Tab 1	**SB 1336** by **Latvala**; (Compare to H 0979) Behavioral Health Care Services
Tab 2	**SB 1420** by **Bean**; (Similar to CS/H 1125) Eligibility for Employment as Child Care Personnel
Tab 3	**SB 1676** by **Sachs**; Child Transportation Safety

The Florida Senate

COMMITTEE MEETING EXPANDED AGENDA

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

MEETING DATE: Wednesday, January 27, 2016
TIME: 1:00—3:00 p.m.
PLACE: 301 Senate Office Building

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

TAB	BILL NO. and INTRODUCER	BILL DESCRIPTION and SENATE COMMITTEE ACTIONS	COMMITTEE ACTION
1	**SB 1336** Latvala (Compare H 979, S 12)	Behavioral Health Care Services; Authorizing the Department of Children and Families to monitor and enforce compliance with ch. 394, F.S., relating to mental health; creating the "Jennifer Act"; requiring service providers to give patients information relating to mental health or substance abuse treatment advance directives; requiring the Department of Children and Families to provide information and forms on its website relating to mental health or substance abuse treatment advance directives, etc. CF 01/27/2016 Favorable AHS AP	Favorable Yeas 5 Nays 0
2	**SB 1420** Bean (Similar CS/H 1125)	Eligibility for Employment as Child Care Personnel; Prohibiting certain job applicants from employment with a child care facility, etc. CF 01/27/2016 Temporarily Postponed CJ RC	Temporarily Postponed
3	**SB 1676** Sachs	Child Transportation Safety; Citing this act as the “Haile Brockington Act"; requiring vehicles used to transport children by public entities or by private organizations for hire to be equipped with a certain alarm system by a specified date; requiring the Department of Highway Safety and Motor Vehicles, the Department of Children and Families, and the State Board of Education to adopt rules and maintain a list of alarm manufacturers and approved alarm systems, etc. CF 01/27/2016 Favorable AED AP	Favorable Yeas 5 Nays 0
4	Improving the Ability of Elders to Stay In Their Community Department of Elder Affairs AARP FLORIDA		Discussed

TAB	BILL NO. and INTRODUCER	BILL DESCRIPTION and SENATE COMMITTEE ACTIONS	COMMITTEE ACTION
	Other Related Meeting Documents		

The Florida Senate

BILL ANALYSIS AND FISCAL IMPACT STATEMENT

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

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

BILL: SB 1336

INTRODUCER: Senator Latvala

SUBJECT: Behavioral Health Care Services

DATE: January 26, 2016 REVISED:

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Crosier	Hendon	CF	**Favorable**
2.			AHS	
3.			AP	

I. Summary:

SB 1336 addresses the current system where behavioral health services for persons with complex, persistent and co-occurring disorders pertaining to mental illness and substance use disorder obtain needed services. The bill recognizes that mental health and substance use disorders are diseases of the brain and subspecialties within the field of medical practice.

The bill directs the behavioral health managing entities (MEs) to develop a plan with each county or circuit in its geographic area to ensure all persons with mental health or substance use disorders subject to involuntary admission receive prompt assessment of the need for evaluation and treatment. The MEs are to develop a transportation plan for each county or circuit within its assigned region in consultation with county officials, law enforcement agencies and local acute care providers.

The criteria for involuntary admission, stabilization, and treatment of persons with substance use or mental health disorders are revised. Additionally, the bill specifies certain professionals who are authorized to execute a certificate for emergency admission. The bill prohibits the courts from charging a filing fee for a petition for involuntary assessment and stabilization.

The bill creates the "Jennifer Act" which addresses the use of Mental Health and Substance Abuse Treatment Advance Directives, which includes the allowable provisions, the process for the execution and revocation of such directives and a suggested form to be used.

The bill has an effective date of July 1, 2016.

II. Present Situation:

Mental Health and Substance Abuse

Mental illness creates enormous social and economic costs.[1] Unemployment rates for persons with mental disorders are high relative to the overall population.[2] People with severe mental illness have exceptionally high rates of unemployment, between 60 percent and 100 percent.[3] Mental illness increases a person's risk of homelessness in America threefold.[4] Studies show that approximately 33 percent of our nation's homeless live with a serious mental disorder, such as schizophrenia, for which they are not receiving treatment.[5] Often the combination of homelessness and mental illness leads to incarceration, which further decreases a person's chance of receiving proper treatment and leads to future re-offenses.[6]
According to the National Alliance on Mental Illness (NAMI), approximately 50 percent of individuals with severe mental health disorders are affected by substance abuse.[7] NAMI also estimates that 29 percent of all people diagnosed as mentally ill abuse alcohol or other drugs.[8] When mental health disorders are left untreated, substance abuse is likely to increase. When substance abuse increases, mental health symptoms often increase as well or new symptoms may be triggered. This could also be due to discontinuation of taking prescribed medications or the contraindications for substance abuse and mental health medications. When taken with other medications, mental health medications can become less effective.[9]

Behavioral Health Managing Entities

In 2008, the Legislature required the department to implement a system of behavioral health managing entities that would serve as regional agencies to manage and pay for mental health and substance abuse services.[10] Prior to this time, the department, through its regional offices, contracted directly with behavioral health service providers. The Legislature found that a management structure that places the responsibility for publicly-financed behavioral health treatment and prevention services within a single private, nonprofit entity at the local level, would promote improved access to care, promote service continuity, and provide for more efficient and effective delivery of substance abuse and mental health services. There are currently seven managing entities across the state.[11]

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[1] Mental Illness: The Invisible Menace, *Economic Impact* http://www.mentalmenace.com/economicimpact.php
[2] Mental Illness: The Invisible Menace, *More impacts and facts* http://www.mentalmenace.com/impactsfacts.php
[3] *Id.*
[4] Family Guidance Center, *How does Mental Illness Impact Rates of Homelessness?* (February 4, 2014) *available at* http://www.familyguidance.org/how-does-mental-illness-impact-rates-of-homelessness/
[5] *Id.*
[6] *Id.*
[7] Donna M. White, LPCI, CACP, Psych Central.com, *Living with Co-Occurring Mental & Substance Abuse Disorders,* (October 2, 2013) *available at* http://psychcentral.com/blog/archives/2013/10/02/living-with-co-occurring-mental-substance-abuse-disorders/
[8] *Id.*
[9] *Id.*
[10] *See* s. 394.9082, F.S., as created by Chapter 2008-243, Laws of Fla.
[11] Department of Children and Families website, http://www.myflfamilies.com/service-programs/substance-abuse/managing-entities, (last visited Jan. 23, 2016).

Baker Act

In 1971, the Legislature adopted the Florida Mental Health Act, known as the Baker Act.[12] The Act authorized treatment programs for mental, emotional, and behavioral disorders. The Baker Act required programs to include comprehensive health, social, educational, and rehabilitative services to persons requiring intensive short-term and continued treatment to facilitate recovery. Additionally, the Baker Act provides protections and rights to individuals examined or treated for mental illness. Legal procedures are addressed for mental health examination and treatment, including voluntary admission, involuntary admission, involuntary inpatient treatment, and involuntary outpatient treatment.

Mental illness creates enormous social and economic costs.[13] Unemployment rates for persons having mental disorders are high relative to the overall population.[14] Rates of unemployment for people having a severe mental illness range between 60 percent and 100 percent.[15] Mental illness increases a person's risk of homelessness in America threefold.[16] Approximately 33 percent of the nation's homeless live with a serious mental disorder, such as schizophrenia, for which they are untreated.[17] Often the combination of homelessness and mental illness leads to incarceration, which further decreases a person's chance of receiving proper treatment and leads to future recidivism.[18]

Marchman Act

In 1993, the Legislature adopted the Hal S. Marchman Alcohol and Other Drug Services Act. The Marchman Act provides a comprehensive continuum of accessible and quality substance abuse prevention, intervention, clinical treatment, and recovery support services. Services must be provided in the least restrictive environment to promote long-term recovery. The Marchman Act includes various protections and rights of patients served.

Transportation to a Facility

The Marchman Act authorizes an applicant seeking to have a person admitted to a facility, the person's spouse or guardian, a law enforcement officer, or a health officer to transport the individual for an emergency assessment and stabilization.[19]

The Baker Act requires each county to designate a single law enforcement agency to transfer the person in need of services. If the person is in custody based on noncriminal or minor criminal behavior, the law enforcement officer will transport the person to the nearest receiving facility.

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[12] Chapter 71-131, Laws of Fla.; The Baker Act is contained in ch. 394, F.S.
[13] MentalMenace.com, *Mental Illness: The Invisible Menace; Economic Impact,* http://www.mentalmenace.com/economicimpact.php (last visited Jan. 23, 2016).
[14] MentalMenace.com, *Mental Illness: The Invisible Menace: More impacts and facts,* http://www.mentalmenace.com/impactsfacts.php (last visited Jan. 23, 2016).
[15] *Id.*
[16] Family Guidance Center for Behavioral Health Care, *How does Mental Illness Impact Rates of Homelessness?,* (February 4, 2014), http://www.familyguidance.org/how-does-mental-illness-impact-rates-of-homelessness/.
[17] *Id.*
[18] *Id.*
[19] Section 397.6795, F.S.

If, however, the person is arrested for a felony the person must first be processed in the same manner as any other criminal suspect. The law enforcement officer must then transport the person to the nearest facility, unless the facility is unable to provide adequate security.[20]

The Marchman Act allows law enforcement officers, however, to temporarily detain substance-impaired persons in a jail setting. An adult not charged with a crime may be detained for his or her own protection in a municipal or county jail or other appropriate detention facility. Detention in jail is not considered to be an arrest, is temporary, and requires the detention facility to provide if necessary transfer of the detainee to an appropriate licensed service provider with an available bed.[21] However, the Baker Act prohibits the detention in jail of a mentally ill person if he or she has not been charged with a crime.[22]

Involuntary Admission to a Facility

Criteria for Involuntary Admission

The Marchman Act provides that a person meets the criteria for involuntary admission if good faith reason exists that the person is substance abuse impaired and because of the impairment:

- Has lost the power of self-control with respect to substance abuse; and either
- Has inflicted, threatened to or attempted to inflict self-harm; or
- Is in need of services and due to the impairment, judgment is so impaired that the person is incapable of appreciating the need for services.[23]

Protective Custody

A person who meets the criteria for involuntary admission under the Marchman Act may be taken into protective custody by a law enforcement officer.[24] The person may consent to have the law enforcement officer transport the person to his or her home, a hospital, or a licensed detoxification or addictions receiving facility.[25] If the person does not consent, the law enforcement officer may transport the person without using unreasonable force.[26]

Time Limits

A critical 72-hour period applies under both the Marchman and the Baker Act. Under the Marchman Act, a person may only be held in protective custody for a 72-hour period, unless a petition for involuntary assessment or treatment has been timely filed with the court within that timeframe to extend protective custody.[27] The Baker Act provides that a person cannot be held in a receiving facility for involuntary examination for more than 72 hours.[28] Within that 72-hour examination period, or, if the 72 hours ends on a weekend or holiday, no later than the next working day, one of the following must happen:

[20] Section 394.462(1)(f) and (g), F.S.
[21] Section 397.6772(1), F.S.
[22] Section 394.459(1), F.S.
[23] Section 397.675, F.S.
[24] Section 397.677, F.S.
[25] Section 397.6771, F.S.
[26] Section 397.6772(1), F.S.
[27] Section 397.6773(1) and (2), F.S.
[28] Section 394.463(2)(f), F.S.

- The patient must be released, unless he or she is charged with a crime, in which case law enforcement will resume custody;
- The patient must be released into voluntary outpatient treatment;
- The patient must be asked to give consent to be placed as a voluntary patient if placement is recommended; or
- A petition for involuntary placement must be filed in circuit court for outpatient or inpatient treatment.[29]

Under the Marchman Act, if the court grants the petition for involuntary admission, the person may be admitted for a period of five days to a facility for involuntary assessment and stabilization.[30] If the facility needs more time, the facility may request a seven-day extension from the court.[31] Based on the involuntary assessment, the facility may retain the person pending a court decision on a petition for involuntary treatment.[32]

Under the Baker Act, the court must hold a hearing on involuntary inpatient or outpatient placement within five working days after a petition for involuntary placement is filed.[33] The petitioner must show, by clear and convincing evidence all available less restrictive treatment alternatives are inappropriate and that the individual:

- Is mentally ill and because of the illness has refused voluntary placement for treatment or is unable to determine the need for placement; and
- Is manifestly incapable of surviving alone or with the help of willing and responsible family and friends, and without treatment is likely suffer neglect to such an extent that it poses a real and present threat of substantial harm to his or her well-being, or substantial likelihood exists that in the near future he or she will inflict serious bodily harm on himself or herself or another person.[34]

Advance Directive for Mental Health or Substance Abuse Treatment

Florida law currently allows an individual to create an advance directive which designates a surrogate to make health care decisions and provides a process for the execution of the directive.[35] Currently law also allows an individual to designate a separate surrogate to consent to mental health treatment if the individual is determined by a court to be incompetent to consent to mental health treatment.[36] A mental health or substance abuse treatment advance directive is much like a living will for health care.[37] Acute episodes of mental illness temporarily destroy the capacity required to give informed consent and often prevent people from realizing they are sick, causing them to refuse intervention.[38] Even in the midst of acute episodes, many people do not

[29] Section 394.463(2)(i)4., F.S.
[30] Section 397.6811, F.S.
[31] Section 397.6821, F.S.
[32] Section 397.6822, F.S.
[33] Sections 394.4655(6) and 394.467(6), F.S.
[34] Section 394.467(1), F.S.
[35] Section 765.202, F.S.
[36] Section 765.202(5), F.S.
[37] Washington State Hospital Association, *Mental Health Advance Directives,* copy on file with the Senate Committee on Children, Families and Elder Affairs.
[38] Judy A. Clausen, *Making the Case for a Model Mental Health Advance Directive Statute,* 14 Yale Journal of Health Policy, Law & Ethics, Winter 2014 on file with the Senate Committee on Children, Families and Elder Affairs.

meet commitment criteria because they are not likely to injure themselves or others and are still able to care for their basic needs.[39] Left untreated, the episode will likely spiral out of control and by the time the person meets the commitment criteria, devastation has already occurred.[40]

The Uniform Law Commissioners enacted the Uniform Health-Care Decisions Act as a model statute to address all types of advance health care planning, including planning for mental illness; however, the Act focuses on end-of-life care and fails to address many issues faced by people with mental illness.[41] A key failure of the Uniform Act is that it does not empower patients to form self-binding arrangements for care.[42] These self-binding arrangements are known as Ulysses arrangement. A Ulysses arrangement is a type of mental health advance directive that serves as a preventative measure for a patient to obtain treatment during an episode because the patient has learned that episodes cause him or her to refuse needed intervention.[43] The arrangement is entered into when the individual has capacity. A Ulysses arrangement authorizes doctors to treat the patient during a future episode when the he or she lacks capacity even if the episode causes the individual to refuse treatment at that time. Without a Ulysses arrangement, an individual whose illness causes him to revoke his mental health advance directive and refuse treatment has no mechanism to secure intervention unless he meets involuntary commitment criteria.[44] Ulysses arrangements are superior to involuntary commitment because involuntary commitment comes too late and is often traumatic; the proceedings can be dehumanizing; and police intervention and apprehension can be dangerous.[45] Additionally, the Ulysses arrangement allows the individual to secure treatment from the individual's regular mental health treatment provider who understands the patient's illness and history, in a facility the individual chooses.[46]

III. Effect of Proposed Changes:

Section 1 amends s. 394.453, F.S., to include in the legislative findings that mental health and substance use disorders are diseases of the brain, are complex medical conditions that encompass biological, genetic, psychological, cultural, and social factors; and are sub-specialties within the field of medical practice. The legislative intent is further amended to authorize licensed, qualified health professionals to exercise the full authority of their respective scopes of practice in the performance of professional functions necessary to carry out the intent of this part. Additionally, the legislative intent is to ensure local systems of acute care services use a common protocol and services are provided using the coordination of care principles characteristic of recovery-oriented services.

Section 2 amends s. 394.66, F.S., to provide that with respect to mental health and substance abuse services, it is the legislative intent to recognize that mental health and substance use disorders are diseases of the brain; are complex medical conditions that encompass biological,

[39] *Id.*
[40] *Id.*
[41] *Id.*
[42] *Id.*
[43] *Id at 2.*
[44] *Id at 6.*
[45] *Id.*
[46] Judy Ann Clausen, *Bring Ulysses to Florida: Proposed Legislative Relief for Mental Health Patients,* article to be published in Marquette University's Elder's Advisor Law Review. Copy on file with the Senate Committee on Children, Families and Elder Affairs.

genetic, psychological, cultural, and social factors; and are sub-specialties within the field of medical practice.

Section 3 amends s. 394.9082, F.S., to provide direction to managing entities in their geographic region to develop a plan to establish and maintain a behavioral health service system with sufficient capacity to ensure all persons with mental health or substance use disorders who are subject to involuntary admission receive prompt assessment of their need for evaluation and treatment. This section requires that the plan must include components such as the designation of a receiving facility that must be used by law enforcement and may be used by other authorized persons and that without a designation by the department, the facility may not hold or treat involuntary patients under chapter 394.

This section also requires the managing entities to coordinate and develop a local plan that includes a county or circuit, establish specifications and minimum standards for access to care in each community and develop a local transportation plan, including an option to procure nonmedical transportation of persons between facilities. The managing entities shall also conduct a needs assessment incorporating community resources designated in such plans and coordinate the resources within its assigned region.

The managing entities are required to develop a transportation plan for each county or circuit within its assigned region in consultation with and approved by local law enforcement agencies, county officials, and local acute care providers. The plan must address the designated public or private substance abuse receiving facility or residential detoxification facility to be used by local law enforcement as their primary receiving facility; how the person will be transported after law enforcement relinquishes physical custody of the person; and specify responsibility for and the means by which transportation to and between facilities will be implemented. The plan department has final review and approval authority for the transportation plans.

Section 4 amends s. 397.305, F.S., to provide that with respect to mental health and substance abuse services, it is the legislative intent to recognize that mental health and substance use disorders are diseases of the brain; are complex medical conditions that encompass biological, genetic, psychological, cultural, and social factors; and are sub-specialties within the field of medical practice. The legislative intent is further amended to recognize that a person’s ability to reason, exercise good judgment, recognize the needs for services, or sufficiently provide self-care, the responsibility for such care must be delegated to a third party and may be vested in an authorized, qualified health professional who can provide such behavioral health services.

Section 5 amends s. 397.675, F.S., to revise the criteria for involuntary admission for persons with substance use or co-occurring mental health disorder to include the refusal or inability to determine whether examination is necessary and that without care or treatment the person is likely to neglect or refuse care to the extent that the neglect or refusal poses a real and present threat of substantial harm to his or her well-being; there is risk of deterioration of his or her physical or mental health or there is substantial likelihood that the person will cause serious bodily harm to himself or herself or others.

Section 6 amends s. 397.6793, F.S., to expand the list of professionals who may initiate a certificate for emergency admission of a person to a hospital or licensed detoxification facility to

include a physician, a clinical psychologist, physician's assistant working under the scope of practice of the supervising physician, psychiatric nurse, advanced registered nurse practitioner, licensed mental health counselor, licensed marriage and family therapist, master's level-certified addiction professional for substance abuse services, or a licensed clinical social worker. The professional executing the certificate must have examined the person within the preceding 5 days and state the observations upon which the conclusion that the person appears to meet the criteria for emergency admission is based.

