

5 - A. Screen Field Tables

Screen Field Tables This section of the manual includes screen images with field tables that describe each of the fields on the CARE data entry screens. These tables are organized numerically by action code.

Table Columns Each table contains three columns as described below.

Column	Description
Field Name	The name of the field as it is displayed on the screen.
Type	The field's type (see descriptions below).
Contents	An explanation of the information to be entered in the field. If the information for the field is found elsewhere in this reference manual, that fact is noted in bold print following the explanation. For example, Component Codes/LSAs . A decode table is noted in bold print as follows: Decode: Perception . In some instances, the decode value is provided.

Field Types The second column on each field table indicates the field's type. Possible types and their descriptions are shown below.

Type	Description
R (Required)	Data is required. You must enter appropriate data in the field.
D (Displayed)	Data displayed is supplied by CARE and cannot be changed.
O (Optional)	Optional data. If data is available, it should be entered.
D/R (Displayed/Required)	Data displayed is supplied by CARE/Required data. The supplied data can be changed.
O/R (Optional/Required)	Optional data in some cases/Required data in others. An explanation of when the data is required is contained in the Contents column.
D/O (Displayed/Optional)	Data is supplied by CARE if it is available.

CARE/OBRA Service Plan II (Action Code 025) 4

CARE/OBRA Specialized Services Refusal (Action Code 040) 5

CARE/OBRA Alternate Placement Entry (Action Code 050)..... 6

CARE/OBRA Client Outcome Deceased (Action Code 060-1) 8

Initial Contact Outcome—Client Location (Action Code 060-2) 9

CARE/OBRA Refuse Services (Action Code 060-3) 10

CARE/OBRA Legal Representative Entry (Action Code 085) 11

CEA1-C/A Evaluation Assessment (Action Code 160)..... 12

CEA1B-C/A Evaluation Assessment for Benefit Design (Action Code 164) 14

Referral/Tracking/Placement (Action Code 304) Screen A-Referral 16

Referral/Tracking/Placement (Action Code 304) Screen B-Referral..... 17

Referral/Tracking/Placement (Action Code 304) Screen C-Referral..... 18

Referral/Tracking/Placement (Action Code 304) Screen D-Closing 19

Referral/Tracking/Placement (Action Code 304) Screen I-Inquiry 20

Campus-based Assignments (Action Code 305)..... 21

Campus-based Discharge/Community Placement (Action Code 310) 23

MR Discharge from State School (Action Code 311) 25

Joint Community Support Plan (Action Code 312) 26

Multiple Campus-based Assignments (Action Code 315)..... 27

CAUA-Child/Adolescent Uniform Assessment (Action Code 316) Screen 1 28

CAUA-Child/Adolescent Uniform Assessment (Action Code 316) Screen 2 29

CAUA-Child/Adolescent Uniform Assessment (Action Code 316) Screen 3 30

CAUA-Child/Adolescent Uniform Assessment (Action Code 316) Screen 4 31

CAUA-Child/Adolescent Uniform Assessment (Action Code 316) Screen 5 32

Child/Adolescent MH Community Assignment (Action Code 319) 34

MR and MH Adult Community-based Assignment (Actions Code 321) 35

Destination Assignment (Action Code 323) 36

Register Client: Client ID (Action Code 325)..... 37

 Register Client: Correspondent Data 39

Diagnostics (Action Code 330)..... 41

Death Review (Action Code 331)..... 45

Voluntary Admission & Commitment (Action Code 332) 46

MH Uniform Assessment (Action Code 333)..... 48

Physical Characteristics (Action Code 335) 50

Permanency Planning Review (Action Code 339)..... 52

MR Needs I (Action Code 340) 54

MR Needs II 56

MR Needs III 58

MR Needs IV 60

MR Needs V 62

MH Acute Level of Care Determination (Action Code 343)..... 63

MH Bed Allocation Exception (Action Code 345)..... 64

MH Adult Uniform Assessment for Benefit Design (Action Code 346)..... 65

Hospitalization Need of MR Person (Action Code 357) 68

Death/Separation of Client (Action Code 360)..... 69

New Generation Medication Tracking (Action Code 375)..... 70

State School Residence Reason (Action Code 391) 72

Add Case to ID/Demographic Update (Action Code 410) 73

Medicaid/Medicare Number Update (Action Code 413)..... 75

OBRA Client Update (Action Code 415) 76

Client Name Update (Action Code 420) 78

Client Address Update (Action Code 430) 79

Client Correspondent Update (Action Code 431)..... 80

Client’s County of Residence Update (Action Code 440)..... 82

Maintain Destination Assignments (Action Code 450) 83

IHFS Indicator (Action Code 460) 84

Independent Employment (Action Code 469) 85

Case Management Assignment (Action Code 490) 86

Aftercare/Brief Intervention (Action Code 495)..... 87

Component (Action Code 605) 88

Non-Residential Services (Action Code 610) 90

Campus-based Residential Ward/Dorm (Action Code 615) 91

MH Community-based Residential Program (Action Code 620)..... 92

MR Community-based Residential Program (Action Code 623) 94

MH & MR Authority (Action Code 625) 96

Accounting Code Assignment (Action Code 635) 97

Accounting Code (Action Code 640) 98

RAJ Ward Information (Action Code 650) 99

Case Management Units (Action Code 660) 100

Case Management Positions (Action Code 670) 101

Case Management Position Reassignments (Action Code 675)..... 102

Client & Family Support Program (Action Code 680) 103

Living Options Process (Action Code 1121) *for Community ICF/MR Facilities*..... 104

Living Options Process (Action Code 1121) *for State Mental Retardation Facilities* 105

Interest List - Services (Action Code W21)..... 106

Travis Questionnaire Entry (Action Code W27) 108

CARE/OBRA Service Plan II (VC020365) (Action Code 025)

```

08-29-95          025:CARE/OBRA SERVICE PLAN II: ADD          VC020365
LAST NAME      :                               CARE ID       :
FIRST NAME     :                               LOCAL CASE NUMBER :
MIDDLE INIT    :                               COMPONENT        :
                                                OBRA ID           :
BEGIN DATE:    ____ (MMDDYYYY)
END DATE :     ____ (MMDDYYYY)   RECEIVE SERVICE? (Y/N)
VENDOR :       ____

B000 OBRA MANDATED - NO APPROPRIATE SERVICES AVAILABLE -
B100 VOCATIONAL SERVICES AND CASE MANAGEMENT           -
B200 MH REHABILITATIVE SERVICES AND CASE MANAGEMENT   -
B300 CASE MANAGEMENT FOR ALTERNATE PLACEMENT SERVICES -
B400 CASE MANAGEMENT FOR NEW SPECIALIZED SERVICES REFERRAL -
B500 CASE MANAGEMENT FOR RE-EVALUATION                 -
B600 REFERRED TO NURSING FACILITY REHABILITATION SERVICES -
B700 REFERRED TO EARLY CHILDHOOD INTERVENTION PROGRAM  -
B800 REFERRED TO LOCAL PUBLIC SCHOOL DISTRICT          -
B900 REFERRED TO EPSDT-CCP                             -
READY TO ADD?   : - (Y/N)

ACT: ____ (000/CARE CLIENTS OBRA FUNCTIONS MENU, M/MENU)

```

Field Name	Type	Contents
LAST NAME	D	Person's last name.
FIRST NAME	D	Person's first name.
MIDDLE INIT	D	Person's middle initial.
CARE ID	D	Person's statewide identification number.
LOCAL CASE NUMBER	D	Person's local case number.
COMPONENT	D	Three-digit code of the component to which the person is assigned.
OBRA ID	D	Person's OBRA identification number.
BEGIN DATE	R	Date the service plan is to begin. MMDDYYYY format.
END DATE	O/R	Date the service plan is to end. MMDDYYYY format.
VENDOR	R	Four-digit number that represents the nursing facility where the individual is currently residing.
RECEIVE SERVICE?	R	Y (Yes) to indicate each service category to be received. <u>Note:</u> Y must be answered for at least one service.

CARE/OBRA Specialized Services Refusal (VC020245)

(Action Code 040)

```

02-28-94      040: CARE/OBRA SPECIALIZED SERVICES REFUSAL: ADD      VC020245

LAST NAME/SUF:                CARE ID      :
FIRST NAME  :                 LOCAL CASE NUMBER :
MIDDLE NAME :                 COMPONENT     :

OBRA ID      : ____          ASSESSMENT DATE  :
OBRA REVIEW NUMBER: ____    DETERMINATION DATE:
                                           DATE LETTER SENT :

      DATE SPECIALIZED SERVICES REFUSED: ____ (MMDDYY)

READY TO ADD?      _ (Y/N)

ACT: ____ (000/CARE CLIENTS OBRA FUNCTIONS MENU,M/MENU)
  
```

Field Name	Type	Contents
LAST NAME/SUF	D	Person's last name and suffix, if any.
FIRST NAME	D	Person's first name.
MIDDLE NAME	D	Person's middle name.
OBRA ID	D	Person's OBRA identification number.
OBRA REVIEW NUMBER	D	Number assigned to the person's OBRA review.
CARE ID	D	Person's statewide identification number.
LOCAL CASE NUMBER	D	Person's local case number.
COMPONENT	D	Three-digit code of the component to which the person is assigned.
ASSESSMENT DATE	D	Date of the assessment.
DETERMINATION DATE	D	Date of the determination.
DATE LETTER SENT	D	Date the determination letter was sent.
DATE SPECIALIZED SERVICES REFUSED	R	Date the specialized services were refused. MMDDYY format.

CARE/OBRA Alternate Placement Entry (VC020255)

(Action Code 050)

```

04-29-94      050:CARE/OBRA ALTERNATE PLACEMENT ENTRY:ADD      VC020255
LAST NAME/SUF:                CARE ID      :
FIRST NAME  :                 LOCAL CASE NUMBER :
MIDDLE NAME :                 COMPONENT     :
OBRA ID    :                 REVIEW ID     :

PLACEMENT BEGAN : ____ (MMDDYY)      PLACEMENT ENDED: ____ (MMDDYY)
PLACEMENT COUNTY: ____              PLACEMENT TYPE : ____
DID YOUR AUTHORITY ASSIST WITH THIS PLACEMENT?(Y/N): _

PLACEMENT ADDRESS COMPONENT: ____ LOCATION CODE: ____
                                -OR-
                                NAME: _____
                                ATTN: _____
                                STREET: _____
                                CITY: _____ STATE: __ ZIP: ____

READY TO ADD? : _ (Y/N)

ACT: ____ (000/CARE OBRA FUNCTIONS MENU, M/MENU)
  
```

Field Name	Type	Contents
LAST NAME/SUF	D	Person's last name and suffix, if any.
FIRST NAME	D	Person's first name.
MIDDLE NAME	D	Person's middle name.
OBRA ID	D	Person's OBRA identification number.
CARE ID	D	Person's statewide identification number.
LOCAL CASE NUMBER	D	Person's local case number.
COMPONENT	D	Three-digit code of the component to which the person is assigned.
REVIEW ID	D	Number that indicates a specific PASARR determination.
PLACEMENT BEGAN	R	Date the person's alternate placement begins. MMDDYY format.
PLACEMENT ENDED	O	Date the person's alternate placement ended. MMDDYY format.
PLACEMENT COUNTY	R	Three-digit code for the county in which the person is placed.
PLACEMENT TYPE	R	Person's preferred alternate placement type. Decode: Alternate Placement Types
DID YOUR AUTHORITY ASSIST WITH THIS PLACEMENT?	R	Y (Yes) or N (No) to indicate if your authority assisted in placing this person outside the nursing facility.

Field Name	Type	Contents
<u>Placement Address</u>		
COMPONENT	R/O	Three-digit component code.
LOCATION CODE	R/O	Location code.
- or -		
NAME	O	Name of the placement location.
ATTN	O	Line to be used for a person's name or title or for an extra line for the address.
STREET	R/O	Street of the placement location.
CITY	R/O	City of the placement location.
STATE	R/O	State of the placement location.
ZIP	R/O	Zip and the zip suffix of the placement location.

CARE/OBRA Client Outcome Deceased (VC020266)

(Action Code 060)

1 - Client Deceased Option

```

02-28-94      060:CARE/OBRA CLIENT OUTCOME DECEASED: ADD      VC020266

LAST NAME   :                               OBRA ID       :
FIRST NAME  :                               REVIEW ID    :
HIC/MEDICARE :                             SSN          :
COMPONENT  :                               RECIPIENT/MEDICAID:

EFFECTIVE DATE OF DEATH (MMDDYY) : _____

READY TO ADD?  _ (Y/N)

ACT:  __ (300/CLIENT DATA ENTRY, M/MENU)
    
```

Field Name	Type	Contents
LAST NAME	D	Person's last name and suffix, if any.
FIRST NAME	D	Person's first name.
HIC/MEDICARE	D	The 1 - 12 character Medicare/HIC number.
COMPONENT	D	Three-digit component code entered on the request screen.
OBRA ID	D	Person's OBRA identification number.
REVIEW ID	D	Number assigned to the person's OBRA review.
SSN	D	Person's social security number.
RECIPIENT/MEDICAID	D	The 1 - 9 digit Medicaid/Recipient number.
EFFECTIVE DATE OF DEATH	R	Effective date of the person's death. <u>Note:</u> This date can be the actual date the person died or the date the authority learned the person was deceased.

