Guidance 16
Florida Assertive Community Treatment (FACT)

Contract Reference: A.1.1.2, C.1.2.6.12

I. Level Of Care Description

The Florida Assertive Community Treatment (FACT) Team model builds upon the evidence-based Assertive Community Treatment model to deliver comprehensive, community-based behavioral health services to individuals diagnosed with serious mental illness. FACT Teams deliver a coordinated range of treatments and interventions through a transdisciplinary approach. Services are available 24 hours a day, seven days per week (24/7), and are delivered in settings where individuals live, work, attend school, or spend their leisure time.

II. Eligibility

FACT Teams serve individuals aged 18 and older diagnosed with one of the following, as referenced in *The Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, Text Revision (DSM-5-TR)* or latest edition:

- Schizophrenia Spectrum and Other Psychotic Disorders,
- Bipolar and Related Disorders,
- Depressive Disorders,
- Anxiety Disorders,
- Obsessive-Compulsive and Related Disorders,
- Dissociative Disorders,
- Somatic Symptom and Related Disorders, and
- Personality Disorders.

The individual must meet at least one of the following seven clinical criteria:

- More than three crisis stabilization unit or psychiatric inpatient admissions within one year,
- History of psychiatric inpatient stays of more than 90 days within one year,

- History of more than three (3) episodes of criminal justice involvement within one year,
- Referred by one of the state's correctional institutions for services upon release,
- Referred from an inpatient detoxification unit with a documented history of co-occurring disorders,
- Referred for services by one of Florida's mental health treatment facilities, or
- High risk for hospital admission or readmission.

The individual must meet at least three of the following six clinical characteristics:

- Inability to consistently perform the range of practical daily living tasks required for basic adult interactional roles in the community without significant assistance from others. Examples of these tasks include:
    - Maintaining personal hygiene
    - Meeting nutritional needs
    - Caring for personal business affairs
    - Obtaining medical, legal, and housing services
    - Recognizing and avoiding common dangers or hazards to self and possessions
- Inability to maintain employment at a self-sustaining level or inability to consistently carry out the homemaker role (e.g., household meal preparation, washing clothes, budgeting, or child-care tasks and responsibilities),
- Inability to maintain a stable living situation (repeated evictions, loss of housing, or no housing).
- Co-occurring substance use disorder of significant duration (greater than six months) or co-occurring mild intellectual disability.
- Destructive behavior to self or others.
- High risk of, or recent history of, criminal justice involvement (arrest and incarceration).

If the above admission requirements are met, substance use disorders and mild intellectual disabilities, as defined in the *DSM-5-TR*® or the latest edition, cannot be used as a basis to deny admission. Individuals served may also have co-occurring substance use disorder.

If an enrollee is eligible for FACT services through Florida Medicaid, FACT providers must seek reimbursement for services from Florida Medicaid with the exception enhancement funds. Individuals will continue membership with their Medicaid Managed Medical Assistance (MMA) Program or Long-term Care (LTC) Program for the provision of medical services. FACT is responsible for coordinating behavioral health services and coordinating care with an individual's MMA or LTC Program. FACT providers shall not be required to maintain a prescribed ratio of Medicaid-eligible to non-Medicaid-eligible enrollees. The composition of enrollees served shall be determined by enrollee eligibility, referral patterns, and actual enrollment.

Target Population

Subject to available capacity, the FACT Team must prioritize the enrollment of individuals who are being directly discharged from a state mental health treatment facility (SMHTF) or behavioral health teaching hospital (BHTH). The FACT Team shall manage admissions to ensure that available service capacity is first directed to this priority population whenever eligible referrals are received.

III. Service Description

FACT Teams are implemented by community behavioral health providers that work collaboratively with eligible individuals and their families to understand cultural backgrounds, beliefs, and values; and to identify strengths as well

as needs. Through this collaborative process, treatment goals are developed and adjusted as needed, and the individual and FACT Team jointly identify non-clinical supports necessary for recovery.

FACT Teams are recovery-oriented, strengths-based, and person-centered. They provide a comprehensive array of services, including behavioral health therapy; assistance with securing and maintaining safe and stable housing; support with education or competitive employment; education regarding mental health conditions and treatment options; assistance with overall health care needs; recovery support for co-occurring substance use disorders; development of practical life skills; medication oversight and support; and active collaboration with individuals' families and other natural supports.

Key program characteristics include:

- Serving as primary provider of services and a fixed point of accountability;
- Delivery of services primarily in community-based settings rather than in an office;
- Flexible, highly individualized service delivery;
- An assertive, "can do" approach to engaging participants; and
- Continuous service provision throughout the individual's participation in the program.

FACT Teams emphasize recovery, choice, outreach, and relationship building, and deliver services tailored to individual's needs. Enhancement funds may be available to assist with housing, medication, and other needs identified through the recovery planning process. The number and frequency of contacts are determined collaboratively rather than by service limits, with service intensity varying based on need - from a minimum of once weekly to multiple contacts per day. This flexibility enables teams to quickly increase service intensity when early signs of decompensation are identified, helping to prevent crises. Teams must provide a minimum of 75% of services and supports in the community, including locations such as the participant's home, public settings, or other locations chosen by the participant.

The FACT Team supports participants in achieving recovery goals and progressing toward less intensive community-based services. The team conducts ongoing assessments of service needs and applies explicit criteria to guide transitions to lower levels of care. Transitions are gradual, individualized, and active collaboration among the participant, the FACT Team, and the receiving provider to ensure continuity and engagement.

FACT services are delivered based on continuous need rather than predetermined lengths of stay. While there are no fixed timeframes, services are designed to promote increasing independence and are not intended to be lifelong. The team-based approach and absence of service limits distinguish FACT as a unique and intensive service model.

Program Goals

The FACT program goals are to:

- Implement services with fidelity to the Assertive Community Treatment (ACT) model;
- Promote and integrate recovery-oriented principles throughout service delivery;
- Treat and reduce the debilitating symptoms of serious mental illness and co-occurring substance use disorders;
- Address basic needs and enhance overall quality of life;
- Improve socialization and support the development of natural supports;
- Assist participants in obtaining and maintaining competitive employment or other vocational goals;
- Reduce hospitalization and increase days spent in the community;
- Collaborate with the criminal justice system to minimize or divert from incarceration;
- Strengthening parenting skills for participants with children; and
- Reduce reliance on family members and significant others as primary caregivers by incorporating formal support services in treatment.

Staffing Requirements

FACT Team staffing configuration integrates practitioners with diverse educational backgrounds, training, and professional experience. This range of skills and expertise enhances the team's ability to deliver comprehensive, individualized care that meets the unique needs of each participant.

Hours of operation and staff coverage must be sufficient to provide services seven (7) days per week, including overlapping shifts, with a minimum of twelve (12) hours per day on weekdays and eight (8) hours per day on weekends and holidays. The FACT Team must also operate an after-hours on-call system, ensuring that a FACT Team professional is available at all times.

The participant-to-direct service staff ratio[1] must not exceed 10:1. Within these staffing ratio guidelines, teams may exercise a degree of flexibility in team composition to best meet the needs of the participants and the requirements of the program. However, a FACT Team must minimally include:

	Small Team (50 individuals[2])	**Large Team** (100 individuals[3])
Team Leader	**1.0 FTE** Team Leader	**1.0 FTE** Team Leader
Psychiatrist or Psychiatric APRN (0.32 hours of psychiatric services must be available for each FACT recipient per week)	At least 16 hours each week for 50 FACT participants	At least 32 hours each week for 100 FACT participants
Nursing Staff	At least **1.0 FTE** Nurse who must be a Registered Nurse (RN). Any additional nursing staff may be a licensed practical nurse (LPN)	At least **2.0 FTE** Nurses At least one FTE must be an RN and any additional nursing staff may be an LPN
Peer Specialist	At least **1.0 FTE** Peer Specialist	At least **1.0 FTE** Peer Specialist
Co-Occurring Disorders Specialist (aka Substance Abuse Specialist)	At least **1.0 FTE** Co-Occurring Disorder Specialist	At least **1.0 FTE** Co-Occurring Disorder Specialist
Vocational Specialist	At least **1.0 FTE** Vocational Specialist	At least **1.0 FTE** Vocational Specialist
Case Manager		At least **1.0 FTE** Case Manager
Administrative Assistant	**1.0 FTE** Administrative Assistant	**1.0 FTE** Administrative Assistant
Total FACT Team Composition	**5.0 FTE** Direct Service Staff	**7.0 FTE** Direct Service Staff

[1] Direct service staff does not include part-time psychiatric care provider or administrative staff.

[2] Admissions to and discharges from the team may temporarily result in caseloads exceeding the established maximum. Therefore, teams are expected to maintain an annual average caseload not exceeding 60 individuals, unless otherwise approved by the Department of Children and Families.

[3] Admissions to and discharges from the team may temporarily result in caseloads exceeding the established maximum. Therefore, teams are expected to maintain an annual average caseload not exceeding 120 individuals, unless otherwise approved by the Department of Children and Families.

	Small Team (50 individuals[2])	**Large Team** (100 individuals[3])
	+ 1.0 FTE Admin Assistant **+** Psychiatric Care Provider	**+ 1.0 FTE** Admin Assistant **+** Psychiatric Care Provider
		+3.0 FTE Additional Direct Service Staff to Achieve a 10:1 Ratio

Staffing Roles and Credentials

The provider must maintain a current organizational chart that identifies all required staff and clearly depicts organizational relationships and responsibilities, including lines of administrative oversight and clinical supervision.