Section 7 amends s. 397.681, F.S., to specify that a court may not charge a fee for the filing of a petition for involuntary assessment and stabilization.

Section 8 amends s. 397.6811, F.S., to allow a petition for involuntary assessment and stabilization to be filed by a person who has direct knowledge that the person is a threat to himself or herself or others.

Section 9 amends s. 397.6818, F.S., to provide that the court's order for involuntary admission is valid until executed or for the period specified in the order. If the order does not provide a time limit, the order is valid for 7 days after the date the order is signed.

Section 10 amends s. 397.697, F.S., to increase the time a court may order a person to undergo involuntary treatment by a licensed service provider from 60 days to 90 days.

Section 11 amends s. 397.6971, F.S., to allow for early release from involuntary substance abuse treatment before the end of the 90 day treatment period if the individual no longer meets the criteria specified in s. 397.675, F.S.

Section 12 amends s. 397.6977, F.S., to revise the time frame that an individual may be ordered into involuntary substance abuse treatment from 60 days to 90 days.

Section 13 amends s. 397.6955, F.S., to require the court to schedule a hearing on the petition for involuntary treatment within 5 days instead of 10 days unless a continuance is granted.

Section 14 provides that the Louis de la Parte Florida Mental Health Institute within the University of South Florida will provide the department copies of documents regarding involuntary examination, outpatient and inpatient placement orders on a monthly basis.

Section 15 amends s. 397.6773, F.S., to correct a cross-reference.

Section 16 redesignates Part V of chapter 765, F.S., as Part IV, and creates a new Part V of chapter 765, F.S., and entitles it as "Mental Health and Substance Abuse Treatment Advance Directives."

Section 17 creates s. 765.501, F.S., to provide that ss. 765.501-765.509, F.S., and this law may be cited as the "Jennifer Act".
Section 18 creates s. 765.502, F.S., to provide legislative findings that individuals with capacity have the ability to control decisions relating to his or her own mental health or substance abuse treatment. The Legislature further finds that substance abuse and mental illness cause individuals

to fluctuate between capacity and incapacity; the individual may be unable to provide informed consent necessary to access needed treatment during a time when the individual's capacity is unclear; early treatment may prevent the individual from becoming so ill that involuntary treatment is necessary; and individuals with mental illness and substance abuse impairment need an established procedure to express their instructions and preferences for treatment and to provide advance consent to or refusal of treatment. This procedure should be less restrictive and less expensive than guardianship.

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

Section 19 creates s. 765.503, F.S., to provide definitions for terms used in this section.

Section 20 creates s. 765.504, F.S., to provide for the creation, execution and allowable provisions of mental health or substance abuse treatment advance directives. An adult with capacity may execute a mental health or substance abuse impairment advance directive. A directive executed in accordance with this part is presumed valid, however, the inability to honor one or more of the provisions of the advance directive does not invalidate the remaining provisions. The directive may include any provision related to mental health or substance abuse treatment or the care of the principal or the principal's personal affairs. Without limitation, the directive may include:

- The individual's preferences and instructions for mental health or substance abuse treatment.
- Refusal to consent to specific types of mental health or substance abuse treatment.
- Descriptions of situations that may cause the individual to experience a mental health or substance abuse crisis.
- Suggested alternative responses that may supplemental or be in lieu of direct mental health or substance abuse treatment, such as treatment approaches from other providers.
- The nomination of a guardian, limited guardian, or guardian advocate, by the individual.
- The directive may be independent of or combined with a nomination of a guardian or other durable power of attorney.

Section 21 creates s. 765.505, F.S., to provide for the execution, effective date and expiration of a mental health or substance abuse advance directive. The bill provides that the advance directive must be in writing, clearly indicate that the individual intends to create a directive. The directive must be witnessed by two adults, who must declare they were present when the individual dated and signed the directive, and that the individual did not appear to be incapacitated, acting under fraud, undue influence or duress. The surrogate named in the directive cannot act as a witness to the execution of the directive and at least one witness must not be the spouse or blood relative of the individual executing the directive.

The bill provides that the directive is valid upon execution but all or part may take effect at a later date as designated in the directive. It also provides that a directive may be revoked in whole or in part or expire under its own terms. A directive may not create an entitlement to mental health, substance abuse, or medical treatment or supersede a determination of medical necessity. The directive does not obligate any health care provider, professional person, or health care

facility to pay the costs associated with requested treatment or to be responsible for the nontreatment or personal care of the individual or his or her affairs outside the facilities' scope of services. Additionally, the directive does not replace or supersede any will, testamentary document or the provision of intestate succession.

Section 22 creates s. 765.506, F.S., to provide for the revocation or waiver of an advance directive. A copy of the revocation of the advance directive must be provided by the individual, and is effective upon receipt by, his or her agent, each health care provider, professional person or health care facility that received a copy of the individual's advance directive. The principal's family, a health care facility, an attending physician, or any other interested person who may be directly affected by a surrogate's decision may seek expedited judicial intervention pursuant to Rule 5.900 of the Florida Probate Code under certain conditions.

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

Section 23 creates s. 765.507, F.S., to provide that a surrogate, health care facility, provider or other person who acts under the direction of a health care facility or provider is not subject to criminal prosecution or civil liability or to have engaged in unprofessional conduct as a result of carrying out a mental health or substance abuse treatment decision contained in a directive.

Section 24 creates s. 765.508, F.S., to provide for the recognition of mental health and substance abuse treatment advance directives that are executed in another state in compliance with the laws of that state are valid.

Section 25 creates s. 765.509, F.S., to provide that a service provider is to give information relating to mental health or substance abuse treatment advance directives to its patients and assist competent and willing patients in completing such documents. The service provider may not require patients to execute a mental health or substance abuse treatment advance directive; however an executed mental health or substance abuse treatment advance directive shall be part of the patient's medical record. The department is directed to develop and publish on its website information on the creation, execution and purpose of mental health or substance abuse treatment advance directives, including a form for such document.

Section 26 amends s. 406.11, F.S., to correct cross-references.

Section 27 amends s. 408.802, F.S., to correct cross-references.

Section 28 amends s. 408.820, F.S., to correct cross-references.

Section 29 amends s. 765.101, F.S., to correct cross-references.

Section 30 amends s. 765.203, F.S., to create a suggested form for a mental health or substance abuse treatment advance directive and the designation of a health care surrogate.

Section 31 provides for an effective date of July 1, 2016.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

This bill prohibits a fee for filing a petition under the Marchman Act. No such fees are currently assessed, therefore, the bill will not reduce any fee revenue to the clerks of court and the state court system.

B. Private Sector Impact:

None

C. Government Sector Impact:

To the extent that the department has to develop and publish information on the creation, execution, and purpose of mental health or substance abuse treatment advance directives, there may be a fiscal impact.

VI. Technical Deficiencies:

Section 3 provides that a designated receiving facility shall be used by law enforcement offices but may be used by other authorized persons. The bill does not provide who the other authorized persons are that may use the designated receiving facility.

Also in Section 3, the managing entity is directed to develop a plan to establish and maintain a behavioral health service system. Subsequently, in the same section, the managing entity is directed to coordinate the development of a local plan and then the managing entity is directed to provide technical assistance to counties or circuits for the development, receipt, and approval of such plans.

Section 14 provides statutory language directing the Louis de la Parte Florida Mental Health Institute within the University of South Florida to provide certain documents to the department on a monthly basis. The provision does not amend a current statute or create a new statute.

VII. Related Issues:

None.

VIII. Statutes Affected:

This bill substantially amends the following sections of the Florida Statutes: 394.453, 394.66, 394.9082, 397.305, 397.675, 397.6793, 397.681, 397.6811, 397.6818, 397.697, 397.6971, 397.6977, 397.6955, 397.6773, 406.11, 408.802, 408.820, 765.101, and 765.203.

This bill creates the following sections of the Florida Statutes: 765.501, 765.502, 765.503, 765.504, 765.505, 765.506, 765.507, 765.508, and 765.509.

IX. Additional Information:

A. Committee Substitute – Statement of Changes:

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

None.

B. Amendments:

None.

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

By Senator Latvala

1 A bill to be entitled
2 An act relating to behavioral health care services;
3 amending s. 394.453, F.S.; revising legislative intent
4 and providing legislative findings for the Florida
5 Mental Health Act; amending ss. 394.66 and 397.305,
6 F.S.; revising legislative intent with respect to
7 mental health and substance abuse treatment services;
8 amending s. 394.9082, F.S.; requiring behavioral
9 health managing entities to coordinate service
10 delivery plans with their respective counties or
11 circuits; providing responsibilities of county
12 governments for designation of receiving facilities
13 for the examination and assessment of persons with
14 mental health or substance use disorders; authorizing
15 the Department of Children and Families to monitor and
16 enforce compliance with ch. 394, F.S., relating to
17 mental health; requiring managing entities to
18 coordinate the development of a certain local plan;
19 requiring managing entities to provide certain
20 technical assistance; requiring managing entities to
21 develop and implement transportation plans; requiring
22 local law enforcement agencies, local governments, and
23 certain providers to review and approve transportation
24 plans; providing departmental authority for final
25 approval of such plans; amending s. 397.675, F.S.;
26 revising criteria for involuntary admission for
27 assessment, stabilization, and treatment of persons
28 with substance use or mental health disorders;
29 amending s. 397.6793, F.S.; specifying professionals
30 authorized to execute a certificate for emergency
31 admission; providing criteria for emergency admission;
32 amending s. 397.681, F.S.; prohibiting a court from

33 charging a fee for the filing of a petition for
34 involuntary assessment and stabilization; amending s.
35 397.6811, F.S.; revising who may file a petition for
36 involuntary assessment and stabilization; amending s.
37 397.6818, F.S.; providing a time limitation on a court
38 order authorizing involuntary assessment and
39 stabilization; amending ss. 397.697, 397.6971, and
40 397.6977, F.S.; revising the maximum duration of
41 court-ordered involuntary treatment and conforming
42 provisions; amending s. 397.6955, F.S.; revising
43 requirements for scheduling a hearing on a petition
44 for involuntary treatment; requiring the Louis de la
45 Parte Florida Mental Health Institute within the
46 University of South Florida to provide certain
47 information to the department on a monthly basis;
48 amending s. 397.6773, F.S.; conforming a cross-
49 reference; redesignating part V of ch. 765, F.S., as
50 part VI of ch. 765, F.S.; creating a new part V of ch.
51 765, F.S., entitled “Mental Health and Substance Abuse
52 Treatment Advance Directives”; creating s. 765.501,
53 F.S.; providing a short title; creating s. 765.502,
54 F.S.; providing legislative findings; creating s.
55 765.503, F.S.; defining terms; creating s. 765.504,
56 F.S.; authorizing the execution of mental health or
57 substance abuse treatment advance directives;
58 authorizing directive provisions; creating s. 765.505,
59 F.S.; providing requirements for the execution of a
60 mental health or substance abuse treatment advance
61 directive; creating s. 765.506, F.S.; providing

62 requirements for the revocation or waiver of a mental
63 health or substance abuse treatment advance directive;
64 creating s. 765.507, F.S.; providing an immunity from
65 liability; providing applicability; creating s.
66 765.508, F.S.; providing for the recognition of a
67 mental health or substance abuse treatment advance
68 directive executed in another state; creating s.
69 765.509, F.S.; requiring service providers to give
70 patients information relating to mental health or
71 substance abuse treatment advance directives;
72 prohibiting a service provider from requiring a
73 patient to execute a mental health or substance abuse
74 treatment advance directive; requiring the Department
75 of Children and Families to provide information and
76 forms on its website relating to mental health or
77 substance abuse treatment advance directives; amending
78 ss. 406.11, 408.802, 408.820, 765.101, and 765.203,
79 F.S.; conforming cross-references; providing an
80 effective date.
81
82 Be It Enacted by the Legislature of the State of Florida:
83
84 Section 1. Section 394.453, Florida Statutes, is amended to
85 read:
86 394.453 Legislative findings and intent.—
87 (1) The Legislature finds that mental health and substance
88 use disorders are diseases of the brain; are complex medical
89 conditions that encompass biological, genetic, psychological,
90 cultural, and social factors; and are subspecialties within the

91 field of medical practice. The Legislature recognizes that
92 behavioral health disorders may temporarily or permanently
93 affect a person’s ability to reason, exercise good judgment,
94 recognize the need for services, or sufficiently provide self-
95 care; thus responsibility for such a person’s care must be
96 delegated to a third party and may be vested in an authorized,
97 licensed, qualified health professional who can provide
98 behavioral health services.
99 (2) It is the intent of the Legislature:
100 (a) To authorize licensed, qualified health professionals
101 to exercise the full authority of their respective scopes of
102 practice in the performance of professional functions necessary
103 to carry out the intent of this part.
104 (b) To ensure that local systems of acute care services use
105 a common protocol and apply consistent practice standards that
106 provide for nondiscriminatory and equitable access to the level
107 and duration of care based on the specific needs and preferences
108 of the persons served.
109 (c) That services provided to persons in this state use the
110 coordination-of-care principles characteristic of recovery-
111 oriented services and include social support services, such as
112 housing support, life skills and vocational training, and
113 employment assistance, necessary for persons with mental health
114 and substance use disorders to live successfully in their
115 communities.
116 (d) To authorize and direct the Department of Children and
117 Families to evaluate, research, plan, and recommend to the
118 Governor and the Legislature programs designed to reduce the
119 occurrence, severity, duration, and disabling aspects of mental,

120 emotional, and behavioral disorders.
121 (e) That state policy and funding decisions be driven by
122 data that is representative of the populations served and the
123 effectiveness of services provided.
124 (f) ~~It is the intent of the Legislature~~ That treatment
125 programs for such disorders shall include, but not be limited
126 to, comprehensive health, social, educational, and
127 rehabilitative services to persons requiring intensive short-
128 term and continued treatment in order to encourage them to
129 assume responsibility for their treatment and recovery. It is
130 intended that:
131 1. Such persons be provided with emergency service and
132 temporary detention for evaluation when required;
133 2. Such persons ~~that they~~ be admitted to treatment
134 facilities on a voluntary basis when extended or continuing care
135 is needed and unavailable in the community;
136 3. ~~that~~ Involuntary placement be provided only when expert
137 evaluation determines that it is necessary;
138 4. ~~that~~ Any involuntary treatment or examination be
139 accomplished in a setting that ~~which~~ is clinically appropriate
140 and most likely to facilitate the person's return to the
141 community as soon as possible; and
142 5. ~~that~~ Individual dignity and human rights be guaranteed
143 to all persons who are admitted to mental health facilities or
144 who are being held under s. 394.463. ~~It is the further intent of~~
145 ~~the Legislature that the least restrictive means of intervention~~
146 ~~be employed based on the individual needs of each person, within~~
147 ~~the scope of available services.~~
148 (3) It is the policy of this state that the use of

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149 restraint and seclusion on clients is justified only as an
150 emergency safety measure to be used in response to imminent
151 danger to the client or others. It is, therefore, the intent of
152 the Legislature to achieve an ongoing reduction in the use of
153 restraint and seclusion in programs and facilities serving
154 persons with mental illness.
155 Section 2. Subsection (2) of section 394.66, Florida
156 Statutes, is amended to read:
157 394.66 Legislative intent with respect to substance abuse
158 and mental health services.—It is the intent of the Legislature
159 to:
160 (2) Recognize that mental health and substance use
161 disorders are diseases of the brain; are complex medical
162 conditions that encompass biological, genetic, psychological,
163 cultural, and social factors; and are subspecialties within the
164 field of medical practice. The Legislature recognizes that
165 behavioral health disorders may temporarily or permanently
166 affect a person's ability to reason, exercise good judgment,
167 recognize the need for services, or sufficiently provide self-
168 care, thus responsibility for such a person's care must be
169 delegated to a third party and may be vested in an authorized,
170 licensed, qualified health professional who can provide
171 behavioral health services ~~mental illness and substance abuse~~
172 ~~impairment are diseases that are responsive to medical and~~
173 ~~psychological interventions and management that integrate~~
174 ~~treatment, rehabilitative, and support services to achieve~~
175 ~~recovery~~.
176 Section 3. Subsections (4) through (12) of section
177 394.9082, Florida Statutes, are renumbered as subsections (6)

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178 though (14), respectively, and new subsections (4) and (5) are
179 added to that section, to read:
180 394.9082 Behavioral health managing entities.—
181 (4) COMMUNITY PLANNING.—Each managing entity shall develop
182 a plan with each county or circuit in its geographic area to
183 establish and maintain a behavioral health service system that
184 has sufficient capacity to ensure that all persons with mental
185 health or substance use disorders who are subject to involuntary
186 admission under this chapter receive prompt assessment of the
187 need for evaluation and treatment. At a minimum, the plan must
188 include the following components:
189 (a) Each county shall work with managing entities, the
190 department, community-based treatment providers, private
191 providers, local hospitals and health departments, law
192 enforcement agencies, the courts, and other local governmental
193 agencies to designate a receiving facility that shall be used by
194 law enforcement officers, but may be used by other authorized
195 persons, for voluntary and involuntary assessments or
196 examinations.
197 1. A county may have more than one facility or may use or
198 share the resources of adjacent counties.
199 2. The department shall suspend or withdraw such
200 designation for failure to comply with this chapter and rules
201 adopted under this chapter. Unless designated by the department,
202 a facility may not hold or treat involuntary patients under this
203 chapter.
204 (b) A managing entity shall coordinate the development of a
205 local plan that:
206 1. Includes the county or circuit.

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207 2. Establishes the specifications and minimum standards for
208 access to care available in each community and specifies the
209 roles, processes, and responsibilities of community intervention
210 programs for the diversion of persons from acute care
211 placements.
212 3. Specifies the method by which local hospitals,
213 ambulatory centers, designated receiving facilities, and acute
214 care inpatient and detoxification providers will coordinate
215 activities to assess, examine, triage, intake, and process
216 persons presented on an involuntary basis.
217 4. Includes a local transportation plan as provided in s.
218 394.462.
219 5. Provides an option to procure nonmedical transportation
220 contracts for the transportation of patients between facilities.
221 (c) A managing entity shall provide technical assistance to
222 counties or circuits for the development, receipt, and approval
223 of such plans and incorporate the community resources designated
224 in such plans when conducting the needs assessment and
225 coordinating the resources within its assigned region.
226 (5) TRANSPORTATION PLANS.—
227 (a) Each managing entity shall develop, in consultation
228 with local law enforcement agencies, county officials, and local
229 acute care providers, a transportation plan for each county or
230 circuit within its assigned region. At a minimum, the plan must
231 address the following:
232 1. The designated public or private substance abuse
233 receiving facility or residential detoxification facility to be
234 used by local law enforcement agencies as their primary
235 receiving facility.

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2. The method of transporting a person after a law enforcement officer has relinquished physical custody of the person at a designated public or private substance abuse receiving facility or residential detoxification facility.

3. Provide for consumer choice with respect to a receiving facility or other designated facility, or other acute care service provider capable of meeting the person's needs, within reasonable parameters of funding, geography, and safety.

4. Specify responsibility for and the means by which transportation to and between facilities of persons in need of behavioral health services will be implemented to support involuntary assessments or examinations, provision of emergency services, acute care placements, and attendance at involuntary court proceedings and resulting commitments.

