SB 238 by **Ring**; (Identical to H 0479) Athletic Coaches

SB 878 by **Montford**; (Similar to H 0055) Children and Youth Cabinet

366808	A	S	CF, Dean	Delete L.23:	03/09 04:43 PM

SB 940 by **Detert (CO-INTRODUCERS) Sachs**; Children in Out-of-home Care

473434	D	S	CF, Detert	Delete everything after	03/10 04:57 PM

SB 1226 by **Detert**; (Identical to H 1225) Guardianship

SB 1340 by **Latvala**; (Similar to H 1017) Mental Health and Substance Abuse

SPB 7048 by **CF**; Developmental Disabilities

The Florida Senate

COMMITTEE MEETING EXPANDED AGENDA

CHILDREN, FAMILIES, AND ELDER AFFAIRS
Senator Sobel, Chair
Senator Altman, Vice Chair

MEETING DATE: Thursday, March 12, 2015
TIME: 9:00 —11:00 a.m.
PLACE: 301 Senate Office Building

MEMBERS: Senator Sobel, Chair; Senator Altman, Vice Chair; Senators Dean, Detert, Garcia, and Ring

TAB	BILL NO. and INTRODUCER	BILL DESCRIPTION and SENATE COMMITTEE ACTIONS	COMMITTEE ACTION
1	**SB 238** Ring (Identical H 479)	Athletic Coaches; Requiring an independent sanctioning authority to dismiss an athletic coach ejected from a game for the remainder of that sport season under certain circumstances; authorizing such athletic coach to resume working under certain circumstances, etc. CF 03/12/2015 CA JU FP	
2	**SB 878** Montford (Similar H 55)	Children and Youth Cabinet; Revising the membership of the cabinet, etc. CF 03/12/2015 ED RC	
3	Presentation by the Office of Program Policy Analysis and Governmental Accountability on Foster Care Group Homes		
4	**SB 940** Detert	Children in Out-of-home Care; Removing provisions requiring the Department of Children and Families to develop, implement, and administer a coordinated community-based system of care for children directed toward specified goals; authorizing children of certain ages to be placed in a residential group home setting using a shift-care model only under specified circumstances; requiring the department to develop a proposal for a continuum of care for children in out-of-home care, etc. CF 03/12/2015 AHS AP	

TAB	BILL NO. and INTRODUCER	BILL DESCRIPTION and SENATE COMMITTEE ACTIONS	COMMITTEE ACTION
5	**SB 1226** Detert (Identical H 1225)	Guardianship; Revising the responsibilities of the executive director for the Office of Public and Professional Guardians; requiring the Office of Public and Professional Guardians to adopt rules; requiring that a professional guardian appointed by a court to represent an allegedly incapacitated person be selected from a registry of professional guardians, etc. CF 03/12/2015 JU FP	
6	**SB 1340** Latvala (Similar H 1017)	Mental Health and Substance Abuse; Authorizing a family member of a patient or an interested party to petition a court for the appointment of a guardian advocate; establishing the Substance Abuse Assistance Pilot Program within the Department of Children and Families; authorizing an adult with capacity to execute a mental health or substance abuse treatment advance directive; prohibiting criminal prosecution of a health care facility, provider, or surrogate who acts pursuant to a mental health or substance abuse treatment decision, etc. CF 03/12/2015 AHS AP	
	Consideration of proposed bill:		
7	**SPB 7048**	Developmental Disabilities; Requiring the Agency for Persons with Disabilities to revise the priority order for the waiver services for specified children which are otherwise not available to them; establishing requirements for children and certain young adults with a category 2 priority, etc.	
	Other Related Meeting Documents		

The Florida Senate

BILL ANALYSIS AND FISCAL IMPACT STATEMENT

(This document is based on the provisions contained in the legislation as of the latest date listed below.)

Prepared By: The Professional Staff of the Committee on Children, Families, and Elder Affairs

BILL: SB 238

INTRODUCER: Senator Ring

SUBJECT: Athletic Coaches

DATE: March 5, 2015 REVISED:

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Preston	Hendon	CF	**Pre-meeting**
2.			CA	
3.			JU	
4.			FP	

I. Summary:

SB 238 requires an independent sanctioning authority to dismiss an athletic coach who is ejected from a game in a league of children who are 12 years of age or younger. The dismissal is in effect at least until the following sport season.

The bill also requires a process for coaches to appeal an ejection to the sanctioning authority.

The bill is anticipated to have no fiscal impact on state government.

The bill has an effective date of July 1, 2015.

II. Present Situation:

Current law defines the term "athletic coach" as a person who is authorized by an independent sanctioning authority to work as a coach, assistant coach, or referee for 20 or more hours within a calendar year, whether for compensation or as a volunteer, for a youth athletic team based in this state and who has direct contact with one or more minors on the youth athletic team.[1]

The term "independent sanctioning authority" is defined as a private, nongovernmental entity that organizes, operates, or coordinates a youth athletic team in this state if the team includes one or more minors and is not affiliated with a private school as defined in s. 1002.01.[2] An independent sanctioning authority is required to do the following:

- Conduct a level 1 background screening pursuant to s. 435.03, F.S., of each current and prospective athletic coach and maintain certain documentation of those screenings for at least 5 years.

[1] Section 943.0438, F.S.
[2] *Id.*

- Adopt policies related to requirements for parents or guardians of a young athlete to annually sign and return an informed consent that explains the nature and risk of concussion and head injury, including the risk of continuing to play after concussion or head injury.
- Adopt policies related to continued participation and return to participation by a young athlete who is suspected of sustaining a concussion or head injury.[3]

III. Effect of Proposed Changes

Section 1 amends s. 943.0438, F.S., to require an independent sanctioning authority to immediately dismiss an athletic coach who has been ejected from a game in a league in which the children are 12 years of age or younger. The dismissed coach may resume work as a coach the following sport season or any time after that if the authority determines the coach is still qualified. A procedure for a coach to appeal an ejection is also required to be established by a sanctioning authority.

Section 2 provides an effective date of July 1, 2015.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

None.

C. Government Sector Impact:

None.

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[3] *Id.*

VI. Technical Deficiencies:

None.

VII. Related Issues:

None.

VIII. Statutes Affected:

This bill substantially amends the following sections of the Florida Statutes: 943.0438.

IX. Additional Information:

A. Committee Substitute – Statement of Changes:

(Summarizing differences between the Committee Substitute and the prior version of the bill.)

None.

B. Amendments:

None.

This Senate Bill Analysis does not reflect the intent or official position of the bill's introducer or the Florida Senate.

By Senator Ring

29-00149-15 2015238__

1 A bill to be entitled
2 An act relating to athletic coaches; amending s.
3 943.0438, F.S.; requiring an independent sanctioning
4 authority to dismiss an athletic coach ejected from a
5 game for the remainder of that sport season under
6 certain circumstances; authorizing such athletic coach
7 to resume working under certain circumstances;
8 requiring an independent sanctioning authority to
9 establish a procedure for an athletic coach to appeal
10 certain decisions; providing an effective date.
11
12 Be It Enacted by the Legislature of the State of Florida:
13
14 Section 1. Paragraph (h) is added to subsection (2) of
15 section 943.0438, Florida Statutes, to read:
16 943.0438 Athletic coaches for independent sanctioning
17 authorities.—
18 (2) An independent sanctioning authority shall:
19 (h) Immediately dismiss an athletic coach who is ejected
20 from a game in a league of children 12 years of age or younger
21 for the remainder of the sport season.
22 1. Except as provided in subparagraph 2., the independent
23 sanctioning authority may allow an athletic coach dismissed
24 under this paragraph to resume working as an athletic coach for
25 the league the following sport season or any time thereafter if
26 the authority determines that the person remains qualified to
27 work as an athletic coach.
28 2. The independent sanctioning authority must establish a
29 procedure of due process to ensure that an athletic coach

29-00149-15 2015238__

30 ejected from a game in a league of children 12 years of age or
31 younger has the opportunity to appeal the ejection to the
32 independent sanctioning authority. The authority shall expedite
33 the appeal process so that disposition of the appeal can be made
34 before the end of the applicable sport season, if possible. If
35 the athletic coach is successful in his or her appeal, the
36 athletic coach shall be reinstated and allowed to continue
37 coaching for the remainder of the sport season and thereafter.
38 Section 2. This act shall take effect July 1, 2015.

CODING: Words ~~stricken~~ are deletions; words underlined are additions.

The Florida Senate

BILL ANALYSIS AND FISCAL IMPACT STATEMENT

(This document is based on the provisions contained in the legislation as of the latest date listed below.)

Prepared By: The Professional Staff of the Committee on Children, Families, and Elder Affairs

BILL: SB 878

INTRODUCER: Senator Montford

SUBJECT: Children and Youth Cabinet

DATE: March 5, 2015 REVISED:

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Preston	Hendon	CF	**Pre-meeting**
2.			ED	
3.			RC	

I. Summary:

SB 878 adds a superintendent of schools to the membership of the Florida Children and Youth Cabinet. The superintendent is to be appointed by the Governor.

The bill does not have a fiscal impact on state government.

The bill has an effective date of July 1, 2015.

II. Present Situation:

The Florida Children and Youth Cabinet (cabinet) was created in 2007[1]for the purpose of developing and implementing a shared vision among the branches of government in order to improve child and family outcomes statewide.[2]

Current cabinet membership includes the Governor and 14 members.[3] These members include the Secretary of Children and Families, the Secretary of Juvenile Justice, the director of the Agency for Persons with Disabilities, the director of the Office of Early Learning, the State Surgeon General, the Secretary of Health Care Administration, the Commissioner of Education, the director of the Statewide Guardian Ad Litem Office, the director of the Office of Child Abuse Prevention,[4]and five members representing children and youth advocacy organizations, who are not service providers and who are appointed by the Governor.[5]

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[1] Chapter 2007-151, L.O.F.

[2] Section 402.56, F.S.

[3] Section 402.56, F.S., currently states that the "cabinet shall consist of 14 members including the Governor and the following persons . . ." However, there are 14 specific members listed in addition to the Governor, bringing the total membership to 15 members. The bill changes the total number to 16 members, which will correct an inaccuracy in current law.

[4] The Office of Child Abuse Prevention was created in 2006 and the name was changed to the Office of Adoption and Child Protection in 2007. See chapters 2006-194 and 2007-124, L.O.F., respectively.

[5] Section 402.56, F.S.

III. Effect of Proposed Changes:

Section 1 amends s. 402.56, F.S., to expand cabinet membership to include a superintendent of schools to be appointed by the Governor.

Section 2 provides for an effective date of July 1, 2015.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

None.

C. Government Sector Impact:

None.

VI. Technical Deficiencies:

None.

VII. Related Issues:

None.

VIII. Statutes Affected:

This bill substantially amends the following sections of the Florida Statutes: 402.56.

IX. Additional Information:

A. Committee Substitute – Statement of Changes:

(Summarizing differences between the Committee Substitute and the prior version of the bill.)

None.

B. Amendments:

None.

This Senate Bill Analysis does not reflect the intent or official position of the bill's introducer or the Florida Senate.

366808

LEGISLATIVE ACTION

Senate	.	House
	.	
	.	
	.	
	.	
	.	

The Committee on Children, Families, and Elder Affairs (Dean) recommended the following:

1 **Senate Amendment**

2

3 Delete line 23

4 and insert:

5 9. The director of the Office of Adoption and Child

6 Protection;

By Senator Montford

3-00422-15 2015878__

A bill to be entitled

An act relating to the Children and Youth Cabinet; amending s. 402.56, F.S.; revising the membership of the cabinet; providing an effective date.

Be It Enacted by the Legislature of the State of Florida:

Section 1. Paragraph (a) of subsection (4) of section 402.56, Florida Statutes, is amended to read:

402.56 Children's cabinet; organization; responsibilities; annual report.—

(4) MEMBERS.—The cabinet shall consist of 16 ~~14~~ members including the Governor and the following persons:

(a)1. The Secretary of Children and Families;

2. The Secretary of Juvenile Justice;

3. The director of the Agency for Persons with Disabilities;

4. The director of the Office of Early Learning;

5. The State Surgeon General;

6. The Secretary of Health Care Administration;

7. The Commissioner of Education;

8. The director of the Statewide Guardian Ad Litem Office;

9. The director of the Office of Child Abuse Prevention; ~~and~~

10. A superintendent of schools, appointed by the Governor; and

11.~~10.~~ Five members who represent ~~representing~~ children and youth advocacy organizations and who~~, who~~ are not service providers, ~~and who are~~ appointed by the Governor.

CODING: Words ~~stricken~~ are deletions; words underlined are additions.

3-00422-15 2015878__

Section 2. This act shall take effect July 1, 2015.

CODING: Words ~~stricken~~ are deletions; words underlined are additions.

Senate Committee on Children, Families, and Elder Affairs

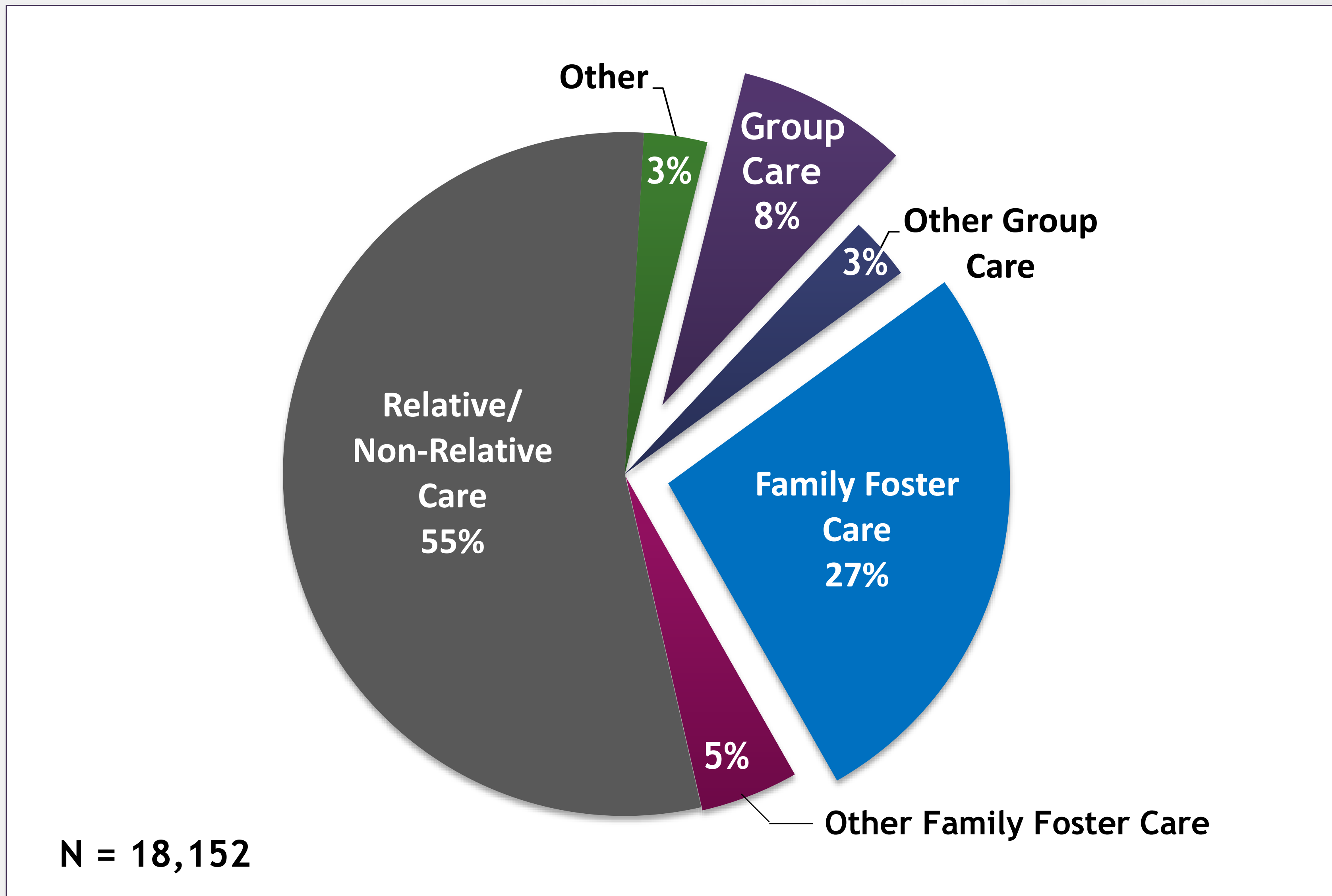
Jennifer Johnson
Health and Human Services Staff Director

March 12, 2015

Residential Group Care

- How is placement in residential group care determined?
- What are the services and costs associated with residential group care?
- How does the population of children in residential group care compare to those in family foster care?

In Fiscal Year 2013-14, There Were 18,152 Dependent Children in Out-of-Home Care



Residential Group Care Models

- Two models
  - Shift-care with staff who work in shifts
  - Family group homes with live-in staff
- Fiscal Year 2013-14, community-based care (CBC) lead agencies contracted with 96 providers
  - 58% shift-care
  - 42% family group homes

How Is Placement in Residential Group Care Determined?

- An assessment for determining placement in a group home must be conducted when the child
  - Is age 11 or older,
  - Has been in licensed family foster care for more than six months and removed more than once, AND
  - Has serious behavioral problems
- The assessment must consider specific factors such as
  - Placement of siblings
  - Availability of more family-like settings

How Is Placement in Residential Group Care Determined?

- DCF has policies and procedures to emphasize the use of family foster care
  - Discourage CBCs from placing children under age 12 in group care unless it keeps siblings together
  - Encourage lead agencies to recruit foster families

How Is Placement in Residential Group Care Determined?

- CBCs have policies and procedures to emphasize the use of family foster care
  - Approval of group care placements by CBC specialists
  - Monthly reviews to find family foster care
  - Limit placement to children with behavioral problems and sibling groups, especially large sibling groups

What Are the Services and Costs Associated with Residential Group Care?

- Residential group care providers must provide a minimum range of activities and services including
  - Basic needs such as food and clothing
  - Opportunities for recreation and activities
  - Arranging necessary medical appointments
  - Ensuring transportation to services and activities
- Medical services, including behavioral health care, are provided by Medicaid

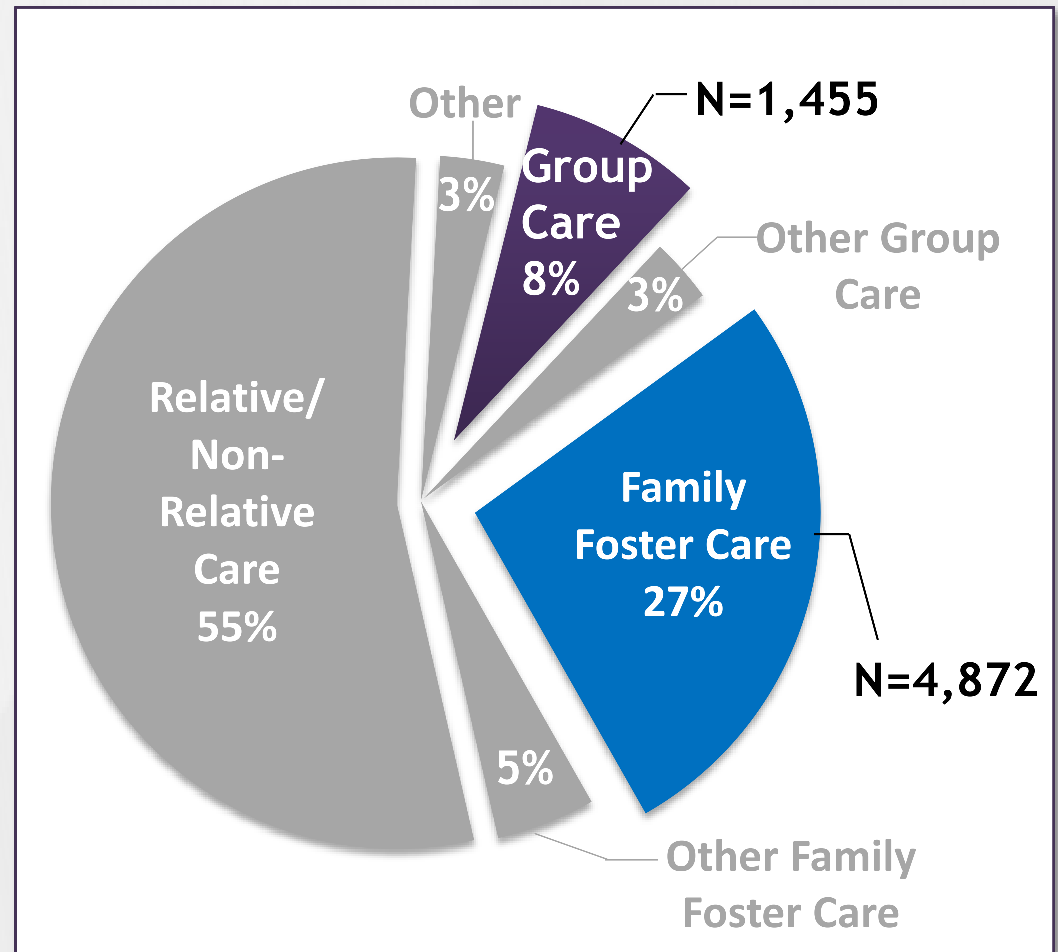
What Are the Services and Costs Associated with Residential Group Care?

- Fiscal Year 2013-14 average per diem rates
  - Shift-care model $124
  - Family group home $97
- CBCs annually negotiate rates and consider several factors
  - E.g., bed capacity, private funding, staff to client ratios, and special needs and services
- Family foster care parents receive an average per diem of $15

How Do Children in Residential Group Care Compare to Children in Family Foster Care?

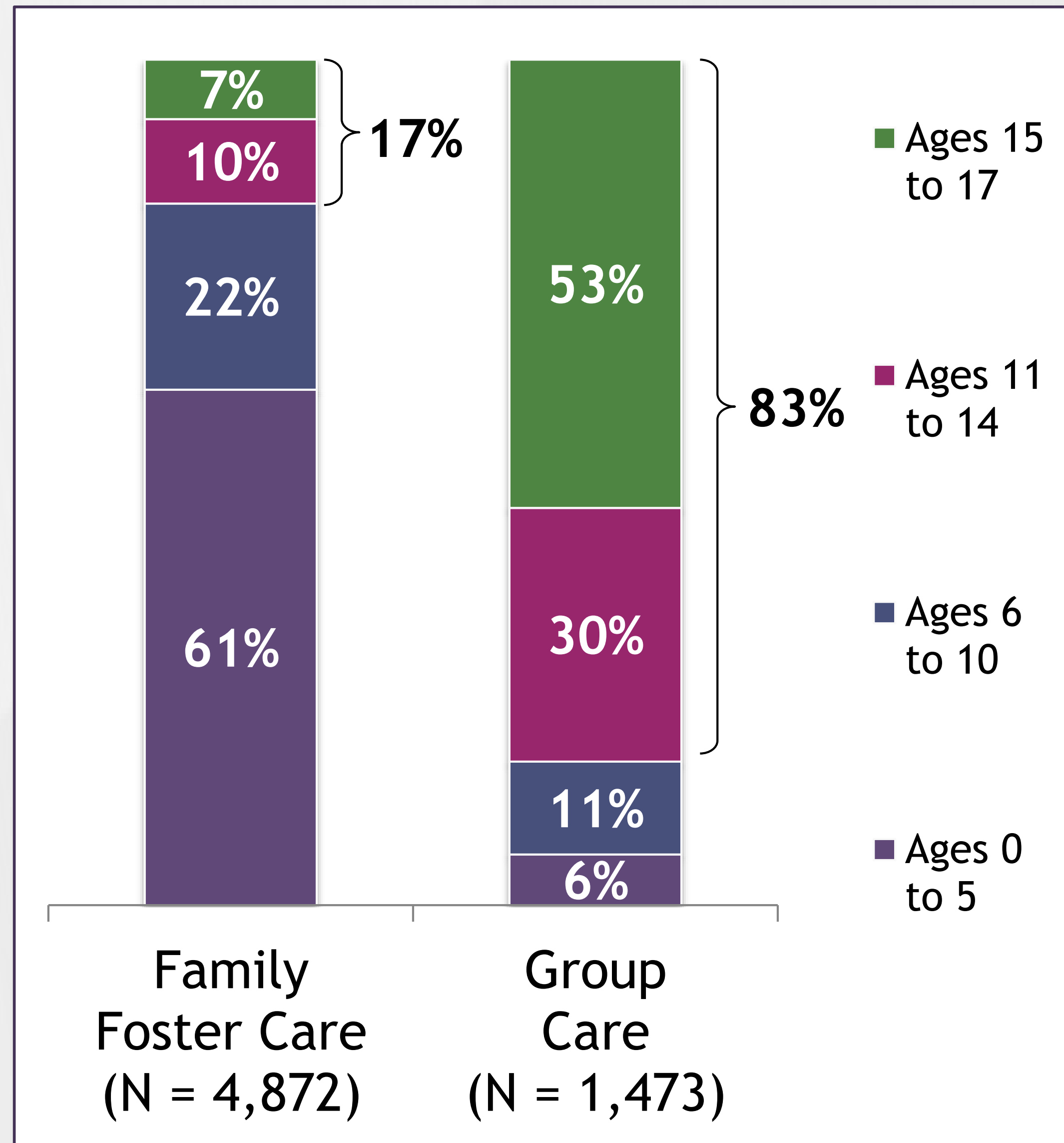
Analyzed DCF data

- Demographics, behavioral characteristics, and experiences prior to group care placement
- Outcomes related to permanency and goals



Demographic Differences

- 83% of children in group care were 11 and older compared to 17% in family foster care
- Of the children under age 11 in group care, 82% were with a sibling but only 1/3 were with a large sibling group



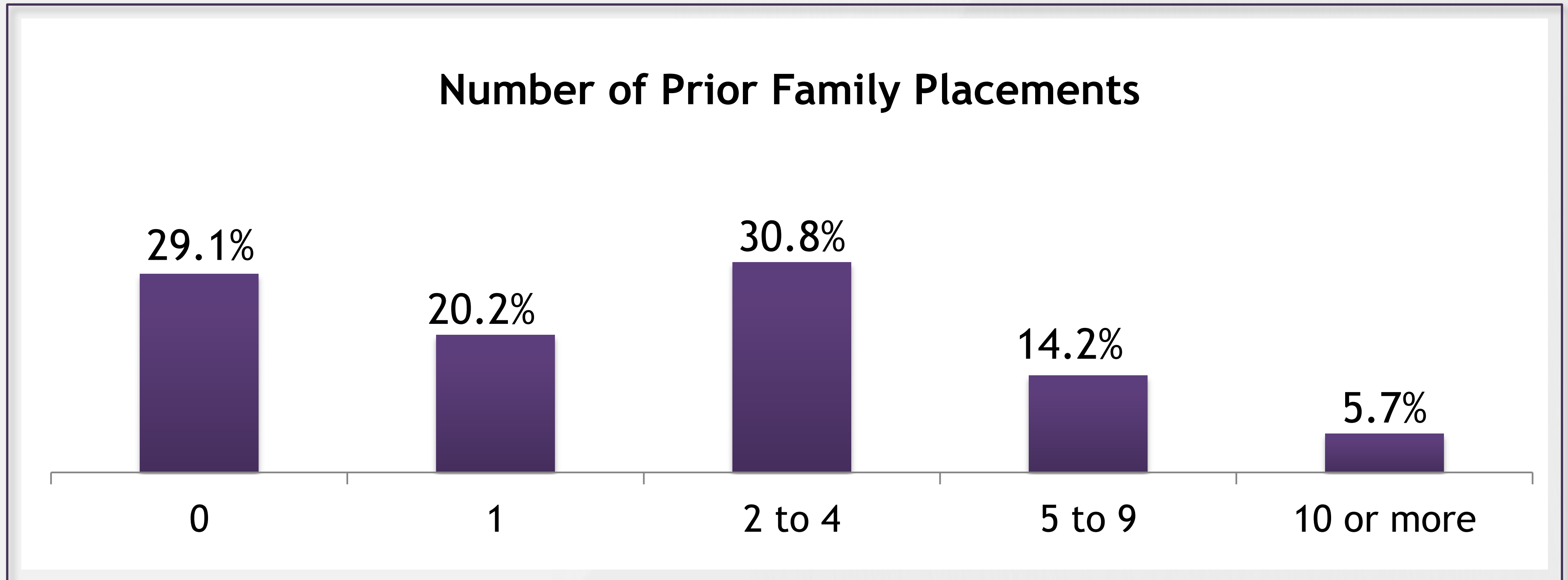
Behavioral Issues

A larger percentage of children in group care had behavioral issues

Age	Type of Care	Does Not Demonstrate Developmentally Appropriate Behavioral Health	History of Substance Use and/or Exposure	History of Arrests and Law Enforcement or Juvenile Justice Involvement	Children with at Least One Identified Specific Behavioral Issue	Average Number of Identified Specific Behavioral Issues
Ages 11 to 14	Family Foster Care (N = 384)	33%	26%	7%	40%	1.2
	Group Care (N = 356)	38%	28%	21%	56%	2.5
Ages 15 to 17	Family Foster Care (N = 262)	28%	30%	26%	48%	1.9
	Group Care (N = 646)	48%	41%	47%	71%	3.2

Prior Family Placements

Almost half of children in group care had fewer than two placements

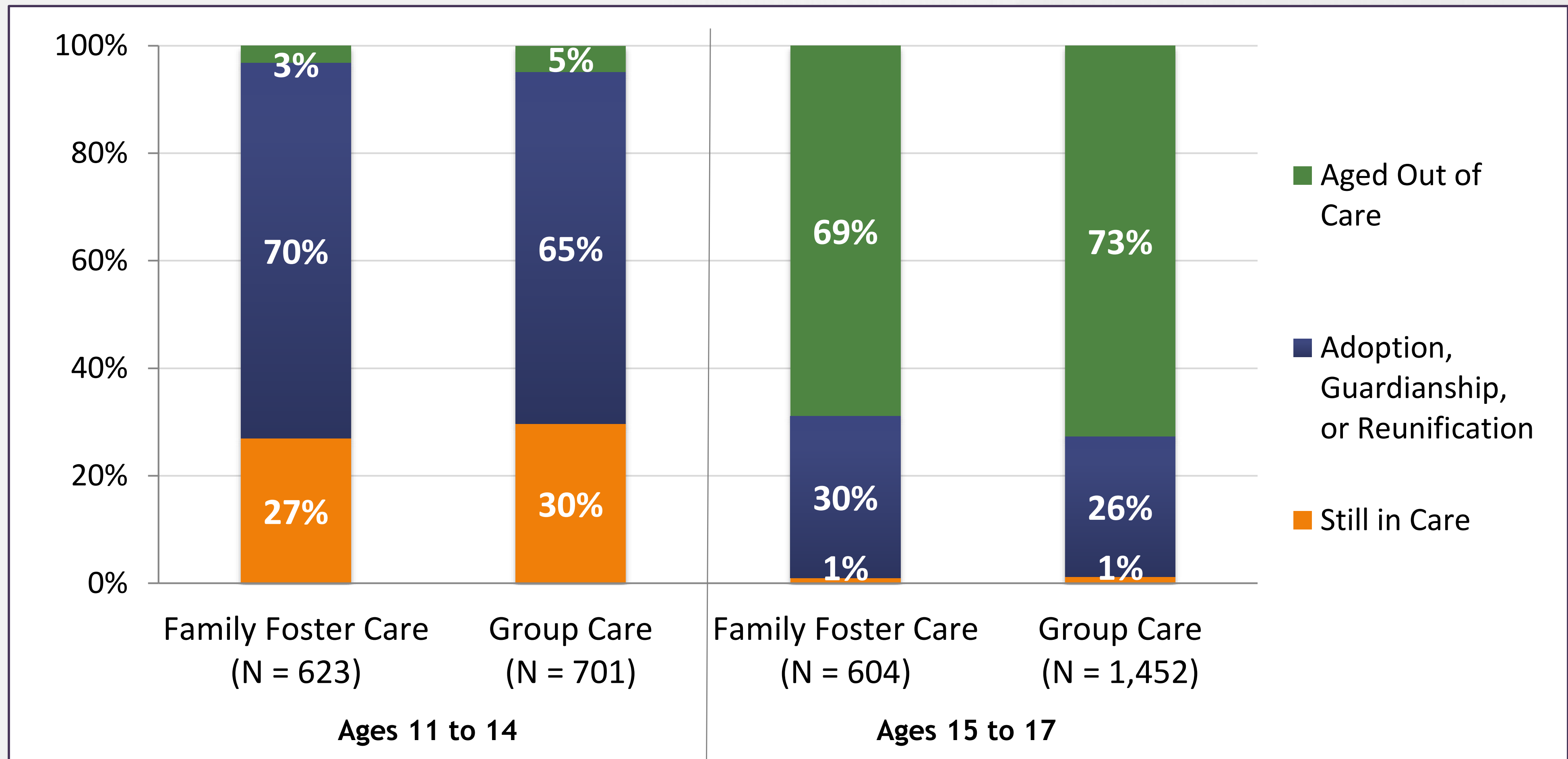


Experience in Group Care

- Children are in group care for a significant portion of their out-of-home placement
  - On average, spent over 50% of time in group care
  - Nearly a quarter spent over 90% of time in group care
- Children in group care also were placed in another county nearly twice as often children in family foster care (45% versus 25%)
- Children run away from group care more than family foster care

Achieving Permanency

Similar percentage of children in group care and family foster homes achieved permanency



Longer-term Outcomes

National surveys suggest that longer-term outcomes were slightly worse for children in Florida who were in group care

Outcomes	Family Foster Care Respondents (N = 210)	Group Care Respondents (N = 417)
Have not completed 11th grade	18%	25%
Have not earned a high school diploma or GED	43%	43%
Unemployed and not in school	10%	16%
Does not have an open bank account	24%	34%
In jail or homeless	2%	7%
Does not reside in own residence	52%	56%
Receives public support (Welfare, housing, or food assistance)	56%	57%
Does not have access to transportation	25%	25%
Does not have a supportive adult in his or her life	20%	17%

CBCs Use Strategies to Decrease Placements in Residential Group Care

- Creating an enhanced family foster care program to include targeted recruitment of parents for adolescents
- Training to work with adolescents
- Providing respite care and supports such as mental health wrap-around services and mentors

Questions

Contact Information

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OPPAGA
research memorandum
THE FLORIDA LEGISLATURE'S OFFICE OF PROGRAM POLICY ANALYSIS & GOVERNMENT ACCOUNTABILITY

Florida's Residential Group Care Program for Children in the Child Welfare System

December 22, 2014

Scope

The Legislature directed OPPAGA to review the residential group care program for dependent children and answered three questions.

1. How is placement in residential group care determined?
2. What are the services and costs associated with residential group care?
3. How does the population of children in residential group care compare to those in family foster care?

Background

In Florida, when child welfare officials determine that children have suffered abuse or neglect and cannot safely remain with their families, they are removed from their homes and provided with safe and appropriate temporary homes. These temporary placements, referred to as out-of-home care, provide housing and services to children until they can return home to their family or achieve permanency with another family through adoption or guardianship. The Department of Children and Families (DCF) contracts with community-based care lead agencies to manage child welfare services in Florida, which includes identifying out-of-home placements for children.

Legislative intent is to place children in a family-like environment when they are removed from their homes. When possible, lead agency case managers place the children with a relative or responsible adult that the child knows and with whom they have a relationship, such as a stepparent or a close family friend. These out-of-home care placements are referred to as relative and non-relative caregivers. When a relative or non-relative caregiver placement is not possible, case managers try to place the children in family foster homes licensed by DCF.