Initial Contact Outcome — Client Location (VC020265)

(Action Code 060)

2 - Client Location Option

```

02-28-94   060:INITIAL CONTACT OUTCOME - CLIENT LOCATION: ADD   UC020265

LAST NAME   :                               COMPONENT           :
FIRST NAME  :                               OBRA ID              :
MIDDLE NAME :                               OBRA REVIEW NUMBER:

                                           ASSESSMENT DATE   :
                                           DETERMINATION DATE:
                                           DATE LETTER SENT  :

      OUTCOME DATE (MMDDYY)                :

      CLIENT LOCATION - OUTCOME CODE      : _ 1 = CLIENT NOT LOCATED
                                           2 = TRANSFER OUTSIDE LSA
                                           4 = CLIENT WILL NOT ENTER NF

      COUNTY                               : __ (OUTCOME CODE 2 ONLY)

READY TO ADD?      _ (Y/N)

ACT: __ (000/CARE CLIENTS OBRA FUNCTIONS MENU,M/MENU)
  
```

Field Name	Type	Contents
LAST NAME	D	Person's last name and suffix, if any.
FIRST NAME	D	Person's first name.
MIDDLE NAME	D	Person's middle name.
COMPONENT	D	Three-digit component code.
OBRA ID	D	Person's OBRA identification number.
OBRA REVIEW NUMBER	D	Number assigned to the person's OBRA review.
ASSESSMENT DATE	D	Date of the assessment.
DETERMINATION DATE	D	Date of the determination.
DATE LETTER SENT	D	Date the determination letter was sent.
OUTCOME DATE	R	The date <ul style="list-style-type: none"> • the person actually left the local service area, • the person said he/she was not going into the facility, <i>or</i> • the authority gave up looking for the person.
CLIENT LOCATION — OUTCOME CODE	R	Code indicating the outcome. 1 = Client Not Located 2 = Transfer Outside LSA 4 = Client Will Not Enter NF
COUNTY	R	Code for the county to which the person is moving. <u>Note:</u> County code cannot be entered unless the OUTCOME CODE is 2.

CARE/OBRA Refuse Services (VC020245)

(Action Code 060)

3 - Refuse Services Option

```

02-28-94          060:CARE/OBRA REFUSE SERVICES: ADD          UC020245

LAST NAME/SUF:                CLIENT ID      :
FIRST NAME  :                 LOCAL CASE NUMBER :
MIDDLE NAME :                 COMPONENT       :

OBRA ID      :                 ASSESSMENT DATE :
OBRA REVIEW NUMBER:           DETERMINATION DATE:
                                           DATE LETTER SENT :

                                DATE SPECIALIZED SERVICES REFUSED:      ____ (MMDDYY)

READY TO ADD?      _ (Y/N)

ACT: ____ (000/CARE CLIENTS OBRA FUNCTIONS MENU,M/MENU)
    
```

Field Name	Type	Contents
LAST NAME/SUF	D	Person's last name and suffix, if any.
FIRST NAME	D	Person's first name.
MIDDLE NAME	D	Person's middle name.
OBRA ID	D	Person's OBRA identification number.
OBRA REVIEW NUMBER	D	Number assigned to the person's OBRA review.
CLIENT ID	D/O	Person's statewide identification number assigned by CARE.
LOCAL CASE NUMBER	D/O	Person's local case number.
COMPONENT	D	Three-digit component code.
ASSESSMENT DATE	D	Date of the assessment.
DETERMINATION DATE	D	Date of the determination.
DATE LETTER SENT	D	Date the determination letter was sent.
DATE SPECIALIZED SERVICES REFUSED	R	Date the specialized services were refused. MMDDYY format.

CARE/OBRA Legal Representative Entry (VC020355)

(Action Code 085)

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02-28-94      085:CARE/OBRA LEGAL REPRESENTATIVE ENTRY: ADD      UC020355

LAST NAME/SUF:                CARE ID      :
FIRST NAME   :                LOCAL CASE NUMBER :
MIDDLE NAME  :                COMPONENT    :
OBRA ID      :

LEGAL REP: NAME: _____ PHONE:  ___  ___
           C/O:  _____
           STREET: _____
           CITY:  _____ STATE:  __ ZIP:  ___  ___

LEGAL REPRESENTATIVE TYPE:  __ (ENTER A CODE FROM BELOW)
01 - COURT APPOINTED GUARDIAN
02 - PARENT OF MINOR CHILD
03 - COURT APPOINTED CONSERVATOR
04 - OTHER

READY TO ADD?  _ (Y/N)

ACT:  __ (M/MENU,Q/QUIT)
    
```

Field Name	Type	Contents
LAST NAME/SUF	D	Person's last name and suffix, if any.
FIRST NAME	D	Person's first name.
MIDDLE NAME	D	Person's middle name.
OBRA ID	D	Person's OBRA identification number.
CARE ID	D	Person's statewide identification number assigned by CARE.
LOCAL CASE NUMBER	D	Person's local case number.
COMPONENT	D	Three-digit code of the component to which the person is assigned.
LEGAL REP:		
NAME	R	Legal representative's name.
PHONE	R/O	Legal representative's area code and telephone number.
C/O	R	Additional address line, if necessary.
STREET	R	Street address of the legal representative.
CITY	R	City associated with the street address.
STATE	R	State associated with the legal representative's address.
ZIP	R	Zip and zip suffix associated with the legal representative's address.
LEGAL REPRESENTATIVE TYPE	R	Two-digit code that describes the legal relationship between the nursing facility resident and the legal representative entered. 01 = Court Appointed Guardian 02 = Parent of Minor Child 03 = Court Appointed Conservator 04 = Other

CEA1 – C/A Evaluation Assessment (VC072161)

(Action Code 160)

```

09-29-03      161:CEA1 - C/A EVALUATION ASSESSMENT: ADD      UC072161
LAST NAME/SUF: JONES JR      CLIENT ID: 14630
FIRST NAME : BUSTERFER      MI: W      LOCAL CASE NUMBER: 0000003214
TYPE OF ASSESSMENT: INTAKE      COMPONENT CODE: 677
CE ASSESSMENT FORM DATE: ____ (HMDDYY)

REFERRAL SOURCE : _      AT RISK OF REMOVAL FROM
AT RISK OF PLACEMENT ? _ (Y/N)      PREFERRED CHILD CARE ? _ (Y/BLNK)
PLACEMENT CRITERIA MET? _ (Y/N)      ED (IN SPECIAL EDUCATION)? _ (Y/N)
EARLY INTERVENTION (EI): _ (Y/BLNK)
CBCL SCORE TYPE: ____ DATE COMPLETED (HMDDYY): ____ -----
T-SCORES: TOTAL ____ INTERNALIZING ____ EXTERNALIZING ____
GAF: __ LEVEL: _ WRAP-AROUND? _ (Y/N) MED/CHIP ELIG&ENRL: _ (M/E/C/N/I)
COMMUNITY FUNCTIONING AND PROBLEM BEHAVIOR RATING SCALES -----
CURR. PAST      CURR. PAST
- - : MH OR SA TREATMENT      - - : JUVENILE JUSTICE INVOLVEMENT
- - : DANGER TO OTHERS      - - : FAMILY PROBLEMS
- - : SCHOOL PROBLEMS      - - : DANGER TO SELF
- - : ALCOHOL OR DRUG USE      CURRENT CAREGIVER CAPACITY _

READY TO ADD?      _ (Y/N)

ACT: ____ (165/CHILDREN MH MENU, M/MAIN MENU)
    
```

Field Name	Type	Contents
LAST NAME/SUF	D	Person's last name and suffix, if any.
FIRST NAME	D	Person's first name.
MI	D	Person's middle initial.
CLIENT ID	D	Person's statewide identification number assigned by CARE.
LOCAL CASE NUMBER	D	Person's local case number.
COMPONENT CODE	D	Three-digit code of the component to which the person is assigned.
TYPE OF ASSESSMENT	D	Indicates the type of assessment as Intake, Update, or Termination.
CE ASSESSMENT FORM DATE	R	Date the assessment is completed.
REFERRAL SOURCE	O	Code of the source that first prompted or suggested the referral. Decode: Referral Source (Children's MH)
AT RISK OF PLACEMENT?	O	Y (Yes) or N (No) to indicate if the child is at risk of being placed out of the home.
AT RISK OF REMOVAL FROM PREFERRED CHILD CARE?	O	Y (Yes) or Blank to indicate if child is at risk of removal from Preferred Child Care.
PLACEMENT CRITERIA MET?	O	Y (Yes) or N (No) to indicate if the parents have requested out-of-home placement or if the Department of Protective and Regulatory Services or Juvenile Court has recommended placement.
ED (IN SPECIAL EDUCATION)?	R	Y (Yes) or N (No) to indicate if child is currently classified as Emotionally Disturbed (ED) in Special Education.
EARLY INTERVENTION (EI)	O	Y (Yes) or Blank to indicate if child is receiving services as part of the early childhood intervention program.

Field Name	Type	Contents
CBCL SCORE TYPE	O/R	Indicates type as CBCL, CBCL 2-3, YSR, TRF.
DATE COMPLETED	O/R	Date the CBCL/YSR/TRF was completed.
T-SCORES		
TOTAL	O/R	CBCL/YSR/TRF score for Total.
INTERNALIZING	O/R	CBCL/YSR/TRF score for Internalizing.
EXTERNALIZING	O/R	CBCL/YSR/TRF score for Externalizing.
GAF	O	One- or two-digit code for the person's global assessment functioning level on the assessment date.
LEVEL	R	Person's Level of Need (1, 2, 3, or A).
WRAP-AROUND?	R	Y (Yes) or N (No) to indicate whether the child is receiving wrap-around services.
MED/CHIP ELIG & ENRL	O	Indicates the child's Medicaid/CHIP eligibility and enrollment status. M = Medicaid eligible and enrolled E = Medicaid eligible and not enrolled C = CHIP eligible and not enrolled N = Not eligible for CHIP or Medicaid I = CHIP enrolled
COMMUNITY FUNCTIONING AND PROBLEM BEHAVIOR RATING SCALES	R	The appropriate rating (0 to 5) for any of the following Community Functioning and Problem Behavior Rating Scales that apply to the person (current or past): MH or SA Treatment Juvenile Justice Involvement Danger to Others Family Problems School Problems Danger to Self Alcohol or Drug Use
CURRENT CAREGIVER CAPACITY	R	The appropriate rating (0 to 5) to indicate the current caregiver's capacity regarding treatment.

CEA1B-C/A Evaluation Assessment for Benefit Design (VC072171)

(Action Code 164)

To be completed by Pilot Sites Only

09-23-03 175:CEA1B - C/A EVAL ASSESSMENT FOR BENEFIT DESIGN: ADD UC072171

LAST NAME/SUF: _____ CLIENT ID: _____

FIRST NAME : _____ MI: _____ LOCAL CASE NUMBER: _____

ASSESSMENT TYPE: INTAKE COMPONENT CODE: _____

FORM DATE: _____ (MMDDYYYY)

REFERRAL SOURCE: _ AT RISK OF PLACEMENT: _ (Y/N) ED (SPEC ED)? : _ (Y/N)

PARENT YOUTH WORKER

SECTION 1: OHIO SCALES PROBLEM SEVERITY SCORE: _ _ _

FUNCTIONING SCORE : _ _ _

LAST 90 DAYS: NBR ARRESTS: _ SCHOOL DAYS MISSED: _ PRIMARY RES: _

SECTION 2: CA-TRAG AND LEVEL OF CARE

A. RISK SELF HARM: _ DISRUP/AGGR BEHAV : _ FAMILY RESOURCES: _

HIST TREATMENT: _ CO-OCCUR SUBST USE: _ JUV JUST INVOL : _

SCHOOL BEHAV : _ PSYCH MED TREAT : _

B. RECOMMENDED (LOC-R): _ AUTHORIZED (LOC-A): _

REASONS FOR DEVIATION FROM LOC-R: MARK ALL THAT APPLY (Y/N)

RESOURCE LIMITS : _ CONSUMER CHOICE: _ CLINICAL OVERRIDE: _

CONTINUITY OF CARE: _ OTHER REASON : _

CA-TRAG COMPLETED BY: _____ DATE: _____ (MMDDYYYY)

READY TO ADD? _ (Y/N)

ACT: _ (165/CHILDREN MH MENU, M/MAIN MENU)

Field Name	Type	Contents
LAST NAME/SUF	D	Person's last name and suffix, if any.
FIRST NAME	D	Person's first name.
MI	D	Person's middle initial.
CLIENT ID	D	Person's statewide identification number assigned by CARE.
LOCAL CASE NUMBER	D	Person's local case number.
COMPONENT CODE	D	Three-digit code of the component to which the person is assigned.
ASSESSMENT TYPE	D	Indicates the type of assessment as Intake, Update, or Termination.
FORM DATE	R	Date the assessment is completed. MMDDYYYY format.
REFERRAL SOURCE	R	Code of the source that first prompted or suggested the referral. Decode: Referral Source (Children's MH)
AT RISK OF PLACEMENT	R	Y (Yes) or N (No) to indicate if the child is at risk of being placed out of the home.
ED (SPEC ED)?	R	Y (Yes) or N (No) to indicate if the child is designated as special education by the school because of emotional disturbance.
SECTION 1: OHIO SCALES		
PROBLEM SEVERITY SCORE	R	Indicates at least one set of scores – Parent, Youth, or Worker. Must have a value 0-100.
FUNCTIONING SCORE	R	Indicates at least one set of scores – Parent, Youth, or Worker. Must have a value 0-80.

Field Name	Type	Contents
LAST 90 DAYS:		
NBR ARRESTS	R	Number of arrests in the last 90 days.
SCHOOL DAYS MISSED	R	Number of school days missed in the last 90 days.
PRIMARY RES	R	Person's primary residence type during the last 90 days. 1=Private Residence, 2=Foster Care, 3=Residential Care, 4=Crisis Residential, 5=Children's Residential Treatment Facility, 6=Institutional Setting, 7=Jail or Correctional Facility, 8=Homeless, 9=Other.
SECTION 2: CA-TRAG AND LEVEL OF CARE		
A. RISK SELF HARM	R	Risk of self-harm. Possible entry: 1-5.
DISRUP/AGGR BEHAV	R	Severe disruptive or aggressive behavior. Possible entry: 1-5.
FAMILY RESOURCES	R	Family resources. Possible entry: 1-5.
HIST TREATMENT	R	History of psychiatric treatment. Possible entry: 1-5.
CO-OCCUR SUBST USE	R	Co-occurring substance use. Possible entry: 1-5.
JUV JUST INVOL	R	Juvenile justice involvement. Possible entry: 1-5.
SCHOOL BEHAV	R	School behavior. Possible entry: 1-5.
PSYCH MED TREAT	R	Psychoactive medication treatment. Possible entries: 1 or 2.
B. RECOMMENDED (LOC-R)	R	Indicates the assigned appropriate level of care based on the completed TRAG.
AUTHORIZED (LOC-A)	R	Indicates the level of care that was authorized by your facility for this child.
REASONS FOR DEVIATION FROM LOC-R: MARK ALL THAT APPLY (Y/N)	R	If LOC-A is different from LOC-R, indicates Y (Yes) or N (No) for all the reasons for the deviation. Resource Limitations Consumer Choice Clinical Override Continuity of Care per UM Guidelines Other Reason
CA-TRAG COMPLETED BY	R	Name of the person completing the CA-TRAG.
DATE	R	Date the CA-TRAG was completed.

Referral/Tracking/Placement (VC021399A)

(Action Code 304)

Screen A - Referral