(b) The transportation plan shall be initiated by the local managing entity and must be reviewed and approved by local law enforcement agencies, county commissioners, and designated acute care providers in the county or circuit before submission to the managing entity. The department has final review and approval authority for the transportation plan.

Section 4. Section 397.305, Florida Statutes, is amended to read:

397.305 Legislative findings, intent, and purpose.—

(1) The Legislature finds that mental health and substance use disorders are diseases of the brain; are complex medical conditions that encompass biological, genetic, psychological, cultural, and social factors; and are subspecialties within the field of medical practice. The Legislature recognizes that behavioral health disorders may temporarily or permanently

affect a person's ability to reason, exercise good judgment, recognize the need for services, or sufficiently provide self-care, thus responsibility for such a person's care must be delegated to a third party and may be vested in an authorized, licensed, qualified health professional who can provide behavioral health services.

(2)~~(1)~~ Substance abuse is a major health problem that affects multiple service systems and leads to such profoundly disturbing consequences as serious impairment, chronic addiction, criminal behavior, vehicular casualties, spiraling health care costs, AIDS, and business losses, and significantly affects the culture, socialization, and learning ability of children within our schools and educational systems. Substance abuse impairment is a disease which affects the whole family and the whole society and requires a system of care that includes prevention, intervention, clinical treatment, and recovery support services that support and strengthen the family unit. ~~Further, it is the intent of the Legislature to require the collaboration of state agencies, service systems, and program offices to achieve the goals of this chapter and address the needs of the public; to establish a comprehensive system of care for substance abuse; and to reduce duplicative requirements across state agencies.~~ This chapter is designed to provide for substance abuse services.

(3)~~(2)~~ It is the goal of the Legislature to discourage substance abuse by promoting healthy lifestyles; healthy families; and drug-free schools, workplaces, and communities.

(4)~~(3)~~ It is the purpose of this chapter to provide for a comprehensive continuum of accessible and quality substance

abuse prevention, intervention, clinical treatment, and recovery support services in the least restrictive environment which promotes long-term recovery while protecting and respecting the rights of individuals, primarily through community-based private not-for-profit providers working with local governmental programs involving a wide range of agencies from both the public and private sectors.

(5) It is the intent of the Legislature to authorize licensed, qualified health professionals to exercise the full authority of their respective scopes of practice in the performance of professional functions necessary to carry out the intent of this chapter.

(6) It is the intent of the Legislature that state policy and funding decisions be driven by data that is representative of the populations served and the effectiveness of services provided.

(7) It is the intent of the Legislature to establish expectations that services provided to persons in this state use the coordination-of-care principles characteristic of recovery-oriented services and include social support services, such as housing support, life skills and vocational training, and employment assistance, necessary for persons with mental health and substance use disorders to live successfully in their communities.

(8) ~~(4)~~ It is the intent of the Legislature to ensure within available resources a full system of care for substance abuse services based on identified needs, delivered without discrimination and with adequate provision for specialized needs.

(9) ~~(5)~~ It is the intent of the Legislature to establish services for individuals with co-occurring substance abuse and mental disorders.

(10) ~~(6)~~ It is the intent of the Legislature to provide an alternative to criminal imprisonment for substance abuse impaired adults and juvenile offenders by encouraging the referral of such offenders to service providers not generally available within the juvenile justice and correctional systems, instead of or in addition to criminal penalties.

(11) ~~(7)~~ It is the intent of the Legislature to provide, within the limits of appropriations and safe management of the juvenile justice and correctional systems, substance abuse services to substance abuse impaired offenders who are placed by the Department of Juvenile Justice or who are incarcerated within the Department of Corrections, in order to better enable these offenders or inmates to adjust to the conditions of society presented to them when their terms of placement or incarceration end.

(12) ~~(8)~~ It is the intent of the Legislature to provide for assisting substance abuse impaired persons primarily through health and other rehabilitative services in order to relieve the police, courts, correctional institutions, and other criminal justice agencies of a burden that interferes with their ability to protect people, apprehend offenders, and maintain safe and orderly communities.

(13) ~~(9)~~ It is the intent of the Legislature that the freedom of religion of all citizens ~~shall~~ be inviolate. ~~Nothing in~~ This act does not ~~shall~~ give any governmental entity jurisdiction to regulate religious, spiritual, or ecclesiastical

services.

Section 5. Section 397.675, Florida Statutes, is amended to read:

397.675 Criteria for involuntary admissions, including protective custody, emergency admission, and other involuntary assessment, involuntary treatment, and alternative involuntary assessment for minors, for purposes of assessment and stabilization, and for involuntary treatment.—A person meets the criteria for involuntary admission if there is good faith reason to believe the person has a substance use or co-occurring mental health disorder and, because of this condition, has refused or is unable to determine whether examination is necessary. The refusal of services is insufficient evidence of an inability to determine whether an examination is necessary unless, without care or treatment ~~is substance abuse impaired and, because of such impairment~~:

(1) The person is likely to neglect or refuse care for himself or herself to the extent that the neglect or refusal poses a real and present threat of substantial harm to his or her well-being;

(2) The person is at risk of the deterioration of his or her physical or mental health and this condition may not be avoided despite assistance from willing family members, friends, or other services; or

(3) There is a substantial likelihood that the person will cause serious bodily harm to himself or herself or others, as shown by the person's recent behavior. ~~Has lost the power of self-control with respect to substance use; and either~~

~~(2)(a) Has inflicted, or threatened or attempted to~~

~~inflict, or unless admitted is likely to inflict, physical harm on himself or herself or another; or~~

~~(b) Is in need of substance abuse services and, by reason of substance abuse impairment, his or her judgment has been so impaired that the person is incapable of appreciating his or her need for such services and of making a rational decision in regard thereto; however, mere refusal to receive such services does not constitute evidence of lack of judgment with respect to his or her need for such services.~~

Section 6. Section 397.6793, Florida Statutes, is amended to read:

397.6793 Professional ~~Physician's~~ certificate for emergency admission.—

(1) A physician, clinical psychologist, physician's assistant working under the scope of practice of the supervising physician, psychiatric nurse, advanced registered nurse practitioner, licensed mental health counselor, licensed marriage and family therapist, master's level-certified addiction professional for substance abuse services, or licensed clinical social worker may execute a certificate stating that he or she has examined a person within the preceding 5 days and finds that the person appears to meet the criteria for emergency admission and stating the observations upon which that conclusion is based. The professional ~~physician's~~ certificate must include the name of the person to be admitted, the relationship between the person and the professional executing the certificate ~~physician~~, the relationship between the applicant and the professional executing the certificate ~~physician~~, and any relationship between the professional

executing the certificate ~~physician~~ and the licensed service provider~~, and a statement that the person has been examined and assessed within 5 days of the application date,~~ and must include factual allegations with respect to the need for emergency admission, including:

(a) The reason for the ~~physician’s~~ belief that the person is substance abuse impaired; and

(b) The reason for the ~~physician’s~~ belief that because of such impairment the person has lost the power of self-control with respect to substance abuse; and either

(c)~~1.~~ The reason for the belief that, without care or treatment:

1. The person is likely to neglect or refuse to care for himself or herself to the extent that the neglect or refusal poses a real and present threat of substantial harm to his or her well-being;

2. The person is at risk of the deterioration of his or her physical or mental health and that this condition may not be avoided despite assistance from willing family members, friends, or other services; or

3. There is a substantial likelihood that the person will cause serious bodily harm to himself or herself or others, as shown by the person’s recent behavior. ~~the physician believes that the person has inflicted or is likely to inflict physical harm on himself or herself or others unless admitted; or~~

~~2. The reason the physician believes that the person’s refusal to voluntarily receive care is based on judgment so impaired by reason of substance abuse that the person is incapable of appreciating his or her need for care and of making~~

~~a rational decision regarding his or her need for care.~~

(2) The professional ~~physician’s~~ certificate must recommend the least restrictive type of service that is appropriate for the person. The certificate must be signed by the professional ~~physician~~. If other less restrictive means are not available, such as voluntary appearance for outpatient evaluation, a law enforcement officer shall take the person named in the certificate into custody and deliver him or her to the nearest facility selected by the county for emergency admission.

(3) A signed copy of the professional ~~physician’s~~ certificate shall accompany the person, and shall be made a part of the person’s clinical record, together with a signed copy of the application. The application and professional ~~physician’s~~ certificate authorize the involuntary admission of the person pursuant to, and subject to the provisions of, ss. 397.679-397.6797.

(4) The professional ~~physician’s~~ certificate must indicate whether the person requires transportation assistance for delivery for emergency admission and specify, pursuant to s. 397.6795, the type of transportation assistance necessary.

Section 7. Subsection (1) of section 397.681, Florida Statutes, is amended to read:

397.681 Involuntary petitions; general provisions; court jurisdiction and right to counsel.—

(1) JURISDICTION.—The courts have jurisdiction of involuntary assessment and stabilization petitions and involuntary treatment petitions for substance abuse impaired persons, and such petitions must be filed with the clerk of the court in the county where the person is located. The court may

468 not charge a fee for the filing of a petition under this
469 section. The chief judge may appoint a general or special
470 magistrate to preside over all or part of the proceedings. The
471 alleged impaired person is named as the respondent.
472 Section 8. Subsection (1) of section 397.6811, Florida
473 Statutes, is amended to read:
474 397.6811 Involuntary assessment and stabilization.—A person
475 determined by the court to appear to meet the criteria for
476 involuntary admission under s. 397.675 may be admitted for a
477 period of 5 days to a hospital or to a licensed detoxification
478 facility or addictions receiving facility, for involuntary
479 assessment and stabilization or to a less restrictive component
480 of a licensed service provider for assessment only upon entry of
481 a court order or upon receipt by the licensed service provider
482 of a petition. Involuntary assessment and stabilization may be
483 initiated by the submission of a petition to the court.
484 (1) If the person upon whose behalf the petition is being
485 filed is an adult, a petition for involuntary assessment and
486 stabilization may be filed by the respondent's spouse or
487 guardian, any relative, a private practitioner, the director of
488 a licensed service provider or the director's designee, or any
489 adult willing to provide testimony that he or she has personally
490 observed the actions of that person and believes that person to
491 be a threat to himself or herself or others ~~three adults who~~
492 ~~have personal knowledge of the respondent's substance abuse~~
493 ~~impairment~~.
494 Section 9. Subsection (4) is added to section 397.6818,
495 Florida Statutes, to read:
496 397.6818 Court determination.—At the hearing initiated in

497 accordance with s. 397.6811(1), the court shall hear all
498 relevant testimony. The respondent must be present unless the
499 court has reason to believe that his or her presence is likely
500 to be injurious to him or her, in which event the court shall
501 appoint a guardian advocate to represent the respondent. The
502 respondent has the right to examination by a court-appointed
503 qualified professional. After hearing all the evidence, the
504 court shall determine whether there is a reasonable basis to
505 believe the respondent meets the involuntary admission criteria
506 of s. 397.675.
507 (4) The order is valid only until executed or, if not
508 executed, for the period specified in the order. If no time
509 limit is specified in the order, the order is valid for 7 days
510 after the date the order is signed.
511 Section 10. Subsection (1) of section 397.697, Florida
512 Statutes, is amended to read:
513 397.697 Court determination; effect of court order for
514 involuntary substance abuse treatment.—
515 (1) When the court finds that the conditions for
516 involuntary substance abuse treatment have been proved by clear
517 and convincing evidence, it may order the respondent to undergo
518 involuntary treatment by a licensed service provider for a
519 period not to exceed 90 ~~60~~ days. If the court finds it
520 necessary, it may direct the sheriff to take the respondent into
521 custody and deliver him or her to the licensed service provider
522 specified in the court order, or to the nearest appropriate
523 licensed service provider, for involuntary treatment. When the
524 conditions justifying involuntary treatment no longer exist, the
525 individual must be released as provided in s. 397.6971. When the

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conditions justifying involuntary treatment are expected to exist after 90 ~~60~~ days of treatment, a renewal of the involuntary treatment order may be requested pursuant to s. 397.6975 before ~~prior to~~ the end of the 90-day ~~60-day~~ period.

Section 11. Section 397.6971, Florida Statutes, is amended to read:

397.6971 Early release from involuntary substance abuse treatment.—

(1) At any time before ~~prior to~~ the end of the 90-day ~~60-day~~ involuntary treatment period, or before ~~prior to~~ the end of any extension granted pursuant to s. 397.6975, an individual admitted for involuntary treatment may be determined eligible for discharge to the most appropriate referral or disposition for the individual when:

(a) The individual no longer meets the criteria specified in s. 397.675 for involuntary admission and has given his or her informed consent to be transferred to voluntary treatment status;

(b) If the individual was admitted on the grounds of likelihood of infliction of physical harm upon himself or herself or others, such likelihood no longer exists; ~~or~~

(c) If the individual was admitted on the grounds of need for assessment and stabilization or treatment, accompanied by inability to make a determination respecting such need, either:

1. Such inability no longer exists; or

2. It is evident that further treatment will not bring about further significant improvements in the individual's condition;

(d) The individual is no longer in need of services; or

(e) The director of the service provider determines that the individual is beyond the safe management capabilities of the provider.

(2) Whenever a qualified professional determines that an individual admitted for involuntary treatment is ready for early release for any of the reasons listed in subsection (1), the service provider shall immediately discharge the individual~~,~~ and must notify all persons specified by the court in the original treatment order.

Section 12. Section 397.6977, Florida Statutes, is amended to read:

397.6977 Disposition of individual upon completion of involuntary substance abuse treatment.—At the conclusion of the 90-day ~~60-day~~ period of court-ordered involuntary treatment, the individual is automatically discharged unless a motion for renewal of the involuntary treatment order has been filed with the court pursuant to s. 397.6975.

Section 13. Section 397.6955, Florida Statutes, is amended to read:

397.6955 Duties of court upon filing of petition for involuntary treatment.—Upon the filing of a petition for the involuntary treatment of a substance abuse impaired person with the clerk of the court, the court shall immediately determine whether the respondent is represented by an attorney or whether the appointment of counsel for the respondent is appropriate. The court shall schedule a hearing to be held on the petition within 5 ~~10~~ days, unless a continuance is granted. A copy of the petition and notice of the hearing must be provided to the respondent; the respondent's parent, guardian, or legal

584 custodian, in the case of a minor; the respondent’s attorney, if
585 known; the petitioner; the respondent’s spouse or guardian, if
586 applicable; and such other persons as the court may direct, and
587 have such petition and order personally delivered to the
588 respondent if he or she is a minor. The court shall also issue a
589 summons to the person whose admission is sought.
590 Section 14. In order to maximize efficiency, avoid
591 duplication, and provide cost savings, the Louis de la Parte
592 Florida Mental Health Institute within the University of South
593 Florida shall provide monthly to the Department of Children and
594 Families copies of each of the following:
595 (1) Ex parte orders for involuntary examination.
596 (2) Professional certificates for initiating involuntary
597 examination.
598 (3) Law enforcement reports on involuntary examination.
599 (4) Involuntary outpatient placement orders.
600 (5) Involuntary inpatient placement orders.
601 Section 15. Subsection (1) of section 397.6773, Florida
602 Statutes, is amended to read:
603 397.6773 Dispositional alternatives after protective
604 custody.—
605 (1) An individual who is in protective custody must be
606 released by a qualified professional when:
607 (a) The individual no longer meets the involuntary
608 admission criteria in s. 397.675 ~~s. 397.675(1)~~;
609 (b) The 72-hour period has elapsed; or
610 (c) The individual has consented to remain voluntarily at
611 the licensed service provider.
612 Section 16. Part V of chapter 765, Florida Statutes, is

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613 redesignated as part VI, and a new part V of chapter 765,
614 Florida Statutes, consisting of ss. 765.501-765.509, is created
615 and entitled “Mental Health and Substance Abuse Treatment
616 Advance Directives.”
617 Section 17. Section 765.501, Florida Statutes, is created
618 to read:
619 765.501 Short title.—Sections 765.501-765.509 may be cited
620 as the “Jennifer Act”.
621 Section 18. Section 765.502, Florida Statutes, is created
622 to read:
623 765.502 Legislative findings.—
624 (1) The Legislature recognizes that an individual with
625 capacity has the ability to control decisions relating to his or
626 her own mental health care or substance abuse treatment. The
627 Legislature also makes the following findings:
628 (a) Substance abuse and some mental illnesses cause
629 individuals to fluctuate between capacity and incapacity.
630 (b) During periods when an individual’s capacity is
631 unclear, the individual may be unable to provide informed
632 consent necessary to access needed treatment.
633 (c) Early treatment may prevent an individual from becoming
634 so ill that involuntary treatment is necessary.
635 (d) Individuals with substance abuse impairment or mental
636 illness need an established procedure to express their
637 instructions and preferences for treatment and provide advance
638 consent to or refusal of treatment. This procedure should be
639 less expensive and less restrictive than guardianship.
640 (2) The Legislature further recognizes the following:
641 (a) A mental health or substance abuse treatment advance

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642 directive must provide the individual with a full range of
643 choices.
644 (b) For a mental health or substance abuse treatment
645 advance directive to be an effective tool, individuals must be
646 able to choose how they want their directives to be applied
647 during periods when they are incompetent to consent to
648 treatment.
649 (c) There must be a clear process so that treatment
650 providers can abide by an individual's treatment choices.
651 Section 19. Section 765.503, Florida Statutes, is created
652 to read:
653 765.503 Definitions.—As used in this part, the term:
654 (1) "Adult" means any individual who has attained the age
655 of majority or is an emancipated minor.
656 (2) "Capacity" means that an adult has not been found to be
657 incapacitated pursuant to s. 394.463.
658 (3) "Health care facility" means a hospital, nursing home,
659 hospice, home health agency, or health maintenance organization
660 licensed in this state, or any facility subject to part I of
661 chapter 394.
662 (4) "Incapacity" or "incompetent" means one or more of the
663 following conditions when present in an adult:
664 (a) An inability to understand the nature, character, and
665 anticipated results of proposed treatment or alternatives or the
666 recognized serious possible risks, complications, and
667 anticipated benefits of treatments and alternatives, including
668 nontreatment.
669 (b) An inability to physically or mentally communicate a
670 willful and knowing decision about mental health care or

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671 substance abuse treatment.
672 (c) An inability to communicate his or her understanding or
673 treatment decisions.
674 (d) Criteria exist for an involuntary examination pursuant
675 to s. 394.463.
676 (5) "Informed consent" means consent voluntarily given by a
677 person after a sufficient explanation and disclosure of the
678 subject matter involved to enable that person to have a general
679 understanding of the treatment or procedure and the medically
680 acceptable alternatives, including the substantial risks and
681 hazards inherent in the proposed treatment or procedures or
682 nontreatment, and to make knowing mental health care or
683 substance abuse treatment decisions without coercion or undue
684 influence.
685 (6) "Interested person" means any person who may reasonably
686 be expected to be affected by the outcome of the particular
687 proceeding involved, including anyone interested in the welfare
688 of an incapacitated person.
689 (7) "Mental health or substance abuse treatment advance
690 directive" means a written document in which the principal makes
691 a declaration of instructions or preferences or appoints a
692 surrogate to make decisions on behalf of the principal regarding
693 the principal's mental health or substance abuse treatment, or
694 both.
695 (8) "Mental health professional" means a psychiatrist,
696 psychologist, psychiatric nurse, or social worker, and such
697 other mental health professionals licensed pursuant to chapter
698 458, chapter 459, chapter 464, chapter 490, or chapter 491.
699 (9) "Principal" means a competent adult who executes a