However, some children may have extraordinary needs that require case managers to place them in an alternative licensed foster care arrangement—residential group care. The primary purpose of residential group care is to provide a setting that addresses the unique needs of children and youth who require more intensive services than a family setting can provide. Florida statutes and rules define residential group care as a living environment providing 24-hour residential care for children who are adjudicated as dependent and are expected to be in foster care for at least six months.[1, 2, 3]

DCF's Child Welfare Office licenses residential group care providers as residential child-caring agencies, and lead agencies are responsible for subcontracting with these providers. According to child welfare officials and advocacy stakeholders, there are two

[1] Section 409.1676(2)(b), *F.S.*, and Ch. 65C-14, *F.A.C.*

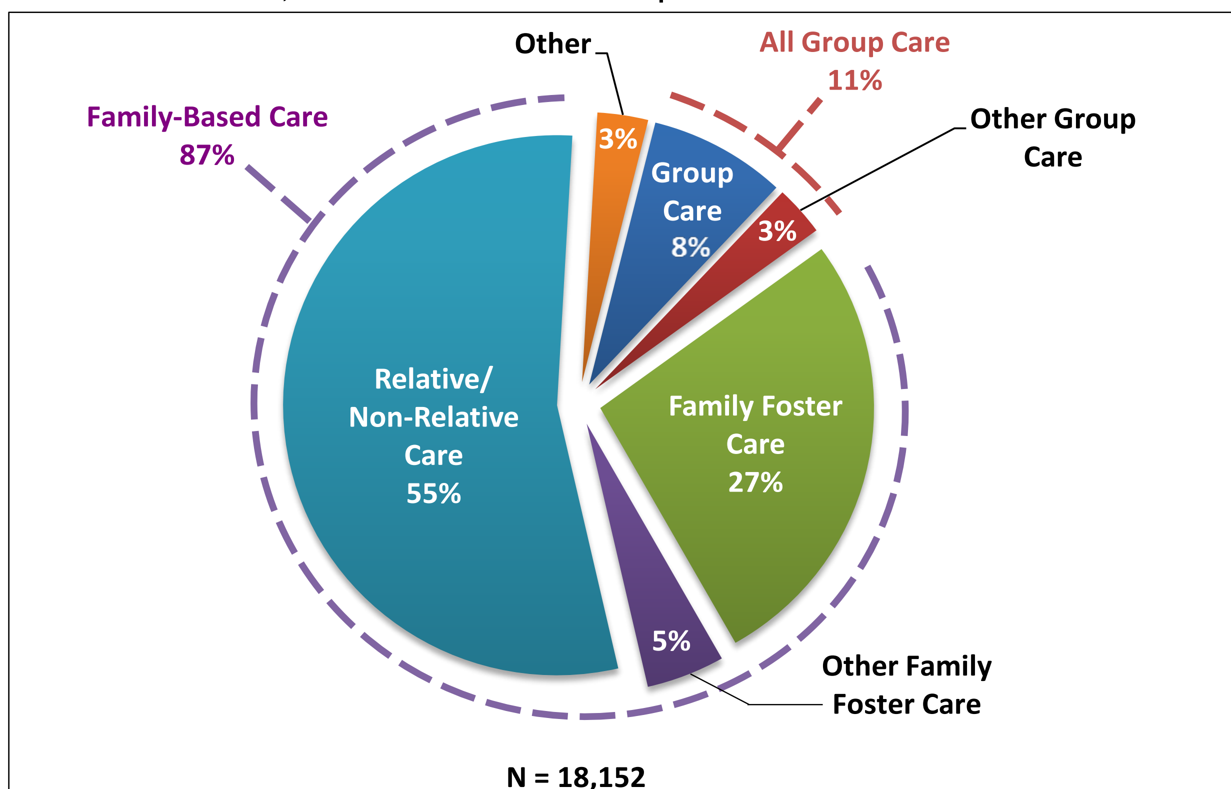
[2] Community-based care lead agencies may place children in other types of residential group care settings based on the child's needs, such as residential treatment programs, therapeutic group care, or developmental disabilities group homes.

[3] As of November 2014, the department was in the process of drafting a new group care administrative rule.

primary models of group care in Florida—shift-care group homes with staff working in shifts providing 24-hour supervision and family group homes with live-in staff, or house parents, who have an apartment within the group home.[4] In Fiscal Year 2013-14, lead agency directors identified 96 distinct providers with whom they subcontract for group care—58% as shift-care group homes and 42% as family group homes.

As shown in Exhibit 1, in Fiscal Year 2013-14, there were 18,152 dependent children in out-of-home care.[5] Eighty-seven percent of these children were in family-based care, with 55% in unlicensed care with a relative or non-relative caregiver, 27% in licensed family foster care, and 5% in other family foster care.[6] Eleven percent of children were in licensed residential group care.[7] Residential group care consists of group care (8%) and other temporary or specialty forms of group care (3%).[8, 9]

Exhibit 1
In Fiscal Year 2013-14, 11% of Children Were in Group Care[1, 2]



[1] Percentages do not total 100% due to rounding.
[2] Children were only included in this analysis if they had been in care for at least eight days.
Source: OPPAGA analysis of Department of Children and Families data.

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[4] According to group care providers, the family group home model varies by whether house parents reside with their biological children or whether house parents are not permitted to reside with their biological children at the program. In addition this model varies by house-parent staffing, i.e., the pattern of time off and use of relief house parents.

[5] As of September 30, 2014, there were 19,663 children in out-of-home care.

[6] Other family foster care primarily consists of licensed therapeutic family foster care and children placed in the care of families out of state.

[7] Three percent of children were in other placements. This primarily consists of children in correctional placements (33%), who ran away (25%), were in emergency services (19%), or were on visitation (13%).

[8] Group care providers are licensed as residential child-caring agencies by the department's child welfare office.

[9] Other group care includes children in the care of providers licensed by the department as emergency shelters (40%), maternity group homes (8%), runaway shelters (6%), wilderness camps (2%), and children with providers licensed by other agencies (41%) as Statewide Inpatient Psychiatric Programs (SIPP), therapeutic group homes, or Agency for Persons with Disabilities group homes.

The overall number of children in residential group care has decreased in Florida since Fiscal Year 2007-08, mirroring the overall decrease in out-of-home care. DCF set a goal to reduce the number of children in out-of-home care by 50% between January 2007 and January 2012. Although it did not meet this goal, it has significantly decreased the number of children in out-of-home care. Between Fiscal Years 2007-08 and 2013-14, the average number of children in group care decreased by 33%, with the number of children in out-of-home care experiencing a similar reduction.[10] (See Appendix A for more details about this decline.) As shown in Exhibit 2, residential group care expenditures decreased by 30% during this same time period.

Exhibit 2
Since Fiscal Year 2007-08, Residential Group Care Expenditures Have Decreased 30%

State Fiscal Year	Cumulative Percentage Change in the Average Number of Children in Group Care[1]	Residential Group Care Expenditures	Cumulative Percentage Change in Residential Group Care Expenditures
2007-08		$112,240,934	
2008-09	-12%	$98,411,631	-12%
2009-10	-22%	$88,778,416	-22%
2010-11	-28%	$87,941,722	-23%
2011-12	-26%	$86,840,671	-24%
2012-13	-31%	$84,482,158	-27%
2013-14	-33%	$81,666,795	-30%

[1] This figure is calculated by averaging the number of children in care at the end of each month in the fiscal year. Both children in group care and other group care were used in this calculation.

Source: OPPAGA analysis of Department of Children and Families data.

How is placement in residential group care determined?

Florida statute and rule guide lead agencies in assessing and placing children in residential group care. Lead agencies must place all children in out-of-home care in the most appropriate available setting after conducting an assessment using child-specific factors.[11] Lead agencies must consider placement in residential group care if specific criteria are met—the child is 11 or older, has been in licensed family foster care for six months or longer and removed from family foster care more than once, and has serious behavioral problems or has been determined to be without the options of either family reunification or adoption. In addition, the assessment must consider information from several sources, including psychological evaluations, professionals with knowledge of the child, and the desires of the child concerning placement.[12] If the lead agency case mangers determine that residential group care would be an appropriate placement, the child must be placed in residential group care if a bed is available. Children who do not meet the specified criteria may be placed in residential group care if it is determined that such placement is the most appropriate for the child.[13]

DCF officials reported that they discourage lead agencies from placing children under age 12 in group care settings unless it keeps sibling groups together. In addition, department staff reported

[10] This reduction in group care use and spending was for group care and other group care combined.

[11] Child-specific factors include the child's age; sex; sibling status; physical, educational, emotional, and developmental needs; alleged maltreatment; community ties; and school placement (Rule 65C-28.004, *F.A.C.*).

[12] Section 39.523(1), *F.S.*

[13] Section 39.523(4), *F.S.*

encouraging lead agencies to focus on recruiting foster families to reduce their reliance on group care, reflecting the statutory direction that the department place children with a relative or non-relative caregiver or in a family foster home when a child is removed from their parent's custody. To reinforce efforts to reduce the use of group care for young children, DCF included a performance measure on the community-based care lead agency scorecard, a component of the department's performance measurement system, related to the use of group care for young children.[14] However, the department does not penalize lead agencies for keeping large sibling groups together in group care.[15]

Lead agencies report that they have policies and procedures emphasizing family foster care placement before considering group care placement, and when possible, they use the family group home model versus the shift-care model. The out-of-home placement process begins with lead agency placement staff trying first to locate a family foster care home before considering group care. Lead agency staff reported requiring their case management organizations to have all group care placements approved by a lead agency placement specialist, who locates an alternative placement if a group care placement is determined not to be appropriate. Lead agency staff also reported conducting regular (monthly or more frequently) reviews of children in residential group care to determine if an appropriate placement in family foster care was available.

Lead agencies reported that they limit residential group care placements to adolescents with behavioral problems and sibling groups for whom there are limited foster family home placements available. Lead agency directors prefer to place children in a family group home, and reported that most children 12 and younger are placed in these facilities. They reported using shift-care group homes with 24/7 supervision more for older children who have behavior problems or a history of physical aggression or violent behavior toward themselves, others, and/or property, or have had multiple foster care placements. Many of these adolescents have substance abuse problems or have an extensive background with delinquency. In addition, lead agencies reported using group care as a step-down placement from therapeutic group care.[16]

Lead agency directors reported using specific strategies to decrease residential group care placements. These strategies include creating an enhanced family foster care program that includes targeted recruitment of foster parents for adolescents, training foster parents to deal with difficult adolescents, paying higher foster care board rates, and providing respite care and other supports for these foster parents. Examples of supports include mental health wrap-around services for the children in their care, in-home behavioral analysis services, support groups, and mentors for foster care parents.

What are the services and costs associated with residential group care?

Licensed residential group care settings must provide an array of services and activities for children. Lead agencies must ensure that children receive the care and attention that fosters a healthy social, emotional, intellectual, and physical development regardless of whether they are with relative or non-relative caregivers or are in licensed placements (both family foster homes and group homes). Licensed residential group care programs are required to provide a minimum

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[14] The performance measure is "children in licensed out-of-home care age 12 and under in DCF-licensed family foster homes."

[15] Section 39.001(1)(k), *F.S.*

[16] Children diagnosed as having a moderate to severe emotional disorder can receive community-based psychiatric residential treatment services in therapeutic group care. To be placed in therapeutic group care, a child must be assessed by a qualified evaluator (a licensed psychologist or psychiatrist) and have the placement authorized by a multidisciplinary team, and the team must reauthorize the placement every six months. Therapeutic group care may also be the preferred placement for children stepping down from a more restrictive residential treatment program or for those who require more intensive community-based treatment to avoid placement in a more restrictive residential treatment setting.

range of activities and services to meet children's needs for healthy development; these activities and services are specified in administrative rule. (See Exhibit 3.) For example, the group care providers must provide basic needs such as food and clothing, provide opportunities for recreation and participation in the community, arrange for necessary medical appointments, and ensure transportation to services and activities. Children with behavioral health needs receive mental health, substance abuse, and supportive services that are provided through Medicaid-funded Behavioral Health Overlay Services (BHOS). Children must be recertified every six months for BHOS eligibility by a licensed practitioner, and residential group care providers receive Medicaid reimbursement for medically necessary behavioral health services.[17]

Exhibit 3
Group Care Programs Directly Provide or Ensure Access to a Variety of Services and Activities

Service or Activity
▪ Provide a range of indoor and outdoor recreation and leisure activities
▪ Arrange for recreational and cultural enrichment in the community
▪ Provide transportation
▪ Arrange for and ensure necessary medical and dental care
▪ Ensure behavioral health counseling services
▪ Ensure participation in work activities at the program
▪ Provide clothing, personal hygiene items, and supplies
▪ Have a positive behavioral management program to correct unwanted behaviors
▪ Conduct assessments and develop service plans
▪ Arrange for educational and vocational services in the community or on-site
▪ Provide each child the opportunity to learn earning, spending, and saving money through an allowance
▪ Provide life skills training, including o Problem solving and decision making, o Social skills, and o Independent living skills

Source: OPPAGA analysis of Ch. 65C-14, *F.A.C.*

Lead agency staff annually negotiate rates with group care providers. In Fiscal Year 2013-14, the 17 lead agencies contracted with 96 residential group care providers. Most lead agencies use a cost-based reimbursement methodology to pay group care providers, with payment based on a negotiated daily bed rate. In Fiscal Year 2013-14, the average per diem rate for the shift-care group home model was $124, with costs ranging from $52 to $283, while the average per diem rate for the family group home model was $97, with costs ranging from $17 to $175.[18] Residential group care is more expensive than family foster care, which pays an average daily rate of $15 intended to cover room and board expenses.[19]

Lead agency directors consider several factors when negotiating rates—the provider's budget and expenses, amount of community support (private funding), staff to client ratios, bed capacity, services provided, special per child considerations (e.g., the child needs his or her own room or requires 24-hour supervision), and the number of children to be served. Rates also vary by type of program. For example, providers serving children or adolescents requiring special

[17] Medicaid pays a daily rate of $32.75 for BHOS in group care; during Fiscal Year 2011-12, Medicaid paid an average of $3,813 per child to BHOS providers.

[18] Median per diem rates were $115 and $97 for shift-care and family group homes, respectively.

[19] By statute and rule, family foster parents are expected to provide a safe, loving, and nurturing environment and activities and support for social, emotional, intellectual, and physical development (s. 409.145(2), *F. S.*, and Ch. 65C-13, *F.A.C.*).

care and treatment, such as those serving sexually abused or sexually reactive adolescents, receive an enhanced room and board rate.

For young adults who choose to remain in the foster care system after turning 18, 25% have chosen to live in a residential group care setting. The 2013 Legislature extended foster care through 21, giving children for whom the state did not reunify with their family or achieve permanency with another family the choice to stay in foster care. The department is still revising rules to address those young adults over 18 who want to stay in residential group care settings.[20] However, lead agency directors told us that, while some adolescents wanted to stay in their current placement, most in residential group care settings did not, and alternative living arrangements were being explored for these adolescents. Lead agency directors said that residential group care providers may not be comfortable having young adults on the same campus as young teenagers or may not have the capacity to serve young adults and that no funding stream exists to help group care providers convert their programs and facilities into transitional living arrangements for the young adult population.

Lead agency directors have developed several types of placements for young adults choosing to remain in foster care. For example, group care providers are creating dorm-like settings with less structure than traditional group care programs, while providers of transitional housing and services for teenagers aging out of foster care are offering these services to young adults in extended foster care. Lead agency directors also reported working with apartment complexes to provide housing for those in extended foster care and recruiting foster families willing to take in young adults. Exhibit 4 shows the monthly costs of extended foster care placements reported by lead agencies.

Exhibit 4
Residential Group Care Is the Most Expensive Living Arrangement for Young Adults in Extended Foster Care

Living Arrangement	Average Monthly Rate	Median Monthly Rate	Monthly Rate Range
Residential Group Care	$859	$800	$297 to $1,300
Apartment	$778	$850	$410 to $1,000
Supervised Living	$567	$557	$401 to $750
Family Foster Care	$543	$533	$445 to $715

Source: OPPAGA analysis of community-based care lead agency data.

Lead agency directors reported that 282 young adults chose extended foster care from January 1, 2014, through June 30, 2014.[21] Of these young adults, 148 chose extended foster care prior to aging out of foster care and 134 previously aged out of foster care at 18 and chose to return to foster care. Lead agencies reported that 45% were in supervised living arrangements, such as transitional living programs or host homes; 25% were in residential group care; 20% were in apartments; and 11% were in a family foster home.

[20] As of November 2014, the department's rules related to extended foster care and foster care and group care licensing were still drafts. In November 2013, the department's general counsel's office issued a memorandum stating that Ch. 2013-178, *Laws of Florida*, takes precedence over the licensing rules contained in Chs. 65C-13 and 65C-14, *F.A.C.;* therefore, young adults 18 or older may not be removed from their current living arrangement. In addition, the draft rule pertaining to extended foster care must be rewritten due to concerns expressed by the Joint Administrative Procedures Committee and the Office of Fiscal Accountability and Regulatory Reform.

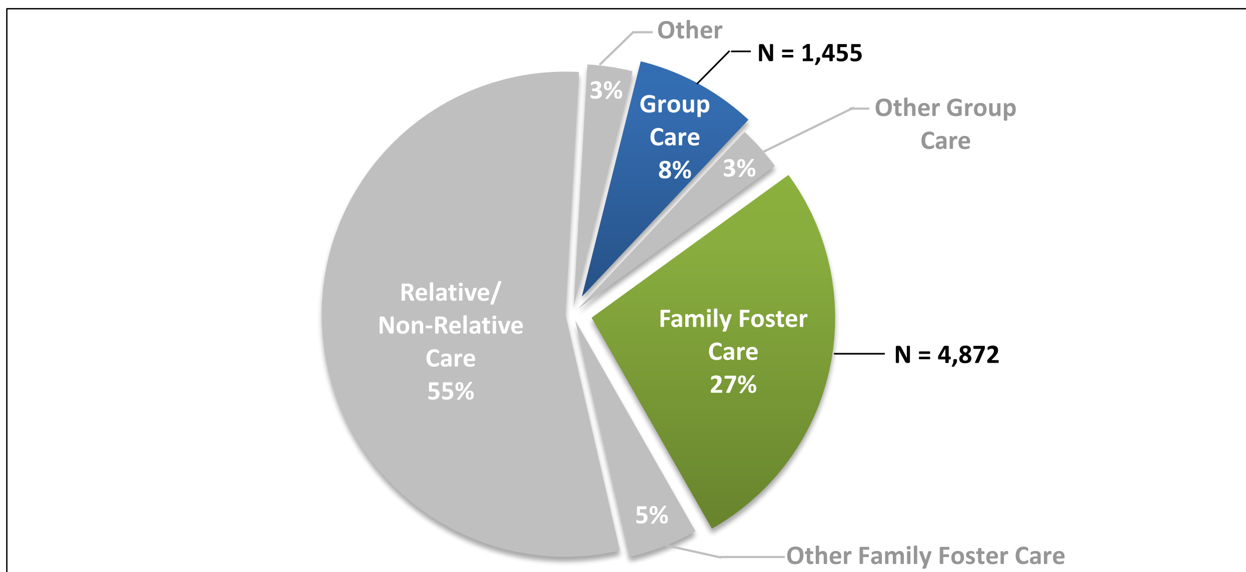
[21] Fourteen of 16 lead agency directors responded to the information request.

How does the population of children in residential group care compare to those in family foster care?

Compared to family foster care, group care programs serve primarily older children and more male and minority children with identified behavioral health issues. When younger children are placed in group care, they usually are in care with siblings. Compared to children who entered family foster care, children who entered group care ran away from care more often, spent more time in care, were placed outside of their home county more often, and were more often reunified with their parents instead of being adopted. In addition, children are in group care for a significant portion of their out-of-home placement, and although younger children (ages 11 to 14) who entered group care went on to the care of a family, many older children (ages 15 to 17) did not leave group care to enter the care of a family before turning 18. Surveys of youth also show that longer-term outcomes for children who were in group care were worse for six of nine measures.

To compare to the population of children in group care to those in family foster care, we analyzed data from DCF's Florida Safe Families Network (FSFN). For children entering group care, we looked at whether the demographics, characteristics, and child welfare experiences leading up to their entry into group care were different from those of children entering family foster care. To analyze outcomes, we examined whether, after entering group care, children had different experiences that may affect their well-being or permanency. As shown in Exhibit 5, this analysis compares the 8% of children in group care to the 27% of children in family foster care.[22]

Exhibit 5
Comparison Analyses Are Between Children in Group Care and Children in Family Foster Care



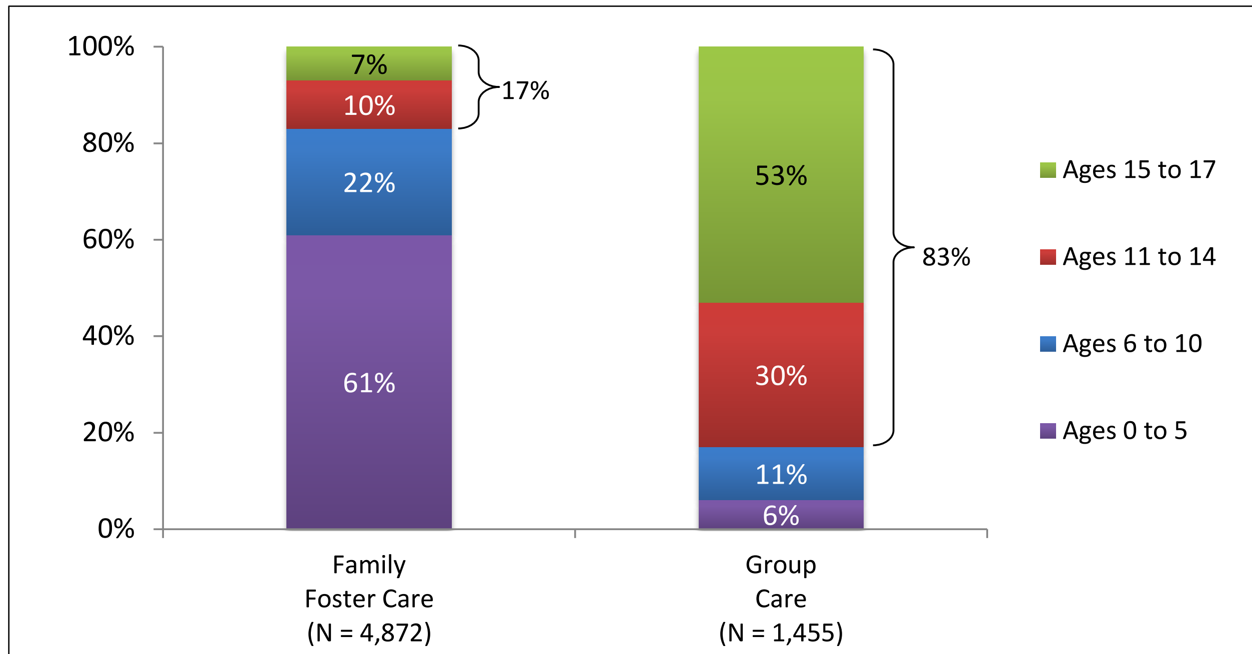
Source: OPPAGA analysis of Department of Children and Families data.

[22] For the purposes of this analysis, as specified in statute and rule, children are considered to be in group care if they are in the care of a program licensed by the DCF as a Child Caring Agency which provides staffed 24-hour residential care of children. This does not include children we categorized as in other group care, such as children in residential care licensed by other agencies (therapeutic group care, Statewide In-Patient Psychiatric facilities, or Agency for Persons with Disabilities' group homes) or children in an emergency shelter, runaway shelter, maternity home, or wilderness camp. For the purposes of this analysis, children are considered to be in family foster care if they are in the care of a foster family licensed as a traditional foster home by Florida's DCF. This does not include children in therapeutic family foster care or in foster homes licensed by other states.

Demographics, Behavioral Characteristics, and Child Welfare Experience Prior to Group Care

Group care programs primarily serve older, male, and minority children. As shown in Exhibit 6, children in group care are significantly older than children in family foster care; 83% of children in group care were 11 or older compared to 17% in family foster care. Legislative intent is to not place children under 11 in residential group care. Lead agencies told us that they typically use group care placements for younger children that are part of a large sibling group, because it can be challenging to identify family foster care placements in which the foster parents are willing to take a large number of siblings into their homes. Of the children under 11 in group care in Fiscal Year 2013-14, 82% were in group care with at least one sibling. However, only one-third of these young children in group care were placed with three or more siblings.[23] Appendix B provides additional details about the placement of young children in group care.

Exhibit 6
Eighty-Three Percent of Children in Group Care Are 11 and Older Compared to 17% in Family Foster Care



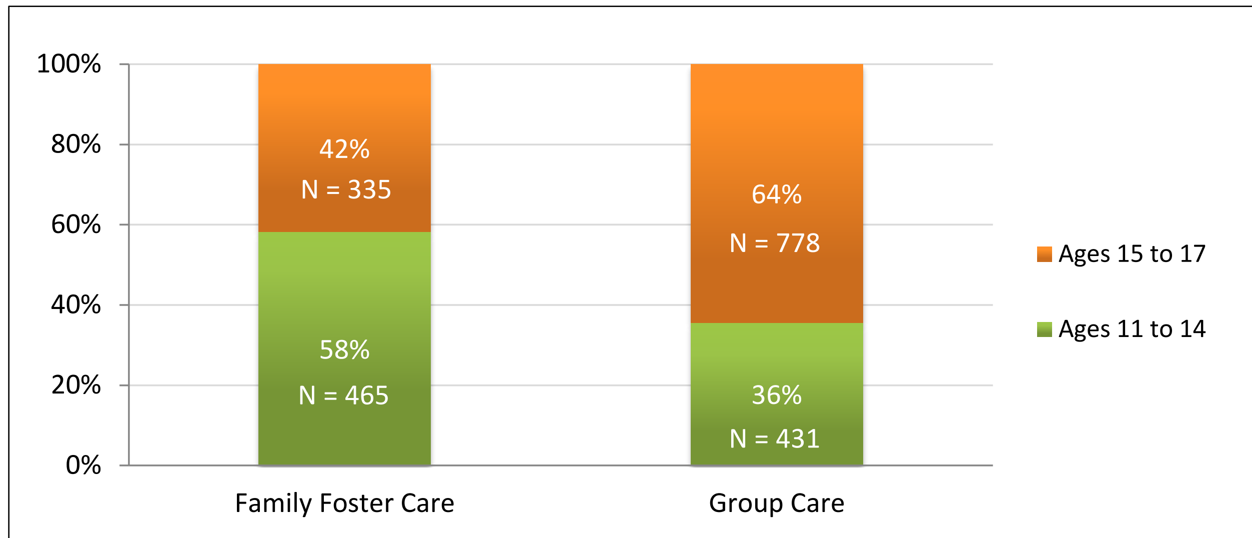
Source: OPPAGA analysis of Department of Children and Families data.

When comparing only children 11 and older, the largest demographic difference between children in group care and family foster care is that a larger percentage of children in group care are ages 15 to 17. Among children 11 and older, 64% of children in group care are ages 15 to 17; in contrast, 42% in family foster care are ages 15 to 17.[24] (See Exhibit 7.)

[23] There may be some imprecision in how FSFN data identifies group care, sibling groups, and whether children are placed together.

[24] Due to the differences between these age ranges, we analyzed the differences between children in residential group care and family foster care by these age categories.

Exhibit 7
A Larger Percentage of Children in Group Care Are Ages 15 to 17 Compared to Family Foster Care



Source: OPPAGA analysis of Department of Children and Families data.

A larger share of children in group care are male, especially among children ages 15 to 17, where 52% of children in group care are male, compared to 44% in family foster care. Consistent with national trends, children in licensed out-of-home care are disproportionately minorities, especially in group care, where 64% of children are minorities. Appendix C provides additional detail on demographics for children in group care compared to family foster care.

A larger percentage of children in residential group care have behavioral issues. Lead agency case worker assessments of the strengths and needs of families involved in the child welfare system indicate that children in group care, especially children 15 and older, are more likely to demonstrate developmentally inappropriate behavioral health. In addition, a larger percentage of children in group care have a history of arrests and involvement with law enforcement or the Department of Juvenile Justice, as well as have a history of substance abuse.[25] (See Exhibit 8.)

Exhibit 8
Children in Group Care Had More Identified Behavioral Issues

Age	Type of Care	Does Not Demonstrate Developmentally Appropriate Behavioral Health	History of Substance Use and/or Exposure	History of Arrests and Law Enforcement or Juvenile Justice Involvement
Ages 11 to 14	Family Foster Care (N = 384)	33%	26%	7%
	Group Care (N = 356)	38%	28%	21%
Ages 15 to 17	Family Foster Care (N = 262)	28%	30%	26%
	Group Care (N = 646)	48%	41%	47%

Source: OPPAGA analysis of Department of Children and Families data.

[25] Rule 65C-30.005, *F.A.C.*, requires child welfare services workers to complete a family assessment within 15 working days of the Early Services Intervention staffing and update the assessment, at a minimum, every six months thereafter. The family assessment is used to analyze the strengths and needs of the family and its members and informs the development of case plans.

Case workers also assess whether children exhibit one or more of 24 specific behavioral issues. Children in group care exhibited more of these issues than children in family foster care. As shown in Exhibit 9, for example, 71% of group care children ages 15 to 17 exhibited at least one of these behavioral issues compared to 48% in family foster care. In addition, case managers identified four or more issues for 39% of children in group care ages 15 to 17 compared to 21% in family foster care. Appendix D provides additional detail.

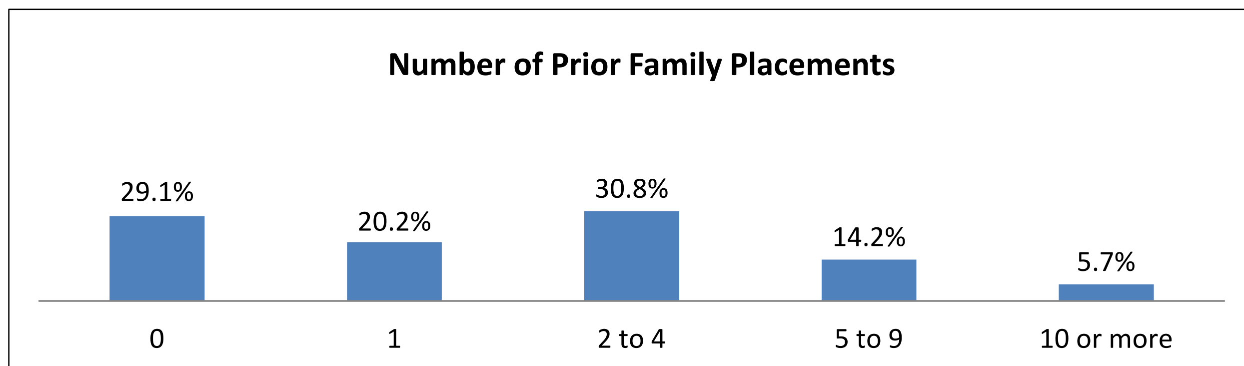
Exhibit 9
Children in Group Care Had More Identified Behavioral Issues

Age	Type of Care	Children with at Least One Identified Specific Behavioral Issue	Children with Four or More Identified Specific Behavioral Issues	Average Number of Identified Specific Behavioral Issues
Ages 11 to 14	Family Foster Care (N = 384)	40%	13%	1.2
	Group Care (N = 356)	56%	28%	2.5
Ages 15 to 17	Family Foster Care (N = 262)	48%	21%	1.9
	Group Care (N = 646)	71%	39%	3.2

Source: OPPAGA analysis of Department of Children and Families data.

Almost 50% of children in group care either had no or only one placement in a family foster home prior to group care placement. Specific criteria for determining that residential group care is the most appropriate placement include that the child has been in licensed family foster care for six months or longer and removed from family foster care more than once. Lead agency staff also reported that children assessed for residential group care include children who have had multiple failed family foster home or caregiver placements. However, 29% of children in group care had no prior placements with a family and 20% only had one prior placement with a family.[26, 27] (See Exhibit 10.)

Exhibit 10
Almost Half of Children in Group Care Have Had Fewer Than Two Prior Family Placements



Source: OPPAGA analysis of Department of Children and Families data.

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[26] This analysis considers all time the child spent in out-of-home care between July 1, 2004, and the start of the placement they were in on November 15, 2013. For children in group care and family foster care on November 15, 2013, we looked at their out-of-home care histories prior to entering their current arrangement.

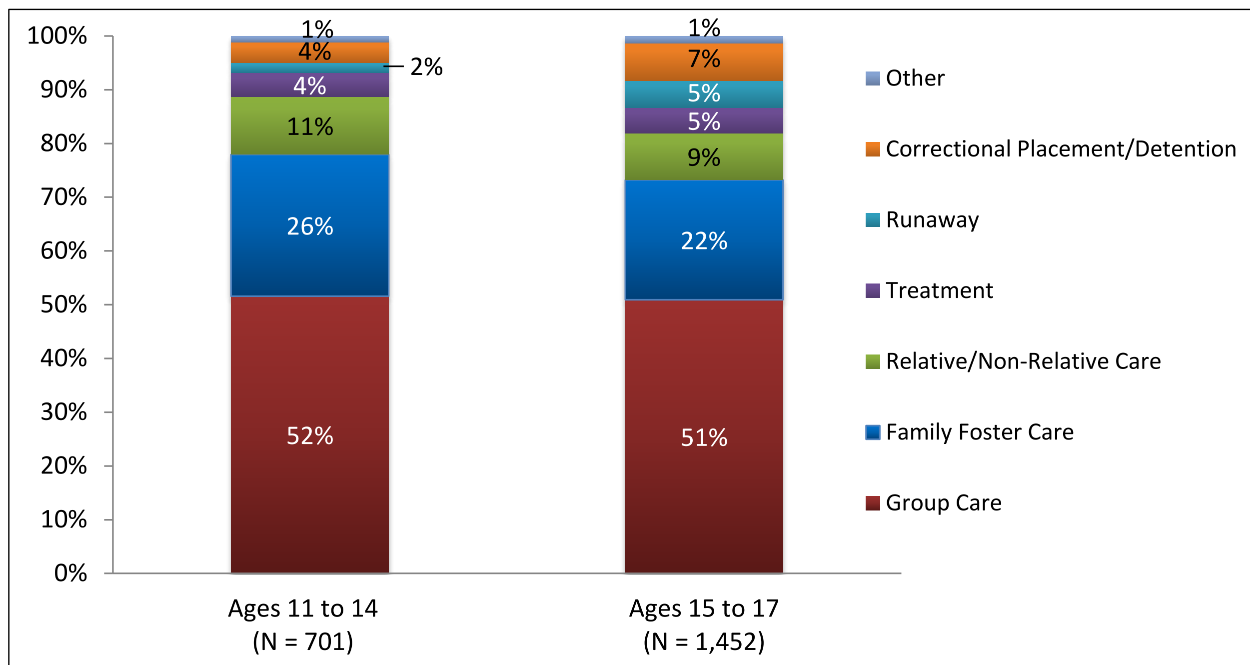
[27] To determine the number of placements a child had, we counted each time a child was placed in the care of a different family or provider. If a child was in the care of a provider and temporarily left that provider's care due to a temporary situation such as short-term hospitalization, visitation, or running away, when the child returned to the prior provider our analysis did not consider this as a new placement. All prior placements with a family were counted including unlicensed relative and non-relative placements and licensed family foster care placements.

Outcomes

To examine the outcomes of children after entering group care, we selected a group of children who entered group care or family foster care in federal Fiscal Year 2010-11 and looked at their experiences through May 2014. We found that, compared to children who entered family foster care, children who entered group care ran away from care more often, spent more time in care, were placed outside of their home county more often, and were more often reunified with their parents instead of being adopted. In addition, children are in group care for a significant portion of their out-of-home placement, and although younger children (11 to 14) who entered group care went on to the care of a family, many older children (15 to 17) did not leave group care to enter the care of a family before turning 18. Surveys of youth also show that longer-term outcomes for children who were in group care were worse for six of nine measures.

Children are in group care for a significant portion of their out-of-home placement, and a larger percentage of children in group care were placed outside of their home county. Child welfare advocates recommend that states use group care as a time-limited placement to stabilize children with more severe behavioral issues and treatment needs so that they can spend most of their time in the care of a family (family foster home or relative or non-relative caregiver). However, as shown in Exhibit 11, most children who entered group care did not leave group care to spend most of their time in the care of a family.[28] On average, they spend over half of their time in group care and about one-third of their time in the care of a family; nearly a quarter of these children spent over 90% of their time in group care. In addition, children who entered group care were placed out of the county in which they resided nearly twice as often as children entering family foster care (45% and 25%, respectively). This may be partly due to the limited availability of group care facilities in certain counties or attempts to place children with group care providers whose programs better address the children's specific needs.