Team Leader

The Team Leader must be a full-time employee with full clinical, administrative, and supervisory responsibility for the team and no responsibilities to other programs during the 40-hour workweek. The Team Leader must hold a Florida license in one of the following professions:

- Licensed Clinical Social Worker, Marriage and Family Therapist, or Mental Health Counselor licensed in accordance with Chapter 491, F.S.
- Psychiatrist licensed in accordance with Chapter 458, F.S.
- Psychologist licensed in accordance with Chapter 490, F.S.

The Team Leader is a practicing clinician who provides FACT services and clinical supervision at least 50 percent of the time. The Team Leader is responsible for the administrative, clinical, and quality oversight of the team and is preferably certified as a clinical supervisor. The Team Leader receives clinical supervision from the Psychiatrist or Psychiatric APRN and administrative supervision from the Chief Executive Officer or designee.

In support of overall FACT Team operations, the Team Leader is responsible for assigning a lead mental health professional and a lead registered nurse. The lead mental health professional assists with supervision of comprehensive assessments, treatment planning, and service delivery. The lead registered nurse oversees medication management, pharmacy coordination, and other medical service activities.

Psychiatrist or Psychiatric APRN

The Psychiatrist or Psychiatric APRN provides clinical consultation to the entire FACT team and delivers psychopharmacological services for all participants. Responsibilities also include monitoring non-psychiatric medical conditions and medications, providing brief therapeutic interventions, and delivering diagnostic and medication education to participants using a shared decision-making approach. When participants are hospitalized, the Psychiatrist or Psychiatric APRN communicates directly with the inpatient psychiatric providers to ensure continuity of care. As needed, they also conduct home and community-based visits with participants.

The Psychiatrist must be board certified or board-eligible through the American Board of Psychiatry and Neurology (ABPN) and licensed in accordance with Chapter 458, F.S. If the team employs a Psychiatric APRN, they must be licensed in accordance with Chapter 464, F.S., and they must have access to a board-certified or board-eligible Psychiatrist for weekly consultation. A minimum of 0.32 hours of psychiatric services per participant per week must be available (e.g., 32 hours for 100 FACT participants or 16 hours for 50 FACT participants).

Nursing Staff

The FACT Team must have a minimum of one full-time registered nurse (RN), with preference given to nurses who hold a Psychiatric-Mental Health Nursing Certification (PMH-BC). Additional nursing staff may include either an RN or a licensed practical nurse (LPN), licensed in accordance with Chapter 464, F.S.

Nursing staff may perform the following critical roles:

- Manage the medication system;
- Administer and document medication treatment;
- Screen and monitor participants for medical conditions and medication side effects;
- Communicate and coordinate care with other medical providers;
- Engage in health promotion, prevention, and education activities, including assessing risky behaviors and supporting behavior change related to physical health;
- Educate team members on monitoring psychiatric symptoms and medication side effects; and
- With participant consent, develop strategies to support medication adherence, such as behavioral tailoring and the use of individualized cues and reminders.

Peer Specialist

There must be at least one full-time Peer Specialist. The Peer Specialist shall have lived experience with receiving mental health services for serious mental illness, providing expertise that cannot be replicated through professional training.

The Peer Specialist provides integrated services that may include:

- Facilitating wellness management and recovery-oriented strategies;
- Modeling recovery-based skills and self-advocacy for participants;
- Providing coaching and consultation to promote self-direction and sustained recovery in both individual and group settings.

Peer Specialists participate in all team activities (e.g., treatment planning and documentation) and contribute essential lived-experience expertise to the team. They help foster a culture in which each member's perspectives, preferences, and lived experiences are recognized, respected, and integrated into care. Peer Specialists must be certified in accordance with Chapter 397, F.S., either at the time of employment, or within one year of employment.

Co-Occurring Disorders Specialist (aka Substance Abuse Specialist)

There must be at least one full-time Co-Occurring Disorders Specialist with a bachelor's or master's degree in psychology, social work, counseling, or other behavioral science; and a minimum of two years of experience working with individuals with co-occurring disorders. Bachelor's level Substance Abuse Specialists must be certified as a Certified Addiction Professional in accordance with Chapter 397, F.S., either at the time of employment or within one year of employment.

The Co-Occurring Disorders Specialist provides integrated treatment for participants with co-occurring mental health and substance use disorders who have a history of substance abuse. These may services include:

- Conducting comprehensive substance use assessments that evaluate the relationship between substance use and mental health conditions;
- Assessing and monitoring participants' stage of change readiness and stage of treatment;
- Utilizing engagement strategies and motivational interviewing techniques to enhance participation and commitment to treatment;
- Conducting integrated treatment utilizing cognitive behavioral approaches and relapse prevention strategies; and
- Providing treatment interventions aligned with the participant's stage of change readiness.

The Co-Occurring Disorders Specialist also provides consultation and training to other team members on

integrated assessment and treatment approaches for co-occurring disorders.

Vocational Specialist

There must be at least one Vocational Specialist who holds a bachelor's degree and has a minimum of one year of experience providing employment services. The Vocational Specialist is responsible for delivering supported employment services as outlined on the Individual Placement and Support (IPS) Employment Center website: http://www.ipsworks.org/.

The Vocational Specialist provides integrated services that may include:

- Providing consultation and cross-training to team members to support the development and implementation of supported employment and education approaches;
- Delivering employment readiness services, workforce development programming, and educational initiatives to assist participants in preparing for, obtaining, and maintaining employment; and
- Providing a comprehensive range of employment services, including job coaching, resume development, career exploration, job placement assistance, and other workforce development activities.

The Vocational Specialist shall also engage with participants who are not actively receiving vocational services. Engagement may occur through informal, exploratory conversations rather than formal assessments and may coincide with a participant's annual comprehensive assessment.

Case Manager

This position requires a minimum of a bachelor's degree in behavioral science and at least one year of work experience with adults with psychiatric disabilities. The Case Manager provides rehabilitation and support services under clinical supervision and serves as an integral member of treatment team.

Responsibilities may include:

- Providing social and communication skills training;
- Implementing interventions designed to enhance participants' independent living skills;
- Conducting ongoing assessment, problem-solving, and assistance with activities of daily living
- Assists with benefit applications
- Facilitates communication and manages coordination with the court in forensic matters; and
- Delivering individualized coaching tailored to each participant's needs.

Administrative Assistant

An Administrative Assistant is responsible for organizing, coordinating, and monitoring the non-clinical operations of the FACT Team. Key functions include direct administrative support to staff, such as monitoring and coordinating daily team schedules and supporting staff activities in both office and field settings.

In addition, the Administrative Assistant serves as a liaison between participants and staff, responding to walk-ins and calls from participants and their natural supports. The Administrative Assistant actively participates in the daily team meetings, contributing to effective communication and coordination across the team.

Staff Communication and Planning

The FACT Team conducts daily organizational staff meetings at regularly scheduled times as determined by the Team Leader. During these meetings, the team completes the following tasks:

- Conduct a brief, clinically relevant review of all participants and contacts (e.g., phone calls, home visits, transportation, etc.) in the past 24 hours and document this information;
- Maintain a weekly schedule for each participant, including all treatment and service contacts necessary to achieve the goals and objectives in the participant's recovery plan;
- Maintain a central file of all weekly schedules;
- Develop a daily staff schedule consisting of a written timetable for all treatment and service contacts, assigned to staff based on:
    - Each participant's weekly schedule;
    - Emerging needs;
    - The need for proactive contacts to prevent future crises, and
    - Revisions to recovery plans, with service contacts added to the daily staff schedule as needed.

Treatment Planning Meeting

The FACT Team conducts treatment planning meetings under the supervision of the Team Leader. These meetings occur with sufficient frequency and duration to ensure that all staff can:

- Become familiar with each participant and their goals and aspirations;
- Participate in the ongoing assessment and reformulation of any emerging problems;
- Problem-solve treatment strategies and rehabilitation options;
- Ensure participant input in the development and revision of the recovery plan; and
- Fully understand the rationale for implementing each participant's recovery plan.

Program Engagement

The FACT Team conducts assertive outreach and engagement by recruiting potential participants from settings such as state mental health treatment facilities, hospitals, crisis stabilization units, emergency rooms, prisons, jails, and shelters. The FACT Team screens individuals for eligibility and obtains consent to participate in FACT services.

If the individual being considered for FACT services is located in a state mental health treatment facility, behavioral health teaching hospital, community hospital, or crisis stabilization unit, the FACT Team will begin to engagement and participate in discharge planning but will not provide FACT services until the individual is discharged.

Although the individual is not formally enrolled during this engagement process, the FACT Team must maintain written documentation that includes:

- Activities conducted during the engagement process and the individual's responses; and
- The name of the FACT staff member(s) performing the engagement activities.

Waiting List

Waiting list records are created when an individual has been determined eligible for FACT services but the FACT Team has reached maximum capacity and services are not immediately available. An individual's consent to participate in FACT services must be obtained prior to adding the individual to a waiting list.

Program Enrollment

Once an individual expresses interest in and a desire to participate in FACT services and meets eligibility requirements, the FACT Team enrolls the individual in the program. When determining the number of new enrollees each month, the team should ensure the maintenance of a stable service environment. The maximum number of participants (including Florida Medicaid recipients and individuals who are not Medicaid recipients) served by a small

FACT Team is 60 individuals and 120 individuals by a large FACT Team, unless otherwise approved by the Department of Children and Families.