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700 mental health or substance abuse treatment advance directive and
701 on whose behalf mental health care or substance abuse treatment
702 decisions are to be made.
703 (10) “Service provider” means a mental health receiving
704 facility, a facility licensed under chapter 397, a treatment
705 facility, an entity under contract with the department to
706 provide mental health or substance abuse services, a community
707 mental health center or clinic, a psychologist, a clinical
708 social worker, a marriage and family therapist, a mental health
709 counselor, a physician, a psychiatrist, an advanced registered
710 nurse practitioner, or a psychiatric nurse.
711 (11) “Surrogate” means any competent adult expressly
712 designated by a principal to make mental health care or
713 substance abuse treatment decisions on behalf of the principal
714 as set forth in the principal’s mental health or substance abuse
715 treatment advance directive created pursuant to this part.
716 Section 20. Section 765.504, Florida Statutes, is created
717 to read:
718 765.504 Mental health or substance abuse treatment advance
719 directive; execution; allowable provisions.—
720 (1) An adult with capacity may execute a mental health or
721 substance abuse treatment advance directive.
722 (2) A directive executed in accordance with this section is
723 presumed to be valid. The inability to honor one or more
724 provisions of a directive does not affect the validity of the
725 remaining provisions.
726 (3) A directive may include any provision relating to
727 mental health or substance abuse treatment or the care of the
728 principal for whom the directive is executed. Without

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729 limitation, a directive may include one or more of the
730 following:
731 (a) Preferences and instructions for mental health or
732 substance abuse treatment.
733 (b) Consent to specific types of mental health or substance
734 abuse treatment.
735 (c) Refusal of and direction not to administer specific
736 types of mental health or substance abuse treatment.
737 (d) Descriptions of situations that may cause the principal
738 to experience a mental health or substance abuse crisis.
739 (e) Suggested alternative responses that may supplement or
740 be in lieu of direct mental health or substance abuse treatment,
741 such as treatment approaches from other providers.
742 (f) The principal’s nomination of a guardian, limited
743 guardian, or guardian advocate as provided under chapter 744.
744 (4) A directive may be combined with or be independent of a
745 nomination of a guardian, a durable power of attorney, or other
746 advance directive.
747 Section 21. Section 765.505, Florida Statutes, is created
748 to read:
749 765.505 Execution of a mental health or substance abuse
750 treatment advance directive.—
751 (1) A directive must have all of the following
752 characteristics:
753 (a) Be in writing.
754 (b) Contain language that clearly indicates that the
755 principal intends to create a directive pursuant to this part.
756 (c) Be dated and signed by the principal or, if the
757 principal is unable to sign, at the principal’s direction in the

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758 principal's presence.
759 (d) Be witnessed by two adults, each of whom must declare
760 that he or she personally knows the principal and was present
761 when the principal dated and signed the directive, and that the
762 principal did not appear to be incapacitated or acting under
763 fraud, undue influence, or duress. The person designated as the
764 surrogate may not act as a witness to the execution of a
765 document designating the mental health care or substance abuse
766 treatment surrogate. At least one person who acts as a witness
767 may not be the principal's spouse or his or her blood relative.
768 (2) A directive is valid upon execution, but all or part of
769 the directive may take effect at a later date as designated by
770 the principal in the directive.
771 (3) A directive may be revoked, in whole or in part,
772 pursuant to s. 765.506 or expire under its own terms.
773 (4) A directive does not or may not:
774 (a) Create an entitlement to mental health, substance
775 abuse, or medical treatment or supersede a determination of
776 medical necessity.
777 (b) Obligate any health care provider, professional person,
778 or health care facility to pay the costs associated with the
779 treatment requested.
780 (c) Obligate a health care provider, professional person,
781 or health care facility to be responsible for the nontreatment
782 or personal care of the principal or the principal's personal
783 affairs outside the scope of services the facility normally
784 provides.
785 (d) Replace or supersede any will or testamentary document
786 or supersede the application of intestate succession.

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787 Section 22. Section 765.506, Florida Statutes, is created
788 to read:
789 765.506 Revocation; waiver.—
790 (1) A principal with capacity may, by written statement of
791 the principal or at the principal's direction in the principal's
792 presence, revoke a directive in whole or in part.
793 (2) The principal shall provide a copy of his or her
794 written statement of revocation to his or her agent, if any, and
795 to each health care provider, professional person, or health
796 care facility that received a copy of the directive from the
797 principal.
798 (3) The written statement of revocation is effective as to
799 a health care provider, professional person, or health care
800 facility upon the individual's or entity's receipt of the
801 statement. The professional person, health care provider, or
802 health care facility, or persons acting under their direction,
803 shall make the statement of revocation part of the principal's
804 medical record.
805 (4) A directive also may:
806 (a) Be revoked, in whole or in part, expressly or to the
807 extent of any inconsistency, by a subsequent directive; or
808 (b) Be superseded or revoked by a court order, including
809 any order entered in a criminal matter. The principal's family,
810 a health care facility, an attending physician, or any other
811 interested person who may be directly affected by a surrogate's
812 decision relating to the principal's health care may seek
813 expedited judicial intervention pursuant to rule 5.900 of the
814 Florida Probate Rules, if that person believes:
815 1. The surrogate's decision is not in accord with the

816 principal’s known desires;
817 2. The advance directive is ambiguous, or the principal has
818 changed his or her mind after execution of the advance
819 directive;
820 3. The surrogate was improperly designated or appointed, or
821 the designation of the surrogate is no longer effective or has
822 been revoked;
823 4. The surrogate has failed to discharge duties, or
824 incapacity or illness renders the surrogate incapable of
825 discharging duties;
826 5. The surrogate has abused his or her power or authority;
827 or
828 6. The principal has sufficient capacity to make his or her
829 own health care decisions.
830 (5) A directive that would have otherwise expired but is
831 effective because the principal is incapacitated remains
832 effective until the principal is no longer incapacitated, unless
833 the principal elected in the directive to be able to revoke
834 while incapacitated and has revoked the directive.
835 (6) When a principal with capacity consents to treatment
836 that differs from, or refuses treatment consented to in, his or
837 her directive, the consent or refusal constitutes a waiver of a
838 particular provision of the directive and does not constitute a
839 revocation of that provision or the directive unless the
840 principal also expressly revokes the provision or directive.
841 Section 23. Section 765.507, Florida Statutes, is created
842 to read:
843 765.507 Immunity from liability; weight of proof;
844 presumption.—

845 (1) A health care facility, provider, or other person who
846 acts under the direction of a health care facility or provider
847 is not subject to criminal prosecution or civil liability, and
848 may not be deemed to have engaged in unprofessional conduct, as
849 a result of carrying out a mental health care or substance abuse
850 treatment decision made in accordance with this part. The
851 surrogate who makes a mental health care or substance abuse
852 treatment decision on a principal’s behalf, pursuant to this
853 part, is not subject to criminal prosecution or civil liability
854 for such action.
855 (2) This section does not apply if it is shown by a
856 preponderance of the evidence that the person authorizing or
857 carrying out a mental health care or substance abuse treatment
858 decision did not exercise reasonable care or, in good faith,
859 comply with this part.
860 Section 24. Section 765.508, Florida Statutes, is created
861 to read:
862 765.508 Recognition of mental health or substance abuse
863 treatment advance directive executed in another state.—A mental
864 health or substance abuse treatment advance directive executed
865 in another state in compliance with the laws of that state is
866 validly executed for the purposes of this part.
867 Section 25. Section 765.509, Florida Statutes, is created
868 to read:
869 765.509 Dissemination of information.—
870 (1) A service provider shall give information relating to
871 mental health or substance abuse treatment advance directives to
872 its patients and assist competent and willing patients in
873 completing mental health or substance abuse treatment advance

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874 directives.
875 (2) A service provider may not require a patient to execute
876 a mental health or substance abuse treatment advance directive
877 or to execute a new mental health or substance abuse treatment
878 advance directive using the service provider's forms. The
879 principal's mental health or substance abuse treatment advance
880 directives shall travel with the principal as part of his or her
881 medical record.
882 (3) The Department of Children and Families shall develop,
883 and publish on its website, information on the creation,
884 execution, and purpose of mental health or substance abuse
885 treatment advance directives and the distinction between mental
886 health treatment advance directives created under this part and
887 those created under part I of this chapter. The department shall
888 also develop, and publish on its website, a mental health
889 treatment advance directive form and a substance abuse treatment
890 advance directive form that may be used by an individual to
891 direct future care.
892 Section 26. Paragraph (b) of subsection (2) of section
893 406.11, Florida Statutes, is amended to read:
894 406.11 Examinations, investigations, and autopsies.—
895 (2)
896 (b) The Medical Examiners Commission shall adopt rules,
897 pursuant to chapter 120, providing for the notification of the
898 next of kin that an investigation by the medical examiner's
899 office is being conducted. A medical examiner may not retain or
900 furnish any body part of the deceased for research or any other
901 purpose which is not in conjunction with a determination of the
902 identification of or cause or manner of death of the deceased or

903 the presence of disease or which is not otherwise authorized by
904 this chapter, part VI ~~part V~~ of chapter 765, or chapter 873,
905 without notification of and approval by the next of kin.
906 Section 27. Subsection (29) of section 408.802, Florida
907 Statutes, is amended to read:
908 408.802 Applicability.—The provisions of this part apply to
909 the provision of services that require licensure as defined in
910 this part and to the following entities licensed, registered, or
911 certified by the agency, as described in chapters 112, 383, 390,
912 394, 395, 400, 429, 440, 483, and 765:
913 (29) Organ, tissue, and eye procurement organizations, as
914 provided under part VI ~~part V~~ of chapter 765.
915 Section 28. Subsection (28) of section 408.820, Florida
916 Statutes, is amended to read:
917 408.820 Exemptions.—Except as prescribed in authorizing
918 statutes, the following exemptions shall apply to specified
919 requirements of this part:
920 (28) Organ, tissue, and eye procurement organizations, as
921 provided under part VI ~~part V~~ of chapter 765, are exempt from s.
922 408.810(5)-(10).
923 Section 29. Subsection (1) and paragraph (d) of subsection
924 (6) of section 765.101, Florida Statutes, are amended to read:
925 765.101 Definitions.—As used in this chapter:
926 (1) "Advance directive" means a witnessed written document
927 or oral statement in which instructions are given by a principal
928 or in which the principal's desires are expressed concerning any
929 aspect of the principal's health care or health information, and
930 includes, but is not limited to, the designation of a health
931 care surrogate, a living will, or an anatomical gift made

pursuant to part VI ~~part V~~ of this chapter.

(6) “Health care decision” means:

(d) The decision to make an anatomical gift pursuant to part VI ~~part V~~ of this chapter.

Section 30. Section 765.203, Florida Statutes, is amended to read:

765.203 Suggested form of designation.—A written designation of a health care surrogate executed pursuant to this chapter may, but need not be, in the following form:

DESIGNATION OF HEALTH CARE SURROGATE

I, ...(name)..., designate as my health care surrogate under s. 765.202, Florida Statutes:

Name: ...(name of health care surrogate)...
Address: ...(address)...
Phone: ...(telephone)...

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

Name: ...(name of alternate health care surrogate)...
Address: ...(address)...
Phone: ...(telephone)...

INSTRUCTIONS FOR HEALTH CARE

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I authorize my health care surrogate to:

...(Initial here)... Receive any of my health information, whether oral or recorded in any form or medium, that:

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

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

I further authorize my health care surrogate to:

...(Initial here)... Make all health care decisions for me, which means he or she has the authority to:

1. Provide informed consent, refusal of consent, or withdrawal of consent to any and all of my health care, including life-prolonging procedures.

2. Apply on my behalf for private, public, government, or veterans’ benefits to defray the cost of health care.

3. Access my health information reasonably necessary for the health care surrogate to make decisions involving my health care and to apply for benefits for me.

4. Decide to make an anatomical gift pursuant to part VI ~~part V~~ of chapter 765, Florida Statutes.

...(Initial here)... Specific instructions and restrictions: ....
....
....

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990 While I have decisionmaking capacity, my wishes are controlling
991 and my physicians and health care providers must clearly
992 communicate to me the treatment plan or any change to the
993 treatment plan prior to its implementation.
994
995 To the extent I am capable of understanding, my health care
996 surrogate shall keep me reasonably informed of all decisions
997 that he or she has made on my behalf and matters concerning me.
998
999 THIS HEALTH CARE SURROGATE DESIGNATION IS NOT AFFECTED BY MY
1000 SUBSEQUENT INCAPACITY EXCEPT AS PROVIDED IN CHAPTER 765, FLORIDA
1001 STATUTES.
1002
1003 PURSUANT TO SECTION 765.104, FLORIDA STATUTES, I UNDERSTAND THAT
1004 I MAY, AT ANY TIME WHILE I RETAIN MY CAPACITY, REVOKE OR AMEND
1005 THIS DESIGNATION BY:
1006 (1) SIGNING A WRITTEN AND DATED INSTRUMENT WHICH EXPRESSES
1007 MY INTENT TO AMEND OR REVOKE THIS DESIGNATION;
1008 (2) PHYSICALLY DESTROYING THIS DESIGNATION THROUGH MY OWN
1009 ACTION OR BY THAT OF ANOTHER PERSON IN MY PRESENCE AND UNDER MY
1010 DIRECTION;
1011 (3) VERBALLY EXPRESSING MY INTENTION TO AMEND OR REVOKE
1012 THIS DESIGNATION; OR
1013 (4) SIGNING A NEW DESIGNATION THAT IS MATERIALLY DIFFERENT
1014 FROM THIS DESIGNATION.
1015
1016 MY HEALTH CARE SURROGATE'S AUTHORITY BECOMES EFFECTIVE WHEN MY
1017 PRIMARY PHYSICIAN DETERMINES THAT I AM UNABLE TO MAKE MY OWN
1018 HEALTH CARE DECISIONS UNLESS I INITIAL EITHER OR BOTH OF THE

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1019 FOLLOWING BOXES:
1020
1021 IF I INITIAL THIS BOX [....], MY HEALTH CARE SURROGATE'S
1022 AUTHORITY TO RECEIVE MY HEALTH INFORMATION TAKES EFFECT
1023 IMMEDIATELY.
1024
1025 IF I INITIAL THIS BOX [....], MY HEALTH CARE SURROGATE'S
1026 AUTHORITY TO MAKE HEALTH CARE DECISIONS FOR ME TAKES EFFECT
1027 IMMEDIATELY. PURSUANT TO SECTION 765.204(3), FLORIDA STATUTES,
1028 ANY INSTRUCTIONS OR HEALTH CARE DECISIONS I MAKE, EITHER
1029 VERBALLY OR IN WRITING, WHILE I POSSESS CAPACITY SHALL SUPERSEDE
1030 ANY INSTRUCTIONS OR HEALTH CARE DECISIONS MADE BY MY SURROGATE
1031 THAT ARE IN MATERIAL CONFLICT WITH THOSE MADE BY ME.
1032
1033 SIGNATURES: Sign and date the form here:
1034 ...(date)... ...(sign your name)...
1035 ...(address)... ...(print your name)...
1036 ...(city)... ...(state)...
1037
1038 SIGNATURES OF WITNESSES:
1039 First witness Second witness
1040 ...(print name)... ...(print name)...
1041 ...(address)... ...(address)...
1042 ...(city)... ...(state)... ...(city)... ...(state)...
1043 ...(signature of witness)... ...(signature of witness)...
1044 ...(date)... ...(date)...
1045 Section 31. This act shall take effect July 1, 2016.

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The Florida Senate

COMMITTEE VOTE RECORD

COMMITTEE: Children, Families, and Elder Affairs
ITEM: SB 1336
FINAL ACTION: Favorable
MEETING DATE: Wednesday, January 27, 2016
TIME: 1:00—3:00 p.m.
PLACE: 301 Senate Office Building

FINAL VOTE								
Yea	**Nay**	**SENATORS**	**Yea**	**Nay**	**Yea**	**Nay**	**Yea**	**Nay**
X		Dean						
X		Detert						
X		Garcia						
X		Hutson						
		Ring						
		Altman, VICE CHAIR						
X		Sobel, CHAIR						
5	0	**TOTALS**						
Yea	**Nay**		**Yea**	**Nay**	**Yea**	**Nay**	**Yea**	**Nay**

CODES: FAV=Favorable, UNF=Unfavorable, -R=Reconsidered, RCS=Replaced by Committee Substitute, RE=Replaced by Engrossed Amendment, RS=Replaced by Substitute Amendment, TP=Temporarily Postponed, VA=Vote After Roll Call, VC=Vote Change After Roll Call, WD=Withdrawn, OO=Out of Order, AV=Abstain from Voting

The Florida Senate

BILL ANALYSIS AND FISCAL IMPACT STATEMENT

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

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

BILL: SB 1420

INTRODUCER: Senator Bean

SUBJECT: Eligibility for Employment as Child Care Personnel

DATE: January 26, 2016 REVISED:

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

I. Summary:

SB 1420 changes the minimum standards for child care personnel to prohibit an applicant for a child care position who has been identified as a sex offender or convicted of felonies or violent misdemeanors referenced in 42 U.S.C. s. 9858f from being employed by any child care facility.

The bill is not anticipated to have a fiscal impact on state government but may have an indeterminate fiscal impact on Broward County.

The bill has an effective date of July 1, 2016.

II. Present Situation:

Child Care Licensure and Personnel

The Department of Children and Families (DCF or department) is responsible for the licensure and regulation of child care facilities, family day care homes, and large family child care homes.[1] In addition, there are child care providers that are not licensed by the department, including those that are only required to register with the department and those that have an exemption from being licensed by virtue of being an integral part of a church or parochial school that meets certain requirements.[2] All child care personnel employed in a setting regulated by DCF, whether it is licensed, registered or exempt because of an affiliation with a religious entity, are required to be background screened as provided in chapter 435, using the level 2 standards for screening set forth in that chapter.[3] If an applicant for employment is disqualified from working with children

[1] *See* ss. 402.301-402.319, F.S.
[2] *See* s. 402.316, F.S.
[3] See s. 402.305, F.S.

due to the results of the level 2 screening, the department may grant an exemption from that disqualification.[4]

Background Screening and Exemptions from Disqualification

Level 2 Background Screening

A level 2 background screening includes but is not limited to fingerprinting for statewide criminal history records checks through the Florida Department of Law Enforcement (FDLE) and national criminal history checks through the Federal Bureau of Investigation (FBI), and may include local criminal records checks through local law enforcement agencies.[5] The applicant has fingerprints taken by a vendor that submits the electronic fingerprints to FDLE for DCF. FDLE then runs statewide checks and submits the electronic file to the FBI for national checks.

Once the background screening is completed, and FDLE receives the information from the FBI, the criminal history information is transmitted to DCF. DCF then determines if the screening contains any disqualifying information for employment. DCF must ensure that no applicant has been arrested for, is awaiting final disposition of, has been found guilty of, or entered a plea of nolo contendere or guilty to any prohibited offense including, but not limited to, such crimes as sexual misconduct, murder, assault, kidnapping, arson, exploitation, lewd and lascivious behavior, drugs, and domestic violence.[6] If the department finds that an individual has a history containing any of these offenses, they must disqualify that individual from employment in child care settings regulated by the department.