Exhibit 11
On Average, Children in Residential Group Care Spend Over Half of Their Time in This Setting



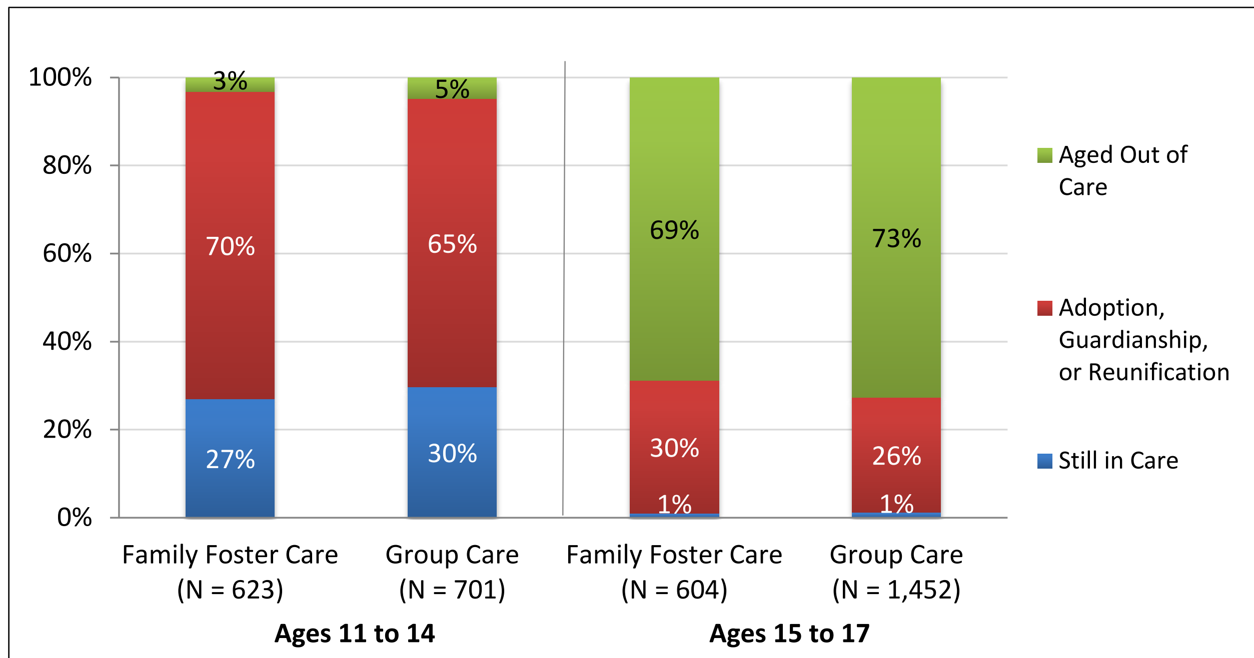
Source: OPPAGA analysis of Department of Children and Families data.

[28] This analysis is based on children who entered group care in Fiscal Year 2010-11.

Children run away from group care more than family foster care. For example, over 37% of children who entered group care at age 16 ran away from the group home compared to 21% of children who entered a family foster home at age 16. Given the behavioral issues of children who enter group care, this larger percentage could be expected. However, children who entered group care did not have a history of running away before entering group care. Over their entire time in out-of-home care, 47% of children in our analysis ran away from at least one of their group care placements even though only 15% of these children had been reported as running away before they entered group care.[29]

Although a similar percentage of children in both types of care achieve permanency in a family home, children in group care take longer to achieve permanency. Children typically leave the child welfare system either by being reunified with their parent or caregiver, entering permanent guardianship, being adopted, or aging out of care. Prior to implementation of extended foster care in Fiscal Year 2013-14, if a child was not discharged from the child welfare system to a permanent family home, when she/he turns 18, the child ages out of care. Exhibit 12 shows that, of children who entered group care between ages 11 and 14, about 65% were discharged to a permanent family home, compared to 70% of children who entered family foster care.[30] Most of the children who entered care between 15 and 17 aged out of care, with only 26% of children who entered group care and 30% of children who entered family foster care being discharged to a permanent family home before turning 18.

Exhibit 12
A Similar Share of Children in Group and Family Foster Care Achieved Permanency



Source: OPPAGA analysis of Department of Children and Families data.

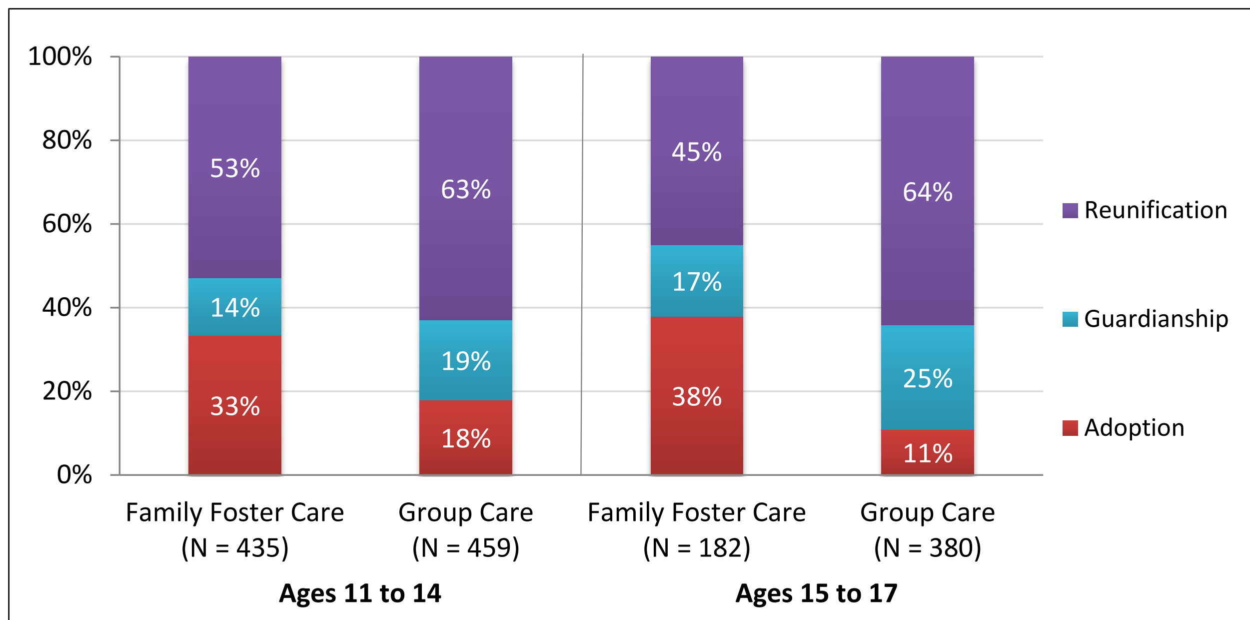
[29] When available, we used provider licensing information to distinguish between residential group care and other group care. However, due to conversion in the department's data systems used for provider licensing, data on providers' full licensing history were not available. Therefore, for this analysis we identified a person's first residential group care placement as the first residential placement lasting at least 15 days. This criterion was used to help minimize the likelihood that we counted an emergency shelter placement as residential group care. However, this may have counted some other group care placements as residential group care.

[30] This analysis looked at children who entered group care or family foster care in Federal Fiscal Year 2010-11 and followed them until May 2014.

However, it tends to take slightly longer for children who enter group care to be discharged to a permanent family home. Within one year of entering care, children who were in group care who had not turned 18 had a 34% likelihood of having been discharged to a permanent family home compared to 38% for children who were in family foster care. In addition, at three years after entering care, children in group care had a 68% likelihood of having been discharged to a permanent family home compared to 73% for children who were in family foster care.[31]

Children who achieved permanency from group care were more often reunified and less often adopted than children who achieved permanency from family foster care. As shown in Exhibit 13, of children ages 15 to 17 who were discharged to a permanent family home from family foster care, 45% were reunified with their parents or caregivers and 38% were adopted. In contrast, 64% of children who achieved permanency from group care were reunified while 11% were adopted. The lower adoption rate for children who were in group care may be partly due to the fact that most children are adopted by their foster parents or a relative or non-relative caregiver. Since children who were in group care tend to spend less of their time in family-based care, their exposure to potential adoptive parents may be reduced.

Exhibit 13
Children in Group Care Are More Often Reunified and Less Often Adopted Than Children in Family Foster Care



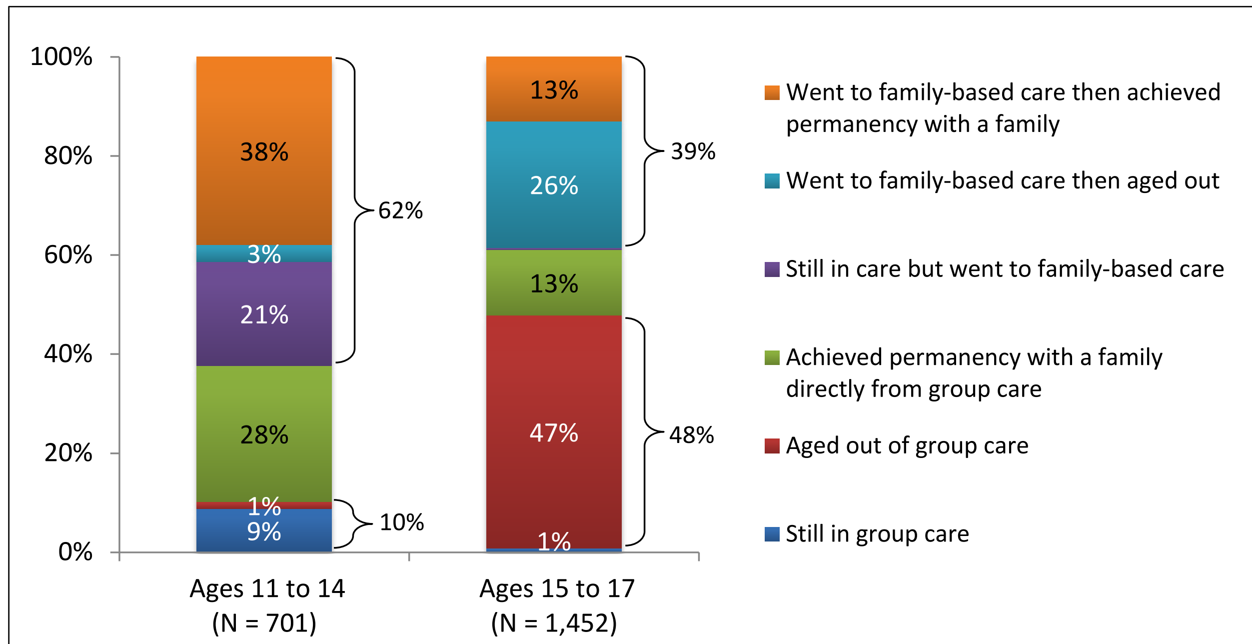
Source: OPPAGA analysis of Department of Children and Families data.

Although most younger children who entered group care went on to the care of a family, a large percentage of older children (ages 15 to 17) turned 18 without moving on to the care of a family . As shown in Exhibit 14, of the children who entered group care between ages 11 and 14,

[31] To examine time to permanency, we selected a cohort of all children who entered out-of-home care between ages 11 and 16 in federal Fiscal Year 2010-11 and went into family foster care or group care before the end of the year. We tracked their care through May 12, 2014. Since children age out of care if they have not achieved permanency by the time they turn 18, we have different lengths of time to track permanency for children who entered care at different ages. Therefore, we used the Kaplan-Meier product-limit estimator, which accounts for these differences, to estimate the probability of having achieved permanency for children who have not yet aged out of care.

only 10% had not moved on to the care of a family.[32] Slightly more than 60% went on to family foster care or a relative or nonrelative caregiver, and another 28% were discharged directly from group care into a permanent family home. In contrast, 48% of children who entered group care between ages 15 and 17 turned 18 without moving on to the care of a family. Only 39% went on to family foster care or a caregiver, and only 13% were discharged directly from group care into a permanent family home.

Exhibit 14
Most Younger Children Left Group Care to Enter the Care of a Family



Source: OPPAGA analysis of Department of Children and Families data.

Surveys of Florida youth suggest that longer-term outcomes are slightly worse for children who were in group care. The National Youth in Transition Database (NYTD) Survey is primarily the results of a survey of youth who age out of foster care, asking them about their outcomes since they left care. Although there is some evidence that NYTD survey responses are not fully representative of all children who had been in care, it is one of the most useful sources of information about long-term outcomes for children who had been in care.[33] As shown in Exhibit 15, outcomes for Florida youth who aged out of care were worse for children who were in group care on six of nine selected measures. For example, 25% of 18- to 19-year-old respondents who had been in group care had not completed the 11th grade compared to 18% who had been in family foster care.

[32] This analysis is based on the status of children as of May 2014.

[33] NYTD survey responses do not provide an accurate reflection of the longer-term outcomes of all children who had been in Florida's child welfare system for several reasons. First, the NYTD survey only reflects the experiences of youth who aged out of care by May 30, 2013, who are about 2/3 to 3/4 of the 15- to 17-year-olds we analyzed. Second, about half of the youth who were eligible to take the survey responded and they are a biased subset of those eligible to respond. In particular, youth who exhibited certain behavioral issues in their family assessments had about a 4% to 12% lower response rate. Lastly, comparisons between survey responses and FSFN data provide some limited evidence that the answers of some respondents may be inaccurate. Forty-four percent (417 of 947) of youth in group care who aged out of care by May 2013 and 53% (210 of 393) of youth in family foster care who aged out of care responded to a NYTD survey.

Exhibit 15
National Youth in Transition Database Survey Outcomes for Former Foster Care Children in Florida

Outcomes	Family Foster Care NYTD Respondents (N = 210)	Group Care NYTD Respondents (N = 417)
Have not completed 11th grade	18%	25%
Have not earned a high school diploma or GED	43%	43%
Unemployed and not in school	10%	16%
Does not have an open bank account	24%	34%
In jail or homeless	2%	7%
Does not reside in own residence	52%	56%
Receives public support (Welfare, housing, or food assistance)	56%	57%
Does not have access to transportation	25%	25%
Does not have a supportive adult in his or her life	20%	17%

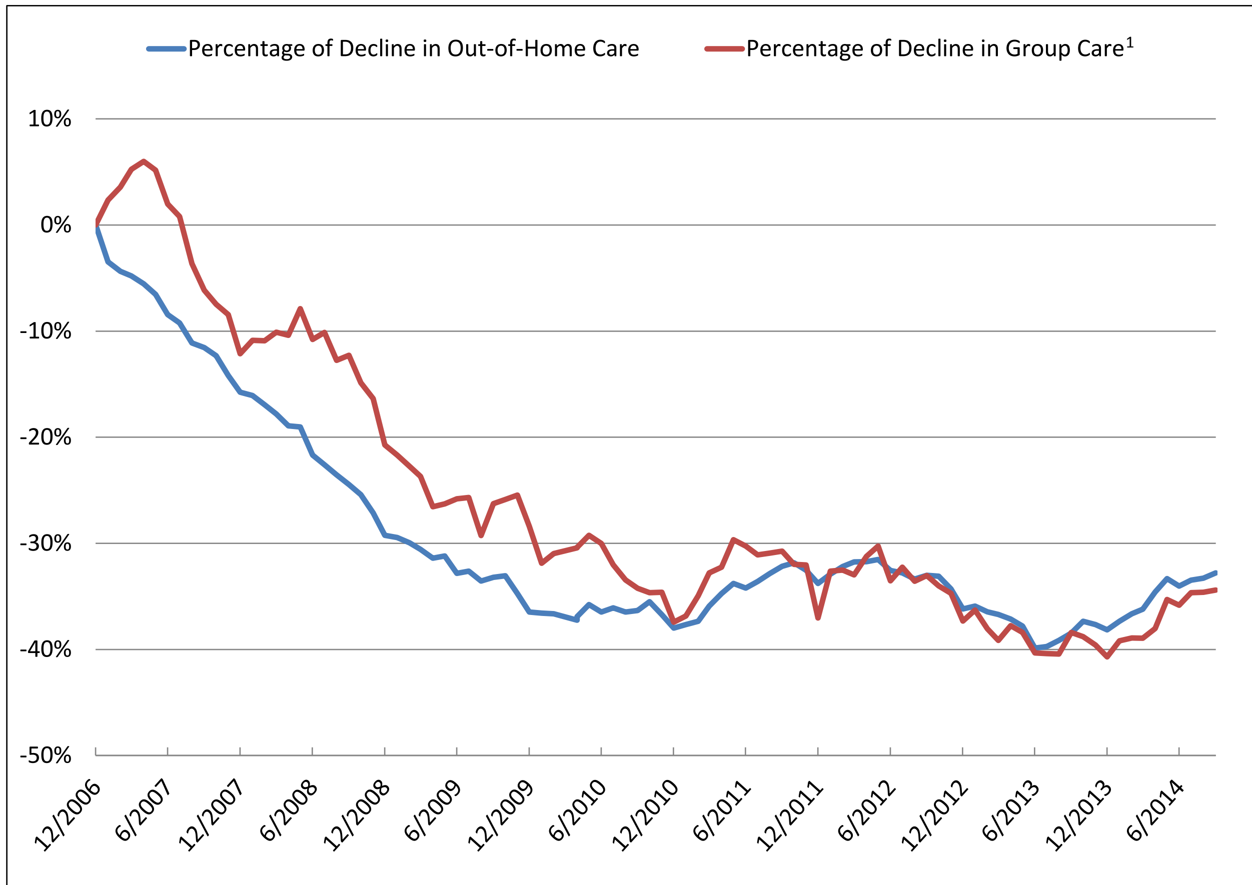
Source: OPPAGA analysis of Department of Children and Families National Youth in Transition Database data.

Appendix A

The Number of Children in Out-of-Home Care and Group Care Has Decreased

Since January 2007, the number of total children in out-of-home care and the number in group care decreased. The department set a goal to reduce the number of children in out-of-home care by 50% between January 2007 and January 2012. By January 2012, the number of children in out-of-home care had decreased by over 30%, with group care experiencing a similar reduction. On December 31, 2006, there were 29,255 children in out-of-home care, of which 11% (3,348) were in group care. As of September 30, 2014, there were 19,663 children in out-of-home care, of which 11% (2,196) were in group care. This represents a 33% reduction in out-of-home care and a 34% reduction in group care.[34]

Exhibit A-1
The Use of Group Care Decreased at a Similar Rate as Total Out-of-Home Care



[1] The trend for group care includes all children in group care at the end of each month, including children in the care of providers licensed by the department as emergency shelters, runaway shelters, wilderness camps, and maternity group homes and children with providers licensed by other agencies as Statewide Inpatient Psychiatric Programs, therapeutic group homes, or Agency for Persons with Disabilities' group homes.

Source: OPPAGA analysis of Department of Children and Families data.

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[34] The percentage decline for children in group care is 1% different between Exhibit 2 and Exhibit A-1 is because the data for Exhibit 2 is calculated using a different starting point and is based on the average annual number of children in care, while Exhibit A-1 is based on the number of children in care at a given point in time.

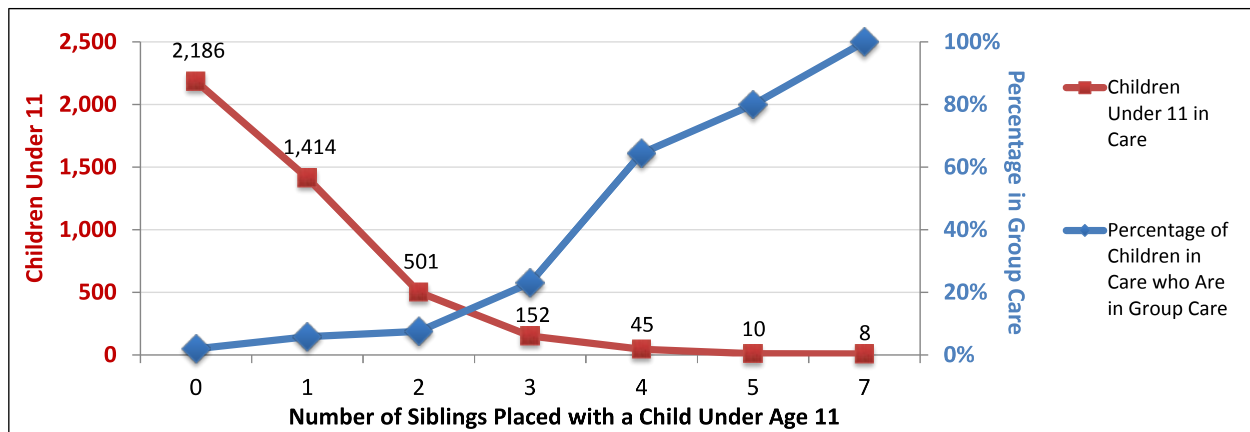
Appendix B

Most Young Children in Group Care Are Not in Care with Many Siblings

While younger children in group care are with siblings, there are few young children in group care with many of their siblings. Lead agency staff reported that children under age 11 typically are not placed in group care unless family foster care placements that will keep siblings together are unavailable. In particular, they reported that it may be challenging to identify foster parents who are willing to take a large number of siblings into their homes. Exhibits B-1 through B-3 show that most young children who are in group care are placed there with at least one sibling, and when children are in care with a large number of siblings (three or more), they are placed in group care. However, there are many young children in group care who do not appear to be in care with a large number of siblings.[35]

In Exhibit B-1, the red line, which is the number of children under age 11 in licensed care (family foster care or group care), shows there are few young children who are placed in licensed care together with a large number of their siblings. The blue line, which is the percentage of the young children who are in group care, shows that when larger sibling groups are kept together, they are typically kept together in group care.

Exhibit B-1
Young Children Placed with Many Siblings in Licensed Care Are Usually in Group Care



Source: OPPAGA analysis of Department of Children and Families data.

[35] A small number of these young children may be in other types of residential placements, such as maternity homes or emergency shelters. In addition, some of these children may be temporarily separated from siblings because one or more siblings ran away, entered a correctional placement or emergency care, or were on visitation.

As shown in Exhibit B-2, 82% of young children in group care were in care with at least one of their siblings. In contrast, 47% of young children in family foster care were placed with at least one sibling. However, only one-third of the young children in group care were with three or more of their siblings.

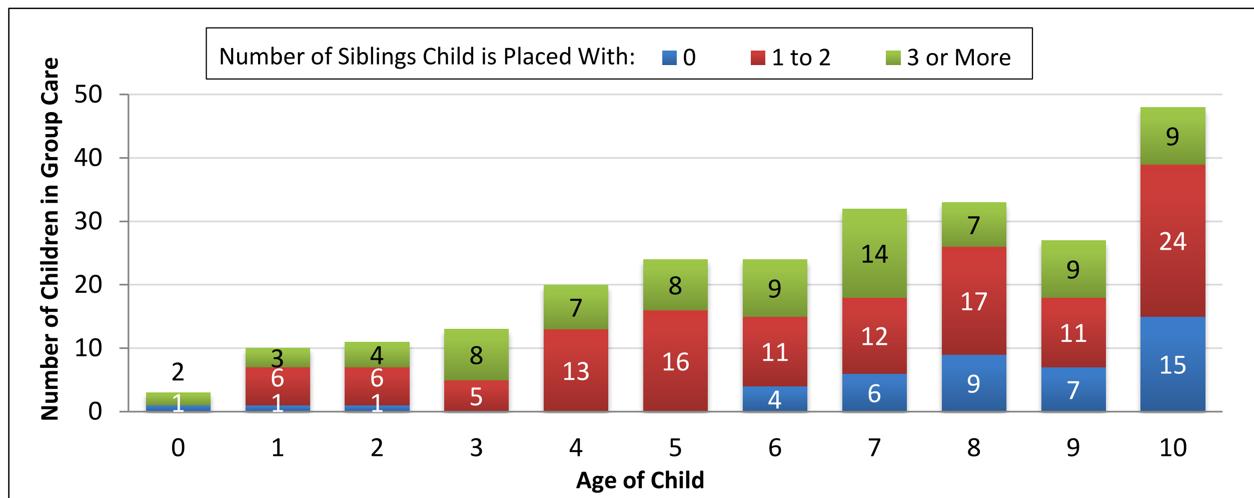
Exhibit B-2
Most Young Children in Group Care Are Placed in Care with at Least One Sibling

Placement with Siblings for Children Under Age 11	Family Foster Care (N = 4,071)	Group Care (N = 245)
Percentage of children placed with at least one sibling	47%	82%
Percentage of children placed with three or more siblings	3%	33%

Source: OPPAGA analysis of Department of Children and Families data.

Exhibit B-3 shows that among children ages 0 to 10, the older children (6 to 10) are more often placed in group care with few siblings. For example, 60% (49 of 81) of children under the age of six in group care were placed with fewer than three siblings. For children ages 6 to 10 in group care, 71% (116 of 164) are placed together with fewer than three siblings, and 25% (41 of 164) are placed with no siblings.

Exhibit B-3
Few Young Children in Group Care Are Placed with a Large Number of Siblings



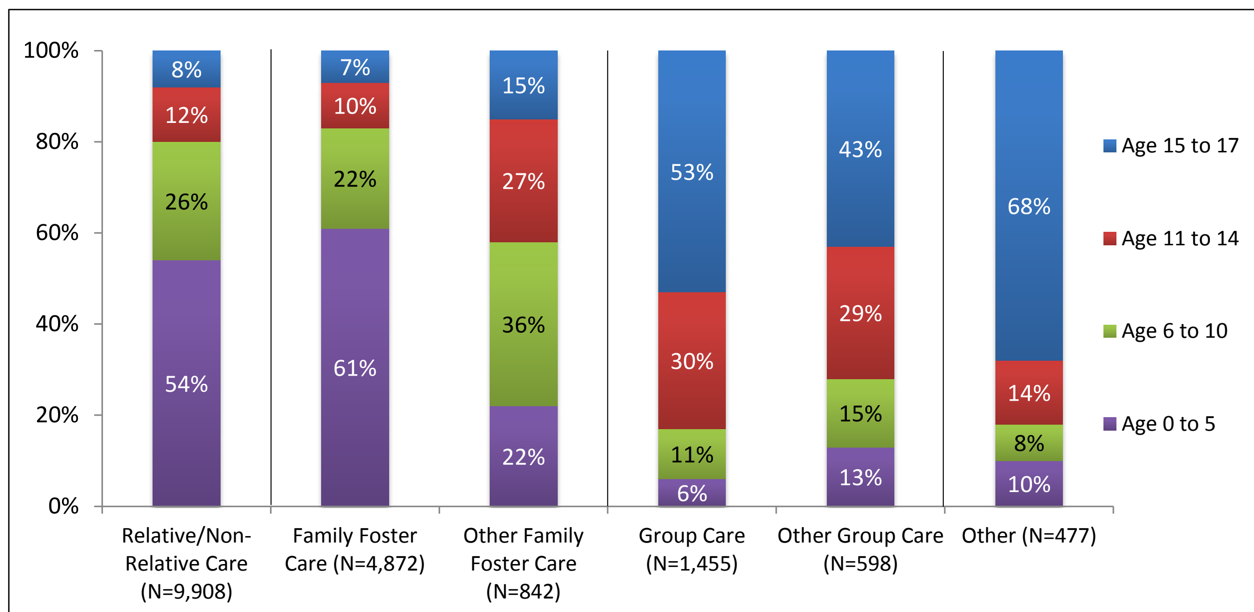
Source: OPPAGA analysis of Department of Children and Families data.

Appendix C

Demographics of Children in Group Care and Family Foster Care

Children in group care are significantly older than children in family-based care. As shown in Exhibit C-1, the distribution of children by age varies across types of out-of-home care. More children in group care were 11 or older compared children in family foster care. Other family foster care primarily consists of licensed therapeutic family foster care and children placed in the care of families out of state. Other group care includes children in the care of providers licensed by the department as emergency shelters, runaway shelters, wilderness camps, and maternity group homes, and children with providers licensed by other agencies as Statewide Inpatient Psychiatric Programs, therapeutic group homes, or group homes for persons with developmental disabilities. Other placements consist of children in correctional placements and children who ran away, were in emergency services, or were on visitation.

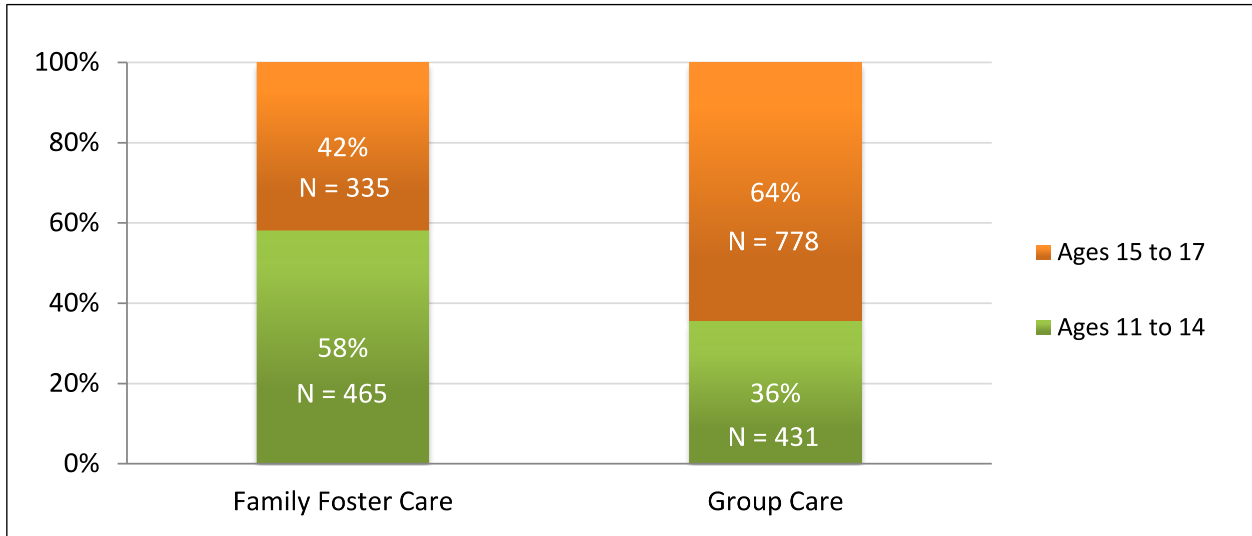
Exhibit C-1
Children in Group Care Are Older



Source: OPPAGA analysis of Department of Children and Families data.

Group care programs serve primarily older, male, and minority children. Our analysis focused on children 11 and older in group care and family foster care. As shown in Exhibits C-2 through C-4, the largest demographic difference between children in group care and family foster care is that children in group care are older. Exhibit C-2 shows that among children 11 or older, 64% of children in group care are 15 to 17, compared to 42% in family foster care.

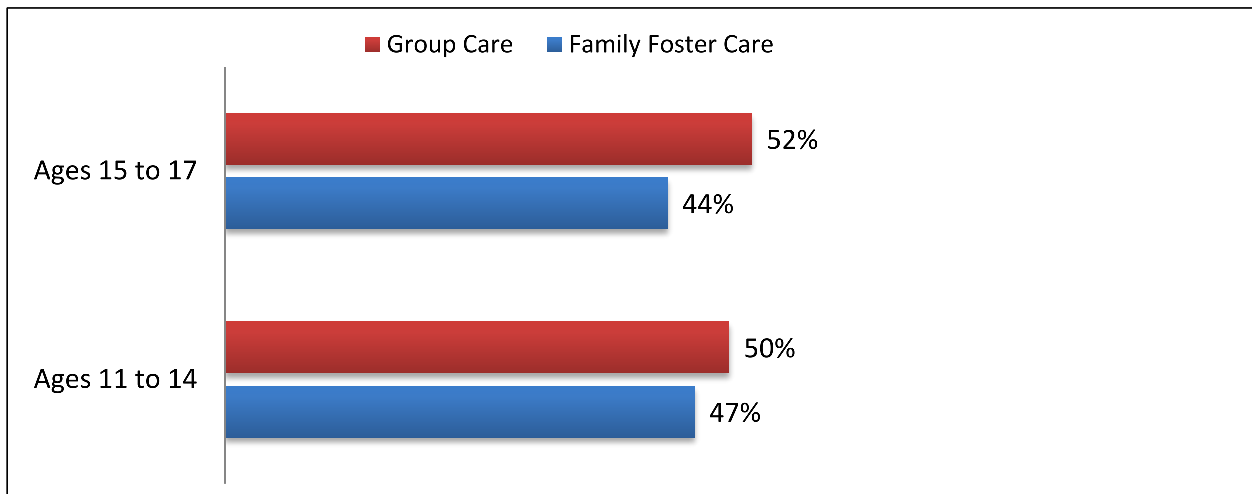
Exhibit C-2
A Larger Percentage of Children in Group Care Are Ages 15 to 17 Compared to Family Foster Care



Source: OPPAGA analysis of Department of Children and Families data.

Exhibit C-3 shows that, compared to family foster care, a larger share of children in group care are male. Fifty-two percent of children ages 15 to 17 in group care are male, compared to 44% in family foster care.

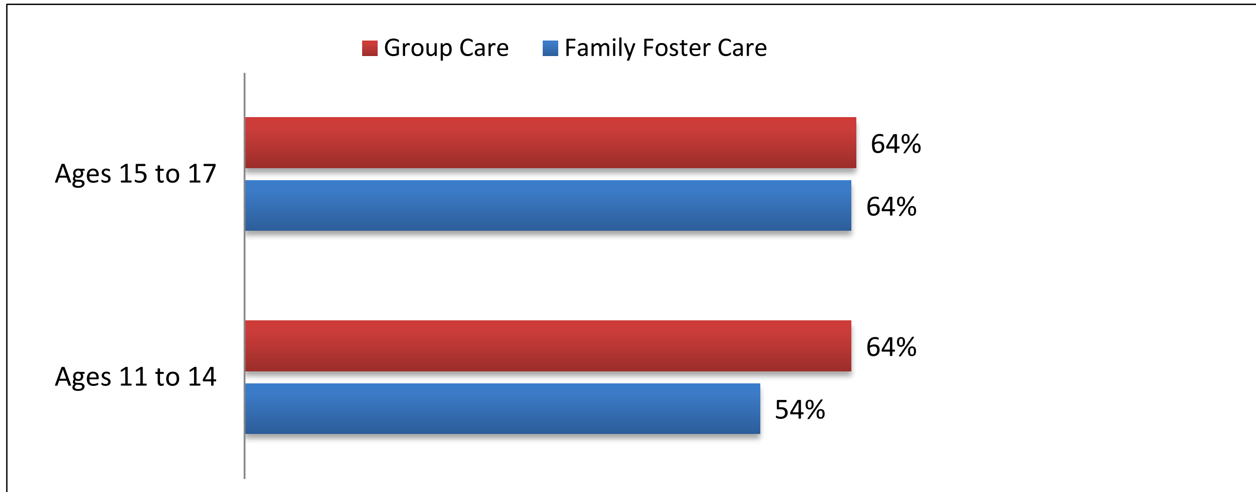
Exhibit C-3
Percentage of Male Children in Licensed Care



Source: OPPAGA analysis of Department of Children and Families data.

As is the case nationally, a larger percentage of children in out-of-home care are minorities, especially group care. Exhibit C-4 shows that 64% of children ages 11 to 14 in group care are minorities, compared to 54% in family foster care. Among children ages 15 to 17, 64% of children in both group care and family foster care are minorities.

Exhibit C-4
Percentage of Minority Children in Licensed Care[1]



[1] For this exhibit, white non-Hispanic children were considered non-minorities.

Source: OPPAGA analysis of Department of Children and Families data.

Appendix D

Assessed Behavioral Issues of Children in Group Care and Family Foster Care

Data shows children in group care exhibited more behavioral issues than children in family foster care. Child welfare services workers are required to complete a family assessment when a family begins receiving services as a result of a child protective investigation.[36] To determine whether group care is primarily used to provide care for adolescents with behavioral problems, we obtained family assessment data for children who were in licensed family foster care or group care on November 15, 2013. To minimize the likelihood that children's assessed behaviors were influenced by the type of care they were in, for each child we attempted to identify the assessment closest to, but before, they entered this placement.[37] Although the percentage of children with a complete assessment varied substantially throughout the state, overall about 91% of children had a family assessment, and about 67% had an assessment near when they entered family or group care.[38, 39] Family assessments are similarly complete for children in group care and family foster care.

The assessment includes a determination of whether the child exhibits one or more of 24 specific behavioral issues.[40] Exhibits D-1 and D-2 show that children in group care exhibited nearly all of the behavioral issues at a higher rate than children in family foster care. For example, 71% of children ages 15 to 17 exhibited at least one of these behavioral issues compared to 48% of children in family foster care. In addition, 39% of children in group care ages 15 to 17 had four or more issues identified compared to 21% of children in family foster care.

[36] Rule 65C-30.005, *F.A.C.*, requires child welfare services workers to complete a family assessment within 15 working days of the Early Services Intervention staffing and update the assessment, at a minimum, every 6 months thereafter. The family assessment is used to analyze the strengths and needs of the family and its members and informs the development of case plans.