Services and Supports

The guiding principles of FACT Team services include participant choice, cultural competence, person-centered planning, protection of rights of individuals served, stakeholder inclusion, and participant voice. In alignment with these principles, the FACT Team is inclusive of the following covered services and activities as defined in Chapter 65E-14.021, Florida Administrative Code[4]:

- Aftercare
- Assessment
- Care Coordination
- Case Management
- Crisis Support/Emergency
- Day Care
- Incidentals Expenses (Enhancements)
- Information and Referrals
- In-Home and On-site
- Intensive Case Management
- Intervention – Individual and Group
- Medical Services
- Medication-Assisted Treatment
- Outpatient – Individual, Family, and Group
- Outreach
- Recovery Support – Individual and Group
- Supported Employment
- Supportive Housing/Living

The FACT Team shall include the following, as detailed below:

- Active Engagement

  Because FACT services are voluntary, FACT Teams should utilize engagement strategies, such as motivational interviewing to foster ongoing participation and strengthen relationships with participants. The FACT Team should also monitor for indicators that a participant may require more assertive engagement. Such indicators may include missing appointments; limited rapport or lack of trust in the therapeutic relationship; inpatient admission; increased or frequent crisis episodes; homelessness or risk of homelessness; loss of natural supports; high-risk behaviors; or substance use that interferes with the participant's ability to engage in treatment.

[4] Florida Department of State - Florida Administrative Code & Florida Administrative Register www.flrules.org/ (accessed February 2026)

Treatment planning and subsequent therapeutic interventions must reflect appropriate, adequate, and timely implementation of services in response to the participant's changing needs.

- Administrative Tasks

  The FACT Team performs administrative tasks, which include the following:

  - Establishment and maintenance of written policies and procedures for:
    - Personnel
    - Program organization
    - Admission and discharge criteria and procedures
    - Assessments and recovery planning
    - Provision of services
    - Medical records management
    - Quality assurance/quality improvement
    - Risk management
    - Rights of persons served
  - Accurate record-keeping that reflects specific services offered to and provided for each participant, with records available for review by the Managing Entity and Department staff.
  - Coordination of services with other entities to ensure the participant's needs are addressed.
  - Staff training and supervision to ensure staff are aware of their obligations as an employee.
  - A disaster support plan that addresses contingencies for staff, provision of needed services and medication, and post-disaster activities to support participants.

- Assertive Community Treatment Transition Readiness Scale (ATR)©

  The Assertive Community Treatment Transition Readiness Scale (ATR)© is a clinical tool used by FACT Teams to 1) identify individuals ready to transition from FACT to less intensive services and/or 2) inform an individual's recovery plan and monitor overall progress.

  The ATR, or comparable ACT transition assessment (with Department approval), must be completed for each participant at least once annually. If the ATR is used by a FACT Team to monitor an individual's overall progress, it is recommended that the ATR be administered at regular intervals throughout receiving FACT services.

  The ATR can be completed by a single FACT staff member or as a team. The intent of the ATR is not to replace clinical and professional judgment but to potentially reduce inherent subjectivity and bias. Details regarding the administration and scoring of the ATR can be found in Appendix C.

- Competency Training

  For participants who are adjudicated incompetent to proceed, the team will provide competency restoration training and assist the participant through the legal process.

- Comprehensive Assessment

  The Team Leader assigns the individual's treatment team, including the Psychiatrist or Psychiatric APRN and primary case manager on the day of admission. The team is responsible for preparing a written Comprehensive Assessment within 60 days of the participant's admission to the program. The Comprehensive Assessment must meet the following requirements:

- Each assessment area is completed by a team member with skill and knowledge in the area being assessed and is based upon all available information.
- At a minimum, the Comprehensive Assessment includes:
  - Psychiatric history and diagnosis,
  - Mental status,
  - Strengths, abilities, and preferences,
  - Physical health,
  - History and current use of drugs or alcohol,
  - Education and employment history and current status,
  - Social development and functioning,
  - Activities of daily living,
  - Family and social relationships and support, and
  - Care recommendations.
- The Comprehensive Assessment must be reviewed and signed by the Team Leader, Psychiatrist, Psychiatric APRN, or another qualified professional on the FACT team. This includes a signed and dated statement confirming that the assessment is complete, clinically appropriate, and that the assessment findings and care recommendations support the individual's diagnosis and needs.
- To supplement the Comprehensive Assessment, the team completes a psychiatric/social functioning history timeline no later than 120 days after the first day of admission.
- The team updates assessments at least annually and uses the updated assessments to update the Recovery Plan. All necessary areas essential for planning must be included in the updated assessment.

- <u>Comprehensive Recovery Plan</u>

  The team develops a Comprehensive Recovery Plan as an extension of the initial plan within 90 days of admission, following completion of all required assessments. The Comprehensive Recovery Plan must adhere to the following guidelines:

  - Planning is person-centered and actively involves the participant, guardian (if applicable),and any family members and significant others the participant wishes to include.
  - The plan is reviewed and updated at least every six (6) months during planned meetings, or sooner if clinically indicated, by the treatment team in collaboration with the participant.
  - The plan is reviewed and signed by the Team Leader, Psychiatrist or Psychiatric APRN, or another qualified professional on the FACT team. This includes a signed and dated statement confirming that the services provided are medically necessary and appropriate for the individual’s diagnosis and treatment needs.
  - The plan is based on assessment findings and:
    - Identifies the participant's strengths, resources, needs and limitations;
    - Establishes short- and long-term goals, including timelines;
    - Reflects the participant’s preferences for services;
    - Outlines measurable treatment objectives as well as the services and activities required to achieve them; and

- Addresses relevant life domains, such as symptom management, education, transportation, housing, activities of daily living, employment, daily structure, and family and social relationships, when identified as needs through assessment and agreed upon as goals by the individual.

- Daily Living Activities (DLA-20): Adult Mental Health

  The DLA-20 must be completed within the first 30 days of intake to establish a functional baseline. After the baseline is established, it should be readministered at regular intervals to monitor changes in functional capacity over time. At a minimum, the DLA-20 must be readministered every six (6) months; however, it may be completed more frequently based on provider preference or programmatic guidance. In addition, the DLA-20 must be administered at key transition points, including:

  - at discharge, except in cases of unplanned discharge;
  - when there is a change in level of care; and
  - following a significant life event.

  If a client's mental health, cognitive functioning, or level of independence demonstrates a noticeable improvement or decline, the DLA-20 may be readministered to document the change. Administration of the DLA-20 without direct contact with the client is considered invalid. Direct contact includes in-person, telehealth/video, or telephone interaction. In cases of unplanned discharge, the score from the most recent DLA-20 administration should be used as the discharge score.

  The Functional Assessment Rating Scale (FARS) may be used in addition to the required DLA-20 to provide supplemental information on an individual's level of functioning. Use of the FARS is optional and only intended to enhance clinical insight, treatment planning, and monitoring of functional progress.

- Initial Assessment and Recovery Plan

  The Team Leader, in coordination with the Psychiatrist or Psychiatric APRN, performs an initial assessment and develops an initial plan of care on the day of the participant's admission to the program. The participant, along with designated team members, will be actively involved in the development of the plan. This process is intended to ensure that immediate needs for medication, treatment, and basic support are addressed without delay. At a minimum, the initial assessment must include the following components:

  - A brief mental status examination
  - Assessment of symptoms
  - An initial psychosocial history
  - An initial health/medical assessment
  - Review of previous clinical information obtained at the time of admission
  - Preliminary identification of the participant's housing, financial, and employment status
  - Preliminary review of the participant's strengths, challenges, and preferences

Discharge Planning and Transitions

Discharge planning should begin immediately upon intake, and the expectations for treatment and the anticipated course of care should be discussed with the participant during the admission process. FACT Teams should review progress toward long-term goals and markers for discharge at each treatment plan update and continuously assess discharge readiness throughout the participant's engagement with FACT Team services. This includes identifying barriers to discharge, monitoring the progress of discharge planning, and addressing any changes to discharge plans.

FACT Teams shall determine readiness for discharge based on the attainment of mutually agreed-upon goals. When evaluating discharge readiness, FACT Teams may utilize the ATR, as well as additional assessment methods or tools as appropriate.

Transition

During the daily meetings, the FACT Team shall assess participants for the continued need for FACT services. If it is determined that the participant could succeed in a lower level of care, the team shall begin addressing transition goals with the participant.

When a participant is ready to transition to a lower level of care, the FACT Team shall update the treatment plan to reflect transition goals and services. This period should continue to emphasize the participant's independence in all areas of life, with the team supporting the participant in gradually utilizing outpatient treatment services, natural supports, and other community resources, allowing the participant to become comfortable accessing a variety of support independently.

The FACT Team shall provide psychoeducation to the participant and any involved natural supports regarding available treatment services and community resources following discharge.

It is encouraged that FACT Team members either attend initial appointments with community psychiatric services alongside the participant or, at a minimum, follow up with both the participant and the community service provider to verify attendance and assist in identifying and addressing any barriers to a successful transition.

Transfers

When a participant plans to move out of the area, the Managing Entities are responsible for coordinating the transfer to the new location. The originating Managing Entity will contact the receiving Managing Entity to determine whether there is capacity to accept the transfer and to propose a transfer date. Once this is established, the originating FACT Team, with the participant's consent, must provide the receiving team with a comprehensive referral packet.

FACT Teams are required to accept transfers if they have capacity. Both the originating and receiving teams must make every effort to ensure the participant has stable housing. Upon arrival, the receiving team shall review the participant's clinical records, conduct an initial assessment and admission process, assess the person's current medication regime, consult with the program Psychiatrist/Psychiatric APRN, and complete a new comprehensive assessment or develop a new recovery plan.

When an individual meets eligibility criteria and there is available capacity, the FACT team must accept and enroll all referrals from the Departments' Substance Abuse and Mental Health regional office or the Managing Entity.