Exemptions from Disqualification

The Secretary of DCF is authorized to grant an exemption from disqualification to applicants for employment, including applicants wanting to work in child care, based on a number reasons:

- Felonies for which at least 3 years have elapsed since the applicant for the exemption has completed or been lawfully released from confinement, supervision, or nonmonetary condition imposed by the court for the disqualifying felony;
- Misdemeanors prohibited under any of the statutes cited in this chapter or under similar statutes of other jurisdictions for which the applicant for the exemption has completed or been lawfully released from confinement, supervision, or nonmonetary condition imposed by the court;
- Offenses that were felonies when committed but that are now misdemeanors and for which the applicant for the exemption has completed or been lawfully released from confinement, supervision, or nonmonetary condition imposed by the court; or
- Findings of delinquency.[7]

The Secretary of the department may not grant an exemption to an individual who is found guilty of, regardless of adjudication, or who has entered a plea of nolo contendere or guilty to, any felony covered by s.435.03 or s.435.04 solely by reason of any pardon, executive clemency, or

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[4] *See* s. 435.07, F.S.
[5] *See* s. 435.04, F.S.
[6] *Id.*
[7] *See* s. 435.07, F.S.

restoration of civil rights.[8] An exemption may also not be granted to anyone who is considered a sexual predator,[9] career offender,[10] or sexual offender (unless not required to register).[11]

Child Care Development Block Grant

The Child Care and Development Fund (CCDF), also known as the Child Care and Development Block Grant (CCDBG), is administered by the U.S. Department of Health and Human Services (HHS). CCDF provides funding for state efforts to provide child care services for low-income family members who work, train for work, attend school, or whose children receive or need to receive protective services. Block grant funding can be used for public or private, religious or non-religious, and center or home-based care. Child care programs that accept funding must comply with state health and safety requirements.[12]

The CCDBG is administered in Florida by the school readiness program in the Office of Early Learning within the Department of Education (DOE).[13] To be eligible to deliver the school readiness program, a school readiness program provider must be:

- A child care facility licensed under s. 402.305;
- A family day care home licensed or registered under s. 402.313;
- A large family child care home licensed under s. 402.3131;
- A public school or nonpublic school exempt from licensure under s. 402.3025;
- A faith-based child care provider exempt from licensure under s. 402.316;
- A before-school or after-school program described in s. 402.305(1)(c); or
- An informal child care provider under certain circumstances.[14]

The DCF regulates many, but not all, child care providers that provide early learning programs.

On November 19, 2014, the Child Care and Development Block Grant (CCDBG) Act of 2014 was signed into law. The new law reauthorizes the block grant program and makes expansive changes focused on improving the health and safety of children in child care, making the program more family-friendly by streamlining eligibility policies, ensuring parents and the general public have transparent information about the child care choices available to them, and improving the overall quality of early learning and afterschool programs.[15]

Reauthorization of the block grant program requires changes to Florida law, including an increase in requirements for screening all child care personnel to include searches of the National Sex Offender Registry, state criminal records, state sex offender registries, and child abuse and neglect registries of all states in which the child care personnel resided during the

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[8] *See* s. 435.07, F.S.
[9] *See* s. 775.21, F.S.
[10] *See* s. 775.261, F.S.
[11] See ss. 943.0435 and 943.04354.
[12] U.S. Department of Education, Office of Non-Public Education, *available at* http://www2.ed.gov/about/offices/list/oii/nonpublic/childcare.html (last visited January 24, 2016).
[13] See .s 1001.213, F.S.
[14] See . 1002.88, F.S.
[15] U.S. Department of Health and Human Services, Office of Child Care, *Program Instruction on CCDF Reauthorization Effective Dates*, *available at* http://www.acf.hhs.gov/programs/occ/resource/pi-2015-02 (last visited January 24, 2016).

preceding five years.[16] It will also require that individuals who are sex offenders or convicted of certain crimes be ineligible for employment with child care providers receiving CCDBG funds.

Based on the new requirements of the CCDBG, in order to continue to receive federal funding, the state must make ineligible for employment by school readiness providers any person who is registered, or is required to be registered, on a state sex offender registry or the National Sex Offender Registry[17] or has been convicted of:

- Murder;
- Child abuse or neglect;
- A crime against children, including child pornography;
- Spousal abuse;
- A crime involving rape or sexual assault;
- Kidnapping;
- Arson;
- Physical assault or battery;
- A drug-related offense committed during the preceding 5 years; or
- A violent misdemeanor committed as an adult against a child, including the following crimes: child abuse, child endangerment, sexual assault, or of a misdemeanor involving child pornography.[18]

However, these Federal prohibitions on employment will not apply to child care facilities that are not school readiness providers and as such do not receive any CCDBG funds.

III. Effect of Proposed Changes

Section 1 amends s. 402.305, F.S., relating to licensing standards for child care facilities to prohibit an applicant for a child care position who has been identified as a sex offender or convicted of felonies or violent misdemeanors referenced in 42 U.S.C. s. 9858f from being employed by any child care facility.

Section 2 provides for an effective date of July 1, 2016.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

[16] Pub. L. No. 113-186, 128 Stat. 1971, Sec. 658H(b).
[17] 42 U.S.C. s. 9858f(c)(1)(C)
[18] 42 U.S.C. s. 9858f(c)(1)

C. Trust Funds Restrictions:

None.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

None.

C. Government Sector Impact:

Broward County conducts background screening for individuals applying to work for child care providers at the county level. It is unknown what impact, if any, the bill will have on the county.

VI. Technical Deficiencies:

- Due to the fact that the language in the bill refers to "a child care position," it is unclear if this applies to personnel of a child care facility governed by s. 402.305, or is it also intended to include child care personnel of a large family child care home, a family day care home or a provider excluded from the statutory definition of a "child care facility."
- The proposed language appears intended to implement the requirements of the CCDBG relating to exemptions from disqualification for employment and would be more appropriately placed in Chapter 435 which contains current provisions relating to exemptions.
- It is unclear whether the bill intends to limit employment of individuals with disqualifying criminal backgrounds by all categories of child care providers or just those receiving funding from the CCDBG.

VII. Related Issues:

None.

VIII. Statutes Affected:

This bill substantially amends section 402.305 of the Florida Statutes.

IX. Additional Information:

A. Committee Substitute – Statement of Changes:

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

None.

B. Amendments:

None.

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

By Senator Bean

4-01590A-16 20161420__

1 A bill to be entitled
2 An act relating to eligibility for employment as child
3 care personnel; amending s. 402.305, F.S.; prohibiting
4 certain job applicants from employment with a child
5 care facility; providing an effective date.
6
7 Be It Enacted by the Legislature of the State of Florida:
8
9 Section 1. Paragraph (b) of subsection (2) of section
10 402.305, Florida Statutes, is amended to read:
11 402.305 Licensing standards; child care facilities.—
12 (2) PERSONNEL.—Minimum standards for child care personnel
13 shall include minimum requirements as to:
14 (b) The department may grant exemptions from
15 disqualification from working with children or the
16 developmentally disabled as provided in s. 435.07. However, an
17 applicant for a child care position who has been identified as a
18 sex offender or convicted of felonies or violent misdemeanors
19 referenced in 42 U.S.C. s. 9858f may not be employed by any
20 child care facility.
21 Section 2. This act shall take effect July 1, 2016.

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

The Florida Senate

BILL ANALYSIS AND FISCAL IMPACT STATEMENT

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

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

BILL: SB 1676

INTRODUCER: Senator Sachs

SUBJECT: Child Transportation Safety

DATE: January 26, 2016 REVISED:

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Preston	Hendon	CF	**Favorable**
2.			AED	
3.			AP	

I. Summary:

SB 1676 creates the "Haile Brockington Act" and requires that by January 1, 2017, specified vehicles used to transport children must be equipped with an approved alarm system that prompts the driver to check the interior and exterior of the vehicle for the presence of children before leaving the area. Those include:

- Vehicles used by public entities or private organizations for hire, including schools, camps and churches.
- Vehicles used by child care facilities and large family child care homes.
- School buses.

The bill requires the Department of Motor Vehicles and Highway Safety (DMVHS), the Department of Children and Families (DCF), and the State Board of Education (BOE) to adopt rules to administer the new requirement and maintain a list of alarm manufacturers and alarm systems that are approved to be installed in vehicles under their respective jurisdictions.

The bill is expected to have a significant fiscal impact on private entities and school districts.

The bill has an effective date of July 1, 2016.

II. Present Situation:

Child Heat Stroke Deaths in Vehicles

In August 2010, 2 1/2 year old Haile Brockington died after being left in her car seat for nearly six hours in the back of a van used by a Palm Beach County child care facility. According to the National Weather Service in Miami, the weather that day reached a high of 91 degrees, but

temperatures in an enclosed vehicle climb much higher.[1] The child care facility was licensed by DCF and had no violations against it at the time of the incident.[2]

"Death by hyperthermia" or vehicular heat stroke deaths have become much more prevalent since Federal law required that children ride in the backseat due to the danger of front passenger seat airbags.[3] The national average number of these deaths is 37 per year.[4] Thirty-one percent of hyperthermia deaths involve children under the age of one.[5] Between 1998 and 2015, Florida has the second highest number of child deaths from vehicular heat stroke.[6]

Technology Based Prevention

Automobile Manufacturers

The auto industry has been aware of the problem for years. General Motors (GM) tried over 10 years ago to find a solution, but found the results were unreliable. At the 2002 New York Auto Show, GM unveiled a system that would be able to detect the heartbeat of a child left in a car and then measure the vehicle's temperature. If it was becoming dangerously hot, it would sound the horn to alert a parent or passersby. GM later reported that the system was abandoned after it was found "not reliable enough to put into production."[7]

Ford was among the other automakers who also expressed interest in developing such a system, but a decade later, the technology isn't available on any automobile as a factory standard feature or option. Auto safety groups have called for manufacturers to do more, but for several reasons including cost, technology, liability and privacy issues, there is still no foolproof way of preventing overheating deaths or warning of the possibility before they happen.[8]

One industry expert believes it shouldn't cost more than a few dollars per vehicle, because of the sophisticated computers already on cars. The Center for Automotive Research reported that cost might not be as much a problem as the possibility of errors.[9]

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[1] Julius Whigham II and Eliot Kleinberg, *Girl, 2 1/2, found dead in van at Delray Beach day care center*, THE PALM BEACH POST, Aug. 5, 2010 (updated Aug. 12, 2010), *available at* http://www.palmbeachpost.com/news/girl-1-1-2-found-dead-in-van-843774.html (last visited January 21, 2016).
[2] *Id.*
[3] See Kids and Cars.org, *Fact Sheet*, *available at* http://www.kidsandcars.org/userfiles/dangers/heat-stroke/heat-stroke-fact-sheet.pdf (last visited January 21, 2016); see also Gene Weingarten, *Fatal Distraction: Forgetting a Child in the Backseat of a Car is a Horrifying Mistake. Is it a Crime?,* THE WASHINGTON POST, Mar. 8, 2009, at W08, *available at* http://www.washingtonpost.com/wp-dyn/content/article/2009/02/27/AR2009022701549.html (last visited January 21, 2016).
[4] *Id.*
[5] *Id.*
[6] California Department of Meteorology and Climate Science, *Heatstroke Deaths of Children in Vehicles by State, available at* http://noheatstroke.org/state.htm (last visited January 21, 2016).
[7] Paul Eisenstein, *Death in Hot Cars: Why Can't the Automakers Prevent the Danger?* July 14, 2014, *available at* http://www.nbcnews.com/storyline/hot-cars-and-kids/death-hot-cars-why-cant-automakers-prevent-danger-n152911 (last visited January 21, 2016).
[8] *Id.*
[9] *Id.*

As recently as this week, General Motors announced it will introduce a new safety system to remind drivers to check for children in the rear seats, and that it could eventually develop features to detect forgotten children.[10]

Aftermarket Systems

There are a number of aftermarket warning systems that alert a parent if they've left a child in a safety seat or shopping cart or somewhere else. But federal regulators have questioned their efficacy.

A preliminary assessment performed on technology devices aimed at helping to prevent a child from being unintentionally left in a hot car concluded that they are not reliable and limited in their effectiveness, according to a new study by the National Highway Traffic Safety Administration (NHTSA) and the Children's Hospital of Philadelphia.[11]

The study found several limitations in these products after conducting tests, including inconsistencies in arming sensitivity, variations in warning signal distance, potential interference from other electronic devices, children inadvertently disarming the device by slumping over or sleeping out of position, and limitations in the products' susceptibility to misuse or other common scenarios, such as an apple juice spill. Many of the products tested require a lot of set-up work by caregivers and parents, potentially giving them a false sense of security. What's more, since the devices are restraint-based, they wouldn't address the 20 to 40 percent of kids who are killed in hot cars when they enter a vehicle without adult permission.[12]

For now, experts suggest parents take several steps to keep their kids safe such as placing a purse or briefcase in the back seat to ensure no child is accidentally left in the vehicle, writing a note or using a stuffed animal placed in the driver's view to indicate a child is in the car seat.[13]

Licensing Standards for Child Care Facilities and Large Family Child Care Homes

The Department of Children and Families (DCF or department) establishes licensing standards that each licensed child care facility in the state must meet.[14] A child care facility is defined in

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[10] David Shepardson, GM has a way to help prevent drivers from forgetting children in the back seat, Business Insider, January 12, 2016. Available at http://www.businessinsider.com/r-gm-unveils-technology-to-help-avoid-child-heatstroke-deaths-2016-1 (last visited January 22, 2016).

[11] Consumer Reports, *Warning systems to detect children left in hot cars found unreliable, study finds*, *available at* http://www.consumerreports.org/cro/news/2012/08/warning-systems-to-detect-children-left-in-hot-cars-found-unreliable-study-finds/index.htm (last visited January 22, 2016).

[12] Ryan Jaslow, *Gov't study: Devices that alert parents they left a child in a car deemed unreliable*, CBS News, July 31, 2012, available at http://www.cbsnews.com/news/govt-study-devices-that-alert-parents-they-left-a-child-in-car-deemed-unreliable/ (last visited January 22, 2016).

[13] National Highway Traffic Safety Association, *NHTSA and Safe Kids Worldwide Announce New Partnership to Prevent Child Heatstroke Deaths in Hot Cars*, July 26, 2012, available at http://www.nhtsa.gov/About+NHTSA/Press+Releases/NHTSA+and+Safe+Kids+Worldwide+Announce+New+Partnership+to+Prevent+Child+Heatstroke+Deaths+in+Hot+Cars (last visited January 22, 2016).

[14] *See* s. 402.305, F.S.

Florida law as "any child care center or child care arrangement which provides child care for more than five children unrelated to the operator and which receives a payment, fee, or grant for any of the children receiving care, wherever operated, and whether or not operated for profit."[15]

A large family child care home is defined as an occupied residence in which child care is regularly provided for children from at least two unrelated families, which receives a payment, fee, or grant for any of the children receiving care, whether or not operated for profit, and which has at least two full-time child care personnel on the premises during the hours of operation.[16]

The department currently oversees 6,178 licensed child care entities including child care facilities, large family child care homes and family day care homes.[17] In addition, there are homes that are only registered by the agency, facilities that are exempt from licensure due to a religious affiliation[18] and homes currently licensed by five counties in the state.[19] Of these homes, 2,362 child care facilities and large family child care homes regulated by the department report that they transport children.[20]

Statutory licensing standards for child care facilities are extensive and reference transportation and vehicles, including the requirement that minimum standards include accountability for children being transported.[21] The Florida Administrative Code provides requirements for licensed child care facilities and large family child care homes to follow in relation to vehicles that are owned, operated, or regularly used by the facility or home, as well as vehicles that provide transportation through a contract or agreement with an outside entity.[22]

Providers are required to maintain a driver's log for all children being transported. This log must include the child's name, date, time of departure, time of arrival, signature of driver, and signature of second staff member to verify the driver's log and that all children have left the vehicle. Upon arrival at the destination, the driver of the vehicle must mark each child off the log as the child departs the vehicle, conduct a physical inspection and visual sweep of the vehicle, and sign, date, and record the driver's log immediately to verify all children were accounted for and that the sweep was conducted. Upon arrival at the destination, a second staff member must also conduct a physical inspection and visual sweep of the vehicle and sign, date, and record the driver's log to verify all children were accounted for and that the driver's log is complete.[23]

Current standards for child care facilities and large family child care homes do not address alarm systems in vehicles, however, in 2012, the Palm Beach County Child Care Licensing Program adopted, through a local county ordinance, standards requiring child care programs which

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[15] *See* s. 402.302(2), F.S.
[16] See s. 402.302(11), F.S.
[17] Florida Department of Children and Families, *DCF Quick Facts*, 7 (Quarter 1, Fiscal Year 2015-2016), *available at* http://www.dcf.state.fl.us/general-information/quick-facts/cc/ (last visited January 21, 2016).
[18] *See* s. 402.316, F.S.
[19] *See* s. 402.306, F.S. Those five counties are Broward, Hillsborough, Palm Beach, Pinellas and Sarasota.
[20] Florida Department of Children and Families, *2016 Agency Legislative Bill Analysis, SB 1676*, January 16, 2016. On file with the Senate Committee on Children, Families and Elder Affairs.
[21] *See* s. 402.305, F.S.
[22] *See* 65C-22.001(6) and 65C-20.13(8), F.A.C.
[23] *Id.*

transport children to install alarms in their vehicles. Additionally, Broward County followed with an ordinance that went into effect on July 1, 2013.[24]

III. Effect of Proposed Changes:

Section 1 designates the act as the "Haile Brockington Act."

Section 2 amends s. 316.6135, F.S., relating to leaving children unattended or unsupervised in motor vehicles, to require vehicles used to transport children by public entities or private organizations for hire, including schools, camps and churches, be equipped with an approved alarm system that prompts the driver to check the interior and exterior of the vehicle for the presence of children before leaving the area. The bill requires the DMVHS to adopt rules to administer the new requirement and maintain a list of alarm manufacturers and alarm systems that are approved to be installed in vehicles covered by the requirement.

Section 3 amends s 402.305, F.S., relating to licensing standards for child care facilities, to require vehicles used to transport children by child care facilities and large family child care homes be equipped with an approved alarm system that prompts the driver to check the interior and exterior of the vehicle for the presence of children before leaving the area. The bill requires DCF to adopt rules to administer the new requirement and maintain a list of alarm manufacturers and alarm systems that are approved to be installed in vehicles covered by the requirement.

Section 4 amends s. 1006.22, F.S., relating to safety and health of students being transported, to require all school buses be equipped with an approved alarm system that prompts the driver to check the interior and exterior of the vehicle for the presence of children before leaving the area. The bill requires the DOE to adopt rules to administer the new requirement and maintain a list of alarm manufacturers and alarm systems that are approved to be installed in vehicles covered by the requirement.

Section 5 provides an effective date of July 1, 2016.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

[24] Florida Department of Children and Families, *2016 Agency Legislative Bill Analysis, SB 1676*, January 16, 2016. On file with the Senate Committee on Children, Families and Elder Affairs.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

Child Care Providers

The department reports that the proposed bill would require approximately 2,362 child care facilities and large family child care homes regulated by the department that transport children to purchase and equip all vehicles with a device approved by the department by January 1, 2017. The department has found three products that may meet the requirements:[25]

Device	Cost Per Unit	Installation	Total Cost for Purchase
Kiddie Voice Child Safety Alarm by ATWEC	$328	$75-$200 depending on the area	$775,350
EP 1 by Child Check-Mate System	$125	self-installed with manuals provided	$295,108
Bus-Scan, The Original Seat-Check Reminder by Robotics Technologies, Inc.	$135	self-installed with manuals provided	$330,680

All three of these products are for commercial vehicles and it is unknown whether they are adaptable for use on personal vehicles.