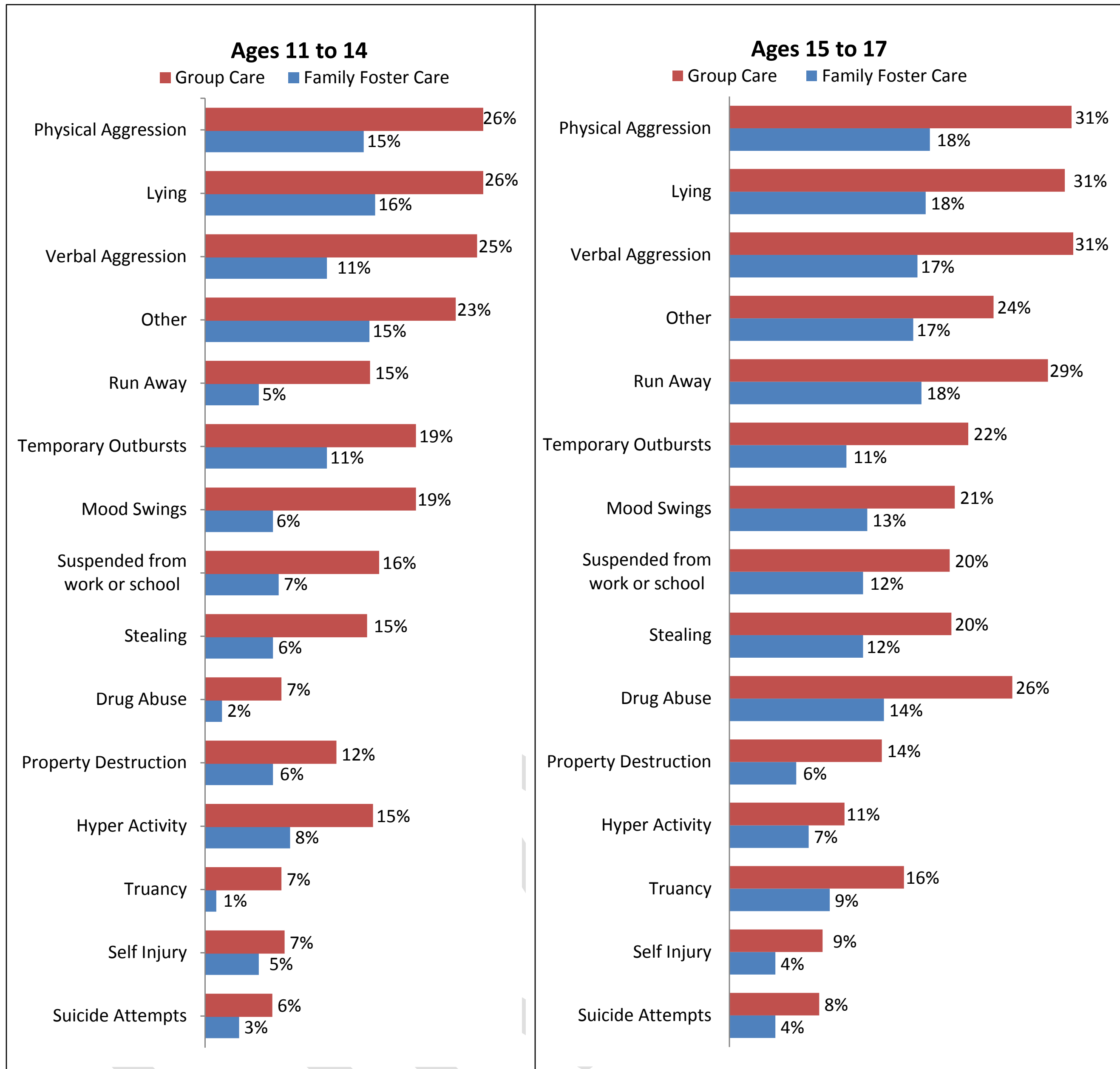
[37] An assessment was considered current if it was completed within six months before and one month after the child entered his or her current placement. Limiting the analysis to children with a current assessment or to children who entered group care for the first time did not substantially change the results. As such, we present the results for all children who had an assessment recorded in FSFN.

[38] This does not include Our Kids, Florida's largest community-based care lead agency, which did not complete the standard family assessment in FSFN. At the time of our review, Our Kids was using an alternative assessment instrument, known as structured decision making. Our Kids will transition to using Florida's revised statewide standard assessment instrument. At the time of our review, Our Kids had about 10% of the state's population of children in family foster care and group care over the age of 11.

[39] Child Net of Palm Beach had, by far, the lowest percentage, with only 49% of children having a complete assessment and only 23% of children having a current assessment.

[40] The exhibits only show 15 behavioral issues, because the 10 least common behavioral issues were collapsed into the category Other. These issues are sleep disturbances, bed wetting, withdrawn or lethargic behavior, fire setting, harming animals, frequent crying, frequent physical complaints, eating disorders, bizarre hallucinations, and other issues.

Exhibit D
Behaviors of Children[1]



[1] Other includes the following categories: sleep disturbances, bed wetting, withdrawn or lethargic behavior, fire setting, harming animals, frequent crying, frequent physical complaints, eating disorders, bizarre hallucinations, and other issues.

Source: OPPAGA analysis of Department of Children and Families data.

The Florida Senate
BILL ANALYSIS AND FISCAL IMPACT STATEMENT

(This document is based on the provisions contained in the legislation as of the latest date listed below.)

Prepared By: The Professional Staff of the Committee on Children, Families, and Elder Affairs

BILL: SB 940

INTRODUCER: Senators Detert and Sachs

SUBJECT: Children in Out-of-home Care

DATE: March 4, 2015 REVISED:

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Preston	Hendon	CF	**Pre-meeting**
2.			AHS	
3.			AP	

I. Summary:

SB 940 makes numerous changes to statutes related to residential group home placements for children in out-of-home care within the child welfare system. The bill requires the Department of Children and Families (DCF or department) to develop a proposal for a continuum of care for children in out-of-home care that will address their placement and service needs.

The bill provides legislative intent and findings related to the placement of children in out-of-home settings that employ a shift care model of care. The bill also requires that placement of children of certain ages in residential group home settings that use a shift-care model be subject to certain restrictions and requires periodic review of those placements.

The bill repeals a number of sections of law related to residential group care.

The bill is not anticipated to have a fiscal impact on government.

The bill has an effective date of July 1, 2015.

II. Present Situation:

The debate around the role of residential group care vs. family based care has been continuing since the late 1800s. Residential group care has many forms and purposes, including serving as a placement component of the child welfare services system of care and as a treatment component of the children's mental health system of care. The multiple roles of group care make an analysis of its effectiveness difficult.[1]

[1] Barth, R. (2002). *Institutions vs. foster homes: The empirical basis for the second century of debate.* Chapel Hill, NC: University of North Carolina, School of Social Work, Jordan Institute for Families, *available at*: http://resourcecentre.savethechildren.se/sites/default/files/documents/2344.pdf. (last visited February 13, 2015).

Some working in child welfare contend that all residential group care is potentially harmful and that its use should be eliminated; others support the position that such placements are beneficial for some children in certain situations, and still others favor the wholesale use of group care as an alternative to the shortage of family placements or reliance on family placements that may expose children to further risk. Both positive and negative claims about the effectiveness of residential group care and its alternatives are often made without sufficient evidence.[2]

There appears to be a growing consensus within the child-welfare community that residential group home settings for children in out-of-home care are sometimes necessary, but should be used sparingly. While some states have been more successful than others, most states have tried to move in the direction of decreasing reliance on group home care.[3]

KVC Health Systems, a private company hired to provide child-welfare services in eastern Kansas, has been very successful in its effort to reduce the number of children in residential group care, reporting that only 3 percent of the 3,100 children it oversees are in group settings, primarily for short-term psychiatric treatment, while virtually all the others are placed with foster families. That's a dramatic change from 1997, when 30 percent of KVC's children were in group care placements. "Change is hard," said KVC's executive vice president. "When a system is looking at making a significant reduction, there's often resistance among providers of residential services who are concerned about their business."[4]

Several advocacy groups are also pushing for an overhaul of the federal funding system for child welfare, with a goal of shifting funding from residential group home settings to alternatives such as family based care. One proposal by the Annie E. Casey Foundation and one of its partners, the Jim Casey Youth Opportunities Initiative, says federal reimbursement should be eliminated for shelters and group care for children under 13 and allowed for older children's group care only for short periods when necessary for psychiatric treatment or other specialized care.[5] Sen. Orrin Hatch (R-Utah), recently proposed a bill that would cut off federal funding for long-term placements in group homes.[6]

Nationally, according to the Adoption and Foster Care Analysis and Reporting System (AFCARS) data, in 2012, nearly half (47 percent) of all children in care lived in the foster family homes of non-relatives. Just over one-quarter (28 percent) lived in family foster homes with relatives, often referred to as "kinship care." Six percent of foster children lived in group homes,

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[2] Child Welfare League of America. (2008). *Residential Transitions Project Phase One Final Report*, *available at*: http://rbsreform.org/materials/Residential%20Transitions%20Project%20-%204%2030%2008%20_2_.pdf. (last visited February 13, 2015).

[3] *Id*. Also see California Health and Human Services Agency. California's Child Welfare Continuum of Care Reform, January 2015, Children's Rights, *What Works in Child Welfare Reform: Reducing Reliance on Congregate Care in Tennessee,* July 2011, and The Annie E. Casey Foundation, *Rightsizing Congregate Care, A Powerful First Step in Transforming Child Welfare System*, 2010.

[4] Crary, D. *Foster care: U.S. Moves to phase out group care for foster kids*, Christian Science Monitor. May 17, 2014, *available at*: http://www.csmonitor.com/The-Culture/Family/2014/0517/Foster-care-US-moves-to-phase-out-group-care-for-foster-kids. (last visited February 16, 2015).

[5] *Id*.

[6] Senate Bill 1518 (2013) proposed eliminating federal matching funds for non-family foster homes for all children age 12 and under and for youth age 13 and older after 1 year of consecutive time spent in a non- family foster home or 18 months non-consecutive care spent in a non-family foster home, whichever comes first.

8 percent lived in institutions, 4 percent lived in pre-adoptive families, and the rest lived in other types of facilities.[7] These are not substantially different from the proportions at the beginning of the decade, though there has been a slight decrease in the number of foster children in group homes and institutions, and a corresponding increase of those in home care.[8]

In Florida, 11 percent of children in foster care are in residential group care and 83 percent of the children in group care are 11 years of age and older, compared to 17 percent in family care settings.[9]

Residential group homes are one of the most expensive placement options for children in the child welfare system. The costs of group home care far exceed those for foster care or treatment foster care. The difference in monthly cost can be 6 to 10 times as high as foster care and 2 to 3 times as high as treatment foster care. Since there is virtually no evidence that these additional expenditures result in better outcomes for children, there is no cost benefit justification for group care, when other placements are available.[10] Nonetheless, some state legislatures have encouraged the expanded use of group home care because of a belief that it better provides for the needs of children.[11]

In Florida, community-based care lead agencies annually negotiate rates for residential group home placements with providers. In Fiscal Year 2013-2014, the average per diem rate for the shift-care group home model was $124, with costs ranging from $52 to $283. The average per diem rate for a family group home model was $97, with costs ranging from $17 to $175. Family foster home care pays an average daily rate of $15.[12] The cost of group home care in Florida for Fiscal Year 2013-2014 was $81.7million.[13]

III. Effect of Proposed Changes:

Section 1 amends s. 409.145, F.S., related to the care of children, to make changes to provisions related to residential group home placements for children in out-of-home care.

The bill provides legislative intent and findings related to the placement of children in out-of-home settings that employ a shift care model of care. Specifically, it is the intent of the legislature to restructure placement options and services in order to reduce reliance on group homes using a shift-care model as a long-term placement setting. This will require redefining the

[7] U.S. Department of Health and Human Services Administration for Children and Families, Children's Bureau. The AFCARS Report (2013) available at: http://www.acf.hhs.gov/sites/default/files/cb/afcarsreport19.pdf. (last visited March 2, 2015).
[8] Child Trends Data Bank, Foster Care Indicators on Children and Youth (2014) *available at*: http://www.childtrends.org/wp-content/uploads/2014/07/12_Foster_Care.pdf. (last visited February 16, 2015).
[9] Office of Program Policy and Government Accountability. Research Memorandum. *Florida's Residential Group Care Program for Children in the Child Welfare System*. December 2014.
[10] Barth, R. (2002). *Institutions vs. foster homes: The empirical basis for the second century of debate.* Chapel Hill, NC: University of North Carolina, School of Social Work, Jordan Institute for Families, *available at*: http://resourcecentre.savethechildren.se/sites/default/files/documents/2344.pdf. (last visited February 13, 2015).
[11] Section 39.523, F.S.
[12] Office of Program Policy and Government Accountability. Research Memorandum. *Florida's Residential Group Care Program for Children in the Child Welfare System* (December 2014).
[13] *Id*.

purpose of residential group care, placing conditions on admissions to certain types of group homes, and increasing the capacity of home-based family care.

The bill also requires that placement of children of certain ages in residential group home settings that use a shift-care model is subject to certain restrictions and requires periodic review as follows:

- In order for children 6 years of age and younger to be placed in a residential shift-care group home setting:
  - The case plan must indicate that short-term specialized and intensive treatment is needed, that there is an anticipated duration of treatment, and that the Assistant Secretary for Child Welfare has approved;
  - Short-term may not exceed 120 days unless the community-based care lead agency (CBC) has made progress in finding supports and services to transition to a family setting and the extension is approved by the Assistant Secretary for Child Welfare; and
  - For every extension that is requested the above requirements must be met and no less than every 60 days the Assistant Secretary for Child Welfare shall approve the continued placement.
- In order for children 7 - 12 years of age to be placed in a residential shift-care group home setting:
  - The case plan must indicate that short-term specialized and intensive treatment is needed, that there is an anticipated duration of treatment and that the Assistant Secretary for Child Welfare has approved;
  - Short-term may not exceed 6 months unless the CBC has made progress in finding supports and services to transition to a family setting and the extension is approved by the Assistant Secretary for Child Welfare; and
  - For every extension that is requested the above requirements must be met and no less than every 60 days the Assistant Secretary for Child Welfare shall approve the continued placement.

The bill requires the department to develop a proposal for a continuum of care for children in out-of-home care that will address their placement and service needs. The continuum must address recruiting, training, and supporting an adequate supply of home-based family care; providing needed services and supports in those family care settings; and limiting congregate care to only those situations in which adequate services cannot be safely provided while a child lives with a family, and then for only the minimum amount of time required for stabilization.

The requirement restricting placement in residential group homes for younger children in care will require an increased capacity in family foster homes. It is unknown how long it will take the department to recruit and license an adequate number of family foster homes. The requirement for the Assistant Secretary for Child Welfare to approve or deny requests for placement of children ages 0 - 12 years in group care could create a delay in child placement.

Section 2 repeals ss. 39.523, 409.165, 409.1676, 409.1677, and 409.1679, F.S. All sections are related to residential group home care.

Section 3 amends s. 409.1451, F.S., relating to the Road-to-Independence Program, to conform cross references.

Section 4 amends s. 39.202, F.S., relating to confidentiality of records in child abuse cases, to conform provisions to changes made by the bill.

Section 5 amends s. 39.5085, F.S., relating to the relative caregiver program, to conform provisions to changes made by the bill.

Section 6 amends s. 1002.3305, F.S., relating to a College-Preparatory Boarding Academy Pilot Program for at-risk students, to conform provisions to changes made by the bill.

Section 7 provides an effective date of July 1, 2015.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

The department reports that there will be an indeterminate decrease in the funding available to shift-care group homes. There will also be an indeterminate decrease in the expenditures made by the shift-care group homes due to fewer children in foster care being placed in those homes.[14]

C. Government Sector Impact:

The department reports that implementation of the bill will require reallocating some of the funding that is currently spent on shift-care group homes to pay for recruitment, training, support services and utilization of additional family foster homes.[15]

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[14] Department of Children and Families, 2015 Agency Legislative Bill Analysis. SB 940. February 18, 2015.
[15] *Id*.

VI. Technical Deficiencies:

None.

VII. Related Issues:

None.

VIII. Statutes Affected:

This bill substantially amends the following sections of the Florida Statutes: 409.145, 409.1451, 39.202, 39.5085, and 1002.3305.

This bill repeals the following sections of the Florida Statutes: 39.523, 409.165, 409.1676, 409.1677, and 409.1679.

IX. Additional Information:

A. Committee Substitute – Statement of Changes:

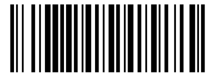
(Summarizing differences between the Committee Substitute and the prior version of the bill.)

None.

B. Amendments:

None.

This Senate Bill Analysis does not reflect the intent or official position of the bill's introducer or the Florida Senate.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LEGISLATIVE ACTION

Senate	.	House
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The Committee on Children, Families, and Elder Affairs (Detert) recommended the following:

1 **Senate Amendment (with title amendment)**
2
3 Delete everything after the enacting clause
4 and insert:
5 Section 1. Section 39.523, Florida Statutes, is amended to
6 read:
7 39.523 Placement in residential group care.—
8 (1) Except as provided in s. 39.407, any dependent child 11
9 years of age or older who has been in licensed family foster
10 care for 6 months or longer and who is then moved more than once

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11 and who is a child with extraordinary needs as defined in s.
12 409.1676 must be assessed for placement in licensed residential
13 group care. The assessment procedures shall be conducted by the
14 department or its agent and shall incorporate and address
15 current and historical information from any psychological
16 testing or evaluation that has occurred; current and historical
17 information from the guardian ad litem, if one has been
18 assigned; current and historical information from any current
19 therapist, teacher, or other professional who has knowledge of
20 the child and has worked with the child; information regarding
21 the placement of any siblings of the child and the impact of the
22 child's placement in residential group care on the child's
23 siblings; the circumstances necessitating the moves of the child
24 while in family foster care and the recommendations of the
25 former foster families, if available; the status of the child's
26 case plan and a determination as to the impact of placing the
27 child in residential group care on the goals of the case plan;
28 the age, maturity, and desires of the child concerning
29 placement; the availability of any less restrictive, more
30 family-like setting for the child in which the foster parents
31 have the necessary training and skills for providing a suitable
32 placement for the child; and any other information concerning
33 the availability of suitable residential group care. If such
34 placement is determined to be appropriate as a result of this
35 procedure, the child must be placed in residential group care,
36 if available.
37 (2) The results of the assessment described in subsection
38 (1) and the actions taken as a result of the assessment must be
39 included in the next judicial review of the child. At each

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subsequent judicial review, the court must be advised in writing of the status of the child’s placement, with special reference regarding the stability of the placement and the permanency planning for the child.

(3) Any residential group care facility that receives children under the provisions of this subsection shall establish special permanency teams dedicated to overcoming the special permanency challenges presented by this population of children. Each facility shall report to the department its success in achieving permanency for children placed by the department in its care at intervals that allow the current information to be provided to the court at each judicial review for the child.

(4) This section does not prohibit the department from assessing and placing children who do not meet the criteria in subsection (1) in residential group care if such placement is the most appropriate placement for such children.

~~(5)(a) By December 1 of each year, the department shall report to the Legislature on the placement of children in licensed residential group care during the year, including the criteria used to determine the placement of children, the number of children who were evaluated for placement, the number of children who were placed based upon the evaluation, and the number of children who were not placed. The department shall maintain data specifying the number of children who were referred to licensed residential child care for whom placement was unavailable and the counties in which such placement was unavailable. The department shall include this data in its report to the Legislature due on December 1, so that the Legislature may consider this information in developing the~~

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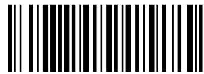
69 ~~General Appropriations Act.~~
70 ~~(b) As part of the report required in paragraph (a), the~~
71 ~~department shall also provide a detailed account of the~~
72 ~~expenditures incurred for "Special Categories: Grants and Aids—~~
73 ~~Specialized Residential Group Care Services" for the fiscal year~~
74 ~~immediately preceding the date of the report. This section of~~
75 ~~the report must include whatever supporting data is necessary to~~
76 ~~demonstrate full compliance with paragraph (6)(c). The document~~
77 ~~must present the information by district and must specify, at a~~
78 ~~minimum, the number of additional beds, the average rate per~~
79 ~~bed, the number of additional persons served, and a description~~
80 ~~of the enhanced and expanded services provided.~~
81 ~~(6)(a) The provisions of this section shall be implemented~~
82 ~~to the extent of available appropriations contained in the~~
83 ~~annual General Appropriations Act for such purpose.~~
84 ~~(b) Each year, funds included in the General Appropriations~~
85 ~~Act for Enhanced Residential Group Care as provided for in s.~~
86 ~~409.1676 shall be appropriated in a separately identified~~
87 ~~special category that is designated in the act as "Special~~
88 ~~Categories: Grants and Aids—Specialized Residential Group Care~~
89 ~~Services."~~
90 ~~(c) Each fiscal year, all funding increases for Enhanced~~
91 ~~Residential Group Care as provided in s. 409.1676 which are~~
92 ~~included in the General Appropriations Act shall be appropriated~~
93 ~~in a lump-sum category as defined in s. 216.011(1)(aa). In~~
94 ~~accordance with s. 216.181(6)(a), the Executive Office of the~~
95 ~~Governor shall require the department to submit a spending plan~~
96 ~~that identifies the residential group care bed capacity shortage~~
97 ~~throughout the state and proposes a distribution formula by~~

 473434

98 ~~district which addresses the reported deficiencies. The spending~~
99 ~~plan must have as its first priority the reduction or~~
100 ~~elimination of any bed shortage identified and must also provide~~
101 ~~for program enhancements to ensure that residential group care~~
102 ~~programs meet a minimum level of expected performance and~~
103 ~~provide for expansion of the comprehensive residential group~~
104 ~~care services described in s. 409.1676. Annual appropriation~~
105 ~~increases appropriated in the lump-sum appropriation must be~~
106 ~~used in accordance with the provisions of the spending plan.~~
107 ~~(d) Funds from "Special Categories: Grants and Aids—~~
108 ~~Specialized Residential Group Care Services" may be used as one-~~
109 ~~time startup funding for residential group care purposes that~~
110 ~~include, but are not limited to, remodeling or renovation of~~
111 ~~existing facilities, construction costs, leasing costs, purchase~~
112 ~~of equipment and furniture, site development, and other~~
113 ~~necessary and reasonable costs associated with the startup of~~
114 ~~facilities or programs upon the recommendation of the lead~~
115 ~~community-based provider if one exists and upon specific~~
116 ~~approval of the terms and conditions by the secretary of the~~
117 ~~department.~~
118 Section 2. Section 409.144, Florida Statutes, is created to
119 read:
120 409.144 Continuum of care; residential group home care.—
121 (1) LEGISLATIVE FINDINGS AND INTENT.—
122 (a) The Legislature finds that children in out-of-home care
123 should live in their communities in home-based family care
124 settings and that the need to recruit, train, and support an
125 adequate number of families to provide home-based family care is
126 an essential part of any initiative to reform out-of-home care

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127 for children.
128 (b) The Legislature also finds that children who initially
129 cannot be safely placed in home-based family care may be still
130 placed into residential group home care, but for only the
131 minimum time required for stabilization and with specific short
132 time-limited plans for their care. When needed, residential
133 group home care should be considered a short-term, specialized,
134 and intensive intervention that is just one part of a continuum
135 of care available for children.
136 (c) The Legislature further finds that, once stabilized,
137 most children should transition from residential group home care
138 into home-based family care with their services following them.
139 (d) Therefore, it is the intent of the Legislature to
140 support an effort to reform the current system of using
141 residential group home care that reflects current research
142 findings and the appropriate place of residential group home
143 care in the child welfare system continuum of care. It is
144 further the intent of the Legislature that the reform effort
145 provides for improved assessments of children and families to
146 make more informed and appropriate initial placement decisions,
147 an emphasis on home-based family care placements for children,
148 appropriate support for those placements with available
149 services, a change in goals for residential group home care
150 placements, and increased transparency and accountability for
151 child outcomes.
152 (2) DUTIES OF THE DEPARTMENT.—The department shall collect
153 and compile data and information necessary to inform the
154 development of a work plan to be used by the Continuum of Care
155 Advisory Council created in subsection (3) to address the

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156 placement and services needs of children who are cared for in
157 out-of-home care. At a minimum, the collected and compiled data
158 and information must include current data and information
159 related to all of the following:
160 (a) Methods of assessing children coming into care for
161 their initial placement.
162 (b) Definitions and characteristics of types of placements
163 in use.
164 (c) Service needs of children in out-of-home care.
165 (d) Program design and quality standards.
166 (e) Licensing categories and accreditation requirements for
167 types of out-of-home placements.
168 (f) Rates and procedures used for payment rate setting.
169 (g) Outcomes, outcome indicators and performance measures.
170 (h) Impact of existing performance measures.
171 (i) Mechanisms that ensure continuous quality improvement
172 and transition strategies from group care to other levels of
173 care.
174 (3) CONTINUUM OF CARE ADVISORY COUNCIL.—The Continuum of
175 Care Advisory Council is created within the department for the
176 purpose of recommending a plan to address the placement and
177 service needs of children who are cared for outside their own
178 homes by creating a continuum of care which consists of
179 recruiting, training, and supporting an adequate supply of home-
180 based family care; providing needed services and supports in
181 those family care settings; and limiting congregate care to only
182 those situations in which adequate services cannot be safely
183 provided while a child lives with a family, and for only the
184 minimum amount of time required for stabilization. The work of

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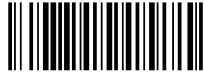
185 the advisory council shall be conducted in collaboration with
186 the primary stakeholders and shall be based on empirical
187 research and best practices data. The process must include
188 gathering research data, holding public meetings, and entering
189 into partnerships with academia and other stakeholders to
190 complete the task. The advisory council shall function as
191 specified in this subsection until the Legislature determines
192 that the advisory council can no longer provide a valuable
193 contribution to the department's efforts to create a continuum
194 of care.
195 (a) The 25 members of the advisory council must be
196 appointed in the following manner:
197 1. Three members from the headquarters and regional offices
198 of the department, to be appointed by the secretary.
199 2. One member with recognized expertise in developmental
200 psychology, to be appointed by the secretary.
201 3. One member with expertise in children's mental health,
202 to be appointed by the secretary.
203 4. One member with expertise in children's health issues,
204 to be appointed by the secretary.
205 5. One member who is an economist with expertise in
206 behavioral economics, to be appointed by the secretary.
207 6. Two members from the community-based care lead agencies,
208 one from the lead agency with the lowest rate and one from the
209 lead agency with the highest rate of residential group home
210 placement, to be appointed by the secretary.
211 7. One member with experience working with children with
212 special needs in residential group home settings, to be
213 appointed by the secretary.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214 8. Two members who are foster parents, to be appointed by
215 the executive director of the Florida State Foster/Adoptive
216 Parent Association.
217 9. Two members who are kinship caregivers, to be appointed
218 by the secretary.
219 10. One member from the Quality Parenting Initiative, to be
220 appointed by the secretary.
221 11. Three members who are residential group home providers,
222 representing different models of residential group home care and
223 who are involved in daily operation of the facilities, to be
224 appointed by the secretary.
225 12. Two members from Florida Youth SHINE, to be appointed
226 by the secretary.
227 13. One member from Florida’s Children First, to be
228 appointed by the secretary.
229 14. One member from the Agency for Persons with
230 Disabilities, to be appointed by the director of the agency.
231 15. One member from the Department of Juvenile Justice, to
232 be appointed by the Secretary of Juvenile Justice.
233 16. One member from the Department of Education, to be
234 appointed by the Commissioner of Education.
235 17. One member from the Florida Institute for Child
236 Welfare, to be appointed by the secretary.
237 (b) The advisory council is encouraged to work with any
238 additional individuals who are knowledgeable in the subject
239 areas; however, those additional individuals may not become
240 members of the council and may not vote on the final report and
241 recommendations of the council, but may submit reports and
242 recommendations for review by the council and may be invited to

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243 speak to the council by a member of the council.
244 (c) Nongovernmental members of the advisory council shall
245 serve without compensation but are entitled to receive per diem
246 and travel expenses in accordance with s. 112.061 while in
247 performance of their duties.
248 (d) The advisory council shall propose a timeline and work
249 plan for reform and an estimate of associated costs and shall
250 submit the proposal and estimate of costs to the Governor, the
251 President of the Senate, and the Speaker of the House of
252 Representatives by December 31, 2016. At a minimum, the proposal
253 must consider the following:
254 1. The impact of group care on children based on their age
255 and history based on an impartial compilation of research
256 related to residential group care.
257 2. Criteria for admission to residential group care and the
258 types of assessments that should be performed to determine
259 whether the admission criteria are being met and who should
260 perform the assessments.
261 3. Policies and procedures needed to ensure that placement
262 in a residential group care is appropriate for each specific
263 child and lasts only as long as necessary to resolve the issue
264 that required the placement.
265 4. Services that are currently available for children in
266 group placements and the types of services that could be
267 provided to eliminate the need for group care.
268 5. The need to develop a classification system for group
269 care.
270 6. Requirements needed in plans for children in group care
271 to transition to family placement.

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272 7. The role of state licensing in determining the quality
273 of care and the need for a new licensing category or categories
274 to better meet the needs of the children in out-of-home care.
275 8. The value of requiring group home accreditation by a
276 national accrediting body.
277 9. The need to plan for any change in federal funding for
278 long-term residential group care.
279 10. Current practices related to the use of residential
280 group home care in order to develop a framework that can be used
281 to transition residential group homes into short-term,
282 specialized, and intensive treatment providers used for the
283 minority of children who cannot safely be served in home-based
284 family care settings.
285 11. Age limitations that should be placed on group care
286 based on developmental research.
287 12. Comparison of cost of group care placement and family
288 based care, and what economic and other incentives exist for
289 placement of children in group care.
290 13. Alternate funding mechanisms for children placed in
291 residential group home care.
292 14. Adjustments to funding to encourage placement in home-
293 based family care settings.
294 15. Standards that should be in effect to ensure that group
295 home staff has adequate training, experience, and supervision to
296 provide therapeutic care to children and youth in the
297 facilities.
298 (e) The department shall provide administrative support to
299 the advisory council to accomplish its assigned tasks. The
300 advisory council shall have access to all appropriate data from

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301 the department, each community-based care lead agency, and other
302 relevant agencies in order to accomplish the tasks set forth in
303 this section. The data collected by the advisory council may not
304 include information that would identify a specific child or
305 young adult.
306 Section 3. This act shall take effect July 1, 2015.
307 ================= T I T L E A M E N D M E N T ================
308 And the title is amended as follows:
309 Delete everything before the enacting clause
310 and insert:
311 A bill to be entitled
312 An act relating to continuum of care for children;
313 amending s. 39.523, F.S.; removing a requirement that
314 the Department of Children and Families submit a
315 report annually to the Legislature on the placement of
316 children in licensed residential group care; removing
317 a provision requiring the department to provide a
318 detailed account of certain expenditures; removing
319 provisions regarding implementation and specified
320 annual funding; creating s. 409.144, F.S.; providing
321 legislative findings and intent; requiring the
322 department to collect and compile specified data and
323 information; creating the Continuum of Care Advisory
324 Council within the department for specified purposes;
325 providing duties of the council; requiring the members
326 of the advisory council to be appointed in specified
327 manners; authorizing the advisory council to work with
328 certain individuals and providing limitations on the
329 involvement of those individuals; providing per diem

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330 and travel expenses for certain members; requiring the
331 advisory council to submit specified information to
332 the Governor and the Legislature by a certain date;
333 requiring the department to provide administrative
334 support to the advisory council; requiring that the
335 advisory council have access to specified information;
336 prohibiting certain data from including information
337 that would identify specific individuals; providing an
338 effective date.

By Senator Detert

A bill to be entitled

An act relating to children in out-of-home care; amending s. 409.145, F.S.; providing legislative findings and intent; removing provisions requiring the Department of Children and Families to develop, implement, and administer a coordinated community-based system of care for children directed toward specified goals; authorizing children of certain ages to be placed in a residential group home setting using a shift-care model only under specified circumstances; requiring the department to develop a proposal for a continuum of care for children in out-of-home care; repealing s. 39.523, F.S., relating to the placement in residential group care; repealing s. 409.165, F.S., relating to alternate care for children; repealing s. 409.1676, F.S., relating to comprehensive residential group care services to children who have extraordinary needs; repealing s. 409.1677, F.S., relating to model comprehensive residential services programs; repealing s. 409.1679, F.S., relating to additional requirement and reimbursement methodology; amending s. 409.1451, F.S.; conforming cross-references; amending ss. 39.202, 39.5085, and 1002.3305, F.S.; conforming provisions to changes made by the act; providing an effective date.

Be It Enacted by the Legislature of the State of Florida:

Section 1. Section 409.145, Florida Statutes, is amended to

read:

409.145 Continuum of care; residential group home placement ~~Care of children~~; quality parenting; "reasonable and prudent parent" standard.~~The child welfare system of the department shall operate as a coordinated community-based system of care which empowers all caregivers for children in foster care to provide quality parenting, including approving or disapproving a child's participation in activities based on the caregiver's assessment using the "reasonable and prudent parent" standard.~~

(1) LEGISLATIVE FINDINGS AND INTENT ~~SYSTEM OF CARE~~.~~The department shall develop, implement, and administer a coordinated community-based system of care for children who are found to be dependent and their families. This system of care must be directed toward the following goals:~~

(a) The Legislature finds that all children, including those in out-of-home care, deserve to grow up with families and develop a sense of community ~~Prevention of separation of children from their families~~.

(b) The Legislature also finds that it is well documented that children residing long term in group homes with shift-based care is not in their best interest. Not only is it developmentally inappropriate, it frequently creates lifelong behaviors requiring institutionalization and contributes to higher levels of involvement with the juvenile justice system and to poor educational outcomes ~~Intervention to allow children to remain safely in their own homes~~.

(c) The Legislature further finds that Florida relies on placing children, particularly older children, in group settings with shift-based care at a high rate, that many of those

children remain in those group settings for 6 months or more, and that the state's inability to recruit and retain a sufficient number of foster families has left few options for getting children out of congregate foster care and into family homes ~~Reunification of families who have had children removed from their care~~.

(d) Therefore, it is the intent of the Legislature to restructure placement options and services in order to reduce reliance on group homes using a shift-care model as a long-term placement setting. This restructuring will be accomplished by narrowly defining the purpose of residential group care, by placing conditions on admissions to certain types of group homes, and by increasing the capacity of home-based family care to better address the individual needs of all children in out-of-home care ~~Safety for children who are separated from their families by providing alternative emergency or longer-term parenting arrangements~~.

~~(e) Focus on the well-being of children through emphasis on maintaining educational stability and providing timely health care.~~

~~(f) Permanency for children for whom reunification with their families is not possible or is not in the best interest of the child.~~

~~(g) The transition to independence and self-sufficiency for older children who remain in foster care through adolescence.~~

(2) RESIDENTIAL GROUP HOME PLACEMENT.—

(a) A child 6 years of age or younger may be placed in a residential group home setting using a shift-care model only under any of the following circumstances:

1. When a case plan indicates that placement is for purposes of providing short-term, specialized, and intensive treatment for the child; the case plan specifies the need for, nature of, and anticipated duration of this treatment; the facility meets the applicable regulations adopted under s. 409.175; and the Assistant Secretary for Child Welfare for the department has approved the case plan.

2. The short-term, specialized, and intensive treatment period may not exceed 120 days, unless the community-based care lead agency has made progress toward or is actively working toward implementing the case plan that identifies the services or supports necessary to transition the child to a family setting, circumstances beyond the lead agency's control have prevented the agency from obtaining those services or supports within the timeline documented in the case plan, and the need for additional time pursuant to the case plan is documented by the caseworker and approved by the Assistant Secretary for Child Welfare for the department.

3. To the extent that placements pursuant to this subsection are extended beyond an initial 120 days, the requirements of subparagraphs 1. and 2. shall apply to each extension. In addition, the Assistant Secretary for Child Welfare for the department shall approve the continued placement no less frequently than every 60 days.