Discharge Categories

FACT Team shall discharge participants based on the following categories:

- **Successfully Completed Treatment/Services**: The participant demonstrates an ability to perform successfully in major role areas (i.e., work, social, and self-care) over time without requiring assistance from the program and no longer requires this level of care (i.e., successful completion).
- **Did Not Complete Treatment - Voluntary**: The participant lost contact, eloped, requested discharge, or chooses not to participate in services despite the FACT Team's repeated efforts to develop a recovery plan acceptable to the participant.
- **Did Not Complete Treatment - Involuntary**: The participant has been admitted to inpatient or short-term residential treatment, for a continuous period of 90 calendar days, with no anticipated discharge date.
    - The FACT Team must communicate with the inpatient or short-term residential treatment provider to determine the anticipated length of stay and likely discharge setting. This information may be used to determine whether continued FACT Team services are appropriate or whether prioritizing individuals on the waiting list would be more beneficial.

- **Incarcerated**: The participant has been adjudicated guilty of a felony offense and sentenced to a state or federal prison for a term exceeding twelve (12) months. Otherwise, the participant remains enrolled with the FACT Team.
    - The FACT Team must communicate with the state or federal prison to determine the term. This information may be used to determine whether continued FACT Team services are appropriate or whether prioritizing individuals on the waiting list would be more beneficial.
- **Death**: The participant dies while receiving services.
- **Transferred to a State Mental Health Treatment Facility or Behavioral Health Teaching Hospital**: The participant has been admitted to a state mental health treatment facility or behavioral health teaching hospital exceeding six (6) months, with no anticipated discharge date.
- **Participant Moved Out of Service Area**: The participant moves out of the FACT Team's service area.
- **Did Not Complete Treatment - Transferred to Another Provider**: The participant was admitted to a nursing facility for long-term care due to medical condition, and there is no anticipated date of discharge.

Discharge Documentation

The following information must be included in the participant's medical record at the time of discharge:

- The reason(s) for discharge.
- The participant's status and condition at the time of discharge.
- A final evaluation summarizing the participant's progress toward the goals and outcomes identified in the recovery plan.
- A discharge plan developed in collaboration with the participant, detailing treatment follow-up, and including the signature of the primary case manager, Team Leader, Psychiatrist/Psychiatric APRN, and participant/legal guardian. If the participant or guardian is unavailable to sign, the reason must be documented in the plan.
- Referral information provided to other agencies upon discharge.
- Documentation that the participant was informed they may return to the FACT Team if desired and space is available.

FACT Advisory Committee

Advisory committees are composed of volunteer stakeholders who support and guide a FACT Team. The primary function of the advisory committee is to promote quality and assist in program oversight through monitoring, problem-solving, and addressing grievances or complaints raised by participants or their families. Details regarding the implementation and operation of the advisory committee, including a FACT Model Fidelity Review sample, are provided in Appendix B.

IV. Outcome Measures

The FACT Team is required to meet the following numerical targets for the target population "Adults with Serious and Persistent Mental Illness" as established in the General Appropriations Act.

- Percent of adults with severe and persistent mental illnesses who live in stable housing environment that is equal to or greater than 90 percent or the most current General Appropriations Act working papers transmitted to the Department of Children and Families; and,
- Average annual days worked for pay for adults with a severe and persistent mental illness that is equal to or greater than 40 days worked for pay or the most current General Appropriations Act working papers transmitted to the Department of Children and Families.

The FACT Teams must incorporate the following performance measures:

- Each quarter, *fewer than 20 percent of all enrolled individuals* will be admitted to a Baker Act Receiving Facility.
- Each quarter, fewer than 5 percent of all enrolled individuals will be admitted to a State Mental Health Treatment Facility or Behavioral Health Teaching Hospital.

FACT Teams must also incorporate the following process measures:

- *90 percent of all initial assessments* will be completed on the day of enrollment with written documentation of the service occurrence in the clinical record.
- *90 percent of assessments to determine willingness to seek vocational goals* will be completed within 60 days of enrollment with written documentation of the service occurrence in the clinical record.
- *90 percent of all comprehensive assessments* will be completed within 60 days of enrollment with written documentation of the service occurrence in the clinical record.
- *90 percent of all comprehensive recovery plans* will be completed within 90 days of enrollment with written documentation of the service occurrence in the clinical record.
- *90 percent of all psychiatric/social functioning history timelines* will be completed within 120 days of enrollment with written documentation of the service occurrence in the clinical record.
- While enrolled, *50 percent of all individuals served* will receive supported employment services[5] toward a goal of obtaining or maintaining paid, competitive employment within one year of enrollment with written documentation of the service occurrence in the clinical record.
- While enrolled, *90 percent of all individuals served* will receive an assessment to determine independent housing goals within one year of enrollment with written documentation of the service occurrence in the clinical record.
- Every month, *90 percent of the staffing requirements* will be maintained including required FACT Team composition and ratio of participants to direct service staff members.

Beginning in Fiscal Year 2026–27, the Department and Managing Entities shall collect and analyze baseline data for the following potential performance measure. During the baseline data collection period, this measure will be used only for monitoring and evaluation. It will not be used to evaluate provider performance or to impose corrective action, financial penalties, or other adverse contractual consequences. The Department and the Managing Entities will evaluate the effectiveness and reasonableness of adopting additional measures for future program implementation. The measure will be adopted July 1, 2028, unless objections are raised.

On an annual basis, *75 percent of all individuals served* will maintain or demonstrate improvement in their functioning, as measured by the Daily Living Activities (DLA-20) Functional Assessment.

- Maintenance or improvement in functioning is determined by comparing the average DLA-20 score from the initial assessment score to the most recent recorded score.
- The numerator is the number of individuals served during the reporting period whose overall functioning score is equal to or greater than their initial score.
- The denominator is the number of individuals served during the reporting period who have more than one recorded DLA-20 score.

[5] Individual Placement and Support Employment Center, https://ipsworks.org/index.php/what-is-ips/ (accessed February 2026)

V. Reporting Requirements

FACT Teams are responsible for submitting the following reports to the managing entity in a timely and accurate manner:

Template 29 – FACT Quarterly Report

This quarterly report displays essential data for the Department to determine outputs and outcomes.

Census Worksheets

The Department may request ad hoc Census Worksheets (effective July 1, 2025) in Excel including the following information for all individuals enrolled in Florida Medicaid during therief therapy requested timeframe:

- Last name
- First name
- Middle initial **or**, if unknown, '**X**'
- Date of birth (mm/dd/yyyy)b
- Social Security Number (no dashes) **or,** if unknown, **pseudo-SSN**
    - as indicated by the Department's FASAMS Pamphlet 155-2 Version 14, Chapter 1, or latest version[6]
- Date of enrollment (mm/dd/yyyy)
- Date of discharge (mm/dd/yyyy)

FACT Enhancement Reconciliation Report

This quarterly report displays the team's monthly expenditures of enhancement funds.

Vacant Position(s) Report

This monthly report displays required FACT Team composition (as indicated in section III) and whether the positions are filled or vacant for the reporting month. This report also displays the ratio of participants to direct service staff members on the last day of the month.

[6] Financial and Services Accountability Management System (FASAMS): https://www.myflfamilies.com/services/samh/providers/FASAMS (accessed February 2026)

VI. Managing Entity Responsibilities and Expectations

The Managing Entities are responsible for:

- Oversight of FACT requirements including report and invoice approvals
- Provision of technical assistance to FACT Teams as needed
- Participation in and oversight of advisory committees
- Assistance with the timely and efficient transfers from state mental health treatment facilities to teams
- Identification of the need for additional FACT Teams,
- Monitoring of the program including:
    - Medical record reviews
    - Personnel records review
    - Policy and procedure reviews
    - Staff credentials review
    - Participant interviews
    - Follow up with corrective action plans, if indicated.

Managing Entities shall determine the eligibility of both Network and non-Network Service Providers to deliver services funded with FACT Enhancement Funds.

- Network Service Providers are those who are part of the Managing Entity's network and are under contract with the Managing Entity. Eligibility will be assessed by reviewing whether licensure or certification is in good standing, the provider's history of licensing or certification complaints, and the appropriateness and quality of services. Additional considerations include staff training, qualifications, and demonstrated competency, as well as the overall organizational competency and capacity. Interviews with organizational staff and any other relevant information specific to the individual provider will also be taken into account in the eligibility determination.

    - Network Service Providers who are treatment providers must be licensed by the Department, Agency for Health Care Administration (AHCA), or a related professional license.

    - Network Service Providers who are recovery support providers must provide documentation of applicable professional certifications, excluding providers who are licensed by the Department, are licensed by AHCA, or are active affiliates in the Oxford House, Inc. network.

Appendix A – FACT Enhancement Guidelines

Introduction

One of the goals of FACT is to promote and respect self-determination, recovery, and full community inclusion. Participation provides the individual with the opportunity to select the services and commodities that they deem necessary for recovery for the purpose of consumption, housing needs, employment, volunteering, or training/education, and facilitates achievement of the individual's recovery plan.

An integral part of participation is accepting responsibility for choosing, spending, recording, and learning how best to use limited funds to achieve a desired state of mental wellness and productivity. The program believes that individuals can purchase needed services and commodities that will help them on their road to recovery. Individual choice drives this system of purchasing.

The program provides access to public funds to purchase adjunct services or commodities not directly provided by the FACT Team. Funding is used to increase or maintain a person's independence and integration into their community. Funding may be used for costs related to housing, pharmaceuticals, tangible items needed for employment/education or other meaningful activity, and specialized treatment (not paid by any other means).