C. Government Sector Impact:

Department of Children and Families

The department reports there may be minimal costs associated with rule development and maintaining the list of approved alarm manufacturers that can be absorbed within current resources.[26]

School Districts

School districts would see increased costs similar to child care providers to comply with the requirement for alarms.

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[25] Florida Department of Children and Families, *2016 Agency Legislative Bill Analysis, SB 1676*, January 16, 2016. On file with the Senate Committee on Children, Families and Elder Affairs.
[26] *Id*.

VI. Technical Deficiencies:

The proposed bill includes requirements for large family child care homes, but the placement of the language within s. 402.305(10), F.S., restricts the requirement to licensed child care facilities, not large family child care homes. The requirement may also need to be added to s. 402.3131.

VII. Related Issues:

- The requirements for vehicles used to transport children by child care providers licensed by DCF do not include those used by family day care homes.
- Sections 2, 3, and 4 of the bill do not specify who is responsible for the cost of or who is to approve the required alert systems.

VIII. Statutes Affected:

This bill substantially amends ss. 316.6135, 402.305 and 1006.22 of the Florida Statutes.

IX. Additional Information:

A. Committee Substitute – Statement of Changes:

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

None.

B. Amendments:

None.

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

By Senator Sachs

A bill to be entitled

An act relating to child transportation safety; providing a short title; amending s. 316.6135, F.S.; requiring vehicles used to transport children by public entities or by private organizations for hire to be equipped with a certain alarm system by a specified date; requiring the Department of Highway Safety and Motor Vehicles to adopt rules and maintain a list of alarm manufacturers and approved alarm systems; amending s. 402.305, F.S.; requiring vehicles used by child care facilities and large family child care homes to be equipped with a certain alarm system by a specified date; requiring the Department of Children and Families to adopt rules and maintain a list of alarm manufacturers and approved alarm systems; amending s. 1006.22, F.S.; requiring school buses to be equipped with a certain alarm system by a specified date; requiring the State Board of Education to adopt rules and maintain a list of alarm manufacturers and approved alarm systems; providing an effective date.

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

Section 1. This act may be cited as the “Haile Brockington Act.”

Section 2. Subsection (8) is added to section 316.6135, Florida Statutes, to read:

316.6135 Leaving children unattended or unsupervised in motor vehicles; penalty; authority of law enforcement officer.—

(8) By January 1, 2017, each vehicle used to transport children by public entities or by private organizations for

hire, including schools, camps, and churches, must be equipped with an alarm system approved by the department which prompts the driver to inspect the interior and the exterior of the vehicle for the presence of children before the driver exits or departs from the immediate vicinity of the vehicle. The department shall adopt rules to administer this subsection and shall maintain a list of alarm manufacturers and alarm systems required by this subsection that are approved to be installed in such vehicles.

Section 3. Subsection (10) of section 402.305, Florida Statutes, is amended to read:

402.305 Licensing standards; child care facilities.—

(10) TRANSPORTATION SAFETY.—

(a) Minimum standards shall include requirements for child restraints or seat belts in vehicles used by child care facilities and large family child care homes to transport children, requirements for annual inspections of the vehicles, limitations on the number of children in the vehicles, and accountability for children being transported.

(b)1. By January 1, 2017, vehicles used by child care facilities and large family child care homes must be equipped with an alarm system approved by the department which prompts the driver to inspect the interior and the exterior of the vehicle for the presence of children before the driver exits or departs from the immediate vicinity of the vehicle.

2. The department shall adopt rules to administer this paragraph and shall maintain a list of alarm manufacturers and alarm systems required by this paragraph that are approved to be installed in such vehicles.

62 Section 4. Subsection (10) of section 1006.22, Florida
63 Statutes, is amended to read:
64 1006.22 Safety and health of students being transported.—
65 Maximum regard for safety and adequate protection of health are
66 primary requirements that must be observed by district school
67 boards in routing buses, appointing drivers, and providing and
68 operating equipment, in accordance with all requirements of law
69 and rules of the State Board of Education in providing
70 transportation pursuant to s. 1006.21:
71 (10) Each district school board shall designate and adopt a
72 specific plan for adequate examination, maintenance, and repair
73 of transportation equipment. Examination of the mechanical and
74 safety condition of each school bus must be made as required
75 pursuant to rule of the State Board of Education. The State
76 Board of Education shall base the rule on student safety
77 considerations.
78 (a) By January 1, 2017, each school bus must be equipped
79 with an alarm system approved by the State Board of Education
80 which prompts the driver to inspect the interior and the
81 exterior of the bus for the presence of children before the
82 driver exits or departs from the immediate vicinity of the bus.
83 (b) The State Board of Education shall adopt rules to
84 administer paragraph (a) and shall maintain a list of alarm
85 manufacturers and alarm systems required by paragraph (a) that
86 are approved to be installed in school buses.
87 Section 5. This act shall take effect July 1, 2016.

The Florida Senate
COMMITTEE VOTE RECORD

COMMITTEE: Children, Families, and Elder Affairs
ITEM: SB 1676
FINAL ACTION: Favorable
MEETING DATE: Wednesday, January 27, 2016
TIME: 1:00—3:00 p.m.
PLACE: 301 Senate Office Building

FINAL VOTE								
Yea	**Nay**	**SENATORS**	**Yea**	**Nay**	**Yea**	**Nay**	**Yea**	**Nay**
X		Dean						
X		Detert						
X		Garcia						
		Hutson						
X		Ring						
		Altman, VICE CHAIR						
X		Sobel, CHAIR						
5	0	**TOTALS**						
Yea	**Nay**		**Yea**	**Nay**	**Yea**	**Nay**	**Yea**	**Nay**

CODES: FAV=Favorable, UNF=Unfavorable, -R=Reconsidered, RCS=Replaced by Committee Substitute, RE=Replaced by Engrossed Amendment, RS=Replaced by Substitute Amendment, TP=Temporarily Postponed, VA=Vote After Roll Call, VC=Vote Change After Roll Call, WD=Withdrawn, OO=Out of Order, AV=Abstain from Voting

REPORTING INSTRUCTION: Publish
01272016.1444

Senate Children, Families, and Elder Affairs

January 27, 2016

Samuel Verghese, Secretary

Homes and Communities

- **4.9 million elders in Florida**
  - Served more than 1.1 million elders through DOEA programs in FY 2014-15
- **11 Area Agencies on Aging across the state**
  - Providers in every community
- **Elder Helpline**
  - 1-800-96-ELDER
- **SHINE**
  - Volunteers at highest number in program history with more than 650 active or in training

Communities for a Lifetime

- Numerous Florida cities, counties, towns, and villages are active partners
- Address the future challenges of the growing aging population
- Help more elders live independently

Dementia Care and Cure Initiative

- **Awareness of the issue**
- **Assistance to communities**
- **Advocacy for care and cure**

Contact Information

- **Main Line: 850-414-2000**
- **Elder Helpline: 1-800-96-ELDER (1-800-963-5337)**
- **Website: elderaffairs.state.fl.us**

- **Secretary Samuel P. Verghese**
- **Jo Morris, Legislative Affairs Director**
  - morrisj@elderaffairs.org

AARP Livable Communities

LIVABLE COMMUNITIES
Great Places for All Ages℠

AARP Livable Communities Definition

"Affordable and appropriate housing, supportive community services, and adequate mobility options, which facilitate personal independence and the engagement of residents in civic and social life."

80% of adults ages 45+ agree or strongly agree with the statement: "What I'd really like to do is stay in my current community for as long as possible."

What Community Amenities Do Older Adults Want Close to Home?

We asked older adults what amenities they want close to home. Access to transportation, food, and green space top the list. These are among the many community indicators that we are measuring as part of the Livability Index project. Find out more about our livability research and the development of our index here: **www.aarp.org/ppi/liv-com/**

% endorsed within 1 mile or less

Amenity	%
Bus Stop	50%
Grocery Store	47%
Park	42%
Pharmacy / Drug Store	42%
Hospital	29%
Church / Religious	29%
Train / Subway	23%
Big Box Store	18%
Entertainment	16%
Mall (shopping)	13%

Source: AARP Public Policy Institute

Source: AARP Home and Community Preferences of the 45+ Population, 2014

THE 8 DOMAINS OF LIVABILITY

The availability and quality of these community features impact the well-being of older adults

The Built Environment

Housing

Transportation

Outdoor Spaces & Buildings

Social Participation

Respect & Social Inclusion

YOUR COMMUNITY

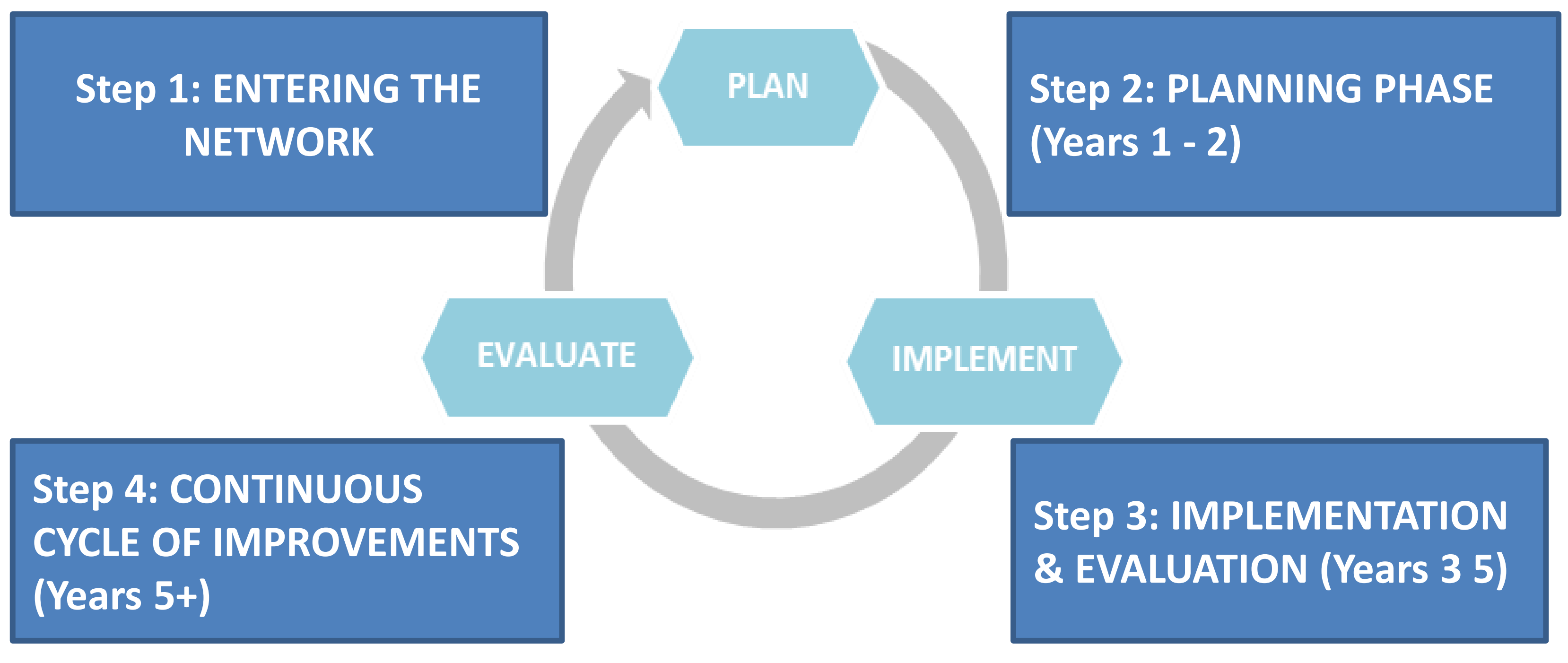
Community Support & Health Services

Communication & Information

Civic Participation & Employment

The Social Environment

Age-Friendly Process



GLOBAL NETWORK OF AGE-FRIENDLY COMMUNITIES

258 Communities /28 Countries/100 million people

Network of Age-Friendly Communities

Updated August 2015

AARP Network of Age-Friendly Communities in Florida

Community	Status	Enrolled
Sarasota County *AgeFriendlySarasota.org* *@AgeFriendlySRQ*	Phase 1	February 24, 2015 *Launched: May 6, 2015*
Tallahassee	Phase 1	June 8, 2015
Winter Haven	Phase 1	October 12, 2015

The Livability Index

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Livability Index | Great Neighborhoods for All Ages

LIVABILITY DEFINED FEATURED COMMUNITIES ABOUT US

personal safety
quality of health care
access to destinations

How **livable** is your **community**?

enter your address, city, state or zip code

air quality
water quality
housing affordability

LEARN MORE

The Livability Index scores cities and communities across the U.S. for the services and amenities that impact your life the most.

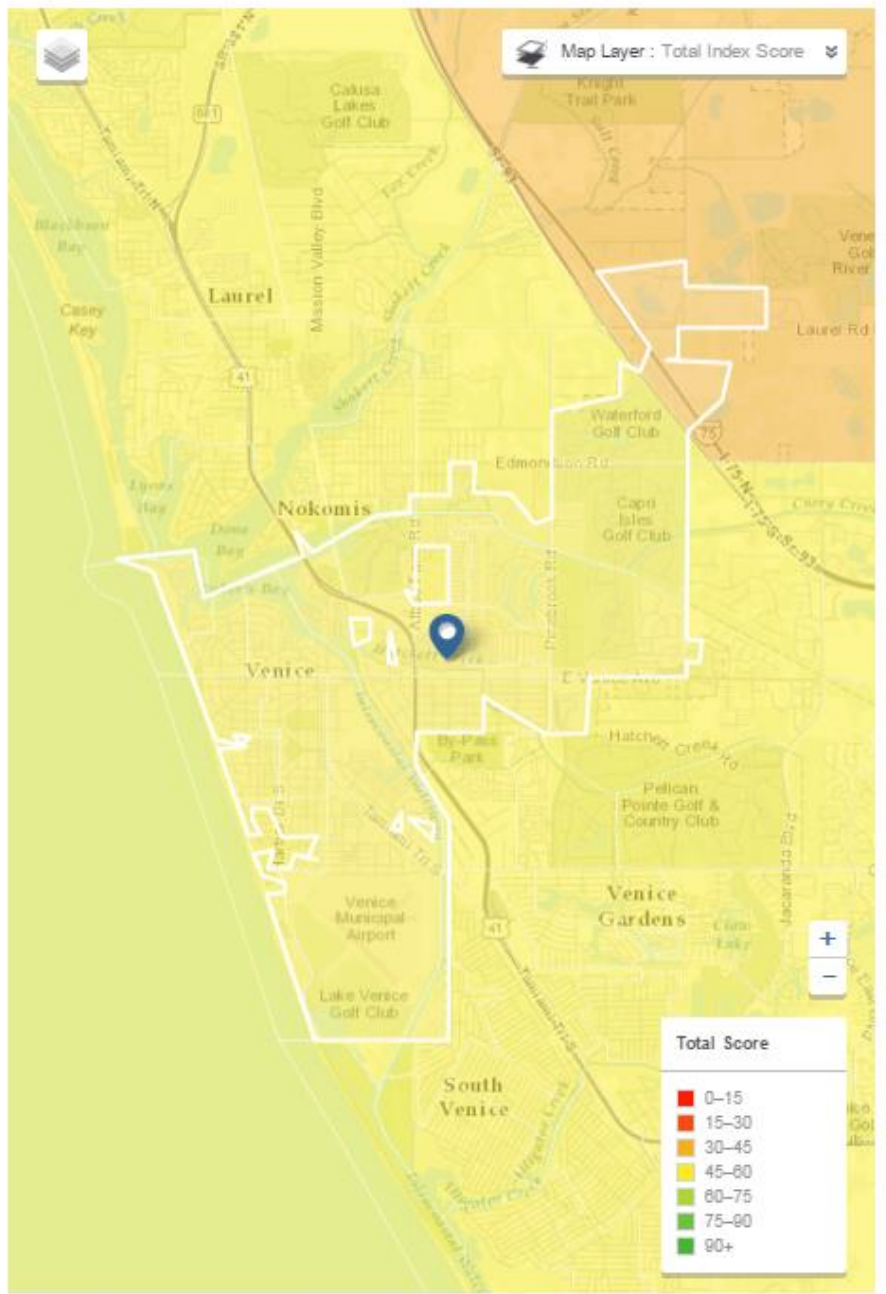
Search for your city or learn more about how we define livability.