(b) A child 7-12 years of age may be placed in a residential group home setting using a shift-care model only under any of the following circumstances:

1. When a case plan indicates that placement is for purposes of providing short-term, specialized, and intensive

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117 treatment for the child; the case plan specifies the need for,
118 nature of, and anticipated duration of this treatment; the
119 facility meets the applicable regulations adopted under s.
120 409.175; and the Assistant Secretary for Child Welfare for the
121 department has approved the case plan.
122 2. The short-term, specialized, and intensive treatment
123 period may not exceed 6 months, unless the community-based care
124 lead agency has made progress toward or is actively working
125 toward implementing the case plan that identifies the services
126 or supports necessary to transition the child to a family
127 setting, circumstances beyond the lead agency's control have
128 prevented the agency from obtaining those services or supports
129 within the timeline documented in the case plan, and the need
130 for additional time pursuant to the case plan is documented by
131 the caseworker and approved by the Assistant Secretary for Child
132 Welfare for the department.
133 3. To the extent that placements pursuant to this
134 subsection are extended beyond an initial 120 days, the
135 requirements of subparagraphs 1. and 2. shall apply to each
136 extension. In addition, the Assistant Secretary for Child
137 Welfare for the department shall approve the continued placement
138 no less frequently than every 60 days.
139 (3) CREATION OF CONTINUUM OF CARE.—The department shall
140 develop a proposal to address the placement and service needs of
141 children who are cared for outside of their own homes by
142 creating a continuum of care that consists of recruiting,
143 training, and supporting an adequate supply of home-based family
144 care; providing needed services and supports in those family
145 care settings; and limiting congregate care to only those

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146 situations in which adequate services cannot be safely provided
147 while a child lives with a family, and then for only the minimum
148 amount of time required for stabilization.
149 (4) ~~(2)~~ QUALITY PARENTING.—A child in foster care shall be
150 placed only with a caregiver who has the ability to care for the
151 child, is willing to accept responsibility for providing care,
152 and is willing and able to learn about and be respectful of the
153 child's culture, religion and ethnicity, special physical or
154 psychological needs, any circumstances unique to the child, and
155 family relationships. The department, the community-based care
156 lead agency, and other agencies shall provide such caregiver
157 with all available information necessary to assist the caregiver
158 in determining whether he or she is able to appropriately care
159 for a particular child.
160 (a) *Roles and responsibilities of caregivers.*—A caregiver
161 shall:
162 1. Participate in developing the case plan for the child
163 and his or her family and work with others involved in his or
164 her care to implement this plan. This participation includes the
165 caregiver's involvement in all team meetings or court hearings
166 related to the child's care.
167 2. Complete all training needed to improve skills in
168 parenting a child who has experienced trauma due to neglect,
169 abuse, or separation from home, to meet the child's special
170 needs, and to work effectively with child welfare agencies, the
171 court, the schools, and other community and governmental
172 agencies.
173 3. Respect and support the child's ties to members of his
174 or her biological family and assist the child in maintaining

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175 allowable visitation and other forms of communication.
176 4. Effectively advocate for the child in the caregiver's
177 care with the child welfare system, the court, and community
178 agencies, including the school, child care, health and mental
179 health providers, and employers.
180 5. Participate fully in the child's medical, psychological,
181 and dental care as the caregiver would for his or her biological
182 child.
183 6. Support the child's school success by participating in
184 school activities and meetings, including Individual Education
185 Plan meetings, assisting with school assignments, supporting
186 tutoring programs, meeting with teachers and working with an
187 educational surrogate if one has been appointed, and encouraging
188 the child's participation in extracurricular activities.
189 7. Work in partnership with other stakeholders to obtain
190 and maintain records that are important to the child's well-
191 being, including child resource records, medical records, school
192 records, photographs, and records of special events and
193 achievements.
194 8. Ensure that the child in the caregiver's care who is
195 between 13 and 17 years of age learns and masters independent
196 living skills.
197 9. Ensure that the child in the caregiver's care is aware
198 of the requirements and benefits of the Road-to-Independence
199 Program.
200 10. Work to enable the child in the caregiver's care to
201 establish and maintain naturally occurring mentoring
202 relationships.
203 (b) *Roles and responsibilities of the department, the*

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204 *community-based care lead agency, and other agency staff.*—The
205 department, the community-based care lead agency, and other
206 agency staff shall:
207 1. Include a caregiver in the development and
208 implementation of the case plan for the child and his or her
209 family. The caregiver shall be authorized to participate in all
210 team meetings or court hearings related to the child's care and
211 future plans. The caregiver's participation shall be facilitated
212 through timely notification, an inclusive process, and
213 alternative methods for participation for a caregiver who cannot
214 be physically present.
215 2. Develop and make available to the caregiver the
216 information, services, training, and support that the caregiver
217 needs to improve his or her skills in parenting children who
218 have experienced trauma due to neglect, abuse, or separation
219 from home, to meet these children's special needs, and to
220 advocate effectively with child welfare agencies, the courts,
221 schools, and other community and governmental agencies.
222 3. Provide the caregiver with all information related to
223 services and other benefits that are available to the child.
224 (c) *Transitions.*—
225 1. Once a caregiver accepts the responsibility of caring
226 for a child, the child will be removed from the home of that
227 caregiver only if:
228 a. The caregiver is clearly unable to safely or legally
229 care for the child;
230 b. The child and his or her biological family are
231 reunified;
232 c. The child is being placed in a legally permanent home

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pursuant to the case plan or a court order; or

d. The removal is demonstrably in the child’s best interest.

2. In the absence of an emergency, if a child leaves the caregiver’s home for a reason provided under subparagraph 1., the transition must be accomplished according to a plan that involves cooperation and sharing of information among all persons involved, respects the child’s developmental stage and psychological needs, ensures the child has all of his or her belongings, allows for a gradual transition from the caregiver’s home and, if possible, for continued contact with the caregiver after the child leaves.

(d) *Information sharing.*—Whenever a foster home or residential group home assumes responsibility for the care of a child, the department and any additional providers shall make available to the caregiver as soon as is practicable all relevant information concerning the child. Records and information that are required to be shared with caregivers include, but are not limited to:

1. Medical, dental, psychological, psychiatric, and behavioral history, as well as ongoing evaluation or treatment needs;

2. School records;

3. Copies of his or her birth certificate and, if appropriate, immigration status documents;

4. Consents signed by parents;

5. Comprehensive behavioral assessments and other social assessments;

6. Court orders;

7. Visitation and case plans;

8. Guardian ad litem reports;

9. Staffing forms; and

10. Judicial or citizen review panel reports and attachments filed with the court, except confidential medical, psychiatric, and psychological information regarding any party or participant other than the child.

(e) *Caregivers employed by residential group homes.*—All caregivers in residential group homes shall meet the same education, training, and background and other screening requirements as foster parents.

(5) ~~(3)~~ REASONABLE AND PRUDENT PARENT STANDARD.—

(a) *Definitions.*—As used in this subsection, the term:

1. “Age-appropriate” means an activity or item that is generally accepted as suitable for a child of the same chronological age or level of maturity. Age appropriateness is based on the development of cognitive, emotional, physical, and behavioral capacity which is typical for an age or age group.

2. “Caregiver” means a person with whom the child is placed in out-of-home care, or a designated official for a group care facility licensed by the department under s. 409.175.

3. “Reasonable and prudent parent” standard means the standard of care used by a caregiver in determining whether to allow a child in his or her care to participate in extracurricular, enrichment, and social activities. This standard is characterized by careful and thoughtful parental decisionmaking that is intended to maintain a child’s health, safety, and best interest while encouraging the child’s emotional and developmental growth.

(b) *Application of standard of care.*—

1. Every child who comes into out-of-home care pursuant to this chapter is entitled to participate in age-appropriate extracurricular, enrichment, and social activities.

2. Each caregiver shall use the reasonable and prudent parent standard in determining whether to give permission for a child living in out-of-home care to participate in extracurricular, enrichment, or social activities. When using the reasonable and prudent parent standard, the caregiver must consider:

a. The child's age, maturity, and developmental level to maintain the overall health and safety of the child.

b. The potential risk factors and the appropriateness of the extracurricular, enrichment, or social activity.

c. The best interest of the child, based on information known by the caregiver.

d. The importance of encouraging the child's emotional and developmental growth.

e. The importance of providing the child with the most family-like living experience possible.

f. The behavioral history of the child and the child's ability to safely participate in the proposed activity.

(c) *Verification of services delivered.*—The department and each community-based care lead agency shall verify that private agencies providing out-of-home care services to dependent children have policies in place which are consistent with this section and that these agencies promote and protect the ability of dependent children to participate in age-appropriate extracurricular, enrichment, and social activities.

(d) *Limitation of liability.*—A caregiver is not liable for harm caused to a child who participates in an activity approved by the caregiver, provided that the caregiver has acted in accordance with the reasonable and prudent parent standard. This paragraph may not be interpreted as removing or limiting any existing liability protection afforded by law.

(6) ~~(4)~~ FOSTER PARENT ROOM AND BOARD RATES.—

(a) Effective January 1, 2014, room and board rates paid to foster parents are as follows:

Monthly Foster Care Rate	0-5 Years Age	6-12 Years Age	13-21 Years Age
	$429	$440	$515

(b) Foster parents shall receive an annual cost of living increase. The department shall calculate the new room and board rate increase equal to the percentage change in the Consumer Price Index for All Urban Consumers, U.S. City Average, All Items, not seasonally adjusted, or successor reports, for the preceding December compared to the prior December as initially reported by the United States Department of Labor, Bureau of Labor Statistics. The department shall make available the adjusted room and board rates annually.

(c) The amount of the monthly foster care board rate may be increased upon agreement among the department, the community-based care lead agency, and the foster parent.

(d) Community-based care lead agencies providing care under

345 contract with the department shall pay a supplemental room and
346 board payment to foster care parents for providing independent
347 life skills and normalcy supports to children who are 13 through
348 17 years of age placed in their care. The supplemental payment
349 shall be paid monthly to the foster care parents on a per-child
350 basis in addition to the current monthly room and board rate
351 payment. The supplemental monthly payment shall be based on 10
352 percent of the monthly room and board rate for children 13
353 through 21 years of age as provided under this section and
354 adjusted annually.
355 (7) ~~(5)~~ RULEMAKING.—The department shall adopt by rule
356 procedures to administer this section.
357 Section 2. Sections 39.523, 409.165, 409.1676, 409.1677,
358 and 409.1679, Florida Statutes, are repealed.
359 Section 3. Paragraph (b) of subsection (2) of section
360 409.1451, Florida Statutes, is amended to read:
361 409.1451 The Road-to-Independence Program.—
362 (2) POSTSECONDARY EDUCATION SERVICES AND SUPPORT.—
363 (b) The amount of the financial assistance shall be as
364 follows:
365 1. For a young adult who does not remain in foster care and
366 is attending a postsecondary school as provided in s. 1009.533,
367 the amount is $1,256 monthly.
368 2. For a young adult who remains in foster care, is
369 attending a postsecondary school, as provided in s. 1009.533,
370 and continues to reside in a licensed foster home, the amount is
371 the established room and board rate for foster parents. This
372 takes the place of the payment provided for in s. 409.145(6) ~~s.~~
373 ~~409.145(4)~~.

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374 3. For a young adult who remains in foster care, but
375 temporarily resides away from a licensed foster home for
376 purposes of attending a postsecondary school as provided in s.
377 1009.533, the amount is $1,256 monthly. This takes the place of
378 the payment provided for in s. 409.145(6) ~~s. 409.145(4)~~.
379 4. For a young adult who remains in foster care, is
380 attending a postsecondary school as provided in s. 1009.533, and
381 continues to reside in a licensed group home, the amount is
382 negotiated between the community-based care lead agency and the
383 licensed group home provider.
384 5. For a young adult who remains in foster care, but
385 temporarily resides away from a licensed group home for purposes
386 of attending a postsecondary school as provided in s. 1009.533,
387 the amount is $1,256 monthly. This takes the place of a
388 negotiated room and board rate.
389 6. The amount of the award may be disregarded for purposes
390 of determining the eligibility for, or the amount of, any other
391 federal or federally supported assistance.
392 7. A young adult is eligible to receive financial
393 assistance during the months when enrolled in a postsecondary
394 educational institution.
395 Section 4. Paragraph (s) of subsection (2) of section
396 39.202, Florida Statutes, is amended to read:
397 39.202 Confidentiality of reports and records in cases of
398 child abuse or neglect.—
399 (2) Except as provided in subsection (4), access to such
400 records, excluding the name of the reporter which shall be
401 released only as provided in subsection (5), shall be granted
402 only to the following persons, officials, and agencies:

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403 (s) Persons with whom the department is seeking to place
404 the child or to whom placement has been granted, including
405 foster parents for whom an approved home study has been
406 conducted, the designee of a licensed residential group home
407 ~~described in s. 39.523~~, an approved relative or nonrelative with
408 whom a child is placed pursuant to s. 39.402, preadoptive
409 parents for whom a favorable preliminary adoptive home study has
410 been conducted, adoptive parents, or an adoption entity acting
411 on behalf of preadoptive or adoptive parents.
412 Section 5. Paragraph (f) of subsection (2) of section
413 39.5085, Florida Statutes, is amended to read:
414 39.5085 Relative Caregiver Program.—
415 (2)
416 (f) Within available funding, the Relative Caregiver
417 Program shall provide caregivers with family support and
418 preservation services, flexible funds ~~in accordance with s.~~
419 ~~409.165~~, school readiness, and other available services in order
420 to support the child's safety, growth, and healthy development.
421 Children living with caregivers who are receiving assistance
422 under this section shall be eligible for Medicaid coverage.
423 Section 6. Subsection (11) of section 1002.3305, Florida
424 Statutes, is amended to read:
425 1002.3305 College-Preparatory Boarding Academy Pilot
426 Program for at-risk students.—
427 (11) STUDENT HOUSING.—Notwithstanding s. ~~ss. 409.1677(3)(d)~~
428 ~~and~~ 409.176 or any other provision of law, an operator may house
429 and educate dependent, at-risk youth in its residential school
430 for the purpose of facilitating the mission of the program and
431 encouraging innovative practices.

432 Section 7. This act shall take effect July 1, 2015.

The Florida Senate

BILL ANALYSIS AND FISCAL IMPACT STATEMENT

(This document is based on the provisions contained in the legislation as of the latest date listed below.)

Prepared By: The Professional Staff of the Committee on Children, Families, and Elder Affairs

BILL: SB 1226

INTRODUCER: Senator Detert

SUBJECT: Guardianship

DATE: March 5, 2015 REVISED:

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Crosier	Hendon	CF	**Pre-meeting**
2.			JU	
3.			FP	

I. Summary:

SB1226 expands the Statewide Public Guardianship Office (Office) within the Department of Elder Affairs (DOEA) to oversee private, professional guardians, and repeals the statutes creating the Statewide Public Guardianship Office. The executive director of the new Office of Public and Professional Guardians is appointed by the Secretary of DOEA. The bill sets out the new duties and responsibilities of the executive director of the Office of Public and Professional Guardians. The duties include oversight of professional guardians' development of curriculum training, setting minimum requirements for instructional hours and examination score necessary for passage of the guardianship training. It also requires the annual registration of professional guardians. DOEA sets the fee for registration and licensing of a professional guardian but it may not exceed $500.

The Office is to adopt rules to establish disciplinary oversight, including the receipt of and investigations into complaints, conduct hearings and take administrative action pursuant to ch. 120, F.S.

The bill also directs the chief judge in each judicial circuit to compile a list of professional guardians and provide such list to the clerk of the court. Professional guardians must be certified by the Office to be included on the list. The court appoints professional guardians in the order in which names appear on the applicable registry, unless the court makes a finding on the record to appoint a professional guardian out of order.

The bill is effective July 1, 2015. The bill will increase costs for the DOEA associated with regulating professional guardians.

II. Present Situation:

Guardianship is a concept whereby a "guardian" acts for another, called a "ward," whom the law regards as incapable of managing his or her own affairs due to age or incapacity. Guardianships[1] are generally disfavored due to the loss of individual civil rights and a guardian may only be appointed if the court finds there is no sufficient alternative to guardianship. There are two main forms of guardianship: guardianship over the person or guardianship over the property, which may be limited or plenary. For adults, a guardianship may be established when a person has demonstrated that he or she is unable to manage his or her own affairs. If the adult is competent, this can be accomplished voluntarily. However, in situations where an individual's mental competence is in question, an involuntary guardianship may be established through the adjudication of incompetence which is based on the determination of a court appointed examination committee.

Florida courts have long recognized the relationship between a guardian and his or her ward as a classic fiduciary relationship.[2] A fiduciary relationship exists between two persons when one of them is under a duty to act for or to give advice for the benefit of another upon matters within the scope of that relation.[3] The most basic duty of a fiduciary is the duty of loyalty: a fiduciary must refrain from self-dealing, must not take unfair advantage of the ward, must act in the best interest of the ward, and must disclose material facts.[4] In addition to the duty of loyalty, a fiduciary also owes a duty of care to carry out its responsibilities in an informed and considered manner. Section 744.362, F.S., imposes specific duties upon a guardian consistent with the basic duties of a fiduciary including protecting and preserving the property of the ward's overall physical and social health. A guardian is also under a duty to file an initial guardianship report,[5] an annual guardianship report,[6] and an annual accounting of the ward's property.[7] Such reports provide evidence of the guardian's faithful execution of his or her fiduciary duties.[8]

At the heart of a court's interpretation of a fiduciary relationship is a concern that persons who assume trustee-like positions with discretionary power over the interests of others might breach their duties and abuse their position. Section 744.446, F.S., explicitly states that the "fiduciary relationship which exists between the guardian and the ward may not be used for the private gain of the guardian other than the remuneration for fees and expenses provided by law." Section 744.446(4), F.S., also provides that in the event of "a breach by the guardian of the guardian's fiduciary duty, the court shall take those necessary actions to protect the ward and the ward's assets."

In Florida, a "professional guardian" means any guardian who has at any time rendered services to three or more wards as their guardian.[9] A professional guardian must register with the

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[2] *Lawrence v. Norris,* 563 So.2d 195, 197 (Fla. 1st DCA 1990).
[3] *Doe v. Evans,* 814 so.2d 370, 374 (Fla. 2002).
[4] *Capital Bank v. MVP, Inc.* 644 So.2d 515, 520 (Fla. 3rd DCA 1994).
[5] Section 744.362, F.S.
[6] Section 744.367, F.S.
[7] Section 744.3678, F.S.
[8] Section 744.368, F.S.
[9] Section 744.102(17), F.S.

Statewide Public Guardianship Office annually.[10] There are currently 465 professional guardians registered with the Statewide Public Guardianship Office.[11] Professional guardians must receive a minimum of 40 hours of instruction and training. Each professional guardian must receive a minimum of 16 hours of continuing education every 2 years after the initial educational requirement is met. The instruction and education must be completed through a course approved or offered by the Statewide Public Guardianship Office.[12] Professional guardians are subject to level 2 background checks,[13] an investigation of the guardian's credit history,[14] and to demonstrate competency to act as a professional guardian by taking an examination approved by DOEA.[15] These requirements do not apply, however, to a professional guardian or the employees of that professional guardian when that guardian is a trust company, a state banking corporation, state savings association authorized and qualified to exercise fiduciary powers in this state, or a national banking association or federal savings and loan association authorized and qualified to exercise fiduciary duties in this state.[16]

In s. 744.701, F.S., the "Public Guardianship Act" was created. In 1999, the Legislature created the Statewide Public Guardianship Office to provide oversight for all public guardians.[17] The executive director of the Statewide Public Guardianship Office, after consultation with the chief judge and other judges within the judicial circuit may establish one or more office of public guardian within the judicial circuit.[18]A public guardian may serve an incapacitated person if there is no family member or friend, other person, bank or corporation willing and qualified to serve as guardian.[19] Persons serving as public guardians are considered a professional guardian for purposes of regulation, education, and registration.[20] Public guardianship offices are established in all 20 circuits in the state.[21]

The process to determine incapacity and an appointment of a guardian begins with petitions filed in the appropriate circuit court. The petitions must be served on and read to the alleged incapacitated person. The notice and copies of the petitioner must be provided to the attorney for the alleged incapacitated person, and served on all next of kin identified in the petition. The notice must include the time and place for the court hearing to inquire into the capacity of the alleged incapacitated person, that an attorney has been appointed to represent that person and that, if he or she is determined to be incapable of exercising certain rights, a guardian will be appointed to exercise those rights on his or her behalf.[22] In the hearing on the petition alleging incapacity, the partial or total incapacity of the person must be established by clear and convincing evidence.[23]

[10] Section 744.1083(1) and (2), F.S.
[11] Telephone conversation with the Department of Elder Affairs on March 9, 2015.
[12] Section 744.1085(3), F.S.
[13] Section 744.1085(5), F.S.
[14] Section 744.1085(4), F.S.
[15] Section 744.1085(6), F.S.
[16] Section 744.1085(10), F.S.
[17] Section 744.7021, F.S.
[18] Section 744.703(1), F.S.
[19] Section 744.704(1), F.S.
[20] Section 744.102(17), F.S.
[21] Meeting with the Department of Elder Affairs on February 2, 2015.
[22] Section 744.331(1), F.S.
[23] Section 744.331(5((c), F.S.

The court must enter a written order determining incapacity after finding that a person is incapacitated with respect to the exercise of a particular right, or all rights. A person is determined to be incapacitated only with respect to those rights specified in the court's order.[24] When an order determines that a person is incapable of exercising delegable rights, the court must consider whether there is an alternative to guardianship that will sufficiently address the problems of the incapacitated person. If an alternative to guardianship will not sufficiently address the problems of the incapacitated person, a guardian will be appointed.[25] If a petition for appointment of a guardian has been filed, an order appointing a guardian must be issued contemporaneously with the order adjudicating the person incapacitated.[26] If a petition for the appointment of a guardian has not been filed at the time of the hearing on the petition to determine incapacity, the court may appoint an emergency temporary guardian.[27]

The court retains jurisdiction over all guardianships and shall review the appropriateness and extent of a guardianship annually.[28] At any time, any interested person, including the ward, may petition the court for review alleging that the guardian is not complying with the guardianship plan or is exceeding his or her authority under the guardianship plan and is not acting in the best interest of the ward. If the petition for review is found to be without merit the court may assess costs and attorney's fees against the petitioner.[29]

Section 744.108, F.S., governs the award of compensation to a guardian or attorney in connection with a guardianship. It provides that "a guardian, or an attorney who has rendered services to the ward or to the guardian on the ward's behalf, is entitled to a reasonable fee for services rendered and reimbursement of costs incurred on behalf of the ward."[30]
Section 744.108(8), F.S., provides that fees and costs incurred in determining compensation are part of the guardianship administration and are generally awardable from the guardianship estate, unless the court finds the requested compensation substantially unreasonable.[31]

A ward has the right to be restored to capacity at the earliest possible time.[32] The ward, or any interested person filing a suggestion of capacity, has the burden of proving the ward is capable of exercising some or all of the rights which were removed. Immediately upon the filing of the suggestion of capacity, the court shall appointment a physician to examine the ward. The physician must examine the ward and file a report with the court within 20 days.[33] All objections to the suggestion of capacity must be filed within 20 days after formal notice is served on the ward, guardian, attorney for the ward, if any, and any other interested persons designated by the court.[34] If an objection is timely filed, or if the medical examination suggests that full restoration

[24] Section 744.331(6), F.S.
[25] Section 744.331(6)(b), F.S.
[26] Section 744.344(3), F.S.
[27] Section 744.344(4), F.S.
[28] Section 744.372, F.S.
[29] Section 744.3415, F.S.
[30] Section 744.108(1), F.S.
[31] Section 744.108(8), F.S.
[32] Section 744.3215(1)(c), F.S.
[33] Section 744.464(2)(b), F.S.
[34] Section 744.464(2)(c),(d)

is not appropriate, the court must set the matter for hearing.[35] The level of proof required to show capacity is not presently spelled out in the statute. In a study and work group report by the Florida Developmental Disabilities Council, dated February 28, 2014, Palm Beach County court personnel performed a limited review of a random sample of 76 guardianship files for persons over the age of 18. Among these, over two thirds were of persons with age-related disabilities. After reviewing the files, the senior auditor for the circuit reported that there were no cases where the guardianship plan recommended the restoration of any rights" of the incapacitated persons.[36]

Beginning on December 6, 2014, the Sarasota Herald Tribune published a series of articles titled "The Kindness of Strangers – Inside Elder Guardianship in Florida," which detailed abuses occurring in guardianships. The paper examined guardianship court case files and conducted interviews with wards, family and friends caught in the system against their will.[37] The paper concluded that Florida has cobbled together an efficient way to identify and care for helpless elders, using the probate court system to place them under guardianship. However, critics say this system often ignores basic individual rights and most often plays out in secret, with hearings and files typically closed to the public.[38] The paper also concluded that monitoring assets and tapping their assets is a growth business: In 2003, there were 23 registered professional guardians in Florida, according to the Department of Elder Affairs. Today there are more than 440 – an increase greater than 1,800 percent in 11 years.[39]

III. Effect of Proposed Changes:

Section 1 directs the Division of Law Revision and Information to add sections to the Florida Statutes created by this bill.

Section 2 directs the Division of Law Revision and Information to retitle Part II of Chapter 744, F.S., from "Venue" to "Public and Professional Guardians".

Section 3 directs the Division of Law Revision and Information to remove part IX of Chapter 744, F.S.

Section 4 amends s. 744.1012, F.S., to provide that private guardianship is inadequate where there is no willing and responsible family member or friend, other person, bank, or corporation available to serve as guardian for an incapacitated person and such person does not have adequate income or wealth for the compensation of the private guardian. The Legislature establishes the Office of Public and Professional Guardians which allows the establishment of public guardians to provide services for incapacitated persons when no private guardian is available and that a public guardian must be provided only to those persons whose needs cannot be met through less drastic means of intervention.

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[35] Section 744.464(2)(e), F.S.

[36] Florida Developmental Disabilities Council, *Restoration of Capacity Study and Work Group Report,* February 28, 2014 (on file with the Senate Committee on Children, Families and Elder Affairs).

[37] Barbara Peters Smith, *the Kindness of Strangers – Inside Elder Guardianship in Florida,* December 6, 2014, *available at* http://extra.heraltribune.com/2014/12/06/well-oiled-machine/

[38] *Id* at page 2.

[39] *Id.*

Section 5 renumbers s. 744.201, F.S., as s. 744.1096, F.S.

Section 6 renumbers s. 744.202, F.S., as s. 744.1097, F.S.

Section 7 renumbers s. 744.2025, F.S., as s. 744.1098, F.S.

Section 8 renumbers s. 744.7021, F.S. as s. 744.2001, F.S. and amends s. 744.2001, F.S. to direct the executive director of the Office of Public and Professional Guardians to review the standards and criteria for the education, registration, and certification of public and professional guardians in Florida. The executive director is directed to develop a guardianship training program curriculum to be offered to all guardians, whether public or private.

The executive director's oversight responsibilities for professional guardians, include, but are not limited to:

- The development and implementation of a monitoring tool to use for regular monitoring activities of professional guardians; however, this monitoring tool does not include a financial audit as required to be performed by the clerk of the circuit court under s. 744.368, F.S.
- The development or procedures for the review of an allegation that a professional guardian has violated an applicable statute, fiduciary duty, standard of practice, rule, regulation, or other requirement governing the conduct of professional guardians.
- The establishment of disciplinary proceedings, including the authority to conduct investigations and take appropriate administrative action under ch. 120, F.S.
- Assist the chief judge in each circuit to establish a registry to allow for the appointment of a professional guardian on a rotating basis.

Section 9 renumbers s. 744.1083, F.S., as s. 744.2002, F.S. and amends s. 744.2002, to conform cross references and remove the reference to Statewide Public Guardianship Office and insert the name of the new Office of Public and Professional Guardians.

Section 10 renumbers s. 744.1085, F.S. as s. 744.2003, F.S. and amends s. 744.2003, F.S., to conform cross-references and change the name of the Statewide Public Guardianship Office to the Office of Public and Professional Guardians.

Section 11 creates 744.2004, F.S., and directs the Office of Public and Professional Guardians to adopt rules to review, and if appropriate, investigate allegations that a professional guardian has violated an applicable statute, fiduciary duty, standard of practice, rule, regulation, or other requirement governing the conduct of professional guardians. The Office is to also establish disciplinary proceedings, conduct hearings, and take administrative action pursuant to ch. 120, F.S. Disciplinary actions may include, but are not limited to, requiring guardians to participate in additional educational courses, impose additional monitoring of the guardianships being served by the professional guardian and suspension and revocation of the guardian's license. In the event the final recommendation is for the suspension or revocation of the guardian's license, the recommendation must be provided to any court that oversees any guardianship to which the professional guardian is appointment.

Section 12 renumbers s. 744.344, F.S., as s 744.2005, F.S., and amends s. 744.2005, F.S., to create a registry of professional guardians for use by the court in appointing guardians. The registry is to be compiled by the chief judge in each circuit and provided to and maintained by the clerk of the court in each county of the circuit. A professional guardian must be certified by the Office to be included on the registry. The court may appoint a professional guardian out of order only upon entering a finding of good cause into the record.

Section 13 renumbers s. 744.703, F.S., as s. 744.2006, and amends s. 744.2006, F.S., to change the name of the Statewide Public Guardianship Office to the Office of Public and Professional Guardians.

Section 14 renumbers s. 744.704, F.S., as s. 744.2007, F.S.

Section 15 renumbers s. 744.705, F.S., as s. 744.2008, F.S.

Section 16 renumbers s. 744.706, F.S., as s. 744.2009, F.S., and amends s. 744.2009, F.S., to change the name of the Statewide Public Guardianship Office to the Office of Public and Professional Guardians.

Section 17 renumbers s. 744.707, F.S., as s. 744.2101, F.S., and amends s. 744.2021, F.S., to change the name of the Statewide Public Guardianship Office to the Office of Public and Professional Guardians.

Section 18 renumbers s. 744.709, F.S., as s. 744.2102, F.S.

Section 19 renumbers s. 744.708, F.S., as s.744.2103, F.S., and amends s. 744.2103, F.S., to change the name of the Statewide Public Guardianship Office to the Office of Public and Professional Guardians.

Section 20 renumbers s. 744.7081, F.S., as s. 744.2104, F.S., and amends s. 744.2014, F.S., to change the name of the Statewide Public Guardianship Office to the Office of Public and Professional Guardians.

Section 21 renumbers s. 744.7082, F.S., as s. 744.2105, F.S., and amends s. 744.2105, F.S., to change the name of the Statewide Public Guardianship Office to the Office of Public and Professional Guardians.

Section 22 renumbers s. 744.712, F.S., as s. 744.2106, F.S., and amends s. 744.2106, F.S. to change the name of the Statewide Public Guardianship Office to the Office of Public and Professional Guardians and provide the legislative intent to establish the Joining Forces for Public Guardianship matching grant program to assist counties in establishing and funding community-supported public guardianship programs.

Section 23 renumbers s. 744.713, F.S., as s. 744.2107, F.S., and amends s. 744.2107, F.S., to change the name of the Statewide Public Guardianship Office to the Office of Public and Professional Guardians.

Section 24 renumbers s. 744.714, F.S., as s. 744.2108, F.S., and amends s. 744.2108, F.S., to change the name of the Statewide Public Guardianship Office to the Office of Public and Professional Guardians.

Section 25 renumbers s. 744.715, F.S., as s. 744.2109, F.S. and amends s. 744.2109, F.S., to change the name of the Statewide Public Guardianship Office to the Office of Public and Professional Guardians.

Section 26 repeals s. 744.701, F.S.

Section 27 repeals s. 744.702, F.S.

Section 28 repeals s. 744.7101, F.S.

Section 29 repeals s. 744.711, F.S.

Section 30 amends s. 400.148, F.S., to change the name of the Statewide Public Guardianship Office to the Office of Public and Professional Guardians.

Section 31 amends s. 744.3135, F.S., to change the name of the Statewide Public Guardianship Office to the Office of Public and Professional Guardians.

Section 32 amends s. 415.1102, F.S., to add that professional guardians may be members of adult protection teams.

Section 33 amends s. 744.331, F.S., to change the name of the Statewide Public Guardianship Office to the Office of Public and Professional Guardians.

Section 34 amends s. 20.415, F.S., to conform cross references.

Section 35 amends s. 744.524, F.S., to conform cross-references.

Section 36 provides an effective date of July 1, 2015.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

B. Private Sector Impact:

Professional guardians will be regulated by DOEA.

C. Government Sector Impact:

The Department of Elder Affairs will see increased costs associated with regulating private guardians. The department would need budget and FTEs to perform the duties required by the bill. There would also be increased costs to the department's general counsel's office as the professional guardians will be able to challenge decisions by the department under ch. 120, F.S. The department currently provides education to professional guardians statewide and there are 456 such guardians that would be regulated under this bill. The number of wards represented by the 456 guardians is unknown as this time and would need to be considered when estimating the cost of regulation.

VI. Technical Deficiencies:

None.

VII. Related Issues:

None.

VIII. Statutes Affected:

This bill substantially amends the following sections of the Florida Statutes: 744.1012, 744.2001, 744.2002, 744.2003, 744.2005, 744.2006, 744.2009, 744.2101, 744.2103, 744.2104, 744.2105, 744.2106, 744.2107, 744.2108, 744.2109, 400.148, 744.3135, 415.1102, 744.331, 20.415 and 744.524.
This bill renumbers the following sections of the Florida Statutes: 744.1096, 744.1097, 744.1098, 744.7021, 744.1083, 744.1085, 744.344, 744.703, 744.704, 744.705, 744.706, 744.707, 744.709, 744.708, 744.7081, 744.7082, 744.712, 744.713, 744.714, and 744.715,
This bill creates the following sections of the Florida Statutes: 744.2004
This bill repeals the following sections of the Florida Statutes: 744.701, 744.702, 744.7101, and 744.711.

IX. Additional Information:

A. Committee Substitute – Statement of Changes:

(Summarizing differences between the Committee Substitute and the prior version of the bill.)

None.

B. Amendments:

None.

This Senate Bill Analysis does not reflect the intent or official position of the bill's introducer or the Florida Senate.

By Senator Detert

28-01081A-15 20151226__

1 A bill to be entitled
2 An act relating to guardianship; providing directives
3 to the Division of Law Revision and Information;
4 amending s. 744.1012, F.S.; revising legislative
5 intent; renumbering s. 744.201, F.S.; renumbering and
6 amending s. 744.202, F.S.; conforming a cross-
7 reference; renumbering s. 744.2025, F.S.; renumbering
8 and amending s. 744.7021, F.S.; revising the
9 responsibilities of the executive director for the
10 Office of Public and Professional Guardians;
11 conforming provisions to changes made by the act;
12 renumbering and amending s. 744.1083, F.S.; removing a
13 provision authorizing the executive director to
14 suspend or revoke the registration of a guardian who
15 commits certain violations; removing the requirement
16 of written notification to the chief judge of the
17 judicial circuit upon the executive director's denial,
18 suspension, or revocation of a registration;
19 conforming provisions to changes made by the act;
20 conforming a cross-reference; renumbering and amending
21 s. 744.1085, F.S.; removing an obsolete provision;
22 conforming provisions to changes made by the act;
23 conforming a cross-reference; creating s. 744.2004,
24 F.S.; requiring the Office of Public and Professional
25 Guardians to adopt rules; requiring the office, under
26 certain circumstances, to make a specified
27 recommendation to a court of competent jurisdiction;
28 renumbering and amending s. 744.344, F.S.; requiring
29 that a professional guardian appointed by a court to

CODING: Words ~~stricken~~ are deletions; words underlined are additions.

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30 represent an allegedly incapacitated person be
31 selected from a registry of professional guardians;
32 requiring the chief judge of a circuit court to
33 compile a list of professional guardians by county and
34 provide the list to the clerk of court in each county;
35 providing requirements for inclusion in the registry;
36 providing procedures for a court to appoint a
37 professional guardian; providing an exception;
38 requiring the clerk of the court to maintain the
39 registry and provide the court with the name of a
40 professional guardian for appointment; renumbering and
41 amending s. 744.703, F.S.; conforming provisions to
42 changes made by the act; renumbering ss. 744.704 and
43 744.705, F.S.; renumbering and amending ss. 744.706
44 and 744.707, F.S.; conforming provisions to changes
45 made by the act; renumbering s. 744.709, F.S.;
46 renumbering and amending ss. 744.708, 744.7081, and
47 744.7082, F.S.; conforming provisions to changes made
48 by the act; renumbering and amending s. 744.712, F.S.;
49 providing legislative intent; conforming provisions;
50 renumbering and amending ss. 744.713, 744.714, and
51 744.715, F.S.; conforming provisions to changes made
52 by the act; repealing s. 744.701, F.S.; relating to a
53 short title; repealing s. 744.702, F.S.; relating to
54 legislative intent; repealing s. 744.7101, F.S.;
55 relating to a short title; repealing s. 744.711, F.S.;
56 relating to legislative findings and intent; amending
57 ss. 400.148, 744.3135, and 744.331, F.S.; conforming
58 provisions to changes made by the act; amending ss.

CODING: Words ~~stricken~~ are deletions; words underlined are additions.