```

02-04-02      304:REFERRAL/TRACKING/PLACEMENT (ADD REFERRAL)      UC021399A
PROVIDER NAME: DALLAS METROCARE SERVICES

COMPONENT      :                               LOCAL CASE NO. :
CLIENT NAME    :                               CARE ID       :
MEDICAID NO.   :                               HIC/MEDICARE NO:

DATE OF REFERRAL (FORMAT MMDDYYYY) : _____

APPLICATION PACKET FORWARDED TO FACILITIES (IF APPLICABLE) : ___
(OPTIONAL: ENTER 1, 2, OR 3 FACILITIES)                    ___
                                                            ___

REFERRAL FROM 1) MRA 2) STATE SCHOOL (FOR TRANSFERS) : _
REFERRAL (FOR ADMISSION) FOR SPECIFIC STATE MENTAL
RETARDATION FACILITIES ONLY: ___
(OPTIONAL: ENTER 1, 2, OR 3 FACILITIES)                    ___
                                                            ___

REFERRAL END DATE (FORMAT MMDDYYYY) : _____

* PRESS ENTER TO CONTINUE *

ACT: ___ (300/CLIENT DATA MENU, M/ MAIN MENU, HLP(PF1)/SCRN DOC)
  
```

Field Name	Type	Contents
COMPONENT	D	Three-digit component code.
CLIENT NAME	D	Person's last and first names.
MEDICAID NO.	D	Person's Medicaid number.
LOCAL CASE NO.	D	Person's local case number.
CARE ID	D	Person's statewide identification number assigned by CARE.
HIC/MEDICARE No.	D	Person's HIC/Medicare number.
DATE OF REFERRAL	R	Date complete application package for admission from MRA was received.
APPLICATION PACKET FORWARDED TO FACILITIES (IF APPLICABLE)	O	Three-digit component code(s) of the facility or facilities to which the application packet was forwarded, if applicable.
REFERRAL FROM 1) MRA 2) STATE SCHOOL (FOR TRANSFERS)	R	Indicates 1 if the referral was from the MRA for state school admission <i>or</i> 2 if the referral was from the state school for transfer. (The servicing facility enters the transfer request.)
REFERRAL (FOR ADMISSION) FOR SPECIFIC STATE MENTAL RETARDATION FACILITIES ONLY	O	Three-digit component code(s) if the referral is for a specific mental retardation facility or facilities. Blank=no preference.
REFERRAL END DATE	O/R	Date referral ends when MRA or individual withdraws admission request.

Referral/Tracking/Placement (VC021399B)
 (Action Code 304)
 Screen B - Referral

```

02-04-02      304:REFERRAL/TRACKING/PLACEMENT (ADD REFERRAL)      VC021399B
PROVIDER NAME:
COMPONENT      : :                               LOCAL CASE NO. :
CLIENT NAME    : |                               CARE ID      :

BEHAVIOR STATUS: _ _ _ _ _                      AMBULATORY STATUS: _
1=Inappropriate sexual behavior                1=Ambulatory
2=Physical agression                           2=Semi-ambulatory
3=Threats/verbal agression                     3=Wheelchair mobile
4=Property destruction/disruption              4=Non-ambulatory
5=SIB
6=Unauthorized departures
7=Other
8=No behavior problem noted

* PRESS ENTER TO CONTINUE *

ACT: ___ (300/CLIENT DATA MENU, H/ MAIN MENU, HLP(PF1)/SCRN DOC)
  
```

Field Name	Type	Contents
PROVIDER NAME	D	Name of the service provider.
COMPONENT	D	Three-digit component code.
CLIENT NAME	D	Person's last and first names.
LOCAL CASE NO.	D	Person's local case number.
CARE ID	D	Person's statewide identification number assigned by CARE.
BEHAVIOR STATUS	R	Code(s) to describe the person's behavior status.
AMBULATORY STATUS	R	Code to describe the person's ambulatory status.

Referral/Tracking/Placement (VC021399C)
 (Action Code 304)
 Screen C - Referral

```

02-04-02      304:REFERRAL/TRACKING/PLACEMENT (ADD REFERRAL)      VC021399C
PROVIDER NAME:

COMPONENT      :                               LOCAL CASE NO. :
CLIENT NAME    :                               CARE ID      :

HEALTH STATUS:  -----                SPECIAL NEEDS:  -----
1=Seizure disorder                1=Specialized diet
2=Diabetes                        2=Oxygen
3=Respiratory                     3=Specialized lifting
4=Cardio-vascular                 4=G-tube / j-tube
5=Gastro-intestinal              5=Adaptive equipment
6=Orthopedic                     6=Enhanced supervision
7=Other                           7=Other
8=No health problem noted         8=No special needs noted

READY TO ADD?   :  _

ACT:  ___  B=1ST SCREEN, (300/CLIENT DATA MENU, M/ MAIN MENU, HLP(PF1)/SCRN DO
  
```

Field Name	Type	Contents
PROVIDER NAME	D	Name of the service provider.
COMPONENT	D	Three-digit component code.
CLIENT NAME	D	Person's last and first names.
LOCAL CASE NO.	D	Person's local case number.
CARE ID	D	Person's statewide identification number assigned by CARE.
HEALTH STATUS	R	Code(s) to describe the person's health status.
SPECIAL NEEDS	R	Code(s) to describe the person's special needs.

Referral/Tracking/Placement (VC021399D)

(Action Code 304)

Screen D - Closing

```

02-05-02  304:REFERRAL/TRACKING/PLACEMENT  (ADD CLOSING)  UC021399D
PROVIDER NAME:
COMPONENT      :                               LOCAL CASE NO. :
CLIENT NAME    :                               CARE ID       :

REFERRAL CLOSED      DATE CLOSED:
REASON CLOSED: _
                                4=INDIVIDUAL CHOICE
                                5=LAR CHOICE
                                6=IDT DECISION

IDT DECISION REASON: _
                                1=BEHAVIOR/PSYCHIATRIC
                                2=MEDICAL
                                3=INDIVIDUAL/FAMILY
                                4=QUALITY OF LIFE
                                5=OTHER REASONS

READY TO ADD?      : _

ACT: ____ (300/CLIENT DATA MENU, M/ MAIN MENU, HLP(PF1)/SCRN DOC)
  
```

Field Name	Type	Contents
PROVIDER NAME	D	Name of the service provider.
COMPONENT	D	Three-digit component code.
CLIENT NAME	D	Person's last and first names.
LOCAL CASE NO.	D	Person's local case number.
CARE ID	D	Person's statewide identification number assigned by CARE.
DATE CLOSED	O	Date the referral was closed as indicated on the MR Needs form.
REASON CLOSED	O/R	Indicates the reason the referral was closed other than death, discharge, or community placement. 4=Individual Choice 5=LAR Choice 6=IDT Decision
IDT DECISION REASON	O/R	If 6 (IDT Decision) is entered as REASON CLOSED, indicate the reason for the IDT decision. 1=Behavior/Psychiatric 2=Medical 3=Individual/Family 4=Quality of Life 5=Other Reasons

Referral/Tracking/Placement (VC021399I)

(Action Code 304)

Screen I - Inquiry

```

02-04-02      304:REFERRAL/TRACKING/PLACEMENT  (ADD INQUIRY)      UC021399I
PROVIDER NAME:
MRA:          :

COMPONENT    :                               LOCAL CASE NO. :
CLIENT NAME  :                               CARE ID       :
MEDICAID NO. :                               HIC/MEDICARE NO:

      (THIS SCREEN FOR INQUIRY TO A STATE MR FACILITY)
      (WHEN APPLICATION PACKAGE IS INCOMPLETE)

DATE OF INQUIRY                (FORMAT MMDDYYYY) : _____
DATE INQUIRY CLOSED:          (FORMAT MMDDYYYY) : _____
ACTIVITY: _____
      (RECORD INFORMATION ABOUT HEALTH, MEDICATIONS, ETC.)

READY TO ADD?   : _
ACT: ____ (300/CLIENT DATA MENU, M/ MAIN MENU, HLP(PF1)/SCRN DOC)
  
```

Field Name	Type	Contents
PROVIDER NAME	D	Name of the service provider.
MRA	D	Three-digit code and name of the Mental Health Authority.
COMPONENT	D	Three-digit component code.
CLIENT NAME	D	Person's last and first names.
MEDICAID NO.	D	Person's Medicaid number.
LOCAL CASE NO.	D	Person's local case number.
CARE ID	D	Person's statewide identification number assigned by CARE.
HIC/MEDICARE NO.	D	Person's HIC/Medicare number.
DATE OF INQUIRY	O/R	Date the inquiry was received (incomplete application packet).
DATE INQUIRY CLOSED	O/R	Date the inquiry was closed.
ACTIVITY	O/R	Text field to record information about the person's health, medications, etc.

Campus-based Assignments (VC021325)

(Action Code 305)

```

10-15-01          305:CAMPUS BASED ASSIGNMENT: ADD          UC021325

LAST NAME/SUF:          .          CLIENT ID          :
FIRST NAME   :          LOCAL CASE NUMBER :
MIDDLE INIT  :          COMPONENT/LOC CODE:
ASSIGNMENT EFFECTIVE DATE (MMDDYY):    TIME (HHMM A/P) :

ASSIGNMENT:                                CURRENT STATUS:
LOCATION CODE (WARD/DORM) : _____    PRIOR DATE   :
ASSIGNMENT/ABSENCE CODE : ADM           PRIOR TIME   :
                                          PRIOR LOC    :
                                          PRIOR ASGN   :
                                          LST NON-RR ASG:

IF ABSENCE FOR TRIAL PLACEMENT (ATP):
DESTINATION COMPONENT CODE : _____
IS THIS PERSON GOING TO A NURSING HOME? (Y/N): _

IF RESIDENTIAL REASSIGNMENT (RR):
DESTINATION WARD/DORM : _____

IF MH LOCATION ADMISSION (ADM):
COUNTY OF ADMISSION : _____

FOR ALL ADMISSIONS: CURRENT RESIDENCE CODE _
READY TO ADD?          : _ (Y/N)

ACT: ____ (332/ADD COMMIT,300/DATA ENTRY MENU,780/DEMO DATA SHEET,H/MENU)

```

Field Name	Type	Contents
LAST NAME/SUF	D	Person's last name and (optional) suffix. (e.g., Jr, Sr)
FIRST NAME	D	Person's first name.
MIDDLE INIT	D	Person's middle initial.
CLIENT ID	D	Person's statewide identification number.
LOCAL CASE NUMBER	D	Person's local case number.
COMPONENT	D	Component code.
LOC CODE	D/O	Location code supplied by CARE if the person is assigned to a location.
ASSIGNMENT EFFECTIVE DATE	D/R	Date assignment is effective. MMDDYY format.
TIME	D/R	Time assignment is effective. HHMM A/P format.
<u>Assignment:</u>		
LOCATION CODE (WARD/DORM)	D/R	Ward or dorm to which the person is admitted or in which the person is currently residing.
ASSIGNMENT/ABSENCE CODE	R	Two or three-character code describing the person's assignment. Decode: Assignment/Absence Code
<p><u>Note:</u> At the time an ATP assignment is <i>added</i>, you will be branched to Action Code 312, <u>Joint Community Support Plan</u>, with the option to enter the JCSP date and Participating Component.</p>		

```

10-15-01          305:CAMPUS BASED ASSIGNMENT: ADD          UC021325

LAST NAME/SUF:          .          CLIENT ID          :
FIRST NAME  :          LOCAL CASE NUMBER :
MIDDLE INIT :          COMPONENT/LOC CODE:
ASSIGNMENT EFFECTIVE DATE (MMDDYY):    TIME (HHMM A/P)  :

ASSIGNMENT:
LOCATION CODE (WARD/DORM) : ___
ASSIGNMENT/ABSENCE CODE : ADM

CURRENT STATUS:
PRIOR DATE      :
PRIOR TIME     :
PRIOR LOC      :
PRIOR ASGN     :
LST NON-RR ASG:

IF ABSENCE FOR TRIAL PLACEMENT (ATP):
DESTINATION COMPONENT CODE : ___
IS THIS PERSON GOING TO A NURSING HOME? (Y/N): _

IF RESIDENTIAL REASSIGNMENT (RR):
DESTINATION WARD/DORM : ___

IF MH LOCATION ADMISSION (ADM):
COUNTY OF ADMISSION : ___

FOR ALL ADMISSIONS: CURRENT RESIDENCE CODE ___
READY TO ADD?          : _ (Y/N)

ACT: ___ (332/ADD COMMIT,300/DATA ENTRY MENU,780/DEMO DATA SHEET,M/MENU)

```

Field Name	Type	Contents
------------	------	----------

If Absence for Trial Placement (ATP):

DESTINATION COMPONENT CODE	O/R	Three-digit code for component to which person is reassigned. Required if ASSIGNMENT/ABSENCE CODE is ATP. Component Codes/LSAs
IS THIS PERSON GOING TO A NURSING HOME? (Y/N)	O/R	<i>For state hospital use only.</i> Y (Yes) or N (No) to indicate whether a person is going to a nursing home when placed on ATP from a state hospital.

If Residential Reassignment (RR):

DESTINATION WARD/DORM	O/R	Ward or dorm to which person is reassigned. Required for residential reassignments only.
-----------------------	-----	--

If MH Location Admission (ADM):

COUNTY OF ADMISSION	O/R	Code for county of admission. Required if ASSIGNMENT/ABSENCE CODE is ADM <i>and</i> the admission is to a state hospital or MH unit at a state center.
---------------------	-----	---

For All Admissions:

CURRENT RESIDENCE CODE	R	Indicates where the person was living before admission. Decode: Current Residence Code
------------------------	---	--

Campus-based Discharge/ Community Placement (VC021335) (Action Code 310)