Venice

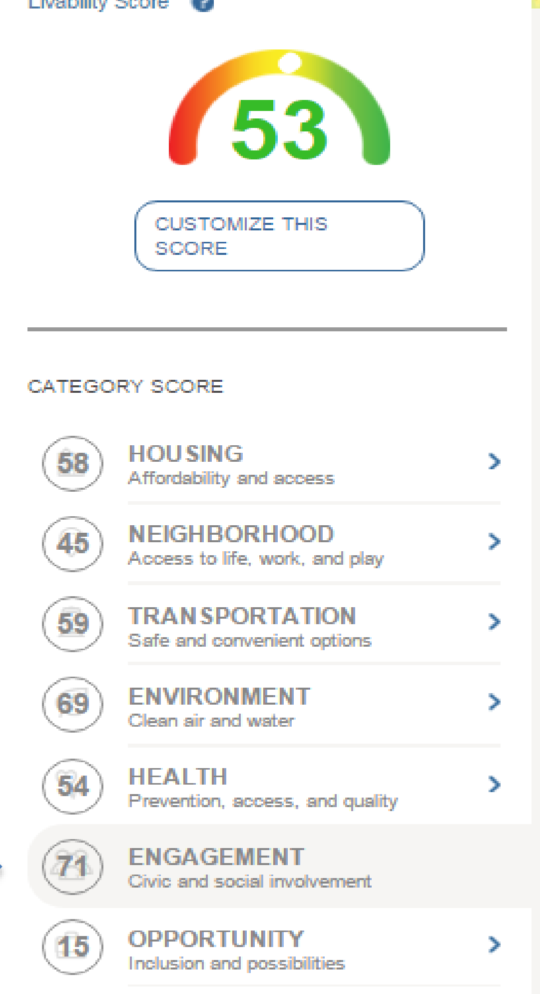
Livability Score

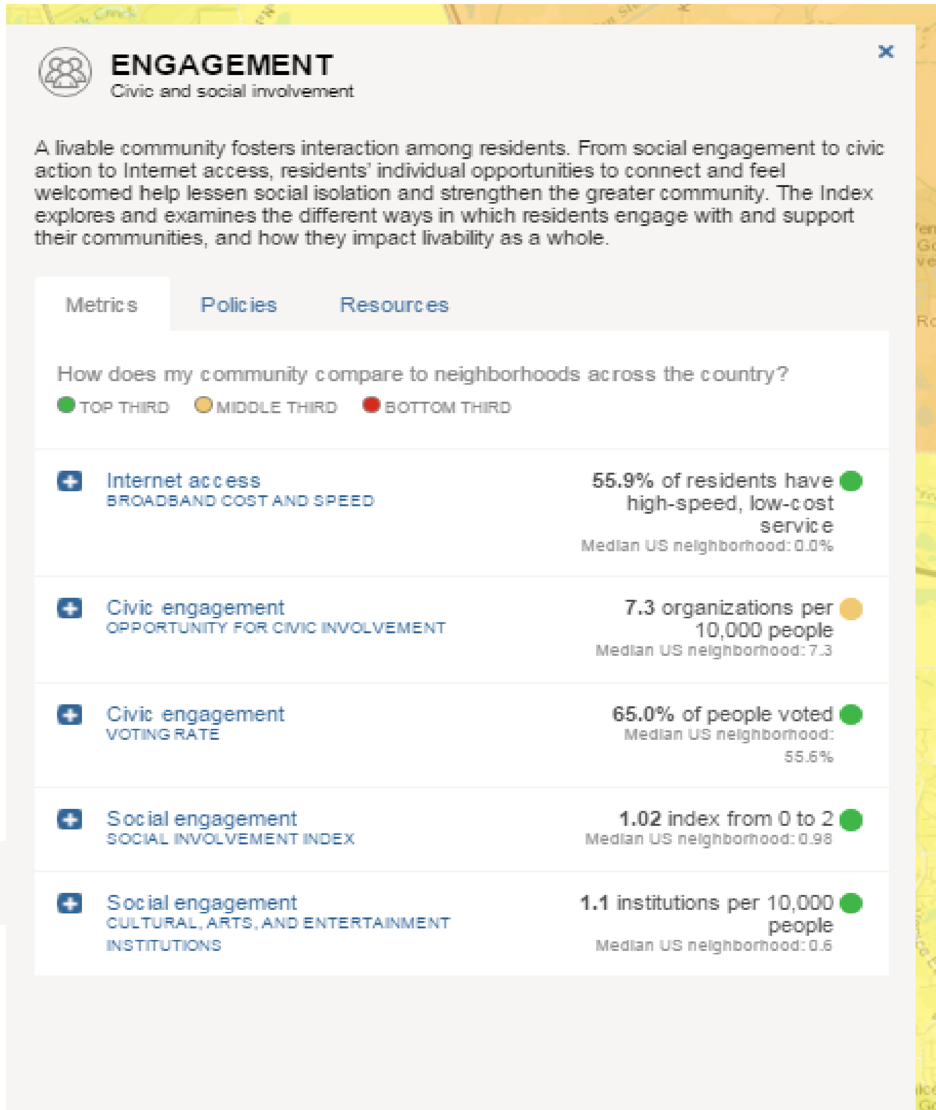
53

CUSTOMIZE THIS SCORE

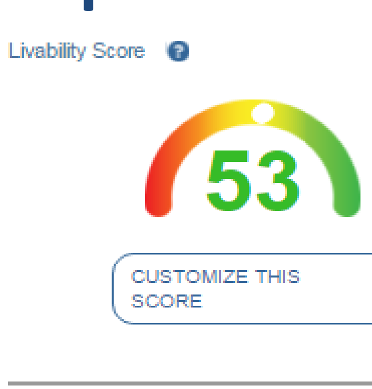


Venice - Engagement

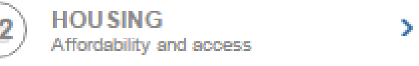


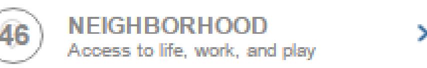


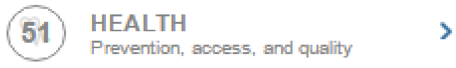
Cape Canaveral - Transportation

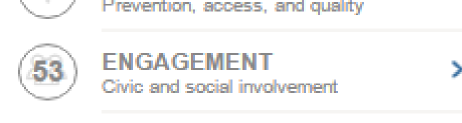


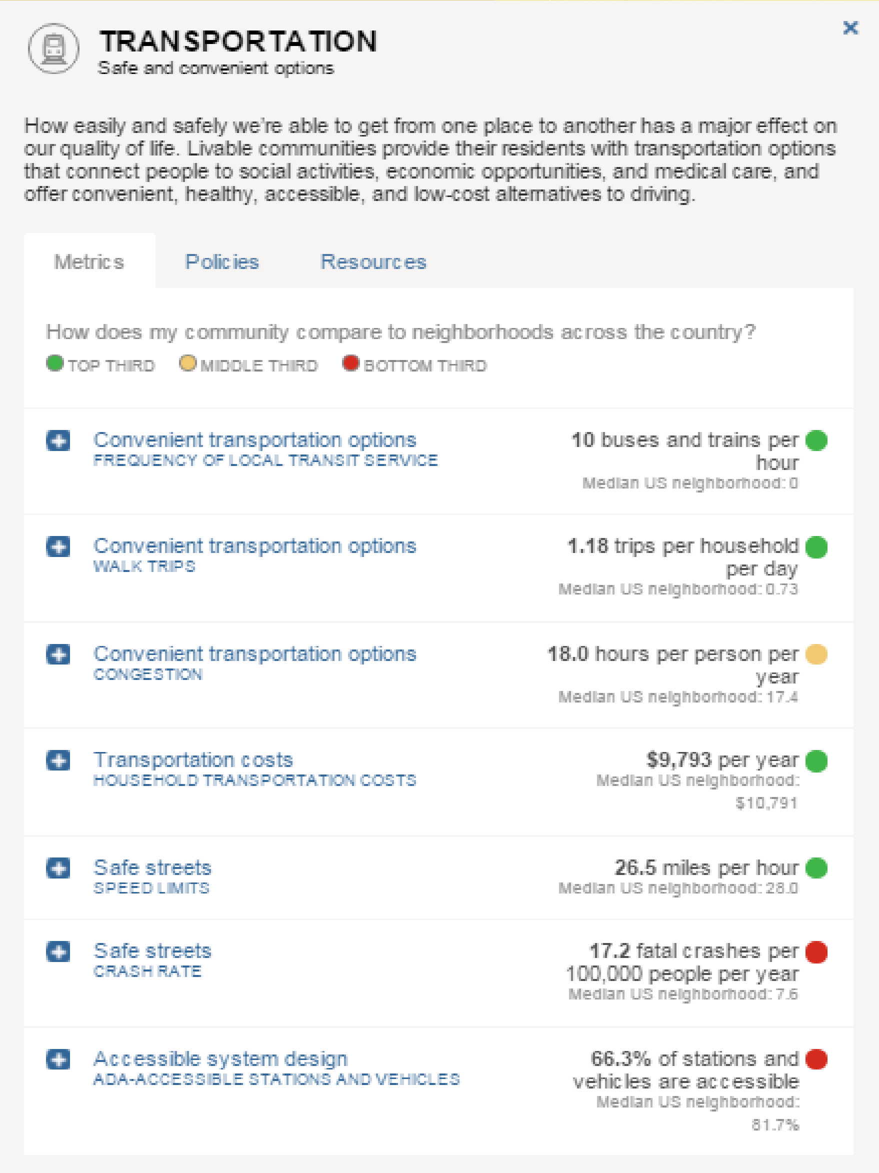
CATEGORY SCORE



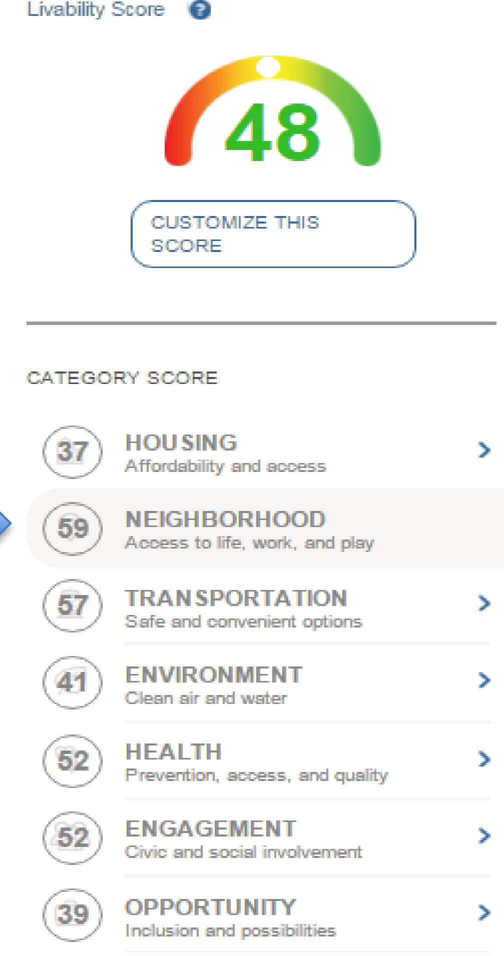


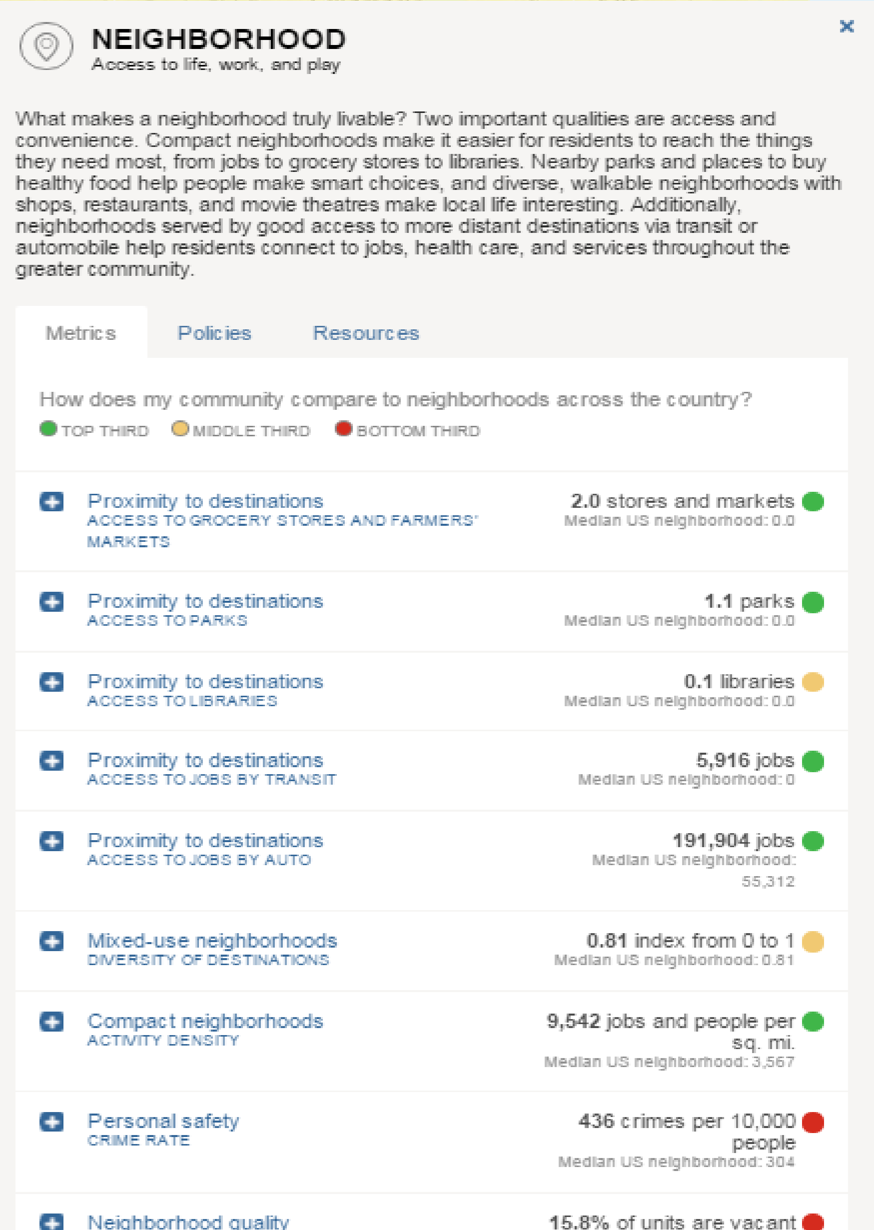






Hollywood - Neighborhood





2016 Telehealth Bills

Senate	House
SB 1686 by Senator Bean	HB 1353 by Representative Jones HB 7087 by Health Select Committee on Affordable Healthcare Access and Representative Sprowls

Percentage of 50+ & 65+ Population by District

Source: AARP Maps
Demographics of FL 50+ & 65+ Communities

Assessed Prioritized Consumer List

12/23/2015

Program	State Total
Unduplicated Consumer Count by Programs	**58,818**
Alzheimer Disease Initiative (ADI)	4,054
Community Care for the Elderly (CCE)	35,402
Home Care for the Elderly (HCE)	5,763
Local Services Programs (LSP)	50
Older Americans Act (OAA)	30,403
Statewide Medicaid Managed Long-term Care (LTCC)	41,049

FY 2015-2016
Long-Term Care Services Funding

Program	Funding	Individuals Served
Statewide Medicaid Managed Care Long Term Care	$3,240,655	212
Program for All-Inclusive Care for the Elderly	$3,024,239	156
Alzheimer's Disease Initiative (ADI)	$1,700,000	167
Community Care for the Elderly	$2,000,000	300
Total	**$9,964,894**	**835**

Thank you
AARP
Real Possibilities
10428
10430
10432
10414
10502

LIVABLE COMMUNITIES ARE GOOD FOR PEOPLE AND BUSINESS

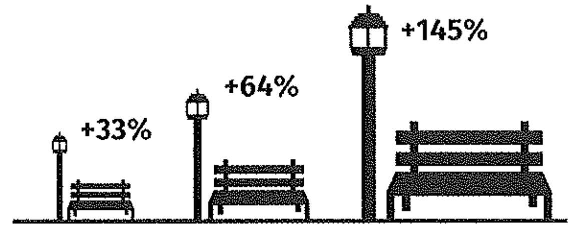
Higher property values, increased economic activity and savings for communities are some of the benefits you'll learn about in **THE LIVABILITY ECONOMY**

A LIVABLE COMMUNITY ...

- Features housing choices that are suitable for people of all ages and life stages.
- Reduces automobile dependence and supports a socially vibrant public realm.
- Integrates land uses so people can live closer to or within walking distance of jobs, community activities and the services they need.
- Has transportation options that enable residents to get around even if they don't drive.

LIVABLE COMMUNITIES INCREASE PROPERTY VALUES

Homes closer to parks and open spaces have higher property values than those further away.



A WalkScore increase of one point can improve the value of a home by as much as **$3,000**.

Demand for compact communities consistently increases property values by more than **15 percent** for office, residential and retail use.

LIVABLE COMMUNITIES INCREASE ECONOMIC ACTIVITY

Bicycling has generated more than **$400 million** in economic activity in Iowa.

LIVABLE COMMUNITIES SAVE MONEY

In Central Texas, compact, infill development decreased infastructure costs by **70%** when compared to typical, more sprawling development models, resulting in a **$7.5 billion** savings.

PEOPLE WANT LIVABLE COMMUNITIES

Boomers and **Millennials** have similar preferences for walkable, mixed-use neighborhoods.

72% | 54%
Want to be near shops, restaurants and offices

62% | 49%
Would move into a smaller home for a shorter commute

42% | 59%
Prefer to live where there's a mix of homes

52% | 55%
Want public transportation options

Learn more by downloading or reading *The Livability Economy: People, Places and Prosperity* online at AARP.org/livability-economy

Learn how livable communities are great places for people of all ages by visiting AARP.org/livable and subscribing to the free *AARP Livable Communities Monthly eNewsletter.*

Real Possibilities

The Livability Index

Great Neighborhoods for All Ages

aarp.org/livabilityindex

Overview of the Livability Index

The Livability Index is a groundbreaking tool of the AARP Public Policy Institute (PPI) that scores every neighborhood and community in the United States for the services and amenities that affect people's lives the most. Using more than 50 national sources of data, the AARP Livability Index provides the clearest picture yet of how well a community meets the current and future needs of people of all ages.

The Index was designed by experts at the PPI, with guidance from a 30-member technical advisory committee with expertise in both policy and data analysis across the range of subject areas evaluated by the Index. The selection of metrics was also informed by a national survey of more than 4,500 Americans 50-plus about the aspects of their communities most important to them. The Livability Index measures 60 indicators spread across seven categories of livability: housing, neighborhood, transportation, environment, health, engagement, and opportunity.

Goals of the Livability Index

By 2030, older adults will account for 20 percent of the U.S. population. AARP surveys consistently show that older adults overwhelmingly desire to age in their homes and communities. The Livability Index can be a powerful tool for local officials and others in adapting their cities so that residents of all ages can stay active and engaged in their communities.

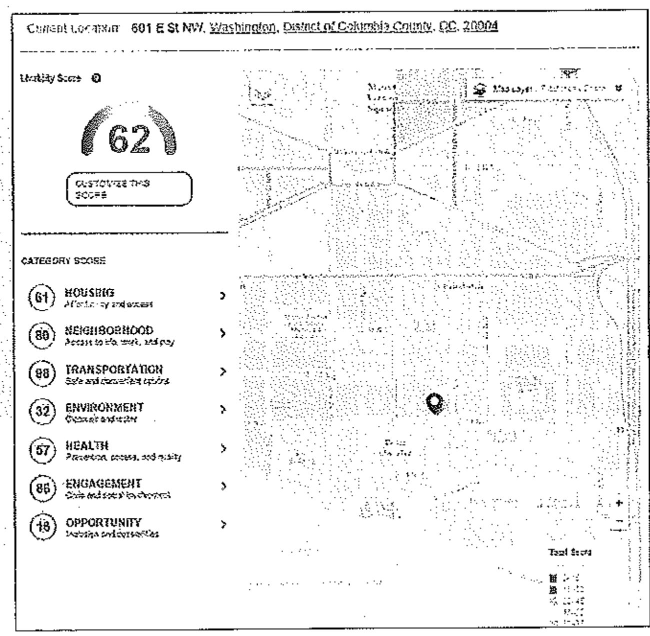
The Index will help community leaders and individuals identify gaps between what people want and need and what their communities provide. By identifying gaps, community leaders can set short- and long-term goals that support independent living through cooperation, planning, design, and services.

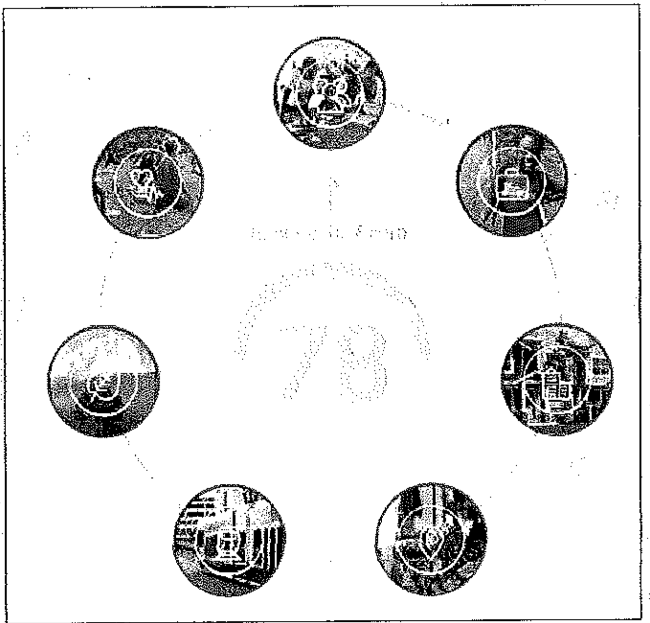
The Index will yield insights that will do the following:

- Help prepare communities for an aging population.
- Help people understand their communities better and encourage them to advocate for livability improvements.
- Inform key stakeholders, including public leaders, policy makers, nonprofit organizations, and community advocates.
- Encourage state and local changes in policy, planning, investment, and development.
- Help prospective residents decide where to live.
- Help private and public developers identify opportunities to meet community development needs.
- Provide a gateway to AARP and other resources that support efforts in making communities great places for all ages.