59 20.415, 415.1102, and 744.524, F.S.; conforming cross-
60 references; making technical changes; providing an
61 effective date.
62
63 Be It Enacted by the Legislature of the State of Florida:
64
65 Section 1. The Division of Law Revision and Information is
66 directed to add ss. 744.1096-744.1098, Florida Statutes, created
67 by this act, to part I of chapter 744, Florida Statutes.
68 Section 2. The Division of Law Revision and Information is
69 directed to retitle part II of chapter 744, Florida Statutes,
70 consisting of ss. 744.2001-744.2109, Florida Statutes, as
71 "PUBLIC AND PROFESSIONAL GUARDIANS."
72 Section 3. The Division of Law Revision and Information is
73 directed to remove part IX of chapter 744, Florida Statutes.
74 Section 4. Section 744.1012, Florida Statutes, is amended
75 to read:
76 744.1012 Legislative intent.—The Legislature finds:
77 (1) That adjudicating a person totally incapacitated and in
78 need of a guardian deprives such person of all her or his civil
79 and legal rights and that such deprivation may be unnecessary.
80 (2) ~~The Legislature further finds~~ That it is desirable to
81 make available the least restrictive form of guardianship to
82 assist persons who are only partially incapable of caring for
83 their needs and that alternatives to guardianship and less
84 intrusive means of assistance should always be explored,
85 including, but not limited to, guardian advocates, before an
86 individual's rights are removed through an adjudication of
87 incapacity.

CODING: Words ~~stricken~~ are deletions; words underlined are additions.

88 (3) By recognizing that every individual has unique needs
89 and differing abilities, the Legislature declares that it is the
90 purpose of this act to promote the public welfare by
91 establishing a system that permits incapacitated persons to
92 participate as fully as possible in all decisions affecting
93 them; that assists such persons in meeting the essential
94 requirements for their physical health and safety, in protecting
95 their rights, in managing their financial resources, and in
96 developing or regaining their abilities to the maximum extent
97 possible; and that accomplishes these objectives through
98 providing, in each case, the form of assistance that least
99 interferes with the legal capacity of a person to act in her or
100 his own behalf. This act shall be liberally construed to
101 accomplish this purpose.
102 (4) That private guardianship is inadequate where there is
103 no willing and responsible family member or friend, other
104 person, bank, or corporation available to serve as guardian for
105 an incapacitated person, and such person does not have adequate
106 income or wealth for the compensation of a private guardian.
107 (5) The Legislature intends, through the establishment of
108 the Office of Public and Professional Guardians, to permit the
109 establishment of offices of public guardians for the purpose of
110 providing guardianship services for incapacitated persons when
111 no private guardian is available.
112 (6) That a public guardian be provided only to those
113 persons whose needs cannot be met through less drastic means of
114 intervention.
115 Section 5. Section 744.201, Florida Statutes, is renumbered
116 as section 744.1096, Florida Statutes.

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Section 6. Section 744.202, Florida Statutes, is renumbered as section 744.1097, Florida Statutes, and subsection (3) of that section is amended to read:

744.1097 ~~744.202~~ Venue.—

(3) When the residence of an incapacitated person is changed to another county, the guardian shall petition to have the venue of the guardianship changed to the county of the acquired residence, except as provided in s. 744.1098 ~~s. 744.2025~~.

Section 7. Section 744.2025, Florida Statutes, is renumbered as section 744.1098, Florida Statutes.

Section 8. Section 744.7021, Florida Statutes, is renumbered as section 744.2001, Florida Statutes, and amended to read:

744.2001 ~~744.7021~~ ~~Statewide Public Guardianship~~ Office of Public and Professional Guardians.—There is hereby created the ~~Statewide Public Guardianship~~ Office of Public and Professional Guardians within the Department of Elderly Affairs.

(1) The Secretary of Elderly Affairs shall appoint the executive director, who shall be the head of the ~~Statewide Public Guardianship~~ Office of Public and Professional Guardians. The executive director must be a member of The Florida Bar, knowledgeable of guardianship law and of the social services available to meet the needs of incapacitated persons, shall serve on a full-time basis, and shall personally, or through a representative ~~representatives~~ of the office, carry out the purposes and functions of the ~~Statewide Public Guardianship~~ Office of Public and Professional Guardians in accordance with state and federal law. The executive director shall serve at the

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pleasure of and report to the secretary.

(2) The executive director shall, within available resources:~~,~~

(a) Have oversight responsibilities for all public and professional guardians.

(b) Review the standards and criteria for the education, registration, and certification of public and professional guardians in Florida.

(3) The executive director’s oversight responsibilities of professional guardians shall include, but not be limited to:

(a) The development and implementation of a monitoring tool to be used for regular monitoring activities of professional guardians related to the management of each ward and his or her personal affairs. This monitoring may not include a financial audit as required by the clerk of the circuit court under s. 744.368.

(b) The development of procedures, in consultation with professional guardianship associations, for the review of an allegation that a professional guardian has violated an applicable statute, fiduciary duty, standard of practice, rule, regulation, or other requirement governing the conduct of professional guardians.

(c) The establishment of disciplinary proceedings, including the authority to conduct investigations and take appropriate administrative action pursuant to chapter 120.

(d) Assist the chief judge in each judicial circuit to establish a registry to allow for the appointment of professional guardians in rotating order as provided in s. 744.2005.

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(4) The executive director’s oversight responsibilities of public guardians shall include, but not be limited to:

(a) The ~~executive director shall~~ review of the current public guardian programs in Florida and other states.

(b) The development ~~executive director~~, in consultation with local guardianship offices, of ~~shall develop~~ statewide performance measures and standards.

(c) The ~~executive director shall~~ review of ~~the~~ various methods of funding public guardianship programs, the kinds of services being provided by such programs, and the demographics of the wards. In addition, the executive director shall review and make recommendations regarding the feasibility of recovering a portion or all of the costs of providing public guardianship services from the assets or income of the wards.

(d) By January 1 of each year, providing ~~the executive director shall provide~~ a status report and providing ~~provide~~ further recommendations to the secretary that address the need for public guardianship services and related issues.

(e) In consultation with the Florida Guardianship Foundation, the development of a guardianship training program curriculum that may be offered to all guardians, whether public or private.

(5) The executive director may provide assistance to local governments or entities in pursuing grant opportunities. The executive director shall review and make recommendations in the annual report on the availability and efficacy of seeking Medicaid matching funds. The executive director shall diligently seek ways to use existing programs and services to meet the needs of public wards.

~~(f) The executive director, in consultation with the Florida Guardianship Foundation, shall develop a guardianship training program curriculum that may be offered to all guardians whether public or private.~~

(6)~~(3)~~ The executive director may conduct or contract for demonstration projects authorized by the Department of Elderly Affairs, within funds appropriated or through gifts, grants, or contributions for such purposes, to determine the feasibility or desirability of new concepts of organization, administration, financing, or service delivery designed to preserve the civil and constitutional rights of persons of marginal or diminished capacity. Any gifts, grants, or contributions for such purposes shall be deposited in the Department of Elderly Affairs Administrative Trust Fund.

Section 9. Section 744.1083, Florida Statutes, is renumbered as section 744.2002, Florida Statutes, subsections (1) through (5) of that section are amended, and subsections (7) and (10) of that section are republished, to read:

744.2002 ~~744.1083~~ Professional guardian registration.—

(1) A professional guardian must register with the ~~Statewide Public Guardianship~~ Office of Public and Professional Guardians established in part II ~~IX~~ of this chapter.

(2) Annual registration shall be made on forms furnished by the ~~Statewide Public Guardianship~~ Office of Public and Professional Guardians and accompanied by the applicable registration fee as determined by rule. The fee may not exceed $100.

(3) Registration must include the following:

(a) Sufficient information to identify the professional

233 guardian, as follows:
234 1. If the professional guardian is a natural person, the
235 name, address, date of birth, and employer identification or
236 social security number of the person.
237 2. If the professional guardian is a partnership or
238 association, the name, address, and employer identification
239 number of the entity.
240 (b) Documentation that the bonding and educational
241 requirements of s. 744.2003 ~~s. 744.1085~~ have been met.
242 (c) Sufficient information to distinguish a guardian
243 providing guardianship services as a public guardian,
244 individually, through partnership, corporation, or any other
245 business organization.
246 (4) Prior to registering a professional guardian, the
247 ~~Statewide Public Guardianship~~ Office of Public and Professional
248 Guardians must receive and review copies of the credit and
249 criminal investigations conducted under s. 744.3135. The credit
250 and criminal investigations must have been completed within the
251 previous 2 years.
252 (5) The executive director of the office may deny
253 registration to a professional guardian if the executive
254 director determines that the guardian's proposed registration,
255 including the guardian's credit or criminal investigations,
256 indicates that registering the professional guardian would
257 violate any provision of this chapter. ~~If a guardian who is~~
258 ~~currently registered with the office violates a provision of~~
259 ~~this chapter, the executive director of the office may suspend~~
260 ~~or revoke the guardian's registration. If the executive director~~
261 ~~denies registration to a professional guardian or suspends or~~

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262 ~~revokes a professional guardian's registration, the Statewide~~
263 ~~Public Guardianship Office must send written notification of the~~
264 ~~denial, suspension, or revocation to the chief judge of each~~
265 ~~judicial circuit in which the guardian was serving on the day of~~
266 ~~the office's decision to deny, suspend, or revoke the~~
267 ~~registration.~~
268 (7) A trust company, a state banking corporation or state
269 savings association authorized and qualified to exercise
270 fiduciary powers in this state, or a national banking
271 association or federal savings and loan association authorized
272 and qualified to exercise fiduciary powers in this state, may,
273 but is not required to, register as a professional guardian
274 under this section. If a trust company, state banking
275 corporation, state savings association, national banking
276 association, or federal savings and loan association described
277 in this subsection elects to register as a professional guardian
278 under this subsection, the requirements of subsections (3) and
279 (4) do not apply and the registration must include only the
280 name, address, and employer identification number of the
281 registrant, the name and address of its registered agent, if
282 any, and the documentation described in paragraph (3)(b).
283 (10) A state college or university or an independent
284 college or university that is located and chartered in Florida,
285 that is accredited by the Commission on Colleges of the Southern
286 Association of Colleges and Schools or the Accrediting Council
287 for Independent Colleges and Schools, and that confers degrees
288 as defined in s. 1005.02(7) may, but is not required to,
289 register as a professional guardian under this section. If a
290 state college or university or independent college or university

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291 elects to register as a professional guardian under this
292 subsection, the requirements of subsections (3) and (4) do not
293 apply and the registration must include only the name, address,
294 and employer identification number of the registrant.
295 Section 10. Section 744.1085, Florida Statutes, is
296 renumbered as section 744.2003, Florida Statutes, subsections
297 (3), (6), and (9) of that section are amended, and subsection
298 (8) of that section is republished, to read:
299 744.2003 ~~744.1085~~ Regulation of professional guardians;
300 application; bond required; educational requirements.—
301 (3) Each professional guardian defined in s. 744.102(17)
302 and public guardian must receive a minimum of 40 hours of
303 instruction and training. Each professional guardian must
304 receive a minimum of 16 hours of continuing education every 2
305 calendar years after the year in which the initial 40-hour
306 educational requirement is met. The instruction and education
307 must be completed through a course approved or offered by the
308 ~~Statewide Public Guardianship~~ Office of Public and Professional
309 Guardians. The expenses incurred to satisfy the educational
310 requirements prescribed in this section may not be paid with the
311 assets of any ward. This subsection does not apply to any
312 attorney who is licensed to practice law in this state.
313 (6) ~~After July 1, 2005,~~ Each professional guardian is ~~shall~~
314 ~~be~~ required to demonstrate competency to act as a professional
315 guardian by taking an examination approved by the Department of
316 Elderly Affairs.
317 (a) The Department of Elderly Affairs shall determine the
318 minimum examination score necessary for passage of guardianship
319 examinations.

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320 (b) The Department of Elderly Affairs shall determine the
321 procedure for administration of the examination.
322 (c) The Department of Elderly Affairs or its contractor
323 shall charge an examination fee for the actual costs of the
324 development and the administration of the examination. The fee
325 for registration and licensing of a professional guardian may
326 not~~, not to~~ exceed $500.
327 (d) The Department of Elderly Affairs may recognize passage
328 of a national guardianship examination in lieu of all or part of
329 the examination approved by the Department of Elderly Affairs,
330 except that all professional guardians must take and pass an
331 approved examination section related to Florida law and
332 procedure.
333 (8) The Department of Elderly Affairs shall waive the
334 examination requirement in subsection (6) if a professional
335 guardian can provide:
336 (a) Proof that the guardian has actively acted as a
337 professional guardian for 5 years or more; and
338 (b) A letter from a circuit judge before whom the
339 professional guardian practiced at least 1 year which states
340 that the professional guardian had demonstrated to the court
341 competency as a professional guardian.
342 (9) ~~After July 1, 2004,~~ The court may ~~shall~~ not appoint any
343 professional guardian who has not met the requirements of this
344 section and s. 744.2002 ~~s. 744.1083~~.
345 Section 11. Section 744.2004, Florida Statutes, is created
346 to read:
347 744.2004 Complaints; disciplinary proceedings; penalties;
348 enforcement.—

349 (1) The Office of Public and Professional Guardians shall
350 adopt rules to:
351 (a) Review, and if determined appropriate, investigate an
352 allegation that a professional guardian has violated an
353 applicable statute, fiduciary duty, standard of practice, rule,
354 regulation, or other requirement governing the conduct of
355 professional guardians.
356 (b) Establish disciplinary proceedings, conduct hearings,
357 and take administrative action pursuant to chapter 120.
358 Disciplinary actions include, but are not limited to, requiring
359 a professional guardian to participate in additional educational
360 courses provided by the Office of Public and Professional
361 Guardians, imposing additional monitoring by the office of the
362 guardianships to which the professional guardian is appointed,
363 and suspension or revocation of a professional guardian's
364 license.
365 (2) If the office makes a final recommendation for the
366 suspension or revocation of a professional guardian's license,
367 it must provide the recommendation to the court of competent
368 jurisdiction for any guardianship case to which the professional
369 guardian is currently appointed.
370 Section 12. Section 744.344, Florida Statutes, is
371 renumbered as section 744.2005, Florida Statutes, and amended to
372 read:
373 744.2005 ~~744.344~~ Order of appointment.—
374 (1) A professional guardian appointed by the court to
375 provide representation of an alleged incapacitated person shall
376 be selected from a registry of professional guardians.
377 (2) In using a registry:

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378 (a) The chief judge of the judicial circuit shall compile a
379 list of professional guardians by county and provide the list to
380 the clerk of court in each county. To be included on a registry,
381 the professional guardian must be certified by the Office of
382 Public and Professional Guardians.
383 (b) The court shall appoint professional guardians in the
384 order in which the names appear on the applicable registry,
385 unless the court makes a finding of good cause on the record for
386 appointment of a professional guardian out of order. The clerk
387 of the court shall maintain the registry and provide to the
388 court the name of the professional guardian for appointment. A
389 professional guardian not appointed in the order in which her or
390 his name appears on the list shall remain next in order.
391 (3) ~~(1)~~ The court may hear testimony on the question of who
392 is entitled to preference in the appointment of a guardian. Any
393 interested person may intervene in the proceedings.
394 (4) The order appointing a guardian must state the nature
395 of the guardianship as either plenary or limited. If limited,
396 the order must state that the guardian may exercise only those
397 delegable rights which have been removed from the incapacitated
398 person and specifically delegated to the guardian. The order
399 shall state the specific powers and duties of the guardian.
400 (5) ~~(2)~~ The order appointing a guardian must be consistent
401 with the incapacitated person's welfare and safety, must be the
402 least restrictive appropriate alternative, and must reserve to
403 the incapacitated person the right to make decisions in all
404 matters commensurate with the person's ability to do so.
405 (6) ~~(3)~~ If a petition for appointment of guardian has been
406 filed, an order appointing a guardian must be issued

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contemporaneously with the order adjudicating the person incapacitated. The order must specify the amount of the bond to be given by the guardian and must state specifically whether the guardian must place all, or part, of the property of the ward in a restricted account in a financial institution designated pursuant to s. 69.031.

(7) ~~(4)~~ If a petition for the appointment of a guardian has not been filed at the time of the hearing on the petition to determine capacity, the court may appoint an emergency temporary guardian in the manner and for the purposes specified in s. 744.3031.

(8) ~~(5)~~ A plenary guardian shall exercise all delegable rights and powers of the incapacitated person.

(9) ~~(6)~~ A person for whom a limited guardian has been appointed retains all legal rights except those which have been specifically granted to the guardian in the court's written order.

Section 13. Section 744.703, Florida Statutes, is renumbered as 744.2006, Florida Statutes, and subsections (1) and (6) of that section are amended, to read:

744.2006 ~~744.703~~ Office of public and professional guardians ~~guardian~~; appointment, notification.—

(1) The executive director of the ~~Statewide Public Guardianship~~ Office of Public and Professional Guardians, after consultation with the chief judge and other circuit judges within the judicial circuit and with appropriate advocacy groups and individuals and organizations who are knowledgeable about the needs of incapacitated persons, may establish, within a county in the judicial circuit or within the judicial circuit,

one or more offices of public and professional guardian and if so established, shall create a list of persons best qualified to serve as the public guardian, who have been investigated pursuant to s. 744.3135. The public guardian must have knowledge of the legal process and knowledge of social services available to meet the needs of incapacitated persons. The public guardian shall maintain a staff or contract with professionally qualified individuals to carry out the guardianship functions, including an attorney who has experience in probate areas and another person who has a master's degree in social work, or a gerontologist, psychologist, registered nurse, or nurse practitioner. A public guardian that is a nonprofit corporate guardian under s. 744.309(5) must receive tax-exempt status from the United States Internal Revenue Service.

(6) Public guardians who have been previously appointed by a chief judge prior to the effective date of this act pursuant to this section may continue in their positions until the expiration of their term pursuant to their agreement. However, oversight of all public guardians shall transfer to the ~~Statewide Public Guardianship~~ Office of Public and Professional Guardians upon the effective date of this act. The executive director of the ~~Statewide Public Guardianship~~ Office of Public and Professional Guardians shall be responsible for all future appointments of public guardians pursuant to this act.

Section 14. Section 744.704, Florida Statutes, is renumbered as section 744.2007, Florida Statutes.

Section 15. Section 744.705, Florida Statutes, is renumbered as section 744.2008, Florida Statutes.

Section 16. Section 744.706, Florida Statutes, is

465 renumbered as section 744.2009, Florida Statutes, and amended to
466 read:
467 <u>744.2009</u> ~~744.706~~ Preparation of budget.—Each public
468 guardian, whether funded in whole or in part by money raised
469 through local efforts, grants, or any other source or whether
470 funded in whole or in part by the state, shall prepare a budget
471 for the operation of the office of public guardian to be
472 submitted to the ~~Statewide Public Guardianship~~ Office <u>of Public</u>
473 <u>and Professional Guardians</u>. As appropriate, the ~~Statewide Public~~
474 ~~Guardianship~~ Office <u>of Public and Professional Guardians</u> will
475 include such budgetary information in the Department of Elderly
476 Affairs’ legislative budget request. The office of public
477 guardian shall be operated within the limitations of the General
478 Appropriations Act and any other funds appropriated by the
479 Legislature to that particular judicial circuit, subject to the
480 provisions of chapter 216. The Department of Elderly Affairs
481 shall make a separate and distinct request for an appropriation
482 for the ~~Statewide Public Guardianship~~ Office <u>of Public and</u>
483 <u>Professional Guardians</u>. However, this section <u>may</u> ~~shall~~ not be
484 construed to preclude the financing of any operations of the
485 office of the public guardian by moneys raised through local
486 effort or through the efforts of the ~~Statewide Public~~
487 ~~Guardianship~~ Office <u>of Public and Professional Guardians</u>.
488 Section 17. Section 744.707, Florida Statutes, is
489 renumbered as section 744.2101, Florida Statutes, and amended to
490 read:
491 <u>744.2101</u> ~~744.707~~ Procedures and rules.—The public guardian,
492 subject to the oversight of the ~~Statewide Public Guardianship~~
493 Office <u>of Public and Professional Guardians</u>, is authorized to:

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494 (1) Formulate and adopt necessary procedures to assure the
495 efficient conduct of the affairs of the ward and general
496 administration of the office and staff.
497 (2) Contract for services necessary to discharge the duties
498 of the office.
499 (3) Accept the services of volunteer persons or
500 organizations and provide reimbursement for proper and necessary
501 expenses.
502 Section 18. <u>Section 744.709, Florida Statutes, is</u>
503 <u>renumbered as section 744.2102, Florida Statutes.</u>
504 Section 19. Section 744.708, Florida Statutes, is
505 renumbered as section 744.2103, Florida Statutes, and
506 subsections (3), (4), (5), and (7) of that section are amended,
507 to read:
508 <u>744.2103</u> ~~744.708~~ Reports and standards.—
509 (3) A public guardian shall file an annual report on the
510 operations of the office of public guardian, in writing, by
511 September 1 for the preceding fiscal year with the ~~Statewide~~
512 ~~Public Guardianship~~ Office <u>of Public and Professional Guardians,</u>
513 which shall have responsibility for supervision of the
514 operations of the office of public guardian.
515 (4) Within 6 months of his or her appointment as guardian
516 of a ward, the public guardian shall submit to the clerk of the
517 court for placement in the ward’s guardianship file and to the
518 executive director of the ~~Statewide Public Guardianship~~ Office
519 <u>of Public and Professional Guardians</u> a report on his or her
520 efforts to locate a family member or friend, other person, bank,
521 or corporation to act as guardian of the ward and a report on
522 the ward’s potential to be restored to capacity.

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(5)(a) Each office of public guardian shall undergo an independent audit by a qualified certified public accountant at least once every 2 years. A copy of the audit report shall be submitted to the ~~Statewide Public Guardianship~~ Office of Public and Professional Guardians.

(b) In addition to regular monitoring activities, the ~~Statewide Public Guardianship~~ Office of Public and Professional Guardians shall conduct an investigation into the practices of each office of public guardian related to the managing of each ward's personal affairs and property. If feasible, the investigation shall be conducted in conjunction with the financial audit of each office of public guardian under paragraph (a).

(7) The ratio for professional staff to wards shall be 1 professional to 40 wards. The ~~Statewide Public Guardianship~~ Office of Public and Professional Guardians may increase or decrease the ratio after consultation with the local public guardian and the chief judge of the circuit court. The basis for the decision to increase or decrease the prescribed ratio must be included in the annual report to the secretary.

Section 20. Section 744.7081, Florida Statutes, is renumbered as section 744.2104, Florida Statutes, and amended to read:

744.2104 ~~744.7081~~ Access to records by the ~~Statewide Public Guardianship~~ Office of Public and Professional Guardians; confidentiality.—Notwithstanding any other provision of law to the contrary, any medical, financial, or mental health records held by an agency, or the court and its agencies, which are necessary to evaluate the public guardianship system, to assess

the need for additional public guardianship, or to develop required reports, shall be provided to the ~~Statewide Public Guardianship~~ Office of Public and Professional Guardians upon that office's request. Any confidential or exempt information provided to the ~~Statewide Public Guardianship~~ Office of Public and Professional Guardians shall continue to be held confidential or exempt as otherwise provided by law. All records held by the ~~Statewide Public Guardianship~~ Office of Public and Professional Guardians relating to the medical, financial, or mental health of vulnerable adults as defined in chapter 415, persons with a developmental disability as defined in chapter 393, or persons with a mental illness as defined in chapter 394, shall be confidential and exempt from s. 119.07(1) and s. 24(a), Art. I of the State Constitution.

Section 21. Section 744.7082, Florida Statutes, is renumbered as section 744.2105, Florida Statutes, and subsections (1) through (5) and (8) of that section are amended, to read:

744.2105 ~~744.7082~~ Direct-support organization; definition; use of property; board of directors; audit; dissolution.—

(1) DEFINITION.—As used in this section, the term "direct-support organization" means an organization whose sole purpose is to support the ~~Statewide Public Guardianship~~ Office of Public and Professional Guardians and is:

(a) A not-for-profit corporation incorporated under chapter 617 and approved by the Department of State;

(b) Organized and operated to conduct programs and activities; to raise funds; to request and receive grants, gifts, and bequests of moneys; to acquire, receive, hold,

invest, and administer, in its own name, securities, funds, objects of value, or other property, real or personal; and to make expenditures to or for the direct or indirect benefit of the ~~Statewide Public Guardianship~~ Office of Public and Professional Guardians; and

(c) Determined by the ~~Statewide Public Guardianship~~ Office of Public and Professional Guardians to be consistent with the goals of the office, in the best interests of the state, and in accordance with the adopted goals and mission of the Department of Elderly Affairs and the ~~Statewide Public Guardianship~~ Office of Public and Professional Guardians.

(2) CONTRACT.—The direct-support organization shall operate under a written contract with the ~~Statewide Public Guardianship~~ Office of Public and Professional Guardians. The written contract must provide for:

(a) Certification by the ~~Statewide Public Guardianship~~ Office of Public and Professional Guardians that the direct-support organization is complying with the terms of the contract and is doing so consistent with the goals and purposes of the office and in the best interests of the state. This certification must be made annually and reported in the official minutes of a meeting of the direct-support organization.

(b) The reversion of moneys and property held in trust by the direct-support organization:

1. To the ~~Statewide Public Guardianship~~ Office of Public and Professional Guardians if the direct-support organization is no longer approved to operate for the office;

2. To the ~~Statewide Public Guardianship~~ Office of Public and Professional Guardians if the direct-support organization

ceases to exist;

3. To the Department of Elderly Affairs if the ~~Statewide Public Guardianship~~ Office of Public and Professional Guardians ceases to exist; or

4. To the state if the Department of Elderly Affairs ceases to exist.

The fiscal year of the direct-support organization shall begin on July 1 of each year and end on June 30 of the following year.

(c) The disclosure of the material provisions of the contract, and the distinction between the ~~Statewide Public Guardianship~~ Office of Public and Professional Guardians and the direct-support organization, to donors of gifts, contributions, or bequests, including such disclosure on all promotional and fundraising publications.

(3) BOARD OF DIRECTORS.—The Secretary of Elderly Affairs shall appoint a board of directors for the direct-support organization from a list of nominees submitted by the executive director of the ~~Statewide Public Guardianship~~ Office of Public and Professional Guardians.

(4) USE OF PROPERTY.—The Department of Elderly Affairs may permit, without charge, appropriate use of fixed property and facilities of the department or the ~~Statewide Public Guardianship~~ Office of Public and Professional Guardians by the direct-support organization. The department may prescribe any condition with which the direct-support organization must comply in order to use fixed property or facilities of the department or the ~~Statewide Public Guardianship~~ Office of Public and Professional Guardians.

(5) MONEYS.—Any moneys may be held in a separate depository account in the name of the direct-support organization and subject to the provisions of the written contract with the ~~Statewide Public Guardianship~~ Office of Public and Professional Guardians. Expenditures of the direct-support organization shall be expressly used to support the ~~Statewide Public Guardianship~~ Office of Public and Professional Guardians. The expenditures of the direct-support organization may not be used for the purpose of lobbying as defined in s. 11.045.

(8) DISSOLUTION.—A ~~After July 1, 2004, any~~ not-for-profit corporation incorporated under chapter 617 that is determined by a circuit court to be representing itself as a direct-support organization created under this section, but that does not have a written contract with the ~~Statewide Public Guardianship~~ Office of Public and Professional Guardians in compliance with this section, is considered to meet the grounds for a judicial dissolution described in s. 617.1430(1)(a). The ~~Statewide Public Guardianship~~ Office of Public and Professional Guardians shall be the recipient for all assets held by the dissolved corporation which accrued during the period that the dissolved corporation represented itself as a direct-support organization created under this section.

Section 22. Section 744.712, Florida Statutes, is renumbered as section 744.2106, Florida Statutes, and subsections (1) and (3) are amended, to read:

744.2106 ~~744.712~~ Joining Forces for Public Guardianship grant program; purpose.—The Legislature intends to establish the Joining Forces for Public Guardianship matching grant program for the purpose of assisting counties to establish and fund

community-supported public guardianship programs. The Joining Forces for Public Guardianship matching grant program shall be established and administered by the ~~Statewide Public Guardianship~~ Office of Public and Professional Guardians within the Department of Elderly Affairs. The purpose of the program is to provide startup funding to encourage communities to develop and administer locally funded and supported public guardianship programs to address the needs of indigent and incapacitated residents.

(1) The ~~Statewide Public Guardianship~~ Office of Public and Professional Guardians may distribute the grant funds as follows:

(a) As initial startup funding to encourage counties that have no office of public guardian to establish an office, or as initial startup funding to open an additional office of public guardian within a county whose public guardianship needs require more than one office of public guardian.

(b) As support funding to operational offices of public guardian that demonstrate a necessity for funds to meet the public guardianship needs of a particular geographic area in the state which the office serves.

(c) To assist counties that have an operating public guardianship program but that propose to expand the geographic area or population of persons they serve, or to develop and administer innovative programs to increase access to public guardianship in this state.

Notwithstanding this subsection, the executive director of the office may award emergency grants if he or she determines that

697 the award is in the best interests of public guardianship in
698 this state. Before making an emergency grant, the executive
699 director must obtain the written approval of the Secretary of
700 Elderly Affairs. Subsections (2), (3), and (4) do not apply to
701 the distribution of emergency grant funds.
702 (3) If an applicant is eligible and meets the requirements
703 to receive grant funds more than once, the ~~Statewide Public~~
704 ~~Guardianship~~ Office of Public and Professional Guardians shall
705 award funds to prior awardees in the following manner:
706 (a) In the second year that grant funds are awarded, the
707 cumulative sum of the award provided to one or more applicants
708 within the same county may not exceed 75 percent of the total
709 amount of grant funds awarded within that county in year one.
710 (b) In the third year that grant funds are awarded, the
711 cumulative sum of the award provided to one or more applicants
712 within the same county may not exceed 60 percent of the total
713 amount of grant funds awarded within that county in year one.
714 (c) In the fourth year that grant funds are awarded, the
715 cumulative sum of the award provided to one or more applicants
716 within the same county may not exceed 45 percent of the total
717 amount of grant funds awarded within that county in year one.
718 (d) In the fifth year that grant funds are awarded, the
719 cumulative sum of the award provided to one or more applicants
720 within the same county may not exceed 30 percent of the total
721 amount of grant funds awarded within that county in year one.
722 (e) In the sixth year that grant funds are awarded, the
723 cumulative sum of the award provided to one or more applicants
724 within the same county may not exceed 15 percent of the total
725 amount of grant funds awarded within that county in year one.

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726
727 The ~~Statewide Public Guardianship~~ Office of Public and
728 Professional Guardians may not award grant funds to any
729 applicant within a county that has received grant funds for more
730 than 6 years.
731 Section 23. Section 744.713, Florida Statutes, is
732 renumbered as section 744.2107, Florida Statutes, and amended to
733 read:
734 744.2107 ~~744.713~~ Program administration; duties of the
735 ~~Statewide Public Guardianship~~ Office of Public and Professional
736 Guardians.—The ~~Statewide Public Guardianship~~ Office of Public
737 and Professional Guardians shall administer the grant program.
738 The office shall:
739 (1) Publicize the availability of grant funds to entities
740 that may be eligible for the funds.
741 (2) Establish an application process for submitting a grant
742 proposal.
743 (3) Request, receive, and review proposals from applicants
744 seeking grant funds.
745 (4) Determine the amount of grant funds each awardee may
746 receive and award grant funds to applicants.
747 (5) Develop a monitoring process to evaluate grant
748 awardees, which may include an annual monitoring visit to each
749 awardee's local office.
750 (6) Ensure that persons or organizations awarded grant
751 funds meet and adhere to the requirements of this act.
752 Section 24. Section 744.714, Florida Statutes, is
753 renumbered as section 744.2108, Florida Statutes, and paragraph
754 (b) of subsection (1) and paragraph (b) of subsection (2) of

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755 that section are amended, to read:
756 744.2108 ~~744.714~~ Eligibility.—
757 (1) Any person or organization that has not been awarded a
758 grant must meet all of the following conditions to be eligible
759 to receive a grant:
760 (b) The applicant must have already been appointed by, or
761 is pending appointment by, the ~~Statewide Public Guardianship~~
762 Office of Public and Professional Guardians to become an office
763 of public guardian in this state.
764 (2) Any person or organization that has been awarded a
765 grant must meet all of the following conditions to be eligible
766 to receive another grant:
767 (b) The applicant must have been appointed by, or is
768 pending reappointment by, the ~~Statewide Public Guardianship~~
769 Office of Public and Professional Guardians to be an office of
770 public guardian in this state.
771 Section 25. Section 744.715, Florida Statutes, is
772 renumbered as section 744.2109, Florida Statutes, and
773 subsections (2) and (4) of that section are amended, to read:
774 744.2109 ~~744.715~~ Grant application requirements; review
775 criteria; awards process.—Grant applications must be submitted
776 to the ~~Statewide Public Guardianship~~ Office of Public and
777 Professional Guardians for review and approval.
778 (2) If the ~~Statewide Public Guardianship~~ Office of Public
779 and Professional Guardians determines that an applicant meets
780 the requirements for an award of grant funds, the office may
781 award the applicant any amount of grant funds the executive
782 director deems appropriate, if the amount awarded meets the
783 requirements of this act. The office may adopt a rule allocating

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784 the maximum allowable amount of grant funds which may be
785 expended on any ward.
786 (4)(a) In the first year of the Joining Forces for Public
787 Guardianship program's existence, the ~~Statewide Public~~
788 ~~Guardianship~~ Office of Public and Professional Guardians shall
789 give priority in awarding grant funds to those entities that:
790 1. Are operating as appointed offices of public guardians
791 in this state;
792 2. Meet all of the requirements for being awarded a grant
793 under this act; and
794 3. Demonstrate a need for grant funds during the current
795 fiscal year due to a loss of local funding formerly raised
796 through court filing fees.
797 (b) In each fiscal year after the first year that grant
798 funds are distributed, the ~~Statewide Public Guardianship~~ Office
799 of Public and Professional Guardians may give priority to
800 awarding grant funds to those entities that:
801 1. Meet all of the requirements of this act for being
802 awarded grant funds; and
803 2. Submit with their application an agreement or
804 confirmation from a local funding source, such as a county,
805 municipality, or any other public or private organization, that
806 the local funding source will contribute matching funds totaling
807 an amount equal to or exceeding $2 for every $1 of grant funds
808 awarded by the office. An entity may submit with its application
809 agreements or confirmations from multiple local funding sources
810 showing that the local funding sources will pool their
811 contributed matching funds to the public guardianship program
812 for a combined total of not less than $2 for every $1 of grant

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813 funds awarded. In-kind contributions allowable under this
814 section shall be evaluated by the ~~Statewide Public Guardianship~~
815 Office of Public and Professional Guardians and may be counted
816 as part or all of the local matching funds.
817 Section 26. Section 744.701, Florida Statutes, is repealed.
818 Section 27. Section 744.702, Florida Statutes, is repealed.
819 Section 28. Section 744.7101, Florida Statutes, is
820 repealed.
821 Section 29. Section 744.711, Florida Statutes, is repealed.
822 Section 30. Subsection (5) of section 400.148, Florida
823 Statutes, is amended to read:
824 400.148 Medicaid “Up-or-Out” Quality of Care Contract
825 Management Program.—
826 (5) The agency shall, jointly with the ~~Statewide Public~~
827 ~~Guardianship~~ Office of Public and Professional Guardians,
828 develop a system in the pilot project areas to identify Medicaid
829 recipients who are residents of a participating nursing home or
830 assisted living facility who have diminished ability to make
831 their own decisions and who do not have relatives or family
832 available to act as guardians in nursing homes listed on the
833 Nursing Home Guide Watch List. The agency and the ~~Statewide~~
834 ~~Public Guardianship~~ Office of Public and Professional Guardians
835 shall give such residents priority for publicly funded
836 guardianship services.
837 Section 31. Subsection (3), paragraph (c) of subsection
838 (4), and subsections (5) and (6) of section 744.3135, Florida
839 Statutes, are amended to read:
840 744.3135 Credit and criminal investigation.—
841 (3) For professional guardians, the court and the ~~Statewide~~