Definitions

1. "Assistive Care Services" or "ACS" means a state payment for services provided by qualified residential care facilities. Funds transferred from the Department of Children and Families to Medicaid draw down federal Title XIX matching funds. This Medicaid optional state plan service is for low-income people who live in qualified assisted living facilities (ALFs), adult family-care homes (AFCHs), and residential treatment facilities (RTFs).
2. "Commodities" means supplies, materials, goods, merchandise, equipment, information technology, and other personal property. The definition does not include pharmaceuticals, medical treatment, glasses, hearing aids, or lab work.
3. "Indigent Drug Program" or "IDP" means the provision of psychotropic medications for individuals served by the Department who have a mental illness, reside in the community, and do not have other means of purchasing prescribed psychotropic medications.
4. "OSS" means Optional State Supplementation, a state program to supplement payments to eligible individuals residing in Assisted Living Facilities, Adult Family-Care Homes, family placement, or any other specialized living arrangement.
5. "Payer of Last Resort" means using FACT enhancement funds after exhausting all other potential sources of funds.
6. "Recovery Plan" means an individual's service/treatment plan
7. "Services" means pharmaceuticals, lab work, treatment, housing assistance, or other assistance given to benefit a person.
8. "SSDI" means Social Security Disability Income that is paid to a person and certain members of the person's family if the person is "insured", meaning the person has worked the required number of quarters and paid Social Security taxes.
9. "SSI" means Supplemental Security Income, a federal income supplement program funded by general tax revenue designed to provide cash to help aged, blind and disabled people who have little or no income to meet basic needs for food, clothing, and shelter.

Guidelines on the Use of Funds

1. Ensuring FACT Team enhancement funds are the payer of last resort

Participants must take responsibility for locating other sources of funding for services or commodities before requesting FACT enhancement funds for the purchase. FACT staff, in collaboration with the participant, must determine if there is another payer source, such as Medicaid, Medicare, OSS, SSI, SSDI, IDP, or ACS. The primary case manager must submit a certification form with the monthly invoice. The certification states that due diligence was exercised in searching for alternative funding to pay for the commodity or service before the use of enhancement funds. If the commodity or service is ongoing, certification is only required for the original purchase. Examples of ongoing purchases include utility and phone bills, refills of existing prescriptions, or any other commodity or service.

2. Price Quotes

Participants are required to provide three price quotes from different vendors for any single commodity costing more than $300. These price quotes may be in the form of vendor circulars or advertisements, vendor website items and price descriptions, in-store price comparisons, and telephone price quotes. Telephone should only be considered if other means of securing a price quote are not possible. Quotes received over the phone and in-store must be verified/witnessed by staff and documented (including date and time). Documentation of the price quotes must be filed (may be a separate file from the clinical record) and available for audit when requested.

3. Emergency purchase

An emergency is considered an unexpected event that causes immediate danger to the health, safety, or welfare of the individual. In such cases, there might not be time to secure three price quotes (e.g., towing a vehicle from the roadway). An emergency purchase without three quotes must be justified and documented to be considered for payment or reimbursement. Emergency purchases must be documented in the clinical record, and if deemed an ongoing need, must be added to the recovery plan.

4. Recovery plan

The member's recovery plan must incorporate the purchase of any commodity or service. The member's recovery plan must explain how the purchase will promote one or more of the member's recovery goals.

5. Dental services, hearing aids, and eyeglass purchases

Medically necessary (recommended by medical practitioner) professional hearing, dental, and vision services will be paid for by the program after all other resources have been exhausted. Decorative or cosmetic purchases, such as color contacts, may not be paid for with FACT enhancement funds.

6. Payment / Reimbursement rate

Commodities and services purchased are paid or reimbursed at a negotiated rate between the participant and the FACT case manager and are dependent on the participant's ability to pay.

7. Making the purchase

The accepted purchase price (quotes and receipt) must be dated after the incorporation of the purchase into the recovery plan. For approved purchases, the participant can either:

a) Make the purchase using his or her funds and later, be reimbursed[7], or

b) Provide an original, itemized estimate of the needed purchase that shows the name of the vendor, the anticipated purchase date, the item, and the amount of the purchase (along with documentation of price quotes).

The amount paid or reimbursed will include the actual price of the item and may include tax, if applicable. Tips are not reimbursed. It is the participant's responsibility to ensure the quality of the item purchased. If a purchased item is

[7] Subject to the FACT provider's preference and the Managing Entity's discretion

defective, inoperable, or unusable, it is the participant's responsibility to resolve the matter with the vendor.

Criteria for purchase approval (Must be able to answer "yes" to all questions)

1. Does the purchase directly relate to the identified needs outlined in the participant's recovery plan?
2. Does the purchase promote independence?
3. Will the purchase enhance employability or recovery for the individual?
4. Have all other options been explored and exhausted before requesting the purchase with FACT enhancement funds?
5. Is the amount of the proposed expenditure reasonable?
6. Is the budget to fulfill the request available?
7. Is the date on the receipt for the purchase after the effective date of the current recovery plan?
8. Is the receipt original?
9. Does the receipt contain vendor information printed on the receipt (name of vendor, address, phone number, etc.)?

Examples of purchases that may be authorized if all criteria above are met

1. Co-pays for adjunct services purchased with Medicaid or Medicare funds.
2. Housing subsidy. Enhancement funds may be used for payments to Assisted Living Facilities (above OSS rate), but all available options that could best meet the individual's needs should be considered (such as Therapeutic Family Care homes, permanent supportive housing, rental subsidies for current lease).
3. Medication.
4. Transportation or mileage reimbursement.
5. Services related to developing employability.
6. Smoking cessation activities under the supervision of a medical doctor.
7. Non-cosmetic dental work.
8. Hearing aids.
9. Non-cosmetic eyeglasses and non-disposable contacts once per year, unless otherwise noted by a licensed eye care professional.
10. Facial cosmetic and make-up products for camouflaging medical conditions, such as facial scars, burns, etc., and to seek or participate in employment.
11. Tutoring.
12. Face-to-face and distance learning educational classes.
13. Time-limited assistance to secure or maintain a more independent living arrangement.
14. Time-limited assistance with vehicle repair for purposes of employment, education and/or transportation or other recovery goal with the intent to increase independence for the person served. Alternative transportation (bus, bike, cab use) should be considered instead of vehicle repair if the cost to repair is more than $1,000.00 or the budget does not permit the expenditures.
15. Specialized treatment not provided by the FACT Team and not paid for by any other means (e.g., eating disorders, behavioral analyst, health club/gym). Approval must be obtained from the Managing Entity for expenditures exceeding $1,500.00.

16. Support tools promoting the safety and security of the individual, including fire alarms, and disability aids such as char, shower or stair rails when explicitly justified by the individual's recovery plan and no other resource is available.

Examples of disallowed purchases:

1. Rent reimbursement for an expired rental lease.
2. Payments to facilities or recovery residences that are not licensed or certified in good standing according to state law.
3. Motel room(s) beyond 21 days. Motel rooms for more than 21 days may be authorized if the team makes an ongoing and consistent effort to find more permanent housing, and this is fully documented in the recovery plan.
4. Purchase of automobiles, sport utility vehicles (SUVs), minivans, motorcycles, recreational scooters, or recreational vehicles.
5. Major repairs or renovations of rental property.
6. Pay-per-view or enhanced programming cable or satellite service.
7. Television, Video Cassette Recorders (VCRs), Digital Video Disc (DVD) or Blu-ray players, video game consoles, stereos, MP3 Players, iPods, iPads, or other types of entertainment appliances.
8. Designer sunglasses.
9. Beauty aids such as spa services, including but not limited to facials, makeup applications, aromatherapy massage, body waxing, manicure, pedicure, therapeutic body wraps, microdermabrasion, tanning booth sessions, wigs and hair pieces, or cosmetics (aside from the purposes described above).
10. Ongoing or continuous purchase of over-the-counter medications over 7 days per episode for allergies and flu-like symptoms.
11. Acupuncture without a prescription/order/referral from the program Psychiatrist.
12. Petty cash for general use.
13. Purchase or rental of firearms.
14. Purchase of alcoholic beverages.
15. Purchase of contraband or illegal products or services.
16. Purchase of tobacco products.
17. Purchase of pets.
18. Purchase or rental of boats.
19. Purchase or lease of burglar alarms.
20. Purchase or lease of cell phones.
21. Purchase or lease of diving equipment.
22. Internet service.
23. Purchase for 3rd parties.
24. Purchase of pornographic books, magazines, or videos.
25. Payment of credit card interest or balances.
26. Payment of court-ordered costs, fines, restitution, or other similar debts.

Participant Certification and Assurances

FACT Team participants are not guaranteed access to enhancement funds. Purchase approval is dependent on the following guidelines:

- All other options have been explored and exhausted before requesting the purchase with FACT enhancement funds.
- The purchase directly relates to the identified needs outlined in the participant's recovery plan.
- The purchase promotes independence.
- The purchase enhances employability or recovery for the individual.
- The amount of the proposed expenditure is reasonable.
- The budget to fulfill the request is available.
- The date on the receipt for the purchase must be after the effective date of the current recovery plan.
- Individuals must provide an original receipt.
- The receipt must contain vendor information printed on the receipt (name of vendor, address, phone number, etc.).

1. By signing below, I agree to adhere to these guidelines and understand that I am responsible for the outcome of all purchases that I make under this program.
2. I agree not to hold the FACT program responsible if I make purchases that are beyond the scope of purchases incorporated into my recovery plan amount and understand that the program is not responsible for the choices I make regarding my finances.

The FACT participant receives a signed copy of these guidelines. The original signed document remains part of the participant's clinical record.