A livable community is one that is safe and secure, has affordable and appropriate housing and transportation options, and offers supportive community features and services. Once in place, those resources enhance personal independence, allow residents to age in place, and foster residents' engagement in the community's civic, economic, and social life.

To gauge the livability of communities, the AARP Public Policy Institute has developed a web-based tool, the Livability Index, to quantify the degree to which a community can meet people's needs, regardless of their age, income, physical ability, ethnicity, and other factors.





Key Features of the Livability Index

- **Location search feature**–Users can search the livability score for any location in the United States by address, town, city, county, or state.
- **Comparison feature**–Users can compare the livability score and category scores for up to three locations (any combination of address, town, city, county, or state).
- **Customization feature**–Users can customize their scores according to which categories are more or less important to them.
- **Map overlays**–Users will find demographic information such as race/ethnicity, age, and a visual display of the indicators comprising the livability scores.
- **Resources tab**–The score results page has a list of resources by category to connect communities to resources that will help them become more livable.

Index Scores

- The Livability Index scores places for their performance on 40 metrics and 20 policies across the seven categories of livability. Metrics measure how livable communities are in the present, while policies capture whether communities are laying the groundwork to become more livable over time. The livability score for a selected neighborhood, city, county or state ranges from 0 to 100. Category scores also range from 0 to 100.
- We score communities by comparing them to one another, so the average community gets a score of 50. Even the best-performing communities show room for improvement in at least one category. The highest scoring community today scores 70, while the highest scoring neighborhood receives a 78.
- For more information on Index Scoring, please visit aarp.org/livabilityindex and click "Calculating Scores" on the navigation bar.

For more information on AARP Livable Communities Resources, please visit us at:

Livable Communities: Policy and Research
www.aarp.org/livablepolicy

Livable Communities: Great Places for People of All Ages
www.aarp.org/livable

FLORIDIANS ARE FAMILY CAREGIVERS

Across Florida family caregivers give their hearts every day, helping their parents, spouses, and other loved ones stay at home.

4 million Family Caregivers

Provide 2.66 billion hours of unpaid care anually

Estimated at $29 billion in unpaid care annually

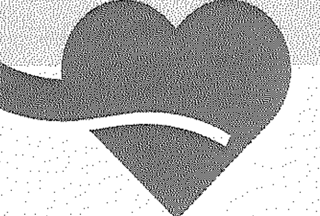
While they wouldn't have it any other way, family caregiving is a huge job. They:

- Use their own money to help provide care
- Change their work schedules
- Oversee medication
- Manage medical tasks
- Aid with household chores
- Help manage finances
- Provide transportation to appointments
- Help with shopping

THE AVERAGE FAMILY CAREGIVER

- Female
- 49 years old
- Cares for a loved one age 78
- Works full or part-time

Heart-ing Family Caregivers Across Florida



I Heart Caregivers is a new initiative from AARP to recognize the contribution and dedication of America's silent army of family caregivers who perform a great labor of love every day: caring for aging parents, spouses, brothers, sisters, aunts, uncles, friends and other loved ones so they can remain in their homes. To view stories – or share your own – visit: aarp.org/iheartcaregivers

Source: Valuing the Invaluable 2011 Update; Understanding the Impact of Family Caregiving on Work (PPI); Caregiving in the U.S. 2009

I ❤ Caregivers℠ AARP Real Possibilities

State Profile: **Florida**

Selected State Background Characteristics

	FL	US
Population		
Total Pop. *(thousands)*	19,553	316,128
Pop. 60+ *(thousands)*	4,395	62,826
% 60+	23.4	19.9
National Ranking 60+	1	N/A
% White (60+)	76.0	78.9
% African American (60+)	8.1	8.8
% Hispanic/Latino (60+)	13.6	7.3
% Asian (60+)	1.4	3.6
% Native Hawaiian/ Pacific Islanders (60+)	0.0	0.1
% American Indian/ Alaska Native (60+)	0.2	0.5
% Two or More Races (60+)	0.7	0.8
Pop. 65+ *(thousands)*	3,260	40,267
% Pop. 65+	17.3	13
National Ranking 65+	1	N/A
Pop. 85+ *(thousands)*	118.5	5,493
% Pop. 85+	2.3	1.8
National Ranking 85+	7	N/A

	FL	US
Economic Indicators		
Per Capita Income	$41,940	$42,693
Median Household Income	$60,119	$53,046
Total State Expenditures Per Capita	9,368	5,385
% Pop. 65+ Below Poverty	10	13

	FL	US
Socio-Demographics		
Average Household Size	2.53	2.61
Average Family Size	3.11	3.19
%Pop. in Rural Area	8.84	19.3
%Households with Persons 65+	24.4	24.9
% Persons Age 65+ Living Alone	9.6	9.4
% Households with Internet Access	81.5	79.3

	FL	US
Informal Caregivers		
# of Caregivers *(thousands)*	1,766	28,828
# of Caregiving Hours (million)	1,892	30,880
Value of Caregiving *(millions)*	$18,768	$306,333
# Grandparents Living with Grandchildren *(thousands)*	152.3	7070
% with Responsibility for the Grandchildren	48.5	38.8
Where to Call to Arrange Help in the Home for Elderly Relatives or Friends		
% Relative or Friend	25.1	21.5
% Self	19.7	17.2
% Medical Support	18.9	21.6
% Religious Support	0.4	0.4
% Area Agency on Aging	1.5	2.0
% Other	2.9	4.5
% Don't Know	31.6	32.7

Updated September 2014. Data sources for selected characteristics are available at https://caregiver.org/50-state-profiles-sources-2014-update

State Profile: **Florida** (cont'd)

Selected State Background Characteristics

	FL	US
■ Long-Term Care ■		
Medicaid Spending on Long-Term Care		
% Spending on Nursing Facilities	58.7	41.1
% Spending on Home Health & Personal Care	32.9	45
# of Certified Nursing Facilities	684	15,465
% of Certified Facilities with Family Groups	51.5	30.5
# of Certified Nursing Facility Beds *(thousands)*	82.6	1,646
% Certified Nursing Facility Occupancy Rate	87.6	83
Average Cost Per Day in a Nursing Home *(private)*	$259	$241
Average Assisted Living Monthly Cost	$3,334	$3,551
Average Daily Cost for Adult Day Care Services	$60	$64
Average Hourly Cost for Home Health Care	$18	$26
# of Home Health Aides	28,180	806,710
Median Hourly Wage		
Certified Medical Assistant	$13.55	$14.24
Home Health Aide	$10.04	$10.10
Personal Care/Home Care Aide	$9.61	$9.18

	FL	US
■ Care Receivers ■		
% Pop. 18-64 Years w/Disability	9.9	10.1
% Pop. 65+ w/Disability	33.9	36.4
% 65+ by Type of Disability		
Hearing Difficulty	14.0	14.9
Ambulatory	21.8	23.5
Self-Care	8.0	8.8
Cognitive	9.0	9.4
Independent Living Difficulty	14.5	16.1
■ Medicare Prescription Drug Plans ■		
# of Organizations Offering PDPs	16	N/A
# of PDP	33	N/A
# of Medicare Advantage Drug Plan Contracts	34	N/A

Updated September 2014. Data sources for selected characteristics are available at https://caregiver.org/50-state-profiles-sources-2014-update

THE FLORIDA SENATE

APPEARANCE RECORD

Waive In-Support

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

1/27/16
Meeting Date

1336
Bill Number (if applicable)

Amendment Barcode (if applicable)

Topic: behavioral health care

Name: Susan Harbin

Job Title: Legislative Advocate

Address: 100 S. Monroe St.
Street

Tallahassee, FL 32301
City, State, Zip

Phone: (770)546-8845

Email:

Speaking: [x] For [ ] Against [ ] Information

Waive Speaking: [x] In Support [ ] Against
(The Chair will read this information into the record.)

Representing: Florida Association of Counties

Appearing at request of Chair: [ ] Yes [x] No

Lobbyist registered with Legislature: [x] Yes [ ] No

While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.

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THE FLORIDA SENATE

APPEARANCE RECORD

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1/27/16
Meeting Date

1336
Bill Number (if applicable)

Amendment Barcode (if applicable)

Topic mental health

Name April Lott

Job Title President\CEO

Address 1437 S. Belcher Rd
Street

Clearwater Fl 33764
City State Zip

Phone 727 524-4464

Email alott@directionsforliving.org

Speaking: [x] For [ ] Against [x] Information

Waive Speaking: [ ] In Support [ ] Against
(The Chair will read this information into the record.)

Representing Florida Council for Behavioral Healthcare

Appearing at request of Chair: [ ] Yes [x] No

Lobbyist registered with Legislature: [ ] Yes [x] No

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S-001 (10/14/14)

THE FLORIDA SENATE

APPEARANCE RECORD

Waive In-Support

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

1-27-16
Meeting Date

1336
Bill Number (if applicable)

Amendment Barcode (if applicable)

Topic

Name THAD LOWREY

Job Title VP Governmental Relations

Address 7720 WASHINGTON St- Suite 102
Street

Phone 727-992-8508

PORT R Chy FL 34608
City State Zip

Email tlowrey@oparpr.org

Speaking: [x] For [ ] Against [ ] Information

Waive Speaking: [x] In Support [ ] Against
(The Chair will read this information into the record.)

Representing OPERATION PAR

Appearing at request of Chair: [ ] Yes [x] No

Lobbyist registered with Legislature: [x] Yes [ ] No

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S-001 (10/14/14)

THE FLORIDA SENATE

APPEARANCE RECORD

Waive In Support

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

1/27/16
Meeting Date

SB 1336
Bill Number (if applicable)

Amendment Barcode (if applicable)

Topic: Substance Abuse & Mental Health

Name: Natalie Kelly

Job Title: Executive Director

Address: 411 East College Ave
Street

Tallahassee FL 32301
City State Zip

Phone: 850)570-5147

Email: natalie.kelly@me.com

Speaking: [x] For [ ] Against [ ] Information

Waive Speaking: [x] In Support [ ] Against
(The Chair will read this information into the record.)

Representing: Florida Association of Managing Entities

Appearing at request of Chair: [ ] Yes [x] No

Lobbyist registered with Legislature: [x] Yes [ ] No

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S-001 (10/14/14)

THE FLORIDA SENATE

APPEARANCE RECORD

For

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

1/27/16
Meeting Date

1336
Bill Number (if applicable)

Amendment Barcode (if applicable)

Topic Behavior Health Care Services

Name Jason King

Job Title Legislative Affairs Manager

Address 700 SE 3rd Ave #400
Street

Phone 954-610-3064

Fort Lauderdale, FL 33316
City State Zip

Email jason.king@aidshealth.org

Speaking: [✓] For [ ] Against [ ] Information

Waive Speaking: [ ] In Support [ ] Against
(The Chair will read this information into the record.)

Representing AIDS Healthcare Foundation

Appearing at request of Chair: [ ] Yes [✓] No

Lobbyist registered with Legislature: [✓] Yes [ ] No

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S-001 (10/14/14)

For

THE FLORIDA SENATE

APPEARANCE RECORD

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

1-27-16
Meeting Date

1336
Bill Number (if applicable)

Amendment Barcode (if applicable)

Topic Substace Abuse + Mental Health

Name MARK FONTAINE

Job Title EXECUTIVE DIRECTOR

Address 2868 MAHAN Drive
Street

Phone 878-2196

Tallahassee FL 32308
City State Zip

Email

Speaking: [X] For [ ] Against [ ] Information

Waive Speaking: [ ] In Support [ ] Against
(The Chair will read this information into the record.)

Representing Florida Alcohol + Drug Abuse Assoc.

Appearing at request of Chair: [ ] Yes [X] No

Lobbyist registered with Legislature: [X] Yes [ ] No

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S-001 (10/14/14)

THE FLORIDA SENATE

APPEARANCE RECORD

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

01-27-16
Meeting Date

Bill Number (if applicable)

Topic Improving the Ability of Elders to Stay in their Community

Amendment Barcode (if applicable)

Name Samuel Verghese

Job Title Secretary of FL Dept. of Elder Affairs

Address 4040 Esplanade Way
Street

Phone 414-2000

Tallahassee FL 32399
City State Zip

Email

Speaking: [ ] For [ ] Against [X] Information

Waive Speaking: [ ] In Support [ ] Against
(The Chair will read this information into the record.)

Representing FL Dept. of Elder Affairs

Appearing at request of Chair: [X] Yes [ ] No

Lobbyist registered with Legislature: [X] Yes [ ] No

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S-001 (10/14/14)

THE FLORIDA SENATE

APPEARANCE RECORD

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1/27/16
Meeting Date

_______ *Bill Number (if applicable)*

_______ *Amendment Barcode (if applicable)*

Topic: AARP Florida Livable Communities

Name: Laura Cantwell

Job Title: Associate State Director Advocacy

Address: _______
Street

St Pete, FL
City *State* *Zip*

Phone _______

Email _______

Speaking: ☐ For ☐ Against ☐ Information

Waive Speaking: ☐ In Support ☐ Against
(The Chair will read this information into the record.)

Representing: AARP

Appearing at request of Chair: ☑ Yes ☐ No

Lobbyist registered with Legislature: ☑ Yes ☐ No

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S-001 (10/14/14)

THE FLORIDA SENATE

APPEARANCE RECORD

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1/27/16
Meeting Date

Bill Number (if applicable)

Topic

Amendment Barcode (if applicable)

Name Kenneth Thomas

Job Title Vol AARP

Address 18711 Ocean Mist Dr.
Street
Boca Raton, FL 33498
City *State* *Zip*

Phone 561 289-8104

Email KETHOMAS@aarp.org

Speaking: ☐ For ☐ Against ☑ Information

Waive Speaking: ☐ In Support ☐ Against
(The Chair will read this information into the record.)

Representing AARP

Appearing at request of Chair: ☑ Yes ☐ No

Lobbyist registered with Legislature: ☐ Yes ☑ No

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S-001 (10/14/14)

THE FLORIDA SENATE

APPEARANCE RECORD

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

1/27/16
Meeting Date

Bill Number (if applicable)

Amendment Barcode (if applicable)

Topic LIVEABLE COMMUNITIES

Name JACK McRAY

Job Title

Address 200 W. COLLEGE ST, #304
Street

TLH FL 32301
City State Zip

Phone 850-577-5187

Email jmcray@aarp.org

Speaking: ☐ For ☐ Against ☑ Information

Waive Speaking: ☐ In Support ☐ Against
(The Chair will read this information into the record.)

Representing AARP

Appearing at request of Chair: ☑ Yes ☐ No

Lobbyist registered with Legislature: ☑ Yes ☐ No

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S-001 (10/14/14)

CourtSmart Tag Report

Room: SB 301 **Case No.:** **Type:**
Caption: Senate Committee Children, Families, and Elder Affairs **Judge:**

Started: 1/27/2016 1:15:01 PM
Ends: 1/27/2016 2:27:30 PM Length: 01:12:30

1:15:10 PM	Meeting called to order
1:15:17 PM	Roll call
1:15:31 PM	Quorum Present
1:15:40 PM	Tab 1 SB 1336
1:15:57 PM	Sen Latvala explains
1:18:04 PM	Sen Latvala explains
1:18:38 PM	Rep Peters speaks
1:19:49 PM	Rep Peters speaks further explaining SB 1336
1:19:54 PM	Public Testimony
1:20:01 PM	Mark Foutaine waives in support
1:20:25 PM	Jason King, Aids Healthcare Foundation, speaks in support
1:20:38 PM	Naalee Kelly waives in support
1:20:46 PM	Thad Lowry waives in support
1:21:25 PM	April Lott, Fl Con for Behaviorial Health Care, speaks in support and to inform
1:22:02 PM	April Lott, Fl Council for Behaviorial Health Care, speaks in support and to inform
1:22:14 PM	Susan Harbin waives in support
1:22:18 PM	Debate
1:22:34 PM	Sen Sobel questions
1:22:48 PM	Sen Sobel questions
1:22:55 PM	Sen Garcia answers
1:23:50 PM	Sen Latvala closes on SB 1336
1:24:07 PM	Roll call on SB 1336
1:24:29 PM	SB 1336 passes favorbly
1:24:41 PM	Sen Deter turns authority over to Chair Sobel
1:24:52 PM	Tab 2 SB 1420 TP
1:25:01 PM	Tab 3 SB 1676
1:25:26 PM	Sen Sachs speaks
1:25:49 PM	Sen Sachs explains
1:27:03 PM	Sen Detert questions
1:28:03 PM	Sen Detert questions
1:28:11 PM	Sen Sachs answers
1:28:17 PM	Sen Detert comments
1:28:52 PM	Sen Detert questions
1:29:02 PM	Sen Sachs answers
1:30:04 PM	Sen Detert questions
1:30:16 PM	Sen Sachs answers
1:32:00 PM	Sen Sachs answers
1:32:07 PM	Sen Garcia question
1:32:17 PM	Sen Sachs answers
1:33:26 PM	Sen Sachs answers
1:33:33 PM	Sen Garcia follow up question
1:33:40 PM	Sen Sachs responds
1:33:58 PM	Sen Sobel question
1:34:54 PM	Sen Sachs responds
1:35:02 PM	Sen Sobel comments
1:35:50 PM	Sen Sachs closing remarks on SB 1676
1:36:04 PM	Roll Call SB 1676
1:36:14 PM	SB 1676 passes favorably
1:36:37 PM	SB 1676 passes favorably
1:37:01 PM	Sen Sobel speaks on Sr. Day at the Capital
1:38:44 PM	Samuel Verghese, Fl Dept of Elder Affairs, speaks to inform
1:39:36 PM	Verghese presents

1:41:29 PM	Sen Sobel comments
1:44:51 PM	Verghese further informs and explains
1:44:57 PM	Sen Sobel question
1:45:03 PM	Verghese answers
1:45:13 PM	Sen Sobel question
1:45:22 PM	Verghese answers
1:45:29 PM	Sen Sobel question
1:46:23 PM	Verghese answers
1:46:53 PM	Sen Detert comments
1:48:44 PM	Sen Detert comments
1:48:48 PM	Sen Sobel comments
1:50:41 PM	Verghese further explains
1:51:49 PM	Verghese further explains
1:52:05 PM	Sen Sobel questions
1:53:43 PM	Verghese answers
1:53:52 PM	Sen Sobel question
1:54:06 PM	Verghese answers
1:54:47 PM	Sen Sobel comments
1:55:12 PM	Jack McRay, AARP, advocacy presenter on livable communities
1:55:27 PM	LaurieCantwell, AARP, presenter on livable communities
1:55:37 PM	Kenneth Thomas, AARP, presenter on livable communities
1:58:01 PM	Laura Cantwell, AARP, explains livable communties
2:00:40 PM	Laura Cantwell, AARP, explains livable communties
2:00:48 PM	Sen Sobel question
2:01:16 PM	Laura Cantwell answers
2:01:22 PM	Sen Sobel question
2:01:39 PM	Ken Thomas, AARP, presents
2:02:42 PM	Sen Sobel comments
2:03:29 PM	Ken Thomas, AARP, responds
2:03:30 PM	Sen Sobel questions
2:06:02 PM	Recording Paused
2:06:29 PM	Recording Resumed
2:06:41 PM	Motion to table the meeting
2:07:00 PM	Meeting adjourned