make the decisions within their roles. Confirm current requirements and availability with the responsible team.

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