```

09-23-03      310:CAMPUS-BASED DISCHARGE/COMMUNITY PLACEMENT:ADD      UC021335

LAST NAME/SUF:          .          CLIENT ID          :
FIRST NAME  :           LOCAL CASE NUMBER :
MIDDLE NAME : .           COMPONENT/LOC CODE:
ASSIGNMENT EFFECTIVE DATE (MMDDYY): 092303  TIME (HHMM A/P) : 0347P
DISCHARGE/MR COMMUNITY PLACEMENT:      (DRE = DISCHARGE WITH REASSIGNMENT
ASSIGNMENT CODE          : ___  DMA=DISCH, AGAINST MED ADVICE
      DNS=DISCH,NO MORE SERVICES CP=MR COMMUNITY PLACEMENT ER=MR END RESPITE)

PERSON GOING TO A NURSING HOME?(Y/N): _  OTHER DEST:  _ (JA,1,2,3,5,95,99)
PERSON REFERRED TO NON MHR PROVIDER?(Y/N): _
COMMUNITY SUPPORT PLAN (Y/N): _  DATE (MMDDYY):  ___  PARTICIPATING COMP:  ___
IF REASSIGNING CLIENT, ENTER THE FOLLOWING:
DESTINATION COMPONENT CODE:  ___  PROGRAM:  _  INP TRANS REAS:  _ (ONLY PROG=1)

IF MR CLIENT IS REASSIGNED TO COMMUNITY-BASED PROGRAM ENTER THE FOLLOWING:
DESTINATION ADDRESS  STREET :  ___
CITY:  ___  STATE:  ___  ZIP CODE:  ___  ___
TYPE OF PLACEMENT:  ___
READY TO ADD?      _ (Y/N)

ACT:  ___ (300/CLIENT DATA ENTRY, M/MENU)

```

Field Name	Type	Contents
LAST NAME/SUF	D	Person's last name and (optional) suffix. (e.g., Jr, Sr)
FIRST NAME	D	Person's first name.
MIDDLE NAME	D	Person's middle name.
CLIENT ID	D	Person's statewide identification number.
LOCAL CASE NUMBER	D	Person's local case number.
COMPONENT	D	Component code.
LOC CODE	D/O	Location code supplied by CARE if the person is assigned to a location.
ASSIGNMENT EFFECTIVE DATE	D/R	Date assignment is effective. MMDDYY format.
TIME	D/R	Time assignment is effective. HHMM A/P format.
DISCHARGE/MR COMMUNITY PLACEMENT ASSIGNMENT CODE	O/R	Assignment Code. Must be DRE, DNS, DMA, CP, or ER.
PERSON GOING TO A NURSING HOME? (Y/N)	O/R	<i>For state hospital use only.</i> Y (Yes) or N (No) to indicate whether this person is being placed on DRE or DNS from a state hospital to a nursing home.
OTHER DEST	O/R	Indicates the person is discharged with another destination. JA =Jail, 1 =Private Residence, 2 =Homeless, 3 = Street, 5 =Other Residential/Institution, 6 =State-funded Community Psychiatric Hospital, 7 =Out of State, 8 =UD Involuntary, 9 =ICF/MR, 10 =Nursing Home, 11 =Other Agency, 12 =UD Voluntary, 13 =Respite, 95 =MHA/MRA, 99 =Unknown.

```

09-23-03      310:CAMPUS-BASED DISCHARGE/COMMUNITY PLACEMENT:ADD      UC021335

LAST NAME/SUF:          .          CLIENT ID          :
FIRST NAME  :           LOCAL CASE NUMBER :
MIDDLE NAME :           COMPONENT/LOC CODE:
ASSIGNMENT EFFECTIVE DATE (MMDDYY): 092303  TIME (HHMM A/P) : 0347P
DISCHARGE/HR COMMUNITY PLACEMENT: (DRE = DISCHARGE WITH REASSIGNMENT
ASSIGNMENT CODE          :           DMA=DISCH, AGAINST MED ADVICE
      DNS=DISCH,NO MORE SERVICES CP=HR COMMUNITY PLACEMENT ER=HR END RESPITE)

PERSON GOING TO A NURSING HOME?(Y/N): _ OTHER DEST: _ (JA,1,2,3,5,95,99)
PERSON REFERRED TO NON MHMR PROVIDER?(Y/N): _
COMMUNITY SUPPORT PLAN (Y/N): _ DATE (MMDDYY): _____ PARTICIPATING COMP: ____
IF REASSIGNING CLIENT, ENTER THE FOLLOWING:
DESTINATION COMPONENT CODE: ____ PROGRAM: _ INP TRANS REAS: _ (ONLY PROG=1)

IF HR CLIENT IS REASSIGNED TO COMMUNITY-BASED PROGRAM ENTER THE FOLLOWING:
DESTINATION ADDRESS  STREET : _____
CITY: _____ STATE:  _ ZIP CODE: _____
TYPE OF PLACEMENT:  _
READY TO ADD?      _ (Y/N)

ACT: ____ (300/CLIENT DATA ENTRY, M/MENU)

```

Field Name	Type	Contents
PERSON REFERRED TO NON-MHMR PROVIDER	O	Y (Yes) or N (No) to indicate whether a person is being referred to a non-MHMR provider.
COMMUNITY SUPPORT PLAN (Y/N)	R	Y (Yes) or N (No) to indicate whether a Joint Community Support Plan has been made.
DATE	O/R	Date the Joint Community Support Plan was made. MMDDYY format.
PARTICIPATING COMP	O/R	Three-digit code of the community-based component participating in the Joint Community Support Plan. Required if COMMUNITY SUPPORT PLAN = Yes.
DESTINATION COMPONENT CODE	O/R	Three-digit code of the component to which person is reassigned. Required if ASSIGNMENT CODE is DRE or CP. Component Codes/LSAs
PROGRAM	O/R	Type of program to which person is reassigned. 1=Campus-based, 2=Community-based. Required if ASSIGNMENT CODE is DRE or CP. If designated as program 2, no assignment is allowed to state hospitals or state schools, or to components 659 and 661.
DESTINATION ADDRESS	O/R	Person's Street, City, State, and Zip Code. Required for MR community-based reassignments only.
TYPE OF PLACEMENT	O/R	Two-digit code for the type of placement in community. Required for MR community placements. Decode: Type of Placement

MR Discharge from State School (VC021327)

(Action Code 311)

```

11-20-00          311:MR DISCHARGE FROM STATE SCHOOL:ADD          UC021327

LAST NAME/SUF:          .          CLIENT ID          :
FIRST NAME  :          LOCAL CASE NUMBER :
MIDDLE NAME :          PLACEMENT SCHOOL  :

COMMUNITY PLACEMENT DATE (MMDDYY):  10-30-88

DISCHARGE SCHOOL: 660 MR DISCHARGE DATE:

READY TO ADD?          _ (Y/N)

ACT:  __ (300/CLIENT DATA ENTRY, H/MENU)
  
```

Field Name	Type	Contents
LAST NAME/SUF	D	Person's last name and (optional) suffix. (e.g., Jr, Sr)
FIRST NAME	D	Person's first name.
MIDDLE NAME	D	Person's middle name.
CLIENT ID	D	Person's statewide identification number.
LOCAL CASE NUMBER	D	Person's local case number.
PLACEMENT SCHOOL	D	Component code of the state school placing the person on CP status.
COMMUNITY PLACEMENT DATE	D	Community placement date supplied by CARE.
DISCHARGE SCHOOL	D	Component code of the state school discharging the person.
DISCHARGE DATE	R	Date of the person's discharge.

Joint Community Support Plan (VC021312)

(Action Code 312)

```

09-05-01          312:JOINT COMMUNITY SUPPORT PLAN: ADD          UC021312

LAST NAME/SUF:          CLIENT ID          :
FIRST NAME  :          LOCAL CASE NUMBER :
MIDDLE NAME :          COMPONENT/LOC CODE:

LATEST EPISODE:
ADMISSION DATE:          CURRENT STATUS:
DISCHARGE DATE:

          DATE OF COMMUNITY SUPPORT PLAN (MMDDYY): _____
          PARTICIPATING COMP:          _____

READY TO ADD?          _ (Y/N)

          ACT: _____ (300/CLIENT DATA ENTRY, M/MENU)

```

Field Name	Type	Contents
LAST NAME/SUF	D	Person's last name and (optional) suffix. (e.g., Jr, Sr)
FIRST NAME	D	Person's first name.
MIDDLE NAME	D	Person's middle name.
CLIENT ID	D	Person's statewide identification number.
LOCAL CASE NUMBER	D	Person's local case number.
COMPONENT	D	Component code.
LOC CODE	D/O	Location code supplied by CARE if the person is assigned to a location.
ADMISSION DATE	D	Date of admission of person's latest episode.
DISCHARGE DATE	D	Date of discharge of person's latest episode.
CURRENT STATUS	D	Person's current assignment status. Decode: Assignment Status
DATE OF COMMUNITY SUPPORT PLAN	R	Date the Joint Community Support Plan was made. MMDDYY format.
PARTICIPATING COMP	R	Three-digit code of the component participating in the Joint Community Support Plan.

Multiple Campus-based Assignments (VC021345) (Action Code 315)

```

03-19-93          315: MULTIPLE CAMPUS-BASED ASSIGNMENTS: ADD          UC021345
COMPONENT CODE          : _____
ASSIGNMENT/ABSENCE ACTION CODE: _____

ASSIGNMENT EFFECTIVE DATE (MMDDYY): _____   TIME (HHMM A/P): _____

CLIENT ID      LOCAL      CLIENT      CLIENT      WARD/DORM  PRIOR
CLIENT ID     CASE NUMBER  LAST NAME  FIRST NAME  CURR  DEST  ASSGN

READY TO ADD?      _ (Y/N)

ACT: _____ (300/DATA ENTRY MENU, M/MENU)
  
```

Field Name	Type	Contents
COMPONENT CODE	D	Component code.
ASSIGNMENT/ABSENCE ACTION CODE	R	Code for the type of reassignment or absence. (ATP <i>cannot</i> be used.) Decode: Assignment/Absence Code
ASSIGNMENT EFFECTIVE DATE	D/R	Date assignment is effective. MMDDYY format.
TIME	D/R	Time assignment is effective. HHMM A/P format.
CLIENT ID	D	Person's statewide identification number.
LOCAL CASE NUMBER	D	Person's local case number.
CLIENT LAST NAME	D	Person's last name.
CLIENT FIRST NAME	D	Person's first name.
CURR WARD/DORM	D	Person's current ward or dorm.
DEST WARD/DORM	O/R	Ward or dorm to which person is reassigned. Required for residential reassignment.
PRIOR ASSGN	D	Person's prior assignment.

CAUA-Child/Adolescent Uniform Assessment (VC072151)

(Action Code 316)

Screen 1

```

02-17-99  316:CAUA- CHILD/ADOLESCENT UNIFORM ASSESSMENT: ADD      UC072151
LAST NAME/SUF:                CLIENT ID      :
FIRST NAME  :                MI:            LOCAL CASE NUMBER:
COMPONENT CODE:
ASSESSMENT DATE (MMDDYYYY): _____  UNIFORM ASSESS RCD:  1 OF  1
                                           SCREEN NO:    1 OF  5

                ASSESSMENT TIME:  _  1) INTAKE
                                           2) 1ST 90 DAY
                                           3) OTH 90 DAY
                                           4) ANNUAL
                                           5) OTHER
                BPRS-C COMPLETE DATE (MMDDYYYY): _____

READY TO ADD?      _ (Y/N)

ACT:  ___ (165/CHILDREN MH MENU, M/MENU, F/FORWARD, B/BACK, Q/QUIT)

```

Field Name	Type	Contents
LAST NAME/SUF	D	Person's last name and (optional) suffix. (e.g., Jr, Sr)
FIRST NAME	D	Person's first name.
MI	D	Person's middle initial.
CLIENT ID	D	Person's statewide identification number.
LOCAL CASE NUMBER	D	Person's local case number.
COMPONENT CODE	D	Component code.
ASSESSMENT DATE	R	Date the assessment is begun. MMDDYYYY format.
ASSESSMENT TIME	R	Code for the assessment time period. 1=Intake 2=First 90-Day 3=Other 90-Day 4=Annual 5=Other
BPRS-C COMPLETE DATE	R	Date the BPRS-C was completed. MMDDYYYY format.

CAUA-Child/Adolescent Uniform Assessment (VC072152)

(Action Code 316)

Screen 2

```

02-17-99  316:CAUA- CHILD/ADOLESCENT UNIFORM ASSESSMENT: ADD      VC072152
LAST NAME/SUF:                CLIENT ID      :
FIRST NAME  :                  MI:          LOCAL CASE NUMBER:
COMPONENT CODE:
ASSESSMENT DATE (MMDDYYYY):    UNIFORM ASSESS RCD:  1 OF  1
                                   SCREEN NO:    2 OF  5

      BRIEF PSYCHIATRIC RATING SCALE FOR CHILDREN

      1 UNCOOPERATIVE           :  -
      2 HOSTILITY                :  -
      3 MANIPULATIVENESS        :  -
      4 DEPRESSED MOOD           :  -
      5 FEELINGS OF INFERIORITY:  -
      6 SUICIDAL IDEATION        :  -
      7 PECULIAR FANTASIES      :  -
      8 DELUSIONS                :  -

READY TO ADD?      _ (Y/N)