842 ~~Public Guardianship~~ Office of Public and Professional Guardians
843 shall accept the satisfactory completion of a criminal history
844 record check by any method described in this subsection. A
845 professional guardian satisfies the requirements of this section
846 by undergoing an electronic fingerprint criminal history record
847 check. A professional guardian may use any electronic
848 fingerprinting equipment used for criminal history record
849 checks. The ~~Statewide Public Guardianship~~ Office of Public and
850 Professional Guardians shall adopt a rule detailing the
851 acceptable methods for completing an electronic fingerprint
852 criminal history record check under this section. The
853 professional guardian shall pay the actual costs incurred by the
854 Federal Bureau of Investigation and the Department of Law
855 Enforcement for the criminal history record check. The entity
856 completing the record check must immediately send the results of
857 the criminal history record check to the clerk of the court and
858 the ~~Statewide Public Guardianship~~ Office of Public and
859 Professional Guardians. The clerk of the court shall maintain
860 the results in the professional guardian’s file and shall make
861 the results available to the court.
862 (4)
863 (c) The Department of Law Enforcement shall search all
864 arrest fingerprints received under s. 943.051 against the
865 fingerprints retained in the statewide automated biometric
866 identification system under paragraph (b). Any arrest record
867 that is identified with the fingerprints of a person described
868 in this paragraph must be reported to the clerk of court. The
869 clerk of court must forward any arrest record received for a
870 professional guardian to the ~~Statewide Public Guardianship~~

871 Office of Public and Professional Guardians within 5 days. Each
872 professional guardian who elects to submit fingerprint
873 information electronically shall participate in this search
874 process by paying an annual fee to the ~~Statewide Public~~
875 ~~Guardianship~~ Office of Public and Professional Guardians of the
876 Department of Elderly Affairs and by informing the clerk of
877 court and the ~~Statewide Public Guardianship~~ Office of Public and
878 Professional Guardians of any change in the status of his or her
879 guardianship appointment. The amount of the annual fee to be
880 imposed for performing these searches and the procedures for the
881 retention of professional guardian fingerprints and the
882 dissemination of search results shall be established by rule of
883 the Department of Law Enforcement. At least once every 5 years,
884 the ~~Statewide Public Guardianship~~ Office of Public and
885 Professional Guardians must request that the Department of Law
886 Enforcement forward the fingerprints maintained under this
887 section to the Federal Bureau of Investigation.
888 (5)(a) A professional guardian, and each employee of a
889 professional guardian who has a fiduciary responsibility to a
890 ward, must complete, at his or her own expense, an investigation
891 of his or her credit history before and at least once every 2
892 years after the date of the guardian's registration with the
893 ~~Statewide Public Guardianship~~ Office of Public and Professional
894 Guardians.
895 (b) The ~~Statewide Public Guardianship~~ Office of Public and
896 Professional Guardians shall adopt a rule detailing the
897 acceptable methods for completing a credit investigation under
898 this section. If appropriate, the ~~Statewide Public Guardianship~~
899 Office of Public and Professional Guardians may administer

900 credit investigations. If the office chooses to administer the
901 credit investigation, the office may adopt a rule setting a fee,
902 not to exceed $25, to reimburse the costs associated with the
903 administration of a credit investigation.
904 (6) The ~~Statewide Public Guardianship~~ Office of Public and
905 Professional Guardians may inspect at any time the results of
906 any credit or criminal history record check of a public or
907 professional guardian conducted under this section. The office
908 shall maintain copies of the credit or criminal history record
909 check results in the guardian's registration file. If the
910 results of a credit or criminal investigation of a public or
911 professional guardian have not been forwarded to the ~~Statewide~~
912 ~~Public Guardianship~~ Office of Public and Professional Guardians
913 by the investigating agency, the clerk of the court shall
914 forward copies of the results of the investigations to the
915 office upon receiving them.
916 Section 32. Paragraph (e) of subsection (2) of section
917 415.1102, Florida Statutes, is amended to read:
918 415.1102 Adult protection teams.—
919 (2) Such teams may be composed of, but need not be limited
920 to:
921 (e) Public and professional guardians as described in part
922 II ~~IX~~ of chapter 744.
923 Section 33. Paragraph (d) of subsection (3) of section
924 744.331, Florida Statutes, is amended to read:
925 744.331 Procedures to determine incapacity.—
926 (3) EXAMINING COMMITTEE.—
927 (d) A member of an examining committee must complete a
928 minimum of 4 hours of initial training. The person must complete

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929 2 hours of continuing education during each 2-year period after
930 the initial training. The initial training and continuing
931 education program must be developed under the supervision of the
932 ~~Statewide Public Guardianship~~ Office of Public and Professional
933 Guardians, in consultation with the Florida Conference of
934 Circuit Court Judges; the Elder Law and the Real Property,
935 Probate and Trust Law sections of The Florida Bar; the Florida
936 State Guardianship Association; and the Florida Guardianship
937 Foundation. The court may waive the initial training requirement
938 for a person who has served for not less than 5 years on
939 examining committees. If a person wishes to obtain his or her
940 continuing education on the Internet or by watching a video
941 course, the person must first obtain the approval of the chief
942 judge before taking an Internet or video course.
943 Section 34. Paragraph (a) of subsection (1) of section
944 20.415, Florida Statutes, is amended to read:
945 20.415 Department of Elderly Affairs; trust funds.—The
946 following trust funds shall be administered by the Department of
947 Elderly Affairs:
948 (1) Administrative Trust Fund.
949 (a) Funds to be credited to and uses of the trust fund
950 shall be administered in accordance with ss. 215.32, 744.534,
951 and 744.2001 ~~744.7021~~.
952 Section 35. Section 744.524, Florida Statutes, is amended
953 to read:
954 744.524 Termination of guardianship on change of domicile
955 of resident ward.—When the domicile of a resident ward has
956 changed as provided in s. 744.1098 ~~s. 744.2025~~, and the foreign
957 court having jurisdiction over the ward at the ward's new

958 domicile has appointed a guardian and that guardian has
959 qualified and posted a bond in an amount required by the foreign
960 court, the guardian in this state may file her or his final
961 report and close the guardianship in this state. The guardian of
962 the property in this state shall cause a notice to be published
963 once a week for 2 consecutive weeks, in a newspaper of general
964 circulation published in the county, that she or he has filed
965 her or his accounting and will apply for discharge on a day
966 certain and that jurisdiction of the ward will be transferred to
967 the state of foreign jurisdiction. If an objection is filed to
968 the termination of the guardianship in this state, the court
969 shall hear the objection and enter an order either sustaining or
970 overruling the objection. Upon the disposition of all objections
971 filed, or if no objection is filed, final settlement shall be
972 made by the Florida guardian. On proof that the remaining
973 property in the guardianship has been received by the foreign
974 guardian, the guardian of the property in this state shall be
975 discharged. The entry of the order terminating the guardianship
976 in this state shall not exonerate the guardian or the guardian's
977 surety from any liability previously incurred.
978 Section 36. This act shall take effect July 1, 2015.

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The Florida Senate
BILL ANALYSIS AND FISCAL IMPACT STATEMENT

(This document is based on the provisions contained in the legislation as of the latest date listed below.)

Prepared By: The Professional Staff of the Committee on Children, Families, and Elder Affairs

BILL: SB 1340

INTRODUCER: Senator Latvala

SUBJECT: Mental Health and Substance Abuse

DATE: March 5, 2015 REVISED:

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Crosier	Hendon	CF	**Pre-meeting**
2.			AHS	
3.			AP	

I. Summary:

SB 1340 creates the Substance Abuse Assistance Pilot Program within the Department of Children and Families (DCF or department). The department will determine the number of participants subject to available funding, be required to develop safe and cost efficient treatment alternatives, contract with specified entities to serve as program managers in the selected regions and provide an annual report to the Governor, the President of the Senate and the Speaker of the House of Representatives by October 1, of each year.

The legislation also creates a process for an adult with capacity to execute a mental health or substance abuse treatment advance directive to guide their treatment should they become incapacitated. The bill provides for the revocation or expiration of the advance directive and the terms for revoking the advance directive. Specifically, for participants in the pilot program, the bill allows an individual to create a self-binding arrangement which specifies the conditions the individual may be admitted for inpatient mental health or substance abuse treatment for up to 14 days. Additionally, the bill prohibits the criminal prosecution of a health care facility, provider or surrogate who acts in accordance with a mental health or substance abuse treatment advance directive.

The bill provides an effective date of July 1, 2015. The fiscal impact of the bill on DCF is indeterminate.

II. Present Situation:

Mental Health, Homelessness and Substance Abuse

According to the Substance Abuse and Mental Health Administration, 20 to 25 percent of the homeless population in the United States suffers from some form of severe mental illness.[1] Poor mental health may also affect physical health.[2] In addition, half of the mentally ill homeless

[1] National Coalition for the Homeless, *Mental Illness and Homelessness,*(July 2009).

[2] *Id.*

population in the United States also suffers from substance abuse and dependence.[3] Some mentally ill people self-medicate using street drugs, which not only can lead to addictions but to disease transmission.[4] This combination of mental illness, substance abuse and poor physical health makes it very difficult for people to obtain employment and residential stability.[5] Better mental health services would combat not only mental illness, but homelessness as well.[6] However, even if homeless individuals with mental illness are provided with housing, they are unlikely to achieve residential stability and remain off the streets unless they have access to continued treatment and services.[7] Research has shown that supported housing is effective for people with mental illnesses and supported housing programs offer services such as mental health treatment, physical health care, education and employment opportunities, peer support, and daily living and money management skills training.[8]

Mental illness creates enormous social and economic costs.[9] Unemployment rates for people with all mental disorders are high.[10] People with severe mental illness have exceptionally high rates of unemployment between 60 to 100 percent.[11] While mental illness increases a person's risk of homelessness in America threefold, there is now a new victim – children and young adults of parents who are having difficulty making ends meet.[12] Studies show that approximately 33 percent of our nation's homelessness live with a serious mental disorder such as schizophrenia for which they are not receiving treatment.[13] Often the combination of homelessness and mental illness creates the perfect storm for incarceration which further decreases a person's chance of receiving proper treatment and lead to future re-offenses.[14]

According to the National Alliance on Mental Illness (NAMI), approximately 50 percent of individuals with severe mental health disorders are affected by substance abuse.[15] NAMI also estimates that 29 percent of all people diagnosed as mentally ill abuse alcohol or other drugs.[16] When mental health disorders are left untreated, substance abuse is likely to increase. One may try to self-medicate with substances to reduce mental health symptoms. One may also increase substance use as a result of stress and inability to cope with issues or situations.[17] When substance abuse increases, mental health symptoms often increase as well or new symptoms may be triggered. This could also be due to discontinuation of taking prescribed medications or the

[3] *Id.*
[4] *Id.*
[5] *Id.*
[6] *Id.*
[7] *Id.*
[8] *Id.*
[9] *Mental Illness: The Invisible Menace; Economic Impact, available at* http://www.mentalmenace.com/economicimpact.php
[10] *Mental Illness: The Invisible Menace: More impacts and facts, available at* http://www.mentalmenace.com/impactsfacts.php
[11] *Id.*
[12] *How does Mental Illness Impact Rates of Homelessness? Available at* http://www.familyguidance.org/how-does-mental-illness-impact-rates-of-homelessness/
[13] *Id.*
[14] *Id.*
[15] Donna M. White, OPCI, CACP, *Living with Co-Occurring Mental & Substance Abuse Disorders, available at* http://psychcentral.com/blog/archives/2013/10/02/living-with-co-occuring-mental-substance
[16] *Id.*
[17] *Id.*

contraindications for substance abuse and mental health medications. When taken with other medications, mental health medications can become less effective.[18]

The best treatment for co-occurring disorders is commonly referred to as an integrated approach. This method of treatment simultaneously combines the treatment of both mental health and substance abuse disorders.[19] Treatment often includes education regarding both substance abuse and mental health diagnoses; however, these individual may require longer treatment than those with a single disorder.[20]

Advance Directive for Mental Health or Substance Abuse Treatment

Florida law currently allows an individual to create an advance directive which designates a surrogate to make health care decisions and provides a process for the execution of the directive.[21] Currently law also allows an individual to designate a separate surrogate to consent to mental health treatment if the individual is determined by a court to be incompetent to consent to mental health treatment[22] A mental health or substance abuse treatment advance directive is much like a living will for health care.[23] Acute episodes of mental illness temporarily destroy the capacity required to give informed consent and often prevent people from realizing they are sick, causing them to refuse intervention.[24] Even in the midst of acute episodes, many people do not meet commitment criteria because they are not likely to injure themselves or others and are still able to care for their basic needs.[25] Left untreated, the episode will likely spiral out of control and by the time the person meets the commitment criteria, devastation has already occurred.[26]

The Uniform Law Commissioners enacted the Uniform Health-Care Decisions Act as a model statute to address all types of advance health care planning, including planning for mental illness; however, the Act focuses on end-of-life care and fails to address many issues faced by people with mental illness.[27] A key failure of the Uniform Act is that it does not empower patients to form self-binding arrangements for care.[28] These self-binding arrangements are known as Ulysses arrangement. A Ulysses arrangement is a type of mental health advance directive that serves as a preventative measure for a patient to obtain treatment during an episode because the patient has learned that episodes cause him or her to refuse needed intervention.[29] The arrangement is entered into when the individual has capacity. A Ulysses arrangement authorizes doctors to treat the patient during a future episode when the he or she lacks capacity even if the episode causes the individual to refuse treatment at that time. Without a Ulysses arrangement, an

[18] *Id.*
[19] *Id.*
[20] *Id.*
[21] Section 765.202, F.S.
[22] Section 765.202(5), F.S.
[23] Washington State Hospital Association, *Mental Health Advance Directives,* copy on file with the Senate Committee on Children, Families and Elder Affairs.
[24] Judy A. Clausen, *Making the Case for a Model Mental Health Advance Directive Statute,* 14 Yale Journal of Health Policy, Law & Ethics (Winter 2014) (on file with the Senate Committee on Children, Families, and Elder Affairs).
[25] *Id.*
[26] *Id.*
[27] *Id.*
[28] *Id.*
[29] *Id at 2.*

individual whose illness causes him to revoke his mental health advance directive and refuse treatment has no mechanism to secure intervention unless he meets involuntary commitment criteria.[30] Ulysses arrangements are superior to involuntary commitment because involuntary commitment comes too late and is often traumatic; the proceedings can be dehumanizing; and police intervention and apprehension can be dangerous.[31] Additionally, the Ulysses arrangement allows the individual to secure treatment from the individual's regular mental health treatment provider who understands the patient's illness and history, in a facility the individual chooses.[32]

III. Effect of Proposed Changes:

Section 1 amends s. 394.4598, F.S., to allow a family member of the patient, or interested party, in addition to the administrator of a receiving or treatment facility, to petition the court for the appointment of a guardian advocate for a patient incompetent to consent to treatment but not adjudicated incapacitated. The bill adds mental health care or substance abuse treatment surrogates to the list of people the court should give preference to when selecting a guardian advocate.

Section 2 creates s. 397.803, F.S., to create the Substance Abuse Assistance Pilot Program within the Department of Children and Families. The pilot program is created to determine whether the provision of comprehensive services through a coordinated system of case management offering a range of recovery support services leads to increased employment, stability in housing, and decreased involvement in the criminal justice system for substance abuse impaired adults. The pilot program in selected regions is to develop safe and cost efficient treatment alternatives and provide comprehensive case management and continuum of care services to participants. Participation in the pilot program may be designated as an alternative to criminal imprisonment for participants.

To be eligible to participate in the pilot program a person must:

- Be 18 years of age or older with a history of chronic substance abuse or addiction.
- Execute a mental health advance directive which must include a self-binding arrangement as defined in s. 765.403, F.S. If the participant does not have a family member or other adult available to serve as a surrogate, the entity under contract with the Statewide Public Guardianship Office shall be appointed to serve as the surrogate.
- Share the responsibility for the costs of the pilot program according to their ability to pay, based on a sliding scale.

The bill directs DCF to contract with the Medicaid managed care organization or behavioral health managing entity in the selected region to serve as program manager and it shall be responsible for the following functions:

- Recruitment, retention and management of a network of qualified service providers to ensure accessibility and quality of care.

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[30] *Id at 6.*
[31] *Id.*
[32] Judy Ann Clausen, *Bring Ulysses to Florida: Proposed Legislative Relief for Mental Health Patients,* article to be published in Marquette University's Elder's Advisor Law Review. Copy on file with the Senate Committee on Children, Families, and Elder Affairs.

- Development and implementation of an organizational structure and operational policies to ensure the provision of coordination of care, continuity of care and the avoidance of duplication of services.
- Comprehensive case management including direct interaction with participants and other activities to assess, plan, implement, and monitor the needed services.
- Administrative functions for the network, including, but not limited to, data management, financial management and contract compliance.

The department is responsible for establishing criteria to ensure an adequate number of qualified providers are included in the network. For the duration of the pilot program, each selected region is limited to one network. The provider network shall:

- Offer a comprehensive range of services for substance abuse impaired or drug addicted adults.
- Divert nonviolent offenders with histories of serious substance abuse or chronic addiction into intensive treatment, comprehensive case management and rehabilitation services through agreements with law enforcement agencies and the criminal justice system.
- Enter into an agreement with the appropriate neighborhood housing services program to provide housing assistance to eligible participants.
- Provide guardians to act as surrogates for eligible participants who do not have family or other adults to perform such duties through an agreement with the public guardianship entity under contract with the Statewide Public Guardianship Office in each selected region.
- In each selected region, enter into an agreement with the local legal services organization to provide legal assistance to participants in the pilot program.

The selected network in each region must be capable of providing, at a minimum, the following services to substance abuse impaired or drug addicted adults:

- Comprehensive case management and continuum of care coordination.
- Outpatient treatment services.
- Crisis care, including mobile response, and detoxification in short-term residential facilities.
- Step-down residential treatment services.
- Housing needs assessment and assistance.
- Employment assistance programs.
- Transportation needs assessment and assistance; and
- Legal services.

The bill provides that general revenue funds appropriated for the pilot program services only pay after an eligible participant's private pay or Medicaid insurance coverage has been exhausted. Eligible participants may share in the cost of provided services based on his or her ability to pay.

The bill directs the department to provide a written report by October 1 of each year to the Governor, the President of the Senate and the Speaker of the House of Representatives which describes the operation and effectiveness of the pilot program. The report must include a recommendation regarding the continuation, expansion, or termination of the pilot program.

Section 3 transfers and renumbers s. 765.401, F.S. as s. 765.311, F.S.

Section 4 transfers and renumbers s. 765.404, F.S. as s. 765.312, F.S.

Section 5 directs the Division of Law Revision and Information to rename part IV of ch. 765, F.S., from "Absence of Advance Directive" to "Mental Health and Substance Abuse Advance Directives."

Section 6 creates s. 765.4015, F.S., to be cited as the "Jennifer Act."

Section 7 creates s. 765.402, F.S., to provide legislative findings that individuals with capacity have the ability to control decisions relating to his or her own mental health or substance abuse treatment. The Legislature further finds that substance abuse and mental illness cause individuals to fluctuate between capacity and incapacity; the individual may be unable to provide informed consent necessary to access needed treatment during a time when the individual's capacity is unclear; early treatment may prevent the individual from becoming so ill that involuntary treatment is necessary; and individuals with mental illness and substance abuse impairment need an established procedure to express their instructions and preferences for treatment and to provide advance consent to or refusal of treatment. This procedure should be less restrictive and less expensive than guardianship.

Mental health or substance abuse treatment advance directives must provide the individual with a full range of choices, including the right of revocation during period of incapacity, and allow the individual to choose how to apply their directives. Treatment providers must abide by the individual's treatment choices.

Section 8 creates s. 765.403, F.S., to provide definitions for terms used in this section.

Section 9 creates s. 765.405, F.S., to provide for the creation, execution and allowable provision of mental health or substance abuse treatment advance directives. An adult with capacity may execute a mental health or substance abuse impairment advance directive. A directive executed in accordance with this part is presumed valid, however, the inability to honor one or more of the provisions of the advance directive does not invalidate the remaining provisions. The directive may include any provision related to mental health or substance abuse treatment or the care of the principal or the principal's personal affairs. Without limitation, the directive may include:
- The individual's preferences and instructions for mental health or substance abuse treatment.
- Refusal to consent to specific types of mental health or substance abuse treatment.
- Consent to admission to and retention in a facility for mental health or substance abuse treatment for up to 14 days; however, such consent must be an affirmative statement contained in the directive and must clearly state whether the consent is revocable by the individual during a mental health or substance abuse crisis.
- Descriptions of situations that may cause the individual to experience a mental health or substance abuse crisis.
- Suggested alternative responses that may supplement or be in lieu of direct mental health or substance abuse treatment, such as treatment approaches from other providers.
- Appointment of a surrogate to make mental health or substance abuse treatment decisions on the individual's behalf. If the directive includes a self-binding arrangement that allows the surrogate to consent to the individual's voluntary admission to inpatient mental health or substance abuse treatment, such authority must be clearly stated.

- The nomination of a guardian, limited guardian, or guardian advocate, by the individual.
- The directive may be independent of or combined with a nomination of a guardian or other durable power of attorney.

Section 10 creates s. 765.406, F.S., to provide for the execution, effective date and expiration of a mental health or substance abuse advance directive. The bill provides that the advance directive must be in writing, clearly indicate that the individual intends to create a directive, clearly indicate whether the individual intends for the surrogate to have the authority to consent to the individual's voluntary admission to inpatient mental health or substance abuse treatment and if such consent is revocable, be dated and signed by the individual or at his or her direction if unable to sign. The directive must be witnessed by two adults, who must declare they were present when the individual dated and signed the directive, and that the individual did not appear to be incapacitated, acting under fraud, undue influence or duress. The surrogate named in the directive cannot act as a witness to the execution of the directive and at least one witness must not be the spouse or blood relative of the individual executing the directive.

The bill provides that the directive is valid upon execution but all or part may take effect at a later date as designated in the directive. It also provides that a directive may be revoked in whole or in part or expire under its own terms. A directive may not create an entitlement to mental health, substance abuse, or medical treatment or supersede a determination of medical necessity. The directive does not obligate any health care provider, professional person, or health care facility to pay the costs associated with requested treatment or to be responsible for the nontreatment or personal care of the individual or his or her affairs outside the facilities' scope of services. Additionally, the directive does not replace or supersede any will, testamentary document or the provision of intestate succession. The directive may not be revoked by the incapacitated individual unless he or she selected the option to permit revocation during incapacitation at execution of the directive or be used to authorize inpatient admission for more than 14 days.

Section 11 creates s. 765.407, F.S., to provide for the revocation or waiver of an advance directive. The bill provides that an individual may revoke his or her advance directive only if, at the time of execution, he or she elected to be able to revoke when incapacitated. A copy of the revocation of the advance directive must be provided by the individual, and is effective upon receipt by, his or her agent, each health care provider, professional person or health care facility that received a copy of the individual's advance directive. The directive may be revoked in whole or in part, expressly or to the extent on any inconsistency by a subsequent directive or be superseded by a court order, including an order entered in a criminal matter. The directive may not be interpreted to interfere with incarceration or detention by the Department of Corrections or a municipal or county jail or the treatment of an individual subject to involuntary treatment pursuant to ch. 394, F.S.

The bill provides that a directive that would have otherwise expired but is effective because the individual is incapacitated remains effective until the individual is no longer incapacitated unless the individual elected to be able to revoke the directive while incapacitated and has revoked the directive.

Section 12 creates s. 765.408, F.S., to provide for the creation of self-binding arrangements to allow competent adults the right of self-determination regarding decisions pertaining to his or her mental health care or substance abuse treatment decisions. The bill provides the legislative intent to ensure such right and establish a procedure to allow individuals to plan for episodes that compromise the ability to recognize need for treatment before meeting the criteria for involuntary commitment. The advance directive must contain a specific provision authorizing the surrogate to direct the course of the individual's mental health or substance abuse treatment. The bill allows the individual to create a self-binding arrangement for care in the event an acute episode renders the individual unable to provide consent or induces him or her to refuse treatment. This arrangement must be affirmatively stated in the directive and include whether the individual has the right to revocation during acute episodes.

The bill provides that in order to create a self-binding arrangement, an individual must obtain a signed, written attestation of capacity from a health care professional, mental health care provider or health care facility. The arrangement must be in writing, dated and signed by the individual or representative if he or she is unable to sign, state whether the individual can revoke the directive at any time or if it remains irrevocable when the individual is unable to consent to treatment or is incapacitated. Failure to state whether the directive is irrevocable means the individual may revoke it at any time. The self-binding arrangement must contain a clear affirmation that the individual is aware of the nature of the document and it was signed freely and voluntarily and be witnessed by at least two adults. Witnesses may not be a member of the individual's treatment team; be related to the individual by blood, adoption or marriage; be in a romantic or dating relationship with the individual; be the surrogate named in the directive; be the owner, operator, or employee of, or a relative of the owner or operator of a treatment facility in which the individual is a patient. The witnesses must attest to their presence when the directive was signed by the individual, that the individual did not appear to be incapacitated or under undue influence or duress and either knows the individual or received identification from the individual. In the event the directive contains a provision that the directive is irrevocable, it must contain a written, signed attestation from a mental health professional that the individual had capacity when the directive was executed. Such attestation is not required if the principal is free to revoke the directive at any time. The directive must appoint a surrogate to make all health care and substance abuse treatment decisions for the individual, including decisions to consent on his or her behalf to inpatient mental health or substance abuse treatment. And that such decisions are effective without judicial approval.

Section 13 creates s. 765.409, F.S., to provide for the admission of an individual to inpatient mental health or substance abuse treatment only if he or she chose not to revoke his or her directive during any period of inability to provide consent or incapacity. The individual may consent to voluntary admission to inpatient mental health or substance abuse treatment or authorize a surrogate to consent on the individual's behalf. The legislation allows the individual to be admitted to or remain in inpatient treatment for up to 14 days. The directive must contain express consent to the use of psychotropic medication to be administered by licensed psychiatrists and only if two psychiatrists recommend, in writing the specific medication. The directive cannot authorize psychosurgery or electroconvulsive therapy.

Section 14 creates s. 765.410, F.S., to provide that a surrogate, health care facility, provider or other person who acts under the direction of a health care facility or provider is not subject to

criminal prosecution or civil liability or to have engaged in unprofessional conduct as a result of carrying out a mental health or substance abuse treatment decision contained in a directive.

Section 15 creates s. 765.411, F.S., to provide for the recognition of a mental health advance directive executed in compliance with the law of another state is valid.

Section 16 amends s. 395.0197, F.S., to correct cross-references.

Section 17 amends s. 395.1051, F.S., to correct cross-references.

Section 18 amends s. 456.0575, F.S., to correct cross-references.

Section 19 amends s. 765.101, F.S. to correct cross-references.

Section 20 amends s. 765.104, F.S., to correct cross-references.

Section 21 reenacts ss. 394.459(3)(b), 394.4598(6) and (7), 394.4655(6)(d) and (7)(f), 394.467(6)(d), 394.46715, and 765.202(5), for the purpose of incorporating the amendments made to s. 394.4598, F.S.

Section 22 creates an effective date of July 1, 2015.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

None.

C. Government Sector Impact:

The pilot program created in the bill would create a fiscal impact on DCF.

VI. Technical Deficiencies:

None.

VII. Related Issues:

None.

VIII. Statutes Affected:

This bill substantially amends the following sections of the Florida Statutes: 394.4598, 395.0197, 395.1051, 456.0575, 765.101, and 765.104.
This bill creates the following sections of the Florida Statutes: 397.803, 765.4015, 765.402, 765.403, 765.405, 765.406, 765.407, 765.408, 765.409, 765.410, and 765.411.
The bill transfers and renumbers the following sections of the Florida Statutes: 765.401, 765.404,
The bill reenacts the following sections of the Florida Statutes: 394.459(3)(b), 394.4598(6),(7), 394.4655(6)(d), 394.4655(7)(f), 394.467(6)(d), 394.46715 and 765.202(5).

IX. Additional Information:

A. Committee Substitute – Statement of Changes:

(Summarizing differences between the Committee Substitute and the prior version of the bill.)

None.

B. Amendments:

None.

This Senate Bill Analysis does not reflect the intent or official position of the bill's introducer or the Florida Senate.

By Senator Latvala

1 A bill to be entitled
2 An act relating to mental health and substance abuse;
3 amending s. 394.4598, F.S.; authorizing a family
4 member of a patient or an interested party to petition
5 a court for the appointment of a guardian advocate;
6 requiring a court to give preference to certain
7 specified surrogates if such surrogate has already
8 been designated by the patient; creating s. 397.803,
9 F.S.; establishing the Substance Abuse Assistance
10 Pilot Program within the Department of Children and
11 Families; requiring the department to determine a
12 target number of participants within available funds;
13 providing the purpose of the pilot program; requiring
14 the program to develop safe and cost efficient
15 treatment alternatives and provide comprehensive case
16 management services for eligible substance abuse
17 impaired adults; authorizing participation in the
18 program as an alternative to criminal imprisonment;
19 requiring that each pilot program submit specified
20 data to the department on a monthly basis; providing
21 eligibility criteria; requiring that maximum
22 enrollment be determined on the basis of available
23 funding; requiring the department to contract with
24 specified entities to serve as program managers;
25 specifying the functions of the program manager;
26 requiring the department to establish certain criteria
27 and qualifications for the project manager; requiring
28 a pilot program site to only have one network in the
29 region; providing requirements for provider networks;

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30 specifying services that must be provided by a
31 provider network; specifying that the primary payor
32 for services provided through the program is the
33 participant’s private pay or Medicaid insurance
34 coverage; allowing eligible participants to share in
35 the cost of provided services based on ability to pay;
36 requiring the department to provide an annual report
37 to the Governor and Legislature evaluating the impact
38 of the program; requiring such report to include
39 specified information; transferring and renumbering s.
40 765.401, F.S.; transferring and renumbering s.
41 765.404, F.S.; providing a directive to the Division
42 of Law Revision and Information; creating s. 765.4015,
43 F.S.; providing a short title; creating s. 765.402,
44 F.S.; providing legislative findings; creating s.
45 765.403, F.S.; defining terms; creating s. 765.405,
46 F.S.; authorizing an adult with capacity to execute a
47 mental health or substance abuse treatment advance
48 directive; providing a presumption of validity if
49 certain requirements are met; providing for execution
50 of the mental health or substance abuse treatment
51 advanced directive; creating s. 765.406, F.S.;
52 establishing requirements for a valid mental health or
53 substance abuse treatment advance directive; providing
54 that a mental health or substance abuse treatment
55 directive is valid upon execution even if a part of
56 the mental health or substance abuse treatment
57 directive takes effect at a later date; allowing a
58 mental health or substance abuse treatment directive

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59 to be revoked, in whole or in part, or to expire under
60 its own terms; specifying that a mental health or
61 substance abuse treatment advance directive does not
62 or may not serve specified purposes; creating s.
63 765.407, F.S.; providing circumstances under which a
64 mental health or substance abuse treatment advance
65 directive may be revoked; providing circumstances
66 under which a principal may waive specific directive
67 provisions without revoking the directive; creating s.
68 765.408, F.S.; providing legislative findings and
69 legislative intent for self-binding arrangements;
70 providing requirements for creating such arrangements;
71 creating s. 765.409, F.S.; specifying the conditions
72 under which a principal may be admitted for inpatient
73 mental health or substance abuse treatment; providing
74 that creation of an irrevocable directive of consent
75 to inpatient treatment creates a rebuttable
76 presumption of incapacity; authorizing a principal to
77 be admitted to, or remain in, inpatient treatment for
78 up to 14 days; requiring express consent in a
79 directive for the administration of psychotropic
80 medication; requiring conditions for administering
81 such medication; prohibiting a principal from
82 authorizing psychosurgery or electroconvulsive therapy
83 in a directive; authorizing a principal to seek
84 specified injunctive relief; creating s. 765.410,
85 F.S.; prohibiting criminal prosecution of a health
86 care facility, provider, or surrogate who acts
87 pursuant to a mental health or substance abuse

88 treatment decision; creating s. 765.411, F.S.;
89 providing for recognition of a mental health and
90 substance abuse treatment advanced directive executed
91 in another state if it complies with the laws of this
92 state; amending ss. 395.0197, 395.1051, 456.0575,
93 765.101, and 765.104, F.S.; conforming cross-
94 references; reenacting ss. 394.459(3)(b), 394.4598(6)
95 and (7), 394.4655(6)(d) and (7)(f), 394.467(6)(d),
96 394.46715, and 765.202(5), F.S., to incorporate the
97 amendment made to s. 394.4598, F.S., in references
98 thereto; providing an effective date.
99
100 Be It Enacted by the Legislature of the State of Florida:
101
102 Section 1. Subsections (1) and (5) of section 394.4598,
103 Florida Statutes, are amended to read:
104 394.4598 Guardian advocate.—
105 (1) The administrator, a family member of the patient, or
106 an interested party, may petition the court for the appointment
107 of a guardian advocate based upon the opinion of a psychiatrist
108 that the patient is incompetent to consent to treatment. If the
109 court finds that a patient is incompetent to consent to
110 treatment and has not been adjudicated incapacitated and a
111 guardian with the authority to consent to mental health
112 treatment appointed, it shall appoint a guardian advocate. The
113 patient has the right to have an attorney represent him or her
114 at the hearing. If the person is indigent, the court shall
115 appoint the office of the public defender to represent him or
116 her at the hearing. The patient has the right to testify, cross-

117 examine witnesses, and present witnesses. The proceeding shall
118 be recorded either electronically or stenographically, and
119 testimony shall be provided under oath. One of the professionals
120 authorized to give an opinion in support of a petition for
121 involuntary placement, as described in s. 394.4655 or s.
122 394.467, must testify. A guardian advocate must meet the
123 qualifications of a guardian contained in part IV of chapter
124 744, except that a professional referred to in this part, an
125 employee of the facility providing direct services to the
126 patient under this part, a departmental employee, a facility
127 administrator, or member of the Florida local advocacy council
128 shall not be appointed. A person who is appointed as a guardian
129 advocate must agree to the appointment.
130 (5) In selecting a guardian advocate, the court shall give
131 preference to a health care, mental health care, or substance
132 abuse treatment surrogate, if one has already been designated by
133 the patient. If the patient has not previously selected a health
134 care, mental health care, or substance abuse treatment
135 surrogate, except for good cause documented in the court record,
136 the selection shall be made from the following list in the order
137 of listing:
138 (a) The patient's spouse.
139 (b) An adult child of the patient.
140 (c) A parent of the patient.
141 (d) The adult next of kin of the patient.
142 (e) An adult friend of the patient.
143 (f) An adult trained and willing to serve as guardian
144 advocate for the patient.
145 Section 2. Section 397.803, Florida Statutes, is created to

146 read:
147 397.803 Substance Abuse Assistance Pilot Program.—
148 (1) PILOT PROGRAM.—
149 (a) There is created within the Department of Children and
150 Families the Substance Abuse Assistance Pilot Program in such
151 regions of the state as may be designated in the general
152 appropriations act.
153 (b) Within available funding, the department shall
154 determine a target number of participants in each pilot program
155 region.
156 (c) The pilot program is created to determine whether the
157 provision of comprehensive care through a coordinated system of
158 case management that offers a range of recovery support services
159 during and after treatment for acute episodes leads to increased
160 employment, stability in housing, and decreased involvement in
161 the criminal justice system on the part of participants.
162 (d) The pilot program shall provide a comprehensive
163 continuum of high-quality and accessible substance abuse
164 intervention, residential and outpatient treatment,
165 comprehensive case management, and recovery support services for
166 substance abuse impaired adults.
167 (e) The pilot program in each selected region shall develop
168 safe and cost efficient treatment alternatives and provide
169 comprehensive case management and continuum of care services for
170 eligible substance abuse impaired adults.
171 (f) Participation in the pilot program may be designated as
172 an alternative to criminal imprisonment for substance abuse
173 impaired adults, as appropriate.
174 (g) Each pilot program region shall submit data to the

175 department on a monthly basis that, at a minimum, reports
176 characteristics of the participants, use of services, and such
177 data as necessary to measure changes in participants' status
178 with regard to housing, employment, and criminal activity.
179 (2) ELIGIBILITY AND ENROLLMENT.—
180 (a) To be eligible for participation in the pilot program,
181 a person must:
182 1. Be 18 years of age or older with a history of chronic
183 substance abuse or addiction.
184 2. Execute a mental health or substance abuse treatment
185 directive as defined in s. 765.403. The directive must include a
186 self-binding arrangement as specified in s. 765.408. In the
187 event that an eligible participant does not have a family member
188 or other adult available to serve as a surrogate as defined in
189 s. 765.403, the entity under contract with the Statewide Public
190 Guardianship Office in that region shall be appointed to serve
191 as the surrogate.
192 3. Eligible participants shall share responsibility for the
193 costs of pilot program services according to their ability to
194 pay, based on a sliding fee scale.
195 (b) Maximum enrollment shall be determined by the
196 department, based on available funding.
197 (3) SYSTEM OF CARE; CASE MANAGEMENT; PAYMENT METHOD.—
198 (a) The department shall contract with the Medicaid managed
199 care organization or behavioral health managing entity operating
200 in the applicable geographic region to serve as program manager.
201 (b) The program manager is responsible for the following
202 functions:
203 1. Network management including recruitment and retention

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204 of an adequate number of qualified service providers to ensure
205 accessibility and quality of care;
206 2. Coordination of care, including the development and
207 implementation of organizational structures and operational
208 policies necessary to ensure that the network provides
209 continuity of care and avoids unnecessary duplication of
210 services;
211 3. Comprehensive case management, which may be provided by
212 the program manager or by a contracted service provider,
213 including direct interaction with participants and other
214 activities necessary to assess, plan, implement, and monitor the
215 needed services; and
216 4. Administrative functions for the network including, but
217 not limited to, data management, financial management, and
218 contract compliance.
219 (c) The department shall establish criteria for ensuring
220 that an adequate number of providers are included in the network
221 and for provider qualifications, which shall be specified in the
222 contract with the program manager. The pilot program shall be
223 limited to one network in the region for the duration of the
224 pilot program. The provider network shall:
225 1. Offer a comprehensive range of services for substance
226 abuse impaired or drug addicted adults.
227 2. Enter into agreements with law enforcement agencies and
228 the criminal justice system to divert nonviolent offenders with
229 histories of serious substance abuse or chronic addiction into
230 intensive treatment, comprehensive case management, and
231 rehabilitation services.
232 3. Enter into an agreement with the appropriate

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233 neighborhood housing services program to provide housing
234 assistance to eligible participants.
235 4. Enter into an agreement with the entity under contract
236 with the Statewide Public Guardianship Office in the pilot
237 program region to provide guardians to act in the capacity of
238 surrogates for eligible participants who do not have family
239 members or other adults available to perform such duties.
240 5. Enter into an agreement with the applicable nonprofit
241 local legal services organization serving the pilot program
242 region to provide legal assistance to eligible participants.
243 (4) SERVICES.—The network must be capable of providing, at
244 a minimum, the following services to substance abuse impaired or
245 drug addicted adults:
246 1. Comprehensive case management and continuum of care
247 coordination;
248 2. Outpatient treatment services;
249 3. Crisis care, including mobile response, and
250 detoxification in short-term residential facilities;
251 4. Inpatient treatment services;
252 5. Step-down residential treatment services;
253 6. Housing needs assessment and assistance;
254 7. Employment assistance programs;
255 8. Transportation needs assessment and assistance; and
256 9. Legal services.
257 (5) PAYMENT FOR SERVICES.—
258 (a) The general revenue funds appropriated by the
259 legislature for the purposes of this section shall be applied to
260 payment for services only after an eligible participant's
261 private pay or Medicaid insurance coverage has been exhausted.