I, _____, have received, reviewed, and agree to the Florida ACT Enhancement Funds guidelines.

Certification Statement as Payer of Last Resort

(Required only on initial purchases of commodities and services)

Name of FACT Participant: _____

Date of Purchase: _____

Name of Vendor: _____

Cost of Item/Service: _____

Item(s)/Services Purchased: _____

_____

_____

Relationship to Recovery Plan (Complete the following table):

Recovery Plan Goal	**Relationship to Purchase**
What goal on the recovery plan does this purchase relate?	
How will this purchase assist in meeting the goal?	
How many more times is this service estimated to be needed?	

I, _____, the primary case manager and/or member of the above-named individual's Treatment Team, certify that this purchase is made to support the person's recovery plan. I further certify that all other resources have been explored and exhausted before purchasing this service/commodity with the payer of last resort enhancement funds.

_____

Signature Date

APPENDIX B – FACT ADVISORY COMMITTEES

The FACT Advisory Committee (Committee) is a group of volunteer stakeholders that come together to ensure the FACT Team's work is consistent with SAMHSA's Assertive Community Treatment (ACT) Evidence-Based Practices (EBP) KIT[8]. The Committee's primary functions are to promote quality FACT programs and assist in the oversight of the program through monitoring, problem-solving, and mediating grievances. Committees are independent of the provider operating the team and therefore have no role in the governance of the team. Committees may, at their discretion, develop additional procedures beyond those identified below.

Purpose:

The purpose of the Advisory Committee is to guide and support local team activities by monitoring ongoing operations; promoting the team's work in the community; and ensuring the team provides each participant with quality and recovery-oriented services.

Membership:

The contracting managing entity (ME) approves individual membership to the Committee. Committees have a minimum of 10 members that consist of at least 26 percent people with psychiatric disabilities and 25 percent family members. Other members may represent stakeholders such as local homeless coalitions, local law enforcement agencies, jail personnel, county commissioners, other providers, hospital representatives, Medicaid, faith-based entities, and advocacy groups. Membership that is representative of the local cultural and linguistic populations is strongly encouraged. The Committee must be committed to promoting recovery and empowerment.

The provider operating the FACT Team is responsible for recruiting Committee members. Names of nominated individuals are submitted to the contracting ME for approval of membership. Membership may be rescinded if, in the view of the contracting ME, an adversarial relationship has developed between the provider, Committee, and the contracting managing and a good faith effort on the part of the ME to resolve the adversarial environment has failed.

Membership Qualifications:

Committee members should be knowledgeable about psychiatric disabilities and the challenges that people with these disabilities face living in the community. Members should be good problem solvers with a positive attitude and be objective and seek to understand the views of all stakeholders. People in recovery and their families are strong candidates for membership.

Membership Requirements:

Committee members become familiar with the Program Standards for ACT Teams and the FACT Guidance 16. Committees meet quarterly or more frequently if desired and members agree to serve at least a 2-year term, staggering termination to maintain a core of experienced members on the Committee. Although Committee Bylaws are not required, it is suggested the Committee elect a Chairperson. If a Chairperson is elected, the Committee must establish a protocol for such election including term of office, method of election, including use of proxy votes, and specific duties of the Chairperson. Minutes of Committee meetings are recorded and submitted to the provider's Chief Executive Officer, the FACT Team Leader, and Managing Entity staff.

Approving and Rescinding Membership:

The contracting ME may use the following criteria in approving and rescinding membership on Committees. These guidelines are subject to change based on the accumulation of practices, data, and issues that may evolve over the course of time and experience.

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[8] Substance Abuse and Mental Health Services Administration, Assertive Community Treatment (ACT) Evidence-Based Practices (EBP) KIT, https://store.samhsa.gov/product/Assertive-Community-Treatment-ACT-Evidence-Based-Practices-EBP-KIT/SMA08-4344 (accessed February 2026)

Approving Membership

- Expressed willingness to volunteer time,
- Expressed interest in Florida's adult community mental health service delivery system,
- Expressed willingness to learn the ACT model of service intervention,
- Expressed willingness to participate in public forums,
- Meets at least one of the membership groups identified as representative of community stakeholders; and
- Has been approved by the contracting ME.

Rescinding Membership

- Repeated unexcused absences from Committee meetings (as determined by the Chair); or
- Creating an adversarial environment that is prolonged for three months or more and such environment diminishes the supportive, collaborative relationship that must exist between the contracting ME, the provider, and the Committee.

FACT Advisory Committee Member Roles:

1. Advocating on behalf of individuals with psychiatric disabilities.
2. Becoming knowledgeable of the ACT model.
3. Identifying community resources for the team such as affordable housing, employment opportunities, and social outlets/supports.
4. Promoting awareness of the team in the community through community dialogues when requested.
5. Providing support, guidance, and assistance to the team.
6. Monitoring ACT fidelity by administering the "FACT Model Fidelity Review" on an annual basis.[9]
7. Participating in planned technical assistance site visits conducted by the Managing Entity to teams.
8. Mediating complaints or grievances between meetings. It is the responsibility of the Chair to convene a mediating panel made up of three Committee members.
9. Spending at least one day observing a daily organizational meeting, recovery planning meeting, or accompanying a team member on a field visit (with consent).[10]
10. Reviewing and commenting on the team's enhancement expenditures and quarterly ad hoc data reports.
11. Developing a schedule of activities for the year.
12. Serving as a resource to the team to problem-solve local issues that may be barriers to successful outcomes.
13. Participating in the development of a protocol for communications between the team, its administration, and the ME to be approved by the ME before implementation.[11]

[9] The FACT Model Fidelity Review is a modified form of the PACT Model Fidelity Review published by the National PACT Center and contains recommended standards. The protocol is attached to Appendix B, revised in May 2014.
[10] Due to the size of Advisory Committees, no more than 2 members should schedule attendance at any meeting at any given time and with prior agreement by the Team Leader.
[11] A suggested format is attached but may be modified at the discretion of the entities developing the protocol.

Providers' Role Relating to FACT Advisory Committees:

1. Attending Committee meetings by the Team Leaders and the provider's Chief Executive Office/Executive Director or designee.
2. Providing enhancement expenditures and quarterly ad hoc data reports.
3. Presenting any grievances/complaints and their outcome.
4. Forwarding of grievances/complaints not resolved at the team level within two weeks from the date of filing to the team's Committee Chair who will convene a grievance mediating panel.
5. Participating in the development of a communication protocol between the team, its administration, the Committee, and the ME for approval from the ME before implementation.
6. Providing the Committee with the necessary administrative support to ensure that documents are provided, and minutes of meetings are distributed.

Managing Entity's Role Relating to FACT Advisory Committees:

1. Inviting the Chair of the Committee to participate in on-site technical assistance and programmatic monitoring completed by the ME.
2. Attending Committee meetings.
3. Participating in the development of a communication protocol between the team, its administration, the Committee, and the ME. Upon completion, prepare an approval memo to the team, its administration, and the Committee that the protocol is approved for implementation.
4. Serving as a liaison and resource person to the Committee for system issues that impact the team's successful outcomes.

Confidentiality

By law, Committee members do not have access to the medical records of participants without the specific, written agreement of the individual. Committee members who may also serve on other councils or entities that, in the course of their duties, have statutory authority to access and review medical records are prohibited from sharing the findings of such reviews with other Committee members without the specific, written agreement of the individual. The specific agreement must be time-limited and can be changed by the individual at any time.

FACT Advisory Committee Agenda Template

Committee meetings address the following items:

- Call to Order and roll call,
- Report of Committee Activities,
- Report on Enhancement Expenditures,
- Report on the FACT Quarterly Data, and
- Report on Grievances Mediated and Outcomes.

Other Business

Next Meeting Date

Adjournment

Suggested Format for Communications Protocol

I. Purpose

The purpose of this protocol is to ensure that a mechanism of communication is in place that enables the Committee, the provider, the contracting ME, and the team to conduct its business while promoting the goals of the FACT initiative. This protocol is not intended to restrict any form of communication between individuals or entities but is intended to establish an agreement between the entities referenced above as to a preferred schedule of time for such communications.

II. Hours of Communication

It is agreed by all parties that business relating to the mission and intent of the Committee can best be served by calling between the hours of _____and _____Monday through Friday. Weekends and holidays will not be used for conducting routine business.

III. Communication Contacts

It is agreed by all parties that the following persons and phone numbers will be designated the primary and secondary contacts:

Primary Contacts:

For the Committee _____ Phone _____

For the FACT Team _____ Phone _____

For the Managing Entity _____Phone _____

Secondary Contacts:

For the Committee _____Phone _____

For the FACT Team _____ Phone _____

For the Managing Entity _____Phone _____

IV. Mitigating Factors

It is agreed by all parties that certain situations may arise that require the parties to prepare, locate, copy, and fax or e-mail information. When a request is made for written information, it is agreed that an appropriate response time to complete the request is _____ days from the date of the request.

V. Agreements

The parties, by their signature, will make a good faith effort to communicate with each other within the agreed-upon parameters established above.

For the Committee	Date
For the Team	Date
For the Provider	Date
For the Managing Entity	Date

Instructions for Completing the FACT Model Fidelity Review

This is a quality improvement exercise and is not intended to serve as a contractual compliance activity. Committee members conducting this survey are prohibited from reviewing individual clinical records. Feedback to the Team Leader at the end of the review will be helpful for continuous quality improvement. This activity will require 7 exercises:

1. Reviewing the staffing chart,
2. Reviewing position descriptions,
3. Reviewing policies and procedures,
4. Touring the entire team office space,
5. Interviewing the Team Leader,
6. Observing a daily organizational meeting, and
7. Reviewing the posted 2-month schedule of treatment team meetings.