ACT:  ___ (165/CHILDREN MH MENU, H/MENU, F/FORWARD, B/BACK, Q/QUIT)
  
```

Field Name	Type	Contents																
LAST NAME/SUF	D	Person's last name and (optional) suffix. (e.g., Jr, Sr)																
FIRST NAME	D	Person's first name.																
MI	D	Person's middle initial.																
CLIENT ID	D	Person's statewide identification number.																
LOCAL CASE NUMBER	D	Person's local case number.																
COMPONENT CODE	D	Component code.																
ASSESSMENT DATE	R	Date the assessment is begun.																
BRIEF PSYCHIATRIC RATING SCALE FOR CHILDREN	R	<p>0 – 6 to indicate the person's score for the following items:</p> <table style="width: 100%; border: none;"> <tr> <td style="width: 50%;">1 Uncooperative</td> <td style="width: 50%;">5 Feelings of Inferiority</td> </tr> <tr> <td>2 Hostility</td> <td>6 Suicidal Ideation</td> </tr> <tr> <td>3 Manipulativeness</td> <td>7 Peculiar Fantasies</td> </tr> <tr> <td>4 Depressed Mood</td> <td>8 Delusions</td> </tr> </table> <p>Possible scores:</p> <table style="width: 100%; border: none;"> <tr> <td style="width: 50%;">0=Not Present</td> <td style="width: 50%;">4=Moderately Severe</td> </tr> <tr> <td>1=Very Mild</td> <td>5=Severe</td> </tr> <tr> <td>2=Mild</td> <td>6=Extremely Severe</td> </tr> <tr> <td>3=Moderate</td> <td></td> </tr> </table>	1 Uncooperative	5 Feelings of Inferiority	2 Hostility	6 Suicidal Ideation	3 Manipulativeness	7 Peculiar Fantasies	4 Depressed Mood	8 Delusions	0=Not Present	4=Moderately Severe	1=Very Mild	5=Severe	2=Mild	6=Extremely Severe	3=Moderate	
1 Uncooperative	5 Feelings of Inferiority																	
2 Hostility	6 Suicidal Ideation																	
3 Manipulativeness	7 Peculiar Fantasies																	
4 Depressed Mood	8 Delusions																	
0=Not Present	4=Moderately Severe																	
1=Very Mild	5=Severe																	
2=Mild	6=Extremely Severe																	
3=Moderate																		

CAUA-Child/Adolescent Uniform Assessment (VC072153)

(Action Code 316)

Screen 3

```

02-17-99  316:CAUA- CHILD/ADOLESCENT UNIFORM ASSESSMENT: ADD      UC072153
LAST NAME/SUF:                CLIENT ID      :
FIRST NAME  :                MI:          LOCAL CASE NUMBER:
COMPONENT CODE:
ASSESSMENT DATE (MMDDYYYY):          UNIFORM ASSESS RCD:  1 OF  1
                                         SCREEN NO:    3 OF  5

          BRIEF PSYCHIATRIC RATING SCALE FOR CHILDREN

          9 HALLUCINATIONS           :  -
          10 HYPERACTIVITY            :  -
          11 DISTRACTIBILITY          :  -
          12 SPEECH OR VOICE PRESSURE:  -
          13 UNDERPRODUCTIVE SPEECH  :  -
          14 EMOTIONAL WITHDRAWAL    :  -
          15 BLUNTED AFFECT          :  -

READY TO ADD?      _ (Y/N)

ACT:  ___ (165/CHILDREN MH MENU, M/MENU, F/FORWARD, B/BACK, Q/QUIT)

```

Field Name	Type	Contents																
LAST NAME/SUF	D	Person's last name and (optional) suffix. (e.g., Jr, Sr)																
FIRST NAME	D	Person's first name.																
MI	D	Person's middle initial.																
CLIENT ID	D	Person's statewide identification number.																
LOCAL CASE NUMBER	D	Person's local case number.																
COMPONENT CODE	D	Component code.																
ASSESSMENT DATE	D	Date the assessment was begun.																
BRIEF PSYCHIATRIC RATING SCALE FOR CHILDREN	R	<p>0 – 6 to indicate the person's score for the following items:</p> <table style="width: 100%; border: none;"> <tr> <td style="width: 50%;">9 Hallucinations</td> <td style="width: 50%;">13 Underproductive Speech</td> </tr> <tr> <td>10 Hyperactivity</td> <td>14 Emotional Withdrawal</td> </tr> <tr> <td>11 Distractibility</td> <td>15 Blunted Affect</td> </tr> <tr> <td>12 Speech or Voice Pressure</td> <td></td> </tr> </table> <p>Possible scores:</p> <table style="width: 100%; border: none;"> <tr> <td style="width: 50%;">0=Not Present</td> <td style="width: 50%;">4=Moderately Severe</td> </tr> <tr> <td>1=Very Mild</td> <td>5=Severe</td> </tr> <tr> <td>2=Mild</td> <td>6=Extremely Severe</td> </tr> <tr> <td>3=Moderate</td> <td></td> </tr> </table>	9 Hallucinations	13 Underproductive Speech	10 Hyperactivity	14 Emotional Withdrawal	11 Distractibility	15 Blunted Affect	12 Speech or Voice Pressure		0=Not Present	4=Moderately Severe	1=Very Mild	5=Severe	2=Mild	6=Extremely Severe	3=Moderate	
9 Hallucinations	13 Underproductive Speech																	
10 Hyperactivity	14 Emotional Withdrawal																	
11 Distractibility	15 Blunted Affect																	
12 Speech or Voice Pressure																		
0=Not Present	4=Moderately Severe																	
1=Very Mild	5=Severe																	
2=Mild	6=Extremely Severe																	
3=Moderate																		

CAUA-Child/Adolescent Uniform Assessment (VC072155)

(Action Code 316)

Screen 5

```

02-17-99  316:CAUA- CHILD/ADOLESCENT UNIFORM ASSESSMENT: ADD      UC072155
LAST NAME/SUF:          CLIENT ID      :
FIRST NAME  :          MI:          LOCAL CASE NUMBER:
COMPONENT CODE:
ASSESSMENT DATE (MMDDYYYY):          UNIFORM ASSESS RCD:  1 OF  1
                                          SCREEN NO:  5 OF  5

          CHILDRENS CASE MANAGEMENT SCREENINGS

          1 HOUSING           :  -
          2 INCOME            :  -
          3 BEHAVIOR          :  -
          4 BASIC LIVING SKILLS:  -
          5 SOCIAL            :  -
          6 WORK/SCHOOL       :  -
          7 LEGAL             :  -
          8 FAMILY STRESSORS  :  -
          9 DEVELOPMENTAL     :  -

ALCOHOL USE:  _  DRUG USE:  _  RISK DUE TO DEVELOP/MEDICAL HIST:  _
READY TO ADD?  _  (Y/N)

ACT:  __ (165/CHILDREN MH MENU, M/MENU, F/FORWARD, B/BACK, Q/QUIT)

```

Field Name	Type	Contents										
LAST NAME/SUF	D	Person's last name and (optional) suffix. (e.g., Jr, Sr)										
FIRST NAME	D	Person's first name.										
MI	D	Person's middle initial.										
CLIENT ID	D	Person's statewide identification number.										
LOCAL CASE NUMBER	D	Person's local case number.										
COMPONENT CODE	D	Component code.										
ASSESSMENT DATE	D	Date the uniform assessment was completed.										
CHILDRENS CASE MANAGEMENT SCREENINGS	O/R	<p>1 - 3 to indicate the person's score for the following items:</p> <table style="width: 100%; border: none;"> <tr> <td style="width: 50%;">1 Housing</td> <td style="width: 50%;">6 Work/School</td> </tr> <tr> <td>2 Income</td> <td>7 Legal</td> </tr> <tr> <td>3 Behavior</td> <td>8 Family Stressors</td> </tr> <tr> <td>4 Basic Living Skills</td> <td>9 Developmental</td> </tr> <tr> <td>5 Social</td> <td></td> </tr> </table> <p>Possible scores: 1=Low 2=Moderate 3=High</p>	1 Housing	6 Work/School	2 Income	7 Legal	3 Behavior	8 Family Stressors	4 Basic Living Skills	9 Developmental	5 Social	
1 Housing	6 Work/School											
2 Income	7 Legal											
3 Behavior	8 Family Stressors											
4 Basic Living Skills	9 Developmental											
5 Social												

Field Name	Type	Contents
ALCOHOL USE	O	0 - 4 to indicate the person's score on the Alcohol Use Scale. 0=Abstinent 1=Use without Impairment 2=Abuse 3=Dependent 4=Dependence with Institutionalization
DRUG USE	O	0 - 4 to indicate the person's score on the Drug Use Scale. 0=Abstinent 1=Use without Impairment 2=Abuse 3=Dependent 4=Dependence with Institutionalization
RISK DUE TO DEVELOP/MEDICAL HIST	O	1 - 3 to indicate the person's Risk Due to Developmental/Medical History. 1=Low 2=Moderate 3=High

Child/Adolescent MH Community Assignment (VC021287)

(Action Code 319)

```

02-18-99      319:CHILD/ADOLESCENT MH COMMUN ASSIGNMENT:ADD      VC021287
                                                    1 OF 1
LAST NAME/SUF:      CLIENT ID      :
FIRST NAME  :      LOCAL CASE NUMBER :
MIDDLE NAME :      COMPONENT      :

      SERV TYPE  BEG DATE  END DATE  LOC/  CASE MGR
      _____  _____  _____  CM UNIT  POSITION
      _____  _____  _____  _____  _____
      _____  _____  _____  _____  _____
      _____  _____  _____  _____  _____
      _____  _____  _____  _____  _____
      _____  _____  _____  _____  _____
      _____  _____  _____  _____  _____
      _____  _____  _____  _____  _____
      _____  _____  _____  _____  _____
      _____  _____  _____  _____  _____
      _____  _____  _____  _____  _____
      _____  _____  _____  _____  _____
      _____  _____  _____  _____  _____

READY TO ADD?      :  _ (Y/N)

ACT:  ___ (300/DATA ENTRY MENU, M/MENU, 165/CHILDREN MH MENU)
  
```

Field Name	Type	Contents
LAST NAME/SUF	D	Person's last name and (optional) suffix. (e.g., Jr, Sr)
FIRST NAME	D	Person's first name.
MIDDLE NAME	D	Person's middle name.
CLIENT ID	D	Person's statewide identification number.
LOCAL CASE NUMBER	D	Person's local case number.
COMPONENT CODE	D	Component code.
SERV TYPE	R	Child/Adolescent MH Community Assignment service type code. Decode: Service Type Community-Based Assignment MH Child/Adolescent
BEG DATE	R	Assignment beginning date. MMDDYY format.
END DATE	O/R	Assignment end date. MMDDYY format.
LOC	O/R	Location code. Required if SERV TYPE is TC07, TC09, or TC17.
CM UNIT	O/R	Case management unit code.
CASE MGR POSITION	O/R	Case manager position number.

MR and MH Adult Community-based Assignment (VC021296) (Action Code 321)

```

01-06-97  321:MR AND MH ADULT COMMUNITY-BASED ASSIGNMENT; ADD  UC021296
                                                1 OF 1
LAST NAME/SUF:                               CLIENT ID      :
FIRST NAME  :                               LOCAL CASE NUMBER :
MIDDLE NAME :                               COMPONENT      :

          SERV TYPE  BEG DATE  END DATE  LOC
          _____  _____  _____  _____
          _____  _____  _____  _____
          _____  _____  _____  _____
          _____  _____  _____  _____
          _____  _____  _____  _____
          _____  _____  _____  _____
          _____  _____  _____  _____
          _____  _____  _____  _____
          _____  _____  _____  _____
          _____  _____  _____  _____
          _____  _____  _____  _____
          _____  _____  _____  _____
          _____  _____  _____  _____

READY TO ADD?      :  _ (Y/N)
ACT:  ___ (300/DATA ENTRY MENU, M/MENU)
  
```

Field Name	Type	Contents
LAST NAME/SUF	D	Person's last name and (optional) suffix. (e.g., Jr, Sr)
FIRST NAME	D	Person's first name.
MIDDLE NAME	D	Person's middle name.
CLIENT ID	D	Person's statewide identification number.
LOCAL CASE NUMBER	D	Person's local case number.
COMPONENT	D	Component code.
SERV TYPE	R	MR or MH service type code. Decode: Service Type - <u>Mental Retardation Community-based Assignment or MH Adult Community-based Assignment</u>
BEG DATE	R	Effective date of the assignment. MMDDYY format.
END DATE	O/R	End date of the assignment. MMDDYY format.
LOC	O/R	Location code. Required if the service type is residential.

Destination Assignment (VC021291)

(Action Code 323)

```

09-05-01                323:DESTINATION ASSIGNMENT: ADD                VC021291
LAST NAME/SUF:          .                CLIENT ID                :
FIRST NAME  :                LOCAL CASE NUMBER                :
MIDDLE NAME :                COMPONENT CODE                :

ASSIGNMENT TO ANOTHER COMPONENT:

DESTINATION COMPONENT CODE : ___
DESTINATION PROGRAM        : -
ASSIGNMENT EFFECTIVE DATE  : ____ (MMDDYYYY)

PLEASE NOTE THAT DATE HAS BEEN CHANGED TO
INCLUDE CENTURY.

READY TO ADD?          : _ (Y/N)
ACT: ____ (300/CLIENT DATA ENTRY, M/MENU)
    
```

Field Name	Type	Contents
LAST NAME/SUF	D	Person's last name and (optional) suffix. (e.g., Jr, Sr)
FIRST NAME	D	Person's first name.
MIDDLE NAME	D	Person's middle name.
CLIENT ID	D	Person's statewide identification number.
LOCAL CASE NUMBER	D	Person's local case number.
COMPONENT CODE	D	Component code.
<u>Assignment to Another Component:</u>		
DESTINATION COMPONENT CODE	R	Three-digit code for component to which the person is reassigned.
DESTINATION PROGRAM	R	Type of program to which the person is reassigned. 1=Campus-based, 2=Community-based. If designated as program 2, no assignment is allowed to state hospitals or state schools, or to components 659 and 661.
ASSIGNMENT EFFECTIVE DATE	R	Effective date of the assignment. MMDDYYYY format.

Register Client: Client ID (VC021360) (Action Code 325)

```

09-23-03          325:REGISTER CLIENT: CLIENT ID          VC021360
ENTER THE FOLLOWING TO GENERATE TOMHMR
STATEWIDE CLIENT IDENTIFICATION NUMBER

CLIENT LAST NAME/SUF: _____
CLIENT FIRST NAME  : _____ LOCAL CASE NUMBER: _____
CLIENT MIDDLE NAME : _____ COMPONENT CODE   : 677

          EITHER OLD ETHNIC OR NEW FEDERAL RACE CODE WORKS
SEX: _ ETHNIC/NEW FED RACE: _ FED ETHNICITY: _ (H=HISP,N=NOT)
CLIENT BIRTHDATE (MMDDYYYY): _____
SOCIAL SECURITY NUMBER : _____ (N=NONE, U=UNKNOWN)
MEDICAID NUMBER: _____ MEDICARE NUMBER: _____

PRESENTING PROBLEM : _ (1=MH, 2=MR, 3=ECI/DD, 4=SA, 5=RC)
REGISTRATION EFFECTIVE DATE: 092303 (MMDDYY) TIME (HHMM A/P) : 0349P

STREET ADDRESS : _____
CITY           : _____ STATE : _ ZIP CODE: _____
COUNTY OF RESIDENCE : _____
          **** PRESS ENTER TO CONTINUE REGISTRATION ****

ACT: ____ (300/CLIENT DATA ENTRY MENU, M/MAIN MENU)
  
```

Field Name	Type	Contents
CLIENT LAST NAME/SUF	R	Person's last name and (optional) suffix. (e.g., Jr, Sr)
CLIENT FIRST NAME	R	Person's first name.
CLIENT MIDDLE NAME	O	Person's middle name.
CLIENT ID	D	Person's statewide identification number will be displayed in this field when the registration process is complete.
LOCAL CASE NUMBER	R	Person's local case number.
COMPONENT CODE	D	Three-digit component code.
SEX	R	Person's sex. M=Male, F=Female.
ETHNIC/NEW FED RACE	R	(Either old Ethnicity or new Federal Race code can be used.) Person's race. I =American Indian or Alaska Native, A =Asian, B =Black or African American, W =White, P =Native Hawaiian or Other Pacific Islander, M =More than One Race Reported
FED ETHNICITY	R	Person's ethnicity. H =Hispanic or Latino, N =Not Hispanic or Latino)
CLIENT BIRTHDATE	R	Person's date of birth. MMDDYYYY format.
SOCIAL SECURITY NUMBER	R	Person's social security number. N=None, U=Unknown.
MEDICAID NUMBER	O	Person's Medicaid number.
MEDICARE NUMBER	O	Person's Medicare number.