262 (b) An eligible participant may share in the cost of
263 provided services based on his or her ability to pay.
264 (6) ACCOUNTABILITY; ANNUAL REPORTS.—
265 (a) By October 1 of each year, the department shall provide
266 a written report to the Governor, the President of the Senate,
267 and the Speaker of the House of Representatives which describes
268 the operation and effectiveness of the pilot program. The report
269 must include, but is not limited to, an evaluation of the impact
270 of the following components of the program:
271 1. Comprehensive case management;
272 2. Care coordination and followup care;
273 3. Housing initiatives; and
274 4. Employment assistance.
275 (b) The report must include a recommendation regarding the
276 continuation, expansion, or termination of the pilot program.
277 Section 3. Section 765.401, Florida Statutes, is
278 transferred and renumbered as section 765.311, Florida Statutes.
279 Section 4. Section 765.404, Florida Statutes, is
280 transferred and renumbered as section 765.312, Florida Statutes.
281 Section 5. The Division of Law Revision and Information is
282 directed to rename part IV of chapter 765, Florida Statutes, as
283 "Mental Health and Substance Abuse Advance Directives."
284 Section 6. Section 765.4015 is created to read:
285 765.4015 Short title.—Sections 765.402-765.411 may be cited
286 as the "Jennifer Act."
287 Section 7. Section 765.402, Florida Statutes, is created to
288 read:
289 765.402 Legislative findings.—
290 (1) The Legislature recognizes that an individual with

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291 capacity has the ability to control decisions relating to his or
292 her own mental health care or substance abuse treatment. The
293 Legislature finds that:
294 (a) Substance abuse and some mental illnesses cause
295 individuals to fluctuate between capacity and incapacity;
296 (b) During periods when an individual's capacity is
297 unclear, the individual may be unable to provide informed
298 consent necessary to access needed treatment;
299 (c) Early treatment may prevent an individual from becoming
300 so ill that involuntary treatment is necessary; and
301 (d) Individuals with substance abuse impairment or mental
302 illness need an established procedure to express their
303 instructions and preferences for treatment and provide advance
304 consent to or refusal of treatment. This procedure should be
305 less expensive and less restrictive than guardianship.
306 (2) The Legislature further recognizes that:
307 (a) A mental health or substance abuse treatment advance
308 directive must provide the individual with a full range of
309 choices.
310 (b) For a mental health or substance abuse directive to be
311 an effective tool, individuals must be able to choose how they
312 want their directives to be applied, including the right of
313 revocation, during periods of incapacity.
314 (c) There must be a clear process so that treatment
315 providers can abide by an individual's treatment choices.
316 Section 8. Section 765.403, Florida Statutes, is created to
317 read:
318 765.403 Definitions.—As used in this section, the term:
319 (1) "Adult" means any individual who has attained the age

320 of majority or is an emancipated minor.
321 (2) "Capacity" means that an adult has not been found to be
322 incapacitated pursuant to s. 394.463.
323 (3) "Health care facility" means a hospital, nursing home,
324 hospice, home health agency, or health maintenance organization
325 licensed in this state, or any facility subject to part I of
326 chapter 394.
327 (4) "Incapacity" or "incompetent" means an adult who is:
328 (a) Unable to understand the nature, character, and
329 anticipated results of proposed treatment or alternatives or the
330 recognized serious possible risks, complications, and
331 anticipated benefits of treatments and alternatives, including
332 nontreatment;
333 (b) Physically or mentally unable to communicate a willful
334 and knowing decision about mental health care or substance abuse
335 treatment;
336 (c) Unable to communicate his or her understanding or
337 treatment decisions; or
338 (d) Determined incompetent pursuant to s. 394.463.
339 (5) "Informed consent" means consent voluntarily given by a
340 person after a sufficient explanation and disclosure of the
341 subject matter involved to enable that person to have a general
342 understanding of the treatment or procedure and the medically
343 acceptable alternatives, including the substantial risks and
344 hazards inherent in the proposed treatment or procedures or
345 nontreatment, and to make knowing mental health care or
346 substance abuse treatment decisions without coercion or undue
347 influence.
348 (6) "Mental health or substance abuse treatment advance

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349 directive” means a written document in which the principal makes
350 a declaration of instructions or preferences or appoints a
351 surrogate to make decisions on behalf of the principal regarding
352 the principal’s mental health or substance abuse treatment, or
353 both.
354 (7) “Mental health professional” means a psychiatrist,
355 psychologist, psychiatric nurse, or social worker, and such
356 other mental health professionals licensed pursuant to chapter
357 458, chapter 464, chapter 490, or chapter 491.
358 (8) “Principal” means a competent adult who executes a
359 mental health or substance abuse treatment directive and on
360 whose behalf mental health care or substance abuse treatment
361 decisions are to be made.
362 (9) “Self-binding arrangement” means an affirmative
363 statement, also known as a Ulysses Arrangement, contained within
364 a mental health or substance abuse treatment directive, executed
365 voluntarily by the principal, which allows the principal to form
366 self-binding arrangements for mental health or substance abuse
367 treatment as a means of ensuring early intervention and to avoid
368 involuntary commitment. The inclusion of a self-binding
369 arrangement is limited to directives executed by participants in
370 a substance abuse assistance pilot program created pursuant to
371 s. 397.803.
372 (10) “Surrogate” means any competent adult expressly
373 designated by a principal to make mental health care or
374 substance abuse treatment decisions on behalf of the principal
375 as set forth in the principal’s mental health or substance abuse
376 treatment advance directive or self-binding arrangement as those
377 terms are defined in this section.

378
379 Section 9. Section 765.405, Florida Statutes, is created to
380 read:
381 765.405 Mental health or substance abuse treatment advance
382 directive; execution; allowable provisions.—
383 (1) An adult with capacity may execute a mental health or
384 substance abuse treatment advance directive.
385 (2) A directive executed in accordance with this section is
386 presumed to be valid. The inability to honor one or more
387 provisions of a directive does not affect the validity of the
388 remaining provisions.
389 (3) A directive may include any provision relating to
390 mental health or substance abuse treatment or the care of the
391 principal or the principal’s personal affairs. Without
392 limitation, a directive may include:
393 (a) The principal’s preferences and instructions for mental
394 health or substance abuse treatment.
395 (b) Consent to specific types of mental health or substance
396 abuse treatment.
397 (c) Refusal to consent to specific types of mental health
398 or substance abuse treatment.
399 (d) Consent to admission to and retention in a facility for
400 mental health or substance abuse treatment for up to 14 days.
401 Such consent must be an affirmative statement contained within
402 the directive and must clearly indicate whether such consent is
403 revocable by the principal during a mental health or substance
404 abuse crisis.
405 (e) Descriptions of situations that may cause the principal
406 to experience a mental health or substance abuse crisis.

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407 (f) Suggested alternative responses that may supplement or
408 be in lieu of direct mental health or substance abuse treatment,
409 such as treatment approaches from other providers.
410 (g) Appointment of a surrogate to make mental health or
411 substance abuse treatment decisions on the principal's behalf.
412 In the event the directive includes a self-binding arrangement
413 allowing the surrogate authority to consent on the principal's
414 behalf to voluntary admission to inpatient mental health or
415 substance abuse treatment, such authority must be clearly stated
416 in the directive.
417 (h) The principal's nomination of a guardian, limited
418 guardian, or guardian advocate as provided chapter 744.
419 (4) A directive may be combined with or be independent of a
420 nomination of a guardian or other durable power of attorney.
421 Section 10. Section 765.406, Florida Statutes, is created
422 to read:
423 765.406 Execution of a mental health or substance abuse
424 advanced directive; effective date; expiration.—
425 (1) A directive must:
426 (a) Be in writing.
427 (b) Contain language that clearly indicates that the
428 principal intends to create a directive.
429 (c) Contain language that clearly indicates whether the
430 principal intends for the surrogate to have the authority to
431 provide consent on the principal's behalf to voluntary admission
432 to inpatient mental health or substance abuse treatment and
433 whether the principal's consent is revocable.
434 (d) Be dated and signed by the principal or, if the
435 principal is unable to sign, at the principal's direction in the

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436 principal's presence.
437 (e) Be witnessed by two adults, each of whom must declare
438 that he or she personally knows the principal and was present
439 when the principal dated and signed the directive, and that the
440 principal did not appear to be incapacitated or acting under
441 fraud, undue influence, or duress. The person designated as the
442 surrogate may not act as a witness to the execution of the
443 document designating the mental health or substance abuse care
444 treatment surrogate. At least one person who acts as a witness
445 must be neither the principal's spouse nor his or her blood
446 relative.
447 (2) A directive is valid upon execution, but all or part of
448 the directive may take effect at a later date as designated by
449 the principal in the directive.
450 (3) A directive may:
451 (a) Be revoked, in whole or in part, pursuant to s.
452 765.407; or
453 (b) Expire under its own terms.
454 (4) A directive does not or may not:
455 (a) Create an entitlement to mental health, substance
456 abuse, or medical treatment or supersede a determination of
457 medical necessity.
458 (b) Obligate any health care provider, professional person,
459 or health care facility to pay the costs associated with the
460 treatment requested.
461 (c) Obligate a health care provider, professional person,
462 or health care facility to be responsible for the nontreatment
463 or personal care of the principal or the principal's personal
464 affairs outside the scope of services the facility normally

CODING: Words ~~stricken~~ are deletions; words underlined are additions.

465 provides.
466 (d) Replace or supersede any will or testamentary document
467 or supersede the provision of intestate succession.
468 (e) Be revoked by an incapacitated principal unless that
469 principal selected the option to permit revocation while
470 incapacitated at the time his or her directive was executed.
471 (f) Be used as the authority for inpatient admission for
472 more than 14 days.
473 Section 11. Section 765.407, Florida Statutes, is created
474 to read:
475 765.407 Revocation; waiver.—
476 (1)(a) A principal with capacity may, by written statement
477 of the principal or at the principal's direction in the
478 principal's presence, revoke a directive in whole or in part.
479 (b) An incapacitated principal may revoke a directive only
480 if he or she elected at the time of executing the directive to
481 be able to revoke when incapacitated.
482 (2) The principal shall provide a copy of his or her
483 written statement of revocation to his or her agent, if any, and
484 to each health care provider, professional person, or health
485 care facility that received a copy of the directive from the
486 principal.
487 (3) The written statement of revocation is effective as to
488 a health care provider, professional person, or health care
489 facility upon receipt. The professional person, health care
490 provider, or health care facility, or persons acting under their
491 direction, shall make the statement of revocation part of the
492 principal's medical record.
493 (4) A directive also may:

494 (a) Be revoked, in whole or in part, expressly or to the
495 extent of any inconsistency, by a subsequent directive; or
496 (b) Be superseded or revoked by a court order, including
497 any order entered in a criminal matter. A directive may be
498 superseded by a court order regardless of whether the order
499 contains an explicit reference to the directive. A directive may
500 not be interpreted in a manner that interferes with:
501 1. Incarceration or detention by the Department of
502 Corrections or in a municipal or county jail; or
503 2. Treatment of a principal who is a subject to involuntary
504 treatment pursuant to chapter 394.
505 (5) A directive that would have otherwise expired but is
506 effective because the principal is incapacitated remains
507 effective until the principal is no longer incapacitated unless
508 the principal elected to be able to revoke while incapacitated
509 and has revoked the directive.
510 (6) When a principal with capacity consents to treatment
511 that differs from, or refuses treatment consented to in, his or
512 her directive, the consent or refusal constitutes a waiver of a
513 particular provision and does not constitute a revocation of the
514 provision or the directive unless that principal also revokes
515 the provision or directive.
516 Section 12. Section 765.408, Florida Statutes, is created
517 to read:
518 765.408 Self-binding arrangements.—
519 (1) The Legislature finds that each competent adult has the
520 fundamental right of self-determination regarding decisions
521 pertaining to his or her own mental health care or substance
522 abuse treatment decisions.

523 (2) The Legislature further finds that the facilitation of
524 advance planning helps:
525 (a) Prevent unnecessary involuntary commitment and
526 incarceration;
527 (b) Improve patient safety and health; and
528 (c) Improve care and enable patients to exercise control
529 over their treatment.
530 (3) To ensure such right is not lost or diminished, the
531 Legislature intends that a procedure be established to allow a
532 person to plan for episodes that compromise his or her ability
533 to recognize his or her need for treatment before meeting
534 involuntary commitment criteria. The principal must include a
535 specific provision in his or her mental health and substance
536 abuse advance directive authorizing the surrogate to direct the
537 course of his or her mental health or substance abuse treatment.
538 (4) A principal has a right to form a self-binding
539 arrangement for care, which allows the principal to obtain
540 treatment in the event that an acute episode renders him or her
541 unable to provide consent to or induces the principal to refuse
542 treatment. Such arrangement must be affirmatively stated in the
543 directive and include whether the principal has the right of
544 revocation during an acute episode.
545 (5) To create an arrangement under this section, the
546 principal must obtain a written, signed attestation of capacity
547 from a health care professional, mental health care provider, or
548 health care facility.
549 (6) A self-binding arrangement must:
550 (a) Be in writing.
551 (b) Be dated and signed by the principal or the principal’s

552 designated representative if the principal is unable to sign.
553 (c) State whether the principal wishes to be able to revoke
554 the directive at any time or whether directive remains
555 irrevocable when the principal is unable to consent to treatment
556 or is incapacitated. Failure to clarify whether the directive is
557 revocable does not render it unenforceable. If the directive
558 fails to state whether it is revocable, the principal may revoke
559 it at any time.
560 (d) Contain a clear affirmation that the principal is aware
561 of the nature of the document signed and that the directive was
562 signed freely and voluntarily.
563 (e) Be witnessed by at least two adults. A witness may not
564 be:
565 1. A member of the principal’s treatment team;
566 2. Related to the principal by blood, adoption, or
567 marriage;
568 3. Be in a romantic or dating relationship with the
569 principal;
570 4. The surrogate named by the principal in the signed
571 directive; or
572 5. The owner, operator, or employee of, or a relative of
573 the owner or operator of, a treatment facility in which the
574 principal is a patient.
575 (f) Be witnessed by persons who attest that:
576 1. They were present when the principal signed the
577 directive;
578 2. The principal did not appear incapacitated or under
579 undue influence or duress when the principal signed the
580 directive; and

581 3. The principal presented identification or the witness
582 personally knows the principal.
583 (g) If it contains a provision that the directive is
584 irrevocable, contain a written, signed attestation from a mental
585 health professional that the principal had capacity at the time
586 the directive was executed. If the principal is free to revoke
587 the directive at any time, such attestation is not required.
588 (h) Be valid upon execution.
589 (i) Contain a designated activation standard other than the
590 principal's inability to provide consent or incapacity by
591 describing the circumstances under which the directive becomes
592 active.
593 (j) Affirmatively state that despite activation, a
594 directive does not prevail over contemporaneous preferences
595 expressed by a principal who has the ability to consent to
596 treatment or capacity and has not included a self-binding
597 arrangement provision in the directive.
598 (k) Appoint a surrogate to make all health care and
599 substance abuse treatment decisions for the principal, including
600 decisions to consent on behalf of the principal to inpatient
601 mental health or substance abuse treatment.
602 (l) Contain a provision that decisions made by a surrogate
603 for a principal's mental health care or substance abuse
604 treatment are effective without judicial approval.
605 Section 13. Section 765.409, Florida Statutes, is created
606 to read:
607 765.409 Admission to inpatient treatment; effect of
608 directive.—
609 (1) A principal may be admitted for inpatient mental health

610 or substance abuse treatment only if he or she:
611 (a) Chose not to be able to revoke his or her directive
612 during any period of inability to provide consent or incapacity;
613 (b) Consented to voluntary admission to inpatient mental
614 health or substance abuse treatment, or authorized a surrogate
615 to consent on the principal's behalf;
616 (c) At the time of admission to inpatient treatment,
617 refuses to be admitted; and
618 (d) The principal created an irrevocable directive that
619 consents to treatment and which the principal is refusing under
620 the influence of a mental health or substance abuse crisis.
621 (2) The creation of an irrevocable directive of consent to
622 inpatient treatment creates a rebuttable presumption of
623 incapacity.
624 (3)(a) The principal may only be admitted to, or remain in,
625 inpatient treatment for a period of up to 14 days.
626 (b) The principal's directive must contain express consent
627 to the administration of psychotropic medication in
628 contravention of illness-induced objections. Such medication may
629 be administered by licensed psychiatrists and only if two
630 psychiatrists recommend, in writing, the specific medication.
631 (c) The principal is prohibited from authorizing
632 psychosurgery or electroconvulsive therapy in his or her
633 directive.
634 (d) The principal may seek injunctive relief for release
635 from the inpatient facility.
636 Section 14. Section 765.410, Florida Statutes, is created
637 to read:
638 765.410 Immunity from liability; weight of proof;

639 presumption.—
640 (1) A health care facility, provider, or other person who
641 acts under the direction of a health care facility or provider
642 is not subject to criminal prosecution or civil liability, and
643 may not be deemed to have engaged in unprofessional conduct, as
644 a result of carrying out a mental health care or substance abuse
645 treatment decision made in accordance with this section. The
646 surrogate who makes a mental health care or substance abuse
647 treatment decision on a principal's behalf, pursuant to this
648 section, is not subject to criminal prosecution or civil
649 liability for such action.
650 (2) This section applies unless it is shown by a
651 preponderance of the evidence that the person authorizing or
652 effectuating a mental health or substance abuse treatment
653 decision did not, in good faith, comply with this section.
654 Section 15. Section 765.411, Florida Statutes, is created
655 to read:
656 765.411 Recognition of mental health and substance abuse
657 treatment advance directive executed in another state.—A mental
658 health or substance abuse treatment advance directive executed
659 in another state in compliance with the law of that state is
660 validly executed for the purposes of this chapter.
661 Section 16. Paragraph (d) of subsection (1) of section
662 395.0197, Florida Statutes, is amended to read:
663 395.0197 Internal risk management program.—
664 (1) Every licensed facility shall, as a part of its
665 administrative functions, establish an internal risk management
666 program that includes all of the following components:
667 (d) A system for informing a patient or an individual

668 identified pursuant to s. 765.311(1) ~~765.401(1)~~ that the patient
669 was the subject of an adverse incident, as defined in subsection
670 (5). Such notice shall be given by an appropriately trained
671 person designated by the licensed facility as soon as
672 practicable to allow the patient an opportunity to minimize
673 damage or injury.
674 Section 17. Section 395.1051, Florida Statutes, is amended
675 to read:
676 395.1051 Duty to notify patients.—An appropriately trained
677 person designated by each licensed facility shall inform each
678 patient, or an individual identified pursuant to s. 765.311(1)
679 ~~765.401(1)~~, in person about adverse incidents that result in
680 serious harm to the patient. Notification of outcomes of care
681 that result in harm to the patient under this section shall not
682 constitute an acknowledgment or admission of liability, nor can
683 it be introduced as evidence.
684 Section 18. Section 456.0575, Florida Statutes, is amended
685 to read:
686 456.0575 Duty to notify patients.—Every licensed health
687 care practitioner shall inform each patient, or an individual
688 identified pursuant to s. 765.311(1) ~~765.401(1)~~, in person about
689 adverse incidents that result in serious harm to the patient.
690 Notification of outcomes of care that result in harm to the
691 patient under this section shall not constitute an
692 acknowledgment of admission of liability, nor can such
693 notifications be introduced as evidence.
694 Section 19. Subsection (15) of section 765.101, Florida
695 Statutes, is amended to read:
696 765.101 Definitions.—As used in this chapter:

697 (15) “Proxy” means a competent adult who has not been
698 expressly designated to make health care decisions for a
699 particular incapacitated individual, but who, nevertheless, is
700 authorized pursuant to s. 765.311 ~~765.401~~ to make health care
701 decisions for such individual.
702 Section 20. Subsection (4) of section 765.104, Florida
703 Statutes, is amended to read:
704 765.104 Amendment or revocation.—
705 (4) Any patient for whom a medical proxy has been
706 recognized under s. 765.311 ~~765.401~~ and for whom any previous
707 legal disability that precluded the patient’s ability to consent
708 is removed may amend or revoke the recognition of the medical
709 proxy and any uncompleted decision made by that proxy. The
710 amendment or revocation takes effect when it is communicated to
711 the proxy, the health care provider, or the health care facility
712 in writing or, if communicated orally, in the presence of a
713 third person.
714 Section 21. Paragraph (b) of subsection (3) of s. 394.459,
715 subsections (6) and (7) of s. 394.4598, paragraph (d) of
716 subsection (6) and paragraph (f) of subsection (7) of s.
717 394.4655, paragraph (d) of subsection (6) of s. 394.467, s.
718 394.46715, and subsection (5) of s. 765.202, Florida Statutes,
719 are reenacted for the purpose of incorporating the amendments
720 made to s. 394.4598, Florida Statutes.
721 Section 22. This act shall take effect July 1, 2015.

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The Florida Senate

BILL ANALYSIS AND FISCAL IMPACT STATEMENT

(This document is based on the provisions contained in the legislation as of the latest date listed below.)

Prepared By: The Professional Staff of the Committee on Children, Families, and Elder Affairs

BILL: SPB 7048

INTRODUCER: For consideration by the Children, Families, and Elder Affairs Committee

SUBJECT: Developmental Disabilities

DATE: March 9, 2015 REVISED:

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Hendon	Hendon		**Pre-meeting**

I. Summary:

SPB 7048 clarifies when the Agency for Persons with Disabilities will provide services to children with disabilities in foster care. The agency administers the Home and Community Based Services Medicaid waiver to provide services beyond those available under the traditional Medicaid program. The bill revises section 393.065, F.S., which establishes categories of priority groups to be added to the waiver. The waiver program currently has a waiting list and this bill clarifies the priority category 2 relating to children in foster care. The Agency for Persons with Disabilities will provide disability specific services to children in extended foster care, ages 18 to 21. The community-based care agencies, under contract with the Department of Children and Families, will continue to provide room and board to children with disabilities in extended foster care.

The bill would have an estimated fiscal impact of approximately $3 million on the Agency for Persons with Disabilities. Costs for the community-based care agencies would be reduced. The bill is effective July 1, 2015.

II. Present Situation:

Children in Foster Care

A child can be placed in foster care by the state as a result of child abuse or neglect by a parent or other caregiver. Suspected child abuse is reported to the Florida Abuse Hotline under the Department of Children and Families. Calls accepted as a report are sent out to child protective investigators across the state to investigate. If the department verifies that the caregiver abused the child, he or she may be removed and placed in foster care. During this time, the department, through its contracted community-based care agencies, attempts to reunify the child with the parents or relatives. When this is not possible, the department moves to terminate parental rights and find adoptive parents for the child.

The removal of the child from the home, the placement of the child, the termination of parental rights, and the adoption of children in the foster care system are all overseen by the state's circuit

courts. Court hearings are required for these actions and attorneys to represent the state are employed by department, the Attorney General's Office, and in one case, a state attorney office. Indigent parents are represented at state expense through the offices of the Regional Conflict Counsel.

There are currently 20,302 children in the child welfare system.[1] This is the number of children who have been removed from their home and placed with relatives, foster families, or group home care. An additional 12,281 children are receiving in-home services. The community-based care agencies and their subcontractors are the primary providers of services to children and families in the child welfare system. There are 17 community-based care agencies with contracts covering all 20 judicial circuits. The agencies and their subcontractors employ case managers and supervisors to oversee the provision of services to children in the child welfare system.

The community-based care agencies provide or contract for placements for children in foster care. This includes shelters, for children recently removed from home, placement in a foster home or group home. Services include, but are not limited to: emergency shelter, family preservation services, foster care, room and board, foster care supervision, case management, coordination of mental health services, therapeutic foster care, residential group care, intensive residential treatment, independent living skills, postplacement supervision, permanent foster care, family reunification, or adoption services.

Medical care for children in foster care is provided through the Medicaid program. All children in care are eligible for Medicaid, including behavioral health services such as mental health and substance abuse. The state provides these services through managed care plans. Florida's Medicaid program offers a specialty plan, Sunshine Health, focusing on children in foster care. Children can also be served through a regular managed care plan.

Due to a lack of reliable data in the child welfare data system (Florida Safe Families Network), an accurate number of children in foster care who have a developmentally disability is unknown. Children in foster care with disabilities receive services to meet their needs through both the public school system and the community-based care agencies.

In 2013, the Legislature extended the age children in foster care who are not reunified with their family or adopted can stay in care until the age of 21.[2] Prior to this change, children who "aged out" of foster care without being reunified with their family or adopted, at age 18. Those with disabilities could stay until their 19th birthday. After exiting foster care, many young adults with disabilities were served by the Agency for Persons with Disabilities. Now, the children who stay in extended foster care with disabilities are served by the community-based care agencies until they reach their 22nd birthday.

Public School Services for Children with Developmental Disabilities

Federal law requires states to make a free appropriate public education available to all children with disabilities residing in the state between the ages of 3 and 21, inclusive, including children

[1] Communication from the Department of Children and Families (March 9, 2015).
[2] Section 39.6251, F.S., created by Chapter 2013-178, Laws of Florida

with disabilities who have been suspended or expelled from school.[3] As the state educational agency, the Department of Education must exercise general supervision over all educational programs for children with disabilities in the state, including all programs administered by other state or local agencies, and ensure that the programs meet the educational standards of the state educational agency.[4]

For each eligible student or child with a disability served by a school district, or other state agency that provides special education and related services either directly, by contract, or through other arrangements, an individual educational plan (IEP) or individual family support plan must be developed, reviewed, and revised.[5] In developing an IEP, the IEP team is required to consider a child's strengths, concerns of the parents for enhancing education, results of the initial evaluation or most recent evaluation of the child, and the academic, developmental, and functional needs of the child, as well as special factors.[6]

Agency for Persons with Disabilities

In October 2004, the Agency for Persons with Disabilities became an agency separate from the Department of Children and Families, specifically tasked with serving the needs of Floridians with developmental disabilities. The agency works in partnership with local communities and private providers to assist people who have developmental disabilities and their families. The agency also provides assistance in identifying the needs of people with developmental disabilities for supports and services. The agency serves more than 50,000 Floridians with the following disabilities:[7]

- Autism
- Cerebral palsy
- Spina bifida
- Intellectual disabilities
- Down syndrome
- Prader-Willi syndrome
- Children age 3-5 who are at a high risk of a developmental disability

The total budget for the Agency for Persons with Disabilities for fiscal year 2014-2015 is $1,153.5 million. The largest program operated by the agency is the Medicaid Home and Community Based Services Waiver. This program is currently funded at $908.6 million.[8] State funds make up $379.6 million of the waiver program funding and these funds are matched by the federal government. The current federal match rate is 59.56 percent.[9] The purpose of the waiver is to allow the state to provide services outside of the Medicaid State Plan to enable persons with developmental disabilities to remain in the community and not be served in an institution. One of the more critical waiver services that is not available under the traditional Medicaid program is residential habilitation. Residential habilitation services include supervision and training of the

[3] 20 U.S.C. s.1400 et. seq., *as amended by* P.L. 108-446; 34 C.F.R. s. 300.17.
[4] 34 C.F.R. s. 300.149.
[5] Rule 6A-6.03028(3), F.A.C.
[6] 20 U.S.C. s.1414(d)(3)(A) and (B).
[7] Florida Agency for Persons with Disabilities website, http://apd.myflorida.com/about/, (last visited March 9, 2015).
[8] Specific Appropriation 268, HB 5001, 2014-2015 General Appropriations Act.
[9] February 15, 2015 Social Services Estimating Conference, Office of Economic and Demographic Research.

person with the disability in performing activities of daily living, such as bathing, dressing, and food preparation. Acquiring these daily living skills can allow the person to remain in the community rather than living in an institution, such as an Intermediate Care Facility.

The Medicaid Home and Community Based Services Waiver has experienced deficits for the last several years and the Legislature has had to make supplemental appropriations and restrict the criteria for placement on the waiver to control costs. Section 393.065, F.S., specifies categories of persons in priority order to be added to the Home and Community Based Services Waiver. Category 2 is children in the child welfare system. Within that group, only those that need services to achieve permanency through adoption, reunification, or permanent placement with a guardian are currently being added to the Home and Community Based Services Waiver.[10]

While the goal is to help persons with developmental disabilities remain in the community, some must be served in an Intermediate Care Facility funded through the Agency for Health Care Administration. The current funding for developmental disabilities served in such facilities is $245.7 million.[11]

III. Effect of Proposed Changes:

Under the bill, the community-based care agencies and the public schools system will continue to care for children with disabilities from birth to age 18. The Agency for Persons with Disabilities will continue to provide waiver services to children in care that need specialized services to achieve permanency.

Section 1 of the bill amends s. 393.065, F.S., to clarify category 2 for the waiver waitlist. For children in care age 18 to 21, the Agency for Persons with Disabilities will serve them on the Home and Community Based Services waiver for disability specific services such as residential rehabilitation, while they are in extended foster care. Community-based care agencies will continue to be responsible for provide room and board.

Under current law, children in care with disabilities can stay in care an extra year to plan for their transition.[12] Such children will be in category 2 for the waiver until they reach their 22nd birthday.

Section 2 of the bill provides an effective date of July 1, 2015.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

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[10] Communication with the Director of the Agency for Persons with Disabilities, Feb. 27, 2015.
[11] Specific Appropriation 240, HB 5001, 2014-2015 General Appropriations Act.
[12] Section 39.6251 (5) (a), F.S.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

Community-based care agencies will receive additional assistance from the Agency for Persons with Disabilities in serving children in extended foster care who have developmental disabilities. This will reduce the costs to the private, community-based care agencies by an amount similar to the increase in costs to the Agency for Persons with Disabilities.

C. Government Sector Impact:

The bill could increase the demand for services under the Home and Community Based Services Medicaid waiver operated by the Agency for Persons with Disabilities. The waiver is funded in the current year at $908.6 million. The number of young adults that would be served under the bill is estimated to be 62 by the Agency for Persons with Disabilities for fiscal year 2015-2016. If that estimate is accurate, the added cost to serve these young adults would be $3.1 million, with state funds accounting for $1.2 million.[13] The impact of the cost of providing these services would depend on the demand for waiver services by other groups and the amount of funding for the waiver in fiscal year 2015-2016.

Fiscal Impact	Fiscal Year 2015-16		
Agency for Persons with Disabilities	GR	Trust	Total
Total	$1,211,672	$1,856,628	$3,068,300

VI. Technical Deficiencies:

None.

VII. Related Issues:

None.

[13] The federal Medicaid match rate for fiscal year 2015-2016 is estimated to be 60.51% according to the Feb. 15, 2015 Social Services Estimating Conference, Office of Economic and Demographic Research.

VIII. Statutes Affected:

This bill substantially amends section 393.065 of the Florida Statutes.

IX. Additional Information:

A. Committee Substitute – Statement of Changes:

(Summarizing differences between the Committee Substitute and the prior version of the bill.)

None.

B. Amendments:

None.

This Senate Bill Analysis does not reflect the intent or official position of the bill's introducer or the Florida Senate.

FOR CONSIDERATION By the Committee on Children, Families, and Elder Affairs

586-01964A-15 20157048pb

A bill to be entitled

An act relating to developmental disabilities; amending s. 393.065, F.S.; requiring the Agency for Persons with Disabilities to revise the priority order for the waiver services for specified children which are otherwise not available to them; establishing requirements for children and certain young adults with a category 2 priority; removing an obsolete provision; providing an effective date.

Be It Enacted by the Legislature of the State of Florida:

Section 1. Subsection (5) of section 393.065, Florida Statutes, is amended to read:

393.065 Application and eligibility determination.—

(5) Except as otherwise directed by law, ~~beginning July 1, 2010,~~ the agency shall assign and provide priority to clients waiting for waiver services in the following order:

(a) Category 1, which includes clients deemed to be in crisis as described in rule.

(b) Category 2, which includes children on the wait list who are from the child welfare system. The agency shall provide to children in category 2 waiver services that are not otherwise available to them through the child welfare system's related services as defined in s. 409.986 or the state Medicaid plan. In addition, the agency shall provide residential habilitation services, such as supervision and training to assist the individual improve skills related to activities of daily living, to young adults in the child welfare system ages 18 to 21.

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586-01964A-15 20157048pb

Children in category 2 must be those with an open case in the Department of Children and Families' statewide automated child welfare information system and who are:

1. Transitioning out of the child welfare system at the finalization of an adoption, a reunification with family members, a permanent placement with a relative, or a guardianship with a nonrelative; or

2. Determined to be 18 to 21 years of age.

(c) Category 3, which includes, but is not required to be limited to, clients:

1. Whose caregiver has a documented condition that is expected to render the caregiver unable to provide care within the next 12 months and for whom a caregiver is required but no alternate caregiver is available;

2. At substantial risk of incarceration or court commitment without supports;

3. Whose documented behaviors or physical needs place them or their caregiver at risk of serious harm and other supports are not currently available to alleviate the situation; or

4. Who are identified as ready for discharge within the next year from a state mental health hospital or skilled nursing facility and who require a caregiver but for whom no caregiver is available.

(d) Category 4, which includes, but is not required to be limited to, clients whose caregivers are 70 years of age or older and for whom a caregiver is required but no alternate caregiver is available.

(e) Category 5, which includes, but is not required to be limited to, clients who are expected to graduate within the next

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59 12 months from secondary school and need support to obtain or
60 maintain competitive employment, or to pursue an accredited
61 program of postsecondary education to which they have been
62 accepted.
63 (f) Category 6, which includes clients 21 years of age or
64 older who do not meet the criteria for category 1, category 2,
65 category 3, category 4, or category 5.
66 (g) Category 7, which includes clients younger than 21
67 years of age who do not meet the criteria for category 1,
68 category 2, category 3, or category 4.
69
70 Within categories 3, 4, 5, 6, and 7, the agency shall maintain a
71 wait list of clients placed in the order of the date that the
72 client is determined eligible for waiver services.
73 Section 2. This act shall take effect July 1, 2015.

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