Using the attached FACT Model Fidelity Review instrument, please complete the following:

1. Check either "Y" for yes or "N" for no at the time of the review,
2. Please note any discrepancies from the standards on a separate page, and
3. Using the results of the survey, prepare a summary of findings to share with the Team Leader.

FACT MODEL FIDELITY REVIEW

Standard	Element	Y	N
A. Staff Composition	Look at the staffing chart for documentation		
	The ratio of participants to direct service staff members must not exceed 10:1		
	Psychiatrist or Psychiatric APRN (A minimum of 0.32 hours of services per recipient per week)		
	1 FTE Administrative Assistant		
	1 FTE Team Leader (Licensed in accordance with Chapters 491, 458, or 490, F.S.)		
	At least 2 FTE Nurses - At least one FTE must be an RN (1 FTE for Small FACT team, must be an RN)		
	At least 1 FTE Case Manager (Not applicable for Small FACT team)		
	At least 1 FTE Co-Occurring Disorders Specialist (aka Substance Abuse Specialist)		
	At least 1 FTE Peer Specialist		
	At least 1 FTE Vocational Specialist		
B. Key Staff Roles	Look at position descriptions for documentation		
1. Team Leader	Provide direct services as a clinician		
	Deliver consistent clinical supervision to staff		
	Participate in treatment planning meetings in which a participant and/or natural support is present		
	Participate in initial and comprehensive assessments		
	Lead daily organizational staff meetings		
	Assign team members, including a primary case manager, to each new participant		
2. Psychiatrist or APRN	Provide the assessment and treatment of participants' symptoms and response to medications, including side effects		
	Provide diagnostic and medication education to participants, with medication decisions based in a shared decision-making paradigm		
	Monitor participants' non-psychiatric medical conditions and non-psychiatric medications		
	If participants are hospitalized, communicates directly with participants' inpatient psychiatric care provider to ensure continuity of care		
	Conduct home and community visits, as needed		
	Collaborate with the team leader in sharing overall clinical responsibility for monitoring participant treatment and service delivery		

Standard	Element	Y	N
	Educate non-medical staff on psychiatric and non-psychiatric medications, their side effects, and health-related conditions		
	Attend the majority of treatment planning meetings		
	Attend daily team meetings in proportion to the minimum time expected for caseload size		
	Actively collaborate with nurses		
3. Nursing Staff	Manage the medication system, administer and document medication treatment		
	Screen and monitor participants for medical conditions/side effects		
	Communicate and coordinate services with the other medical providers		
	Engage in health promotion, prevention, and education activities (i.e., assess for risky behaviors and attempt behavior change)		
	Educate other team members to help them monitor psychiatric symptoms and medication side effects		
	Develop strategies to maximize the taking of medications as prescribed (e.g., development of individual cues and reminders)		
4. Vocational Specialist	Provide consultation and cross-training to team members to support the development and implementation of supported employment and education approaches		
	Deliver employment readiness services, workforce development programming, and educational initiatives to assist participants in preparing for, obtaining, and maintaining employment		
	Provide a comprehensive range of employment services, including job coaching, resume development, career exploration, job placement assistance, and other workforce development activities		
5. Peer Specialist	Provide coaching and consultation to participants to promote recovery and self-direction (individual or group)		
	Facilitate wellness management and recovery strategies		
	Model recovery-oriented skills to participants		
	Participating in all team activities (e.g., treatment planning, chart notes) equivalent to fellow team members		
	Provide cross-training to other team members in recovery principles and strategies		
6. Co-Occurring Disorders Specialist (aka Substance Abuse Specialist)	Conduct ongoing comprehensive substance use assessments that consider the relationship between substance use and mental health		
	Assess and track participants' stages of change readiness and stages of treatment		
	Use outreach techniques or other strategies to connect with participants (e.g. Motivational Interviewing)		
	Conduct ongoing integrated treatment utilizing cognitive behavioral approaches and relapse prevention strategies		

Standard	Element	Y	N
	Provide treatment interventions aligned with the participant's stage of change readiness		
C. Program Size & Intensity	Look at policies for documentation		
	Participants are contacted at the number and frequency agreed upon through collaboration. Service intensity is dependent on need and may vary from minimally once weekly to several contacts per day		
	Clinically compromised participants are contacted multiple times daily		
D. Admission & Discharge Criteria	Look at policies for documentation		
	Admission criteria specify the target population		
	Discharge criteria include demonstrated ability to perform successfully in major role areas over time		
	Discharges are mutually determined by the participant and team		
	The team assumes long-term treatment orientation		
E. Office Space	Tour office space for documentation		
	Easily accessible to participants and families		
	Common workspace, layout promotes communication		
	In-office medication storage area that meets the requirements of 499.0121, Florida Statutes, such as proper temperature control, secure access, cleanliness, and separation of expired or damaged medications.		
F. Inter-Agency Relationships	Interview Team Leader and ask for evidence of collaboration for documentation		
	Active collaboration with other human services providers		
	Active participant-specific liaison with the Social Security Administration, Healthcare providers, other agency-assigned workers		

Standard	Element	Y	N
G. Hours of Operation	Look at policies for documentation		
	Staff on duty 7 days per week		
	Program operates 12 hours on weekdays		
	Program operates at least 8 hours on weekend days and holidays		
	Operates an after-hours on-call system, ensuring that a FACT Team professional is available at all times		
	Team members available by phone and face-to-face with back-up by Team Leader and Psychiatrist or APRN		
H. Team Communication & Planning	Look at policies, observe daily organizational meeting, and ask to see a 2-month posting of treatment team meetings for documentation		
	Organizational team meetings held daily M-F		
	Meetings completed within 45-60 minutes		
	Member status reviewed via daily log and staff report		
	Team Leader facilitates discussion & recovery planning		
	Services & contacts scheduled per recovery plans and triage		
	Staff assignments determined		
	Daily staff assignments prepared schedule		
	Service provision monitored and coordinated		
	All staff contacts with participants are logged		
	Recovery planning meetings held weekly		
	Recovery planning meetings held by senior staff		
	Recovery planning meetings scheduled and posted 2 months ahead		

Standard	Element	Y	N
I. Policy and Procedure Manual	Look at policies for documentation		
	Admission and discharge criteria and procedures		
	Job descriptions, performance appraisals, training plan		
	Program organization & operation (program hours, on-call, service intensity, staff communication, team approach & staff supervision)		
	Assessment and recovery planning		
	Medical records management		
	Service Scope		
	a. Case management		
	b. Crisis assessment & intervention		
	c. Symptom assessment, management & supportive therapy		
	d. Medication prescription, administration, monitoring & documentation		
	e. Substance abuse services		
	f. Work related services		
	g. Activities of daily living		
	h. Social, interpersonal relationships & leisure time		
	i. Support services		
	j. Education & support to families & other supports		
	Enrolled participant rights		
	Program performance improvement and evaluation		
	Strive for participants to maintain independent living in the community		
	Legal advocacy provided as needed		

NOTES:

APPENDIX C – ASSERTIVE COMMUNITY TREATMENT TRANSITION READINESS SCALE (ATR)©

Below is a summary for use of the ATR from *The Assertive Community Treatment Transition Readiness Scale© User's Manual* by Gary S. Cuddeback, Ph. D[12]. Dr. Cuddeback gave the Department express written consent for FACT Teams to use the ATR.

The ATR is an 18-item measure that covers the following:

- psychiatric and behavioral stability
- hospitalization and incarceration
- housing stability
- treatment engagement
- medication compliance
- independence
- complexity of health and behavioral issues
- intensity of service need
- benefits
- social support
- resources
- insight
- daily structure
- employment

Each item is scored on a four-point scale: strongly disagree (1), disagree (2), agree (3), strongly agree (4). For example, Item 1 reads, "He/she no longer needs intensive services." If you strongly agree with this statement about the FACT participant, record a score of 4. If you strongly disagree with the statement, indicating the participant still needs intensive services, record a score of 1.

Reverse-scored items: responses to four items must be reverse-scored so that for each item a higher score indicates greater potential to transition from FACT to less intensive services.

As previously stated, when you complete the ATR, you will be asked to rate each participant on a series of questions using a 4-point scale: strongly disagree (1), disagree (2), agree (3), strongly agree (4). The items that need to be reverse-scored are:

- Item 5 – He/she has been in the psychiatric hospital within the last six months.
- Item 7 – He/she has been incarcerated within the last six months.
- Item 12 – He/she has complex needs (i.e., personality disorders, health problems, substance use).
- Item 17 – His/her behaviors have not been stable over the last six months.

For example, if you respond strongly disagree (1) on item 5, this response should be reverse scored to 4 before computing a Total or Mean score. If you respond strongly agree (4) to Item 12, "He/she has complex needs (i.e., personality disorders, health problems, substance use," reverse score the item to a 1 before computing a Total or Mean score.

ATR Scoring

Higher scores on the ATR indicate greater potential to transition from FACT to less intensive services.

[12] Cuddeback, G. S., & Wu, J. C. (2021). The Psychometric Properties of the Assertive Community Treatment Transition Readiness Scale (ATR). Community Mental Health Journal, 57(7), 1301–1309. https://doi.org/10.1007/s10597-021-00806-9

Either a Total or a Mean score for the ATR can be computed. Total scores are the sum of all item responses on a measure and Mean score are the average of all item responses (**reverse score items 5, 7, 12, and 17 before computing)**.

A Total or Mean score on the ATR should not be computed if fewer than 80% of the items are completed. That is, at least 14 of the 18 items must be completed before scoring the ATR.