```

09-23-03          325:REGISTER CLIENT: CLIENT ID          UC021360
                  ENTER THE FOLLOWING TO GENERATE TDHMR
                  STATEWIDE CLIENT IDENTIFICATION NUMBER

CLIENT LAST NAME/SUF: _____
CLIENT FIRST NAME  : _____ LOCAL CASE NUMBER: _____
CLIENT MIDDLE NAME : _____ COMPONENT CODE   : 677

                EITHER OLD ETHNIC OR NEW FEDERAL RACE CODE WORKS
SEX: _ ETHNIC/NEW FED RACE: _ FED ETHNICITY: _ (H=HISP,N=NOT)
CLIENT BIRTHDATE (MMDDYYYY): _____
SOCIAL SECURITY NUMBER : _____ (N=NONE, U=UNKNOWN)
MEDICAID NUMBER: _____ MEDICARE NUMBER: _____

PRESENTING PROBLEM : _ (1=MH, 2=MR, 3=ECI/DD, 4=SA, 5=RC)
REGISTRATION EFFECTIVE DATE: 092303 (MMDDYY) TIME (HHMM A/P) : 0349P

STREET ADDRESS : _____
CITY           : _____ STATE : _ ZIP CODE: _____
COUNTY OF RESIDENCE : _____
                **** PRESS ENTER TO CONTINUE REGISTRATION ****

ACT: _ (300/CLIENT DATA ENTRY MENU, M/MAIN MENU)

```

Field Name	Type	Contents
PRESENTING PROBLEM	R	One-digit code to indicate person's presenting problem. 1=MH (Mental Health), 2=MR (Mental Retardation), 3=ECI/DD (Early Childhood Intervention/Developmentally Delayed), 4=SA (Substance Abuse), 5=RC (Related Condition-MR only).
REGISTRATION EFFECTIVE DATE	D/R	Date the registration is effective. MMDDYY format.
TIME	D/R	Time the registration is effective. HHMM A/P format.
STREET ADDRESS	O	Person's street address.
CITY	O	Person's city of residence.
STATE	O	Person's state of residence.
ZIP CODE	O	Up to nine digits to record postal zip code and zip code suffix of the person's residence.
COUNTY OF RESIDENCE	R	Three-digit code for the person's county of residence. County Codes and Local Service Areas

Register Client: Correspondent Data (VC021369)

```

05-30-02          325:REGISTER CLIENT: CORRESPONDENT DATA          UC021369

LAST NAME/SUF:          CLIENT ID          :
FIRST NAME  :          LOCAL CASE NUMBER:
MIDDLE NAME : _____ COMPONENT CODE  :

                                LEGAL GUARDIANSHIP: _

MARITAL STATUS : _
FAMILY SIZE   : _   ESTIMATED ANNUAL GROSS FAMILY INCOME : _____

PRIMARY CORRESPONDENT:
CORRES. NAME  : _____ CORRES. RELATIONSHIP : _
CORRES. STREET : _____ CORRES. TELEPHONE:  _ _ _
CORRES. CITY  : _____ STATE : _   ZIP CODE :  _ _ _

SECONDARY CORRESPONDENT:
CORRES. NAME  : _____ CORRES. RELATIONSHIP : _
CORRES. STREET : _____ CORRES. TELEPHONE:  _ _ _
CORRES. CITY  : _____ STATE : _   ZIP CODE :  _ _ _

READY TO ADD RECORD? _ (Y/N)
**MSG: 1939 PREVIOUS INFORMATION ADDED
ACT: _ (300/CLIENT DATA ENTRY MENU, M/MAIN MENU)
    
```

Field Name	Type	Contents
LAST NAME/SUF	D	Person's last name and (optional) suffix. (e.g., Jr, Sr)
FIRST NAME	D	Person's first name.
MIDDLE NAME	D	Person's middle name.
CLIENT ID	D	Person's statewide identification number.
LOCAL CASE NUMBER	D	Person's local case number.
COMPONENT CODE	D	Component code.
LEGAL GUARDIANSHIP	O	Person's legal status. Decode: Legal Status
MARITAL STATUS	O	Person's marital status. Decode: Marital Status
FAMILY SIZE	O	Number of persons supported on the person's estimated annual gross family income. Includes the person, number of parents and/or dependent children living in the household, and any other persons dependent on the family for support.
ESTIMATED ANNUAL GROSS FAMILY INCOME	O	Total annual gross income of all family members living with the person, rounded to the nearest thousand. Do not enter commas or decimal points.

```

05-30-02          325:REGISTER CLIENT: CORRESPONDENT DATA          UC021369

LAST NAME/SUF:          CLIENT ID          :
FIRST NAME  :          LOCAL CASE NUMBER:
MIDDLE NAME : _____ COMPONENT CODE   :

                                LEGAL GUARDIANSHIP: _
MARITAL STATUS : _
FAMILY SIZE  : _ ESTIMATED ANNUAL GROSS FAMILY INCOME : _____

PRIMARY CORRESPONDENT:
CORRES. NAME  : _____ CORRES. RELATIONSHIP : _
CORRES. STREET : _____ CORRES. TELEPHONE:  _ _
CORRES. CITY  : _____ STATE : _ ZIP CODE :  _ _

SECONDARY CORRESPONDENT:
CORRES. NAME  : _____ CORRES. RELATIONSHIP : _
CORRES. STREET : _____ CORRES. TELEPHONE:  _ _
CORRES. CITY  : _____ STATE : _ ZIP CODE :  _ _

READY TO ADD RECORD? _ (Y/N)
**MSG: 1939 PREVIOUS INFORMATION ADDED
ACT: _ (300/CLIENT DATA ENTRY MENU, M/MAIN MENU)

```

Field Name	Type	Contents
<u>Primary Correspondent</u>		
CORRES. NAME	O	Name of the first person to contact on behalf of the person in case of an emergency.
CORRES. RELATIONSHIP	O/R	Relationship of the Primary Correspondent to the person. If a Primary Correspondent is named, this field is required. Decode: Relationship
CORRES. STREET	O	Primary Correspondent's street address.
CORRES. TELEPHONE	O	Telephone number of Primary Correspondent. If the telephone number is entered, the area code is required.
CORRES. CITY	O	Primary Correspondent's city of residence.
STATE	O	Primary Correspondent's state of residence.
ZIP CODE	O	Zip Code and zip code suffix (if available) of Primary Correspondent.
<u>Secondary Correspondent</u>		
CORRES. NAME	O	Name of the second person to contact on behalf of the person in case of an emergency if the Primary Correspondent cannot be reached.
CORRES. RELATIONSHIP	O/R	Relationship of the Secondary Correspondent to the person. If a Secondary Correspondent is named, this field is required. Decode: Relationship
CORRES. STREET	O	Secondary Correspondent's street address.
CORRES. TELEPHONE	O	Secondary Correspondent's telephone number. If the telephone number is entered, the area code is required.
CORRES. CITY	O	Secondary Correspondent's city of residence.
STATE	O	Secondary Correspondent's state of residence.

ZIP CODE

O Zip code and zip code suffix (if available) of Secondary Correspondent.

Diagnostics (VC021375) (Action Code 330)

```

09-17-97          330:DIAGNOSTICS: ADD          UC021375
LAST NAME/SUF:   /          CLIENT ID          :
FIRST NAME      :          LOCAL CASE NUMBER  :
MIDDLE INIT     :          COMPONENT          :
DECISION DATE (MMDDVV) : _____          DIAGNOSTIC RECORD  1 OF 1
                                          MH PRI POP:
REASON FOR ACTION : _ PRINCIPAL DIAG AXIS : 1 FORM TIME (HHMM/P): 0424P
      LEV1  LEV2  LEV3  LEV4  LEV5  LEV6
AXIS I          _____
AXIS II         _____
AXIS III        _____ AX III DATE: _____
AXIS IV : -----
AXIS V CUR: 45 PREV: 45 CURRENT ABL : _ POTENTIAL ABL _
PRIMARY AMD : _ SECONDARY AMD : _ TERTIARY AMD : _
GENETIC      : _ CRANIAL ANOMALY: _ SENSORY IMPAIR : _
PERCEPTION   : _ CONVULSIVE DIS : _ PSY IMPAIR   : _
MOTOR DYSFUNC : --- AMD DATE : _____
DSM VERSION  : 4 ICD VERSION : 9 AMD VERSION : 77
IQ SCORE     : _ IQ TEST DATE : _____ IQ TEST TYPE : _
SQ SCORE     : _ SQ TEST DATE : _____ SQ TEST TYPE : _
READY TO ADD? : _ (Y/N)
ACT: _____ (300/DATA ENTRY MENU, 771/DSM&ICD CODE-TEXT SEARCH, M/MENU)
    
```

Field Name	Type	Contents
LAST NAME/SUF	D	Person's last name and (optional) suffix. (e.g. Jr, Sr)
FIRST NAME	D	Person's first name.
MIDDLE INIT	D	Person's middle initial.
CLIENT ID	D	Person's statewide identification number.
LOCAL CASE NUMBER	D	Person's local case number.
COMPONENT	D	Component code.
DIAGNOSTIC RECORD	D	Record number of the number of diagnostic records.
MH PRI POP	D	Y (Yes) or N (No) to indicate whether the diagnosis places the person in the MH priority population.
REASON	D	If MH PRI POP is N , the reason the person is <i>not</i> in the MH priority population will be displayed. <u>Note:</u> This field will <i>not</i> be displayed if MH PRI POP is Y .
DECISION DATE	R	Date the person's diagnosis was determined. MMDDYY format.
REASON FOR ACTION	R	Reason diagnostic data is being submitted. Decode: Reason for Action
PRINCIPAL DIAG AXIS	D/R	Person's principal diagnosis. Using DSM IV, 1=Axis I (Psychiatric Syndrome or Mental Health), 2=Axis II (Personality and Specific Developmental Disorder or Mental Retardation).

```

09-17-97          330:DIAGNOSTICS: ADD          UC021375
LAST NAME/SUF:   /          CLIENT ID          :
FIRST NAME      :          LOCAL CASE NUMBER   :
MIDDLE INIT     :          COMPONENT          :
DECISION DATE (MMDDVV) : _____          DIAGNOSTIC RECORD  1 OF 1
                                                MH PRI POP:
REASON FOR ACTION : _ PRINCIPAL DIAG AXIS : 1 FORM TIME (HHMM/P): 0424P
      LEV1  LEV2  LEV3  LEV4  LEV5  LEV6
AXIS I          _____
AXIS II         _____
AXIS III        _____          AX III DATE: _____
AXIS IV : -----
AXIS V CUR: 45 PREV: 45 CURRENT ABL : _ POTENTIAL ABL _
PRIMARY AMD    : _          SECONDARY AMD     : _          TERTIARY AMD    : _
GENETIC        : _          CRANIAL ANOMALY   : _          SENSORY IMPAIR : _
PERCEPTION     : _          CONVULSIVE DIS  : _          PSY IMPAIR     : _
MOTOR DYSFUNC : _ _ _ _          AMD DATE      : _____
DSM VERSION    : 4          ICD VERSION     : 9          AMD VERSION    : 77
IQ SCORE       : _          IQ TEST DATE    : _____          IQ TEST TYPE   : _
SQ SCORE       : _          SQ TEST DATE    : _____          SQ TEST TYPE   : _
READY TO ADD?  : _ (Y/N)
ACT: _ (300/DATA ENTRY MENU, 771/DSM&ICD CODE-TEXT SEARCH, M/MENU)
    
```

Field Name	Type	Contents
AXIS I: LEVELS 1-6	O/R	Up to six fields for recording DSM-IV codes representing the person's diagnosis on Axis I. Axis I, Level 1 is required if PRINCIPAL DIAG AXIS is 1. Level 1 is for most significant, Level 6 least significant. DSM Codes
AXIS II: LEVELS 1-4	O/R	Up to four fields for recording DSM-IV codes representing the person's diagnosis on Axis II. Axis II, Level 1 is required if PRINCIPAL DIAG AXIS is 2. Level 1 is for most significant, Level 4 least significant. DSM Codes
AXIS III: LEVELS 1-6	O/R	Up to six fields for recording ICD-9-CM codes representing the person's physical diagnosis on Axis III. Level 1 is for most significant, Level 6 least significant. If a 3 (death) is coded for REASON FOR ACTION, Level 1 is required.
AX III DATE	O	Date of the physician's examination in which the Axis III diagnosis was determined. MMDDYY format. Must be the same as or earlier than DECISION DATE.
AXIS IV	O/R	Up to nine fields to identify the person's psychosocial and environmental problems. (For MH campus-based persons only). Decode: Axis IV-Psychosocial and Environmental Problems
AXIS V	O/R	One or two-digit code to identify the person's highest level of adaptive functioning in the current year and the person's highest level of adaptive functioning in the previous year. Required for current year for MH persons. Decode: Axis V-Level of Functioning

Field Name	Type	Contents
CURRENT ABL	O/R	One-digit code to identify the person's current adaptive behavior level. Required if principal diagnosis is MR. Decode: ABL
POTENTIAL ABL	O	One-digit code to identify the person's potential adaptive behavior level. For MR persons only. Decode: ABL
PRIMARY AAMD	O	Three-digit code to indicate the person's primary AAMD disorder, if one exists. For MR persons only. AAMD Classifications
SECONDARY AAMD	O	Three-digit code to indicate the person's secondary AAMD disorder, if one exists. For MR persons only. AAMD Classifications
TERTIARY AAMD	O	Three-digit code to indicate the person's tertiary AAMD disorder, if one exists. For MR persons only. AAMD Classifications
GENETIC	O	Two-digit code to indicate whether the person has a genetic defect. For MR persons only. Decode: Genetic
CRANIAL ANOMALY	O	Two-digit code to indicate whether the person has a cranial anomaly. For MR persons only. Decode: Cranial Anomaly
SENSORY IMPAIR	O	Two-digit code to indicate whether the person has a sensory impairment. For MR persons only. Decode: Sensory Impairment
PERCEPTION	O	Two-digit code to indicate whether the person has a perception disorder. For MR persons only. Decode: Perception
CONVULSIVE DIS	O	Two-digit code to indicate whether the person has a convulsive disorder. For MR persons only. Decode: Convulsive Disorder
PSY. IMPAIR	O	Two-digit code to indicate whether the person has a psychiatric impairment. For MR persons only. Decode: Psychiatric Impairment
MOTOR DYSFUNC	O	Four-digit field to indicate the person's motor dysfunction. First two digits indicate Motor Dysfunction Type. Third digit indicates Motor Dysfunction Location. Fourth digit indicates Motor Dysfunction Severity. For MR persons only. Decode: Motor Dysfunction Type Motor Dysfunction Location Motor Dysfunction Severity
AAMD DATE	O	Date of the physician's examination in which the AAMD diagnoses were determined. MMDDYY format. Must be the same as or earlier than DECISION DATE. For MR persons only.

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09-17-97          330:DIAGNOSTICS: ADD          UC021375
LAST NAME/SUF:   /          CLIENT ID          :
FIRST NAME      :          LOCAL CASE NUMBER   :
MIDDLE INIT     :          COMPONENT          :
DECISION DATE (MMDDVV) : _____  DIAGNOSTIC RECORD  1 OF 1
                                          MH PRI POP:
REASON FOR ACTION : _  PRINCIPAL DIAG AXIS : 1 FORM TIME (HHMM/P): 0424P
      LEV1  LEV2  LEV3  LEV4  LEV5  LEV6
AXIS I          _____
AXIS II         _____
AXIS III        _____  AX III DATE: _____
AXIS IV : -----
AXIS V CUR: 45 PREV: 45 CURRENT ABL : _ POTENTIAL ABL _
PRIMARY AAMD   : _      SECONDARY AAMD : _      TERTIARY AAMD : _
GENETIC        : _      CRANIAL ANOMALY: _      SENSORY IMPAIR : _
PERCEPTION     : _      CONVULSIVE DIS : _      PSY IMPAIR    : _
MOTOR DYSFUNC : _ _ _ _      AAMD DATE      : _____
DSM VERSION    : 4          ICD VERSION     : 9          AAMD VERSION : 77
IQ SCORE       : _          IQ TEST DATE   : _____  IQ TEST TYPE  : _
SQ SCORE       : _          SQ TEST DATE   : _____  SQ TEST TYPE  : _
READY TO ADD?  : _ (Y/N)
ACT: _ (300/DATA ENTRY MENU, 771/DSM&ICD CODE-TEXT SEARCH, M/MENU)

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Field Name	Type	Contents
DSM VERSION	D	Version of the DSM codes used for diagnosis.
ICD VERSION	D	Version of the ICD codes used for diagnosis.
AAMD VERSION	D	Version of the AAMD codes used for diagnosis.
IQ SCORE	O/R	Three-digit field for the person's IQ score. Required if IQ TEST DATE or IQ TEST TYPE is entered.
IQ TEST DATE	O/R	Date of the IQ test. MMDDYY format. Required if IQ SCORE or IQ TEST TYPE is entered.
IQ TEST TYPE	O/R	Type of IQ test. Required if IQ SCORE or IQ TEST DATE is entered. Decode: IQ Test Type
SQ SCORE	O/R	Three-digit field for the person's SQ score. Required if SQ TEST DATE or SQ TEST TYPE is entered.
SQ TEST DATE	O/R	Date of the SQ test. MMDDYY format. Required if SQ SCORE or SQ TEST TYPE is entered.
SQ TEST TYPE	O/R	Type of SQ test. Required if SQ SCORE or SQ TEST DATE is entered. Decode: SQ Test Type

Death Review (VC021975)

(Action Code 331)

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05-16-95                331:DEATH REVIEW: ADD                VC021975

LAST NAME/SUF:          CLIENT ID      :
FIRST NAME  :           LOCAL CASE NUMBER :
MIDDLE NAME :           COMPONENT CODE  :
LOG NUMBER  :

REVIEW DATE (MMDDYY):  _____ REVIEW TIME (HHMM A/P):  _____

LOCATION OF DEATH:  _   WAS THIS DEATH RULED A SUICIDE?  _
1=NURSING HOME      1=NOT A SUICIDE
2=JAIL              2=SUSPECTED SUICIDE
3=ACUTE CARE HOSPITAL 3=CONFIRMED SUICIDE
4=PERSONAL HOME     4=UNKNOWN
5=CAMPUS RESIDENTIAL LOCATION
6=COMMUNITY RESIDENTIAL LOCATION
7=OTHER
99=UNKNOWN AT THIS TIME

WAS AN AUTOPSY PERFORMED? (Y/N/U):  _

READY TO ADD? :  _ (Y/N)

ACT:  _ (300/DATA ENTRY MENU, M/MENU)

```

Field Name	Type	Contents
LAST NAME/SUF	D	Person's last name and (optional) suffix. (e.g., Jr, Sr)
FIRST NAME	D	Person's first name.
MIDDLE NAME	D	Person's middle name.
LOG NUMBER	D	Number assigned to the death review.
CLIENT ID	D	Person's statewide identification number.
LOCAL CASE NUMBER	D	Person's local case number.
COMPONENT CODE	D	Component code.
REVIEW DATE	R	Date of the person's death review. MMDDYY format.
REVIEW TIME	R	Time of the person's death review. HHMM A/P format.
LOCATION OF DEATH	R	Code to indicate the location of the person's death.
WAS THIS DEATH RULED A SUICIDE?	R	One-digit code to indicate whether the death was ruled a suicide.
WAS AN AUTOPSY PERFORMED?	R	Y (Yes) or N (No) or U (Unknown) to indicate whether an autopsy was performed.

Voluntary Admission & Commitment (VC021888)

(Action Code 332)

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09-05-01      332:VOLUNTARY ADMISSION AND COMMITMENT: ADD      UC021888

LAST NAME/SUF:      /      CLIENT ID      :
FIRST NAME  :      LOCAL CASE NUMBER :
MIDDLE INIT :      COMPONENT/LOC      :

IF VOLUNTARY, ENTER THE FOLLOWING:
TYPE : __ (1/VOLUNTARY, 2/RESPITE, 32/MR EMERGENCY)
EFFECTIVE DATE : ____ (MMDDYYYY)
EXPIRATION DATE : ____ (MMDDYYYY,N=N/A) <OR> LENGTH : __ (DAYS)

IF INVOLUNTARY, ENTER THE FOLLOWING:  DISTRICT COURT# ____
COMMITMENT TYPE : __      COMMITMENT DATE : ____ (MMDDYYYY)
COMMITMENT CNTY : __      CAUSE NUMBER  : ____
COMMITMENT EXPIRATION DATE : ____ (MMDDYYYY,N=N/A)
<OR> LENGTH OF COMMITMENT : __ (DAYS)
OFFENSE TYPE/CODES HOSP 4601/02/03 : _ (M-MISDEMEANOR/F-FELON)
OFFENSE CODES      ____
IS THE CLIENT LEGALLY ADJUDICATED INCOMPETENT? : N (Y/N)

READY TO ADD?      _ (Y/N)

ACT: ____ (300/CLIENT DATA ENTRY, M/MENU)
    
```

Field Name	Type	Contents
LAST NAME/SUF	D	Person's last name and (optional) suffix. (e.g. Jr, Sr)
FIRST NAME	D	Person's first name.
MIDDLE INIT	D	Person's middle initial.
CLIENT ID	D	Person's statewide identification number.
LOCAL CASE NUMBER	D	Person's local case number.
COMPONENT/LOC	D	Component code/Location code.

If Voluntary, Enter the Following:

TYPE	O/R	Code to indicate the type of admission. 1=Voluntary, 2=Respite, 32=MR Emergency.
EFFECTIVE DATE	O/R	Effective date of the admission. MMDDYYYY format. Required for Voluntary or Respite admissions.
EXPIRATION DATE	O/R	Date the episode expires. Enter a date in MMDDYYYY format <i>or</i> enter N (not available).
LENGTH (DAYS)	O/R	Number of days the episode is to last. Required if a date in MMDDYYYY format is not entered in the EXPIRATION DATE field.

Field Name	Type	Contents
------------	------	----------

If Involuntary, Enter the Following:

DISTRICT COURT #	O/R	District Court number. Required for state schools and state centers for Commitment Types 9, 11, 13, or 19 only.
COMMITMENT TYPE	O/R	Two-digit code for the type of commitment or court order. Decode: Commitment Type
COMMITMENT DATE	O/R	Date of commitment. MMDDYYYY format.
COMMITMENT CNTY	O/R	Three-digit code for the commitment county. County Codes and Local Service Areas
CAUSE NUMBER	O/R	Cause number from commitment papers. Alpha or numeric field.
COMMITMENT EXPIRATION DATE	O/R	Expiration date of commitment. Enter a date in MMDDYYYY format <i>or</i> enter N (not available).
LENGTH OF COMMITMENT (DAYS)	O/R	Length of commitment in days. Required if a date in MMDDYYYY format is not entered in the COMMITMENT EXPIRATION DATE field.
OFFENSE TYPE/CODES HOSP 4601/02/03	O/R	M to indicate misdemeanor or F to indicate felony. Required if using 46.01, 46.02 or 46.03 commitment codes (Type=14-17, 19-23, 33, 42-44).
OFFENSE CODES	O/R	Four-digit offense codes. Required if using 46.02 and 46.03 commitment codes (Type=14-17, 19-23, 33).
IS THE CLIENT LEGALLY ADJUDICATED INCOMPETENT?	D/O	Y (Yes) or N (No) to indicate if the person is currently legally adjudicated incompetent.

MH Uniform Assessment (VC021379)

(Action Code 333)

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09-05-01          333:MH UNIFORM ASSESSMENT: ADD          UC021379
LAST NAME/SUF:   /          CLIENT ID          :
FIRST NAME      :          LOCAL CASE NUMBER   :
MIDDLE NAME     :          COMPONENT          :
                                     UNIFORM ASSESS RCD:
                                     ASSESSMENT STATUS :
                                     (MMDDYY)
ASSESSMENT DATE :          TIME (HHMM/P): 1252P -----
BPRS DATE:      SCORES: 1. 2. 3. 4. 5. 6. 7. 8. 9. 10
11. 12. 13. 14. 15. 16. 17. 18. 19. 20. 21. 22.
23. 24. TOTAL:  REASON: (1=INIT,2=INTERIM,3=DISCH)
MULTNOMAH CA SCALE -----
FUNC:  ADJ TO LV:  SOC CPT:  COM/CHPLY:  SUH:  DATE:
LEVEL OF NEED:  DATE:
COMMUNITY ASSESSMENT -----
RESIDENTIAL:  PAID EMPLOY-A:  PAID EMPLOY-B:  PRI FIN SPT:
LEGAL ARRESTS:  P/J NIGHTS:  P/J EPISODES:  PAR/PROB:
VICIINIZATION:  DATE:
READY TO ADD?  :  (Y/N)
ACT:  (300/DATA ENTRY MENU, M/MENU)
    
```

Field Name	Type	Contents
LAST NAME/SUF	D	Person's last name and (optional) suffix. (e.g. Jr, Sr)
FIRST NAME	D	Person's first name.
MIDDLE NAME	D	Person's middle name.
CLIENT ID	D	Person's statewide identification number.
LOCAL CASE NUMBER	D	Person's local case number.
COMPONENT	D	Component code.
ASSESSMENT STATUS	D	Indicates Full for full assessment, Partial for partial assessment.
ASSESSMENT DATE	R	Date the person's assessment is completed. MMDDYY format.
TIME (HHMM/P)	R	Time the person's assessment is completed.
BPRS DATE	R	Date of the Brief Psychiatric Rating Scale (BPRS).
SCORES	O/R	Scores for the 24 BRPS items as 1 through 7 or N (Not Applicable). Required for state hospitals.
TOTAL	O/R	BPRS total score. Not required for state hospitals.
REASON	O/R	1=Initial, 2=Interim, 3=Discharge. Required for detail reporting.