Total Scores: A Total score on the ATR can be computed by adding up all the item responses. Total scores on the ATR can range from 18 to 72, with higher scores indicating greater potential to transition from FACT to less intensive services (**reverse-score items 5, 7, 12, and 17 first)**.

Mean Scores: The Mean score on the ATR can be computed by adding up item responses and dividing by the number of completed items. The Mean score can range from 1.0 to 4.0.

To help FACT Teams use the ATR to help make decisions about participants who might be ready to transition to less intensive services, cutoff scores were developed. *Cutoff scores should only be used as guides rather than definitive, set-in-stone rules for making transition decisions.*

In this context, participants with Total scores on the ATR equal to or greater than 50 could be considered candidates for transition from FACT to less intensive services. Similarly, participants with Mean scores equal to or greater than 2.8 could be considered for the transition from FACT to less intensive services.

As stated, these cutoffs are only to be used as a guide. The ATR should not be the only method used to help make transition decisions. Clinical and professional judgment remains an important part of identifying whether a participant is ready to transition from FACT Team services. However, the ATR is used to formalize and codify the transition decision-making process by providing relevant information to consider about transitioning a participant to less intensive services. The intent of the ATR is not to replace clinical and professional judgment but to potentially reduce inherent subjectivity and bias.

This is the **Assertive Community Treatment Transition Readiness Scale© (ATR©)**. Each item is scored on a four-point scale: strongly disagree (1), disagree (2), agree (3), strongly agree (4). For example, Item 1 reads, "He/she no longer needs intensive services." If you strongly agree with this statement, a consumer would receive a score of 4 for this item. Before computing Total or Mean scores, the responses to Items 5, 7, 12, and 17 must be reverse-scored. So, if you respond strongly disagree (1) to Item 5, this response should be reverse-scored to 4 before computing Total or Mean scores. At least 14 of the 18 items must be completed before scoring the ATR©. A Total score can be computed by adding up all item responses. Total scores range from 18 to 72. Mean scores can be computed by adding up all item responses and dividing by the number of completed items. Mean scores range from 1.0 to 4.0. Higher Total and Mean scores indicate greater potential to transition from ACT to less intensive services.

Questions about the ATR© should be addressed to Gary S. Cuddeback, Ph.D., University of North Carolina at Chapel Hill, 325 Pittsboro Street, CB#3550, Chapel Hill, NC, 27599, 919.962.4363, cuddeback@mail.schsr.unc.edu.

NAME_____ **DATE** _____ **TOTAL or MEAN SCORE** _____

		Strongly Disagree	Disagree	Agree	Strongly Agree
1.	He/she no longer needs intensive services.	○	○	○	○
2.	He/she has structure in his/her daily life.	○	○	○	○
3.	His/her symptoms have been stable over the last six months.	○	○	○	○
4.	He/she has had stable housing over the last several months.	○	○	○	○
5.	He/she has been in the psychiatric hospital within the last six months.	○	○	○	○
6.	He/she has insight into his/her mental illness.	○	○	○	○
7.	He/she has been incarcerated within the last six months.	○	○	○	○
8.	He/she has benefits in place.	○	○	○	○
9.	He/she is engaged in treatment.	○	○	○	○
10.	He/she is independent.	○	○	○	○
11.	He/she is compliant with his/her medication.	○	○	○	○
12.	He/she has complex needs (i.e., personality disorders, health problems, substance use).	○	○	○	○
13.	He/she has adequate resources.	○	○	○	○
14.	He/she has social support.	○	○	○	○
15.	He/she is gainfully employed.	○	○	○	○
16.	He/she keeps appointments without help.	○	○	○	○
17.	His/her behaviors have not been stable over the last six months.	○	○	○	○
18.	He/she has met his/her treatment goals.	○	○	○	○

APPENDIX D – DEFINITION OF KEY TERMS

Assertive Community Treatment Transition Readiness Scale (ATR)© is an 18-item measure used by FACT Teams to: 1) identify individuals ready to transition from FACT to less intensive services and/or 2) inform an individual's recovery plan and monitor overall progress. The ATR is used to formalize and codify the transition decision-making process by providing relevant information to consider about transitioning a participant. The intent of the ATR is not to replace clinical and professional judgment but to potentially reduce inherent subjectivity and bias.

Comprehensive assessment means an organized process of gathering information to evaluate a person's mental and interactional status and his or her treatment, rehabilitation, and support needs that will enhance recovery. The results of the assessment are used to develop an individual recovery plan for the person.

Culturally competent services mean acknowledging and incorporating variances in normative acceptable behaviors, beliefs, and values in determining an individual's mental wellness/illness and incorporating those variances into assessments and treatment that promotes recovery.

Daily Living Activities-20 (DLA-20) Functional Assessment is a reliable, evidence-based functional assessment tool designed for use by behavioral health providers with individuals aged 6 years through adulthood, regardless of diagnosis. It assesses the impact of mental health symptoms and substance use on an individual's ability to perform essential daily living activities**.**

Empowerment means the process where the provider of services encourages the individual to make choices in matters affecting their lives and to accept personal responsibility for those choices. The empowerment process will include but is not limited to 1) freedom of choice regarding services; 2) influence over the operation and structure of service provision; 3) participation in system-wide recovery planning; and 4) participation in decision-making at the community level.

Enhancement Funds

Funding is used to increase or maintain a person's independence and integration into their community. It may be used for costs related to housing, medications, employment, education, and specialized treatment not paid by any other means. Detailed guidelines on the use of enhancement funds may be found in Appendix A.

Engage as it relates to new admissions means the process of identifying, recruiting, and considering a person for enrollment. A person being considered for FACT who is in a state mental health treatment facility, behavioral health teaching hospital, local hospital, or crisis stabilization unit (CSU) cannot be enrolled until discharge takes place. Team members may begin to visit the person in the hospital and participate in developing the discharge plan but will not officially assume responsibility for providing treatment services until the person is discharged. A person already enrolled in a FACT program continues to be enrolled even though hospitalization via a CSU, local hospital, state mental health treatment facility or behavioral health teaching hospital occurs. Even though a person going through the engagement process has not formally been enrolled in a team, the team must keep a written record on:

- Activities that took place during the engagement process,
- The person's response to engagement activities, and
- The name of the FACT staff member conducting the engagement activities.

Functional Assessment Rating Scale (FARS) is a standardized tool used to measure an individual's level of functioning across multiple domains of daily life. It's designed to quantify how well someone can perform essential activities and manage real-world demands, often in the context of mental health, substance use, or developmental services. The FARS may be used in addition to the required DLA-20 to provide supplemental information on an individual's level of functioning. Use of the FARS is optional and intended to enhance clinical insight, treatment planning, and monitoring of functional progress.

Incompetent to proceed, pursuant to s. 916.106, F.S., means the condition that a defendant is unable to proceed at any material stage of a criminal proceeding due to mental impairment. Those stages shall include a trial of the case

and pretrial hearings involving questions of fact on which the defendant might be expected to testify. It shall also include an entry of a plea, proceedings for violations of probation or violations of community control, sentencing, and hearings on issues regarding a defendant's failure to comply with court orders. It also considers conditions or other matters in which the mental competence of the defendant is necessary for a just resolution of the issues being considered.

Initial assessment and recovery plan means the initial evaluation of a person's mental health status and initial practical resource needs (e.g., housing, finances). The initial recovery plan is completed on the day of admission and guides services until the comprehensive assessment and recovery plan are completed.

Mental illness means an impairment of the mental or emotional processes that exercise conscious control of one's actions or of the ability to perceive or understand reality, which impairment substantially interferes with a person's ability to meet the ordinary demands of living. For this part, the term does not include a developmental disability as defined in Chapter 393, intoxication, or conditions manifested only by antisocial behavior or substance use.[13]

Not guilty by reason of insanity, pursuant to s. 916.15, F.S., means a ruling by a court acquitting a defendant of criminal charges because of a mental deficiency or illness sufficient under the law to preclude conviction.

Psychiatric/social functioning history timeline is the process that helps to organize, chronicle, and evaluate **information** about significant events in a person's life, experience with mental illness, and treatment history.

Psychotropic medication means any drug used to treat, manage, or control psychiatric symptoms or disordered behavior, including but not limited to antipsychotic, antidepressant, mood-stabilizing, or anti-anxiety agents.

Recovery means a process of change through which individuals improve their health and wellness, live a self-directed life and strive to reach their full potential.

Recovery Plan means the culmination of a continuing process involving the participant, family or other supports upon consent, and the team. The plan reflects individualized service activity and intensity to meet person-specific needs that promote recovery. The plan documents the person's goals and the services necessary to achieve them. The plan must reflect the individual's preferences for services and choices in the selection of living arrangements. The plan delineates the roles and responsibilities of the team members who will carry out the services.

Recovery Plan Review means a written summary describing the person's progress since the last recovery-planning meeting; it outlines interactional strengths and limitations at the time the recovery plan is rewritten.

Rehabilitation means services and supports that promote recovery, full community integration, and improved quality of life for persons diagnosed with any mental health condition that seriously impairs their ability to lead meaningful lives. Rehabilitation services are collaborative, person-directed, and individualized. They focus on helping individuals develop skills and access resources needed to increase their capacity to be successful and satisfied in the living, working, learning, and social environments of their choice.[14]

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[13] Chapter 394.455(28), F.S.

[14] Allness, Deborah J., and William H. Knoedler. A Manual for ACT Start-up: Based on the PACT Model of Community Treatment for Persons with Severe and Persistent Mental Illnesses. Arlington, VA: NAMI, 2003. Print.