Field Name	Type	Contents
MULTNOMAH CA SCALE		
FUNC	O/R	Person's score on the Functioning element of the Multnomah Community Ability Scale. Required for community-based assessments.
ADJ TO LV	O/R	Person's score on the Adjustment to Living element of the Multnomah Community Ability Scale. Required for community-based assessments.
SOC CPT	O/R	Person's score on the Social Competence element of the Multnomah Community Ability Scale. Required for community-based assessments.
COM/CMPLY	O/R	Person's score on the Community/Compliance element of the Multnomah Community Ability Scale. Required for community-based assessments.
SUM	O/R	Total sum of all elements of the Multnomah Community Ability Scale. Required for community-based assessments.
DATE	O/R	Date of the Multnomah Community Ability Scale total scores. Required for community-based assessments.
LEVEL OF NEED	O/R	Level of need determined for the person. Required for community-based assessments.
DATE	O/R	Date of the Level of Need determination. Required for community-based assessments.
COMMUNITY ASSESSMENT		
RESIDENTIAL	O/R	Person's score on the Residential element of the Community Assessment. Required for community-based assessments.
PAID EMPLOY-A	O/R	Person's score on the Paid Employment A element of the Community Assessment. Required for community-based assessments.
PAID EMPLOY-B	O/R	Person's score on the Paid Employment B element of the Community Assessment. Required for community-based assessments.
PRI FIN SPT	O/R	Person's score on the Primary Financial Support element of the Community Assessment. Required for community-based assessments.
LEGAL ARRESTS	O/R	Total number of arrests the person has had in the last 3 months. Required for community-based assessments.
P/J NIGHTS	O/R	Number of prison/jail nights the person has had in the last 3 months. Required for community-based assessments.
P/J EPISODES	O/R	Number of prison/jail episodes the person has had in the last 3 months. Required for community-based assessments.
PAR/PROB	O/R	Y (Yes) or N (No) to indicate if the person has been on parole/probation over the last 3 months. Required for community-based assessments.
VICTIMIZATION	O	Indicates none <i>or</i> the number of times the person has been victimized.
DATE	R	Date of the Community Assessment. Required for community-based assessments.

Physical Characteristics (VC021385)

(Action Code 335)

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02-18-99          335:PHYSICAL CHARACTERISTICS: ADD          UC021385

LAST NAME/SUF:                CLIENT ID      :
FIRST NAME   :                LOCAL CASE NUMBER :
MIDDLE NAME  :                COMPONENT/LOC CODE:
EFFECTIVE DATE (MMDDYYYY): _____

IMPAIRMENT: ENTER APPROPRIATE NUMBER
HEALTH STATUS (1-4) : -          MOBILITY      (1-5) : -
COORDINATION (1-3) : -          HEARING LOSS (1-6) : -
VISION (1-4) : -              SPEECH      (1-4) : -
BEHAVIOR MGT (1-5) : -

PROSTHETICS:   ENTER (Y/N)                                (Y/N)
HEARING AID    : -          DENTAL PROSTHETIC : -
CORRECTIVE LENSES : -      WHEELCHAIR      : -
WALKER/CANE    : -          ORTHOPEDIC SHOES : -
ORTHOPEDIC APPLIANCES : -  SPEC. POSITIONING EQUIP.: -
ADAPTIVE EATING DEVICES : -  AUGMENTED COMMUN DEVICES: -
OTHER          : -

READY TO ADD?  _ (Y/N)

ACT: ____ (300/SUBMENU, N/MENU)
  
```

Field Name	Type	Contents
LAST NAME/SUF	D	Person's last name and (optional) suffix. (e.g. Jr, Sr)
FIRST NAME	D	Person's first name.
MIDDLE NAME	D	Person's middle name.
CLIENT ID	D	Person's statewide identification number.
LOCAL CASE NUMBER	D	Person's local case number.
COMPONENT	D	Component code.
LOC CODE	D/O	Location code supplied by CARE if the person is assigned to a location.
EFFECTIVE DATE	R	Date the Client Physical Characteristics (CARE PC1) form was completed and signed. MMDDYYYY format.
<u>Impairment:</u>		
HEALTH STATUS	R	One-digit code to identify the person's health status impairment. Decode: Health Status
MOBILITY	R	One-digit code to identify the person's mobility impairment. Decode: Mobility
COORDINATION	R	One-digit code to identify the person's coordination impairment. Decode: Coordination

Field Name	Type	Contents
<u>Impairment (continued):</u>		
HEARING LOSS	R	One-digit code to identify the person's hearing loss impairment. Decode: Hearing Loss
VISION	R	One-digit code to identify the person's vision impairment. Decode: Visual Handicap
SPEECH	R	One-digit code to identify the person's speech impairment. Decode: Speech Handicap
BEHAVIOR MGT	R	One-digit code to identify the person's behavior management impairment. Decode: Behavior Management
<u>Prosthetics:</u>		
HEARING AID	O/R	Y (Yes) or N (No) to identify the person's need for a hearing aid.
DENTAL PROSTHETIC	O/R	Y (Yes) or N (No) to identify the person's need for a dental prosthetic.
CORRECTIVE LENSES	O/R	Y (Yes) or N (No) to identify the person's need for corrective lenses.
WHEELCHAIR	O/R	Y (Yes) or N (No) to identify the person's need for a wheelchair.
WALKER/CANE	O/R	Y (Yes) or N (No) to identify the person's need for a walker/cane.
ORTHOPEdic SHOES	O/R	Y (Yes) or N (No) to identify the person's need for orthopedic shoes.
ORTHOPEdic APPLIANCES	O/R	Y (Yes) or N (No) to identify the person's need for orthopedic appliances.
SPEC. POSITIONING EQUIP.	O/R	Y (Yes) or N (No) to identify the person's need for special positioning equipment.
ADAPTIVE EATING DEVICES	O/R	Y (Yes) or N (No) to identify the person's need for adaptive eating devices.
AUGMENTED COMMUN. DEVICES	O/R	Y (Yes) or N (No) to identify the person's need for augmented communication devices.
OTHER	O/R	Y (Yes) or N (No) to identify the person's need for other prostheses.

Permanency Planning Review (VC021303)

(Action Code 339)

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10-21-03          339:PERMANENCY PLANNING REVIEW: ADD          VC021303
LAST NAME/SUF:          CLIENT ID          :
FIRST NAME :          LOCAL CASE NUMBER :
MIDDLE NAME :          COMPONENT          :
AGE :          PERMANENCY PLAN RCD: 1 OF 1
REVIEW DATE: _____
PERMANENCY PLAN GOAL: _ CONTACT FREQ: _ # VISIT BY FAM: _ # VISIT TO FAM: _
TRAUMATIC BRAIN INJURY (Y/N): _ DOES FAMILY/LAR SUPPORT GOAL (Y/N): _
FAMILY AND COMMUNITY SUPPORTS TO ACHIEVE GOAL
ENTER FOR EACH SUPPORT (N)EED=Y/N/_ (A)VAIL=Y/N/_ (U)NDER DEVEL=Y/N/_
      N A U          N A U          N A U
ARCHITECTURAL MOD --- BEHAV INTERVENTION --- CHILD CARE ---
CRISIS INTERVENTION --- DURABLE MED EQUIP --- TRANSPORTATION ---
FAM BASED ALTERNATIV --- IN HOME HLTH SVCS --- MH SVC, COUNSELING ---
NIGHT TIME PERSON --- ONGOING MED SVC --- PERS ASST- ADL ---
RESPITE-IN HOME --- RESPITE OUT HOME --- SPEC EQUIPMENT ---
SPECIALIZED THERAP --- SPEC TRANSPORT --- TRAINING ---
VOLUNTEER ADVOCAT ---
CONTACT NAME : _____ CONTACT PHONE : _____
READY TO ADD? : _ (Y/N)
ACT: ___ (300/C00/L00 DATA ENTRY, M/MENU)
  
```

Field Name	Type	Contents
LAST NAME/SUF	D	Person's last name and (optional) suffix. (e.g. Jr, Sr)
FIRST NAME	D	Person's first name.
MIDDLE NAME	D	Person's middle name.
AGE	D	Person's age.
CLIENT ID	D	Person's statewide identification number.
LOCAL CASE NUMBER	D	Person's local case number.
COMPONENT	D	Component code.
REVIEW DATE	R	Date of the person's permanency planning review.
PERMANENCY PLAN GOAL	R	Code indicating the permanency plan goal. 1 =Return to family, 2 =Move to family-based alternative (e.g., foster, extended family care, open adoption), 3 =Alternative living arrangement determined by individual and Legally Authorized Representative (LAR) (for individuals 18 through 21 only), 4 =Remain in current residence as determined by individual and LAR (for individuals 18 through 21 only).
CONTACT FREQ	R	Code indicating the frequency of parent/guardian contact with the individual during the last six months. 1 =New Admission, 2 =Daily, 3 =Weekly, 4 =Monthly, 5 =1-3 Times, 6 =None.

Field Name	Type	Contents
# VISIT BY FAM	R	Number of visits to the facility by the parent/guardian.
# VISIT TO FAM	R	Number of the resident's visits to the home.
TRAUMATIC BRAIN INJURY	O	Y (Yes) or N (No) to indicate if the person has a history of traumatic brain injury.
DOES THE FAMILY/LAR SUPPORT GOAL?	R	Y (Yes) if the family/LAR agrees with the goal <i>if and when the needed supports can be accessed</i> and supports activities to achieve it; N (No) if the family/LAR chooses for the individual to remain in the current residence even if needed supports can be accessed.
<p>Family and Community Supports to Achieve Goal (N=Needed, A=Available, U=Under Development)</p> <p><i>Note: This section must be completed for all individuals under age 18 and for individuals 18 to 21 years of age who have a Permanency Plan Goal of 1, 2, or 3. This section is not required for individuals 18 to 21 years of age with a Permanency Plan Goal of 4.</i></p>		<p>Y (Yes), N (No), or Blank for each support. (The system records a blank as No.) If Yes, indicate if support need is available or under development.</p> <ul style="list-style-type: none"> Architectural Modifications Behavioral Intervention Child Care Crisis Intervention Durable Medical Equipment Transportation Family/LAR Support Family Based Alternative In Home Health Services MH Services, Counseling Night Time Person Ongoing Medical Services Personal Assistance-ADL Respite – In-Home Respite – Out of Home Special Equipment Specialized Therapies Specialized Transportation Training Volunteer Advocate
CONTACT NAME	R	Name of the person responsible for conducting permanency planning activities.
CONTACT PHONE	R	Telephone number of the person responsible for conducting permanency planning activities.

MR Needs I (VC021391)

(Action Code 340)

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09-26-03                340:MR NEEDS I: ADD                UC021391
LAST NAME/SUF:          CLIENT ID      :
FIRST NAME  :           LOCAL CASE NUMBER :
MIDDLE NAME :           COMPONENT/LOC CODE:
STAFFING DATE (MMDDYYYY): 09262003
REASON FOR ACTION: _ (A=ANNUAL STAFF,U=UPDATE TO STAFF)
STRUCTURED PROGRAMS: ENTER ONLY PRIORITY NEEDS
  M = MET, U = UNMET, P = PARTIALLY MET, N = NOT PRIORITY

  A. PHYSICAL HABILITATION : _   B. SENSORY STIMULATION   : _
  C. ATTENTION SPAN       : _   D. MOBILITY SKILLS         : _
  E. SELF-HELP SKILLS    : _   F. COMMUNICATION SKILLS    : _
  G. ACADEMIC SKILLS     : _   H. PREVOCATIONAL/VOCATIONAL : _
  I. INDEPENDENT LIVING SKILLS : _ J. SELF-MED AND HEALTH CARE : _
  K. LEISURE SKILLS      : _   L. SEX EDUCATION           : _
  M. BEHAVIOR THERAPY    : _   N. SOCIALIZATION           : _
  O. OTHER                : _

READY TO ADD?          _ (Y/N)

ACT: ___ (300/SUBMENU, M/MENU)
  
```

Field Name	Type	Contents
LAST NAME/SUF	D	Person's last name and (optional) suffix. (e.g. Jr, Sr)
FIRST NAME	D	Person's first name.
MIDDLE NAME	D	Person's middle name.
CLIENT ID	D	Person's statewide identification number.
LOCAL CASE NUMBER	D	Person's local case number.
COMPONENT	D	Component code.
LOC CODE	D/O	Location code supplied by CARE if the person is assigned to a location.
STAFFING DATE	R	Date of the annual staffing or interim staffing when a change was determined for the client's care. MMDDYYYY format.
REASON FOR ACTION	R	Reason data is submitted. A =Annual Staff, U =Update to Staff.

Structured Programs: Enter only Priority Needs

Client's needs in the categories below are: **M**=Met, **U**=Unmet, **P**=Partially Met, **N**=Not Priority

Note: Do not enter an N if the need is not a priority. The N is supplied by CARE.

A. PHYSICAL HABILITATION	O	Indicates the status of the person's need for physical habilitation.
B. SENSORY STIMULATION	O	Indicates the status of the person's need for sensory stimulation.
C. ATTENTION SPAN	O	Indicates the status of the person's need for an attention span program.

Field Name	Type	Contents
D. MOBILITY SKILLS	O	Indicates the status of the person's need for a mobility skills program.
E. SELF-HELP SKILLS	O	Indicates the status of the person's need for a self-help skills program.
F. COMMUNICATION SKILLS	O	Indicates the status of the person's need for a communication skills program.
G. ACADEMIC SKILLS	O	Indicates the status of the person's need for an academic skills program.
H. PREVOCATIONAL/ VOCATIONAL	O	Indicates the status of the person's need for a prevocational/ vocational program.
I. INDEPENDENT LIVING SKILLS	O	Indicates the status of the person's need for an independent living skills program.
J. SELF-MED AND HEALTH CARE	O	Indicates the status of the person's need for a self-med and health care program.
K. LEISURE SKILLS	O	Indicates the status of the person's need for a leisure skills program.
L. SEX EDUCATION	O	Indicates the status of the person's need for sex education.
M. BEHAVIOR THERAPY	O	Indicates the status of the person's need for behavior therapy.
N. SOCIALIZATION	O	Indicates the status of the person's need for socialization.
O. OTHER	O	Indicates the status of the person's need for other Structured Programs.

MR Needs II (VC021392)

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09-26-03                340:MR NEEDS II: ADD                UC021392
LAST NAME/SUF:          CLIENT ID      :
FIRST NAME   :          LOCAL CASE NUMBER :
MIDDLE NAME  :          COMPONENT/LOC CODE:
STAFFING DATE (MMDDYYYY): 09262003

SPECIALIZED THERAPIES  STATUS: M = MET, U = UNMET, P = PARTIALLY MET
A. PHYSICAL THERAPY   : -                B. OCCUPATIONAL THERAPY   : -
C. ORAL FEEDING THERAPY : -            D. SPEECH THERAPY        : -
E. COUNSELING         : -                F. RECREATION THERAPY    : -
G. ART/DANCE/MUSIC    : -                H. OTHER                  : -
ICF LEVEL OF CARE     : -                NEED FOR ADVOCATE        : -

HEALTH CARE SERVICES  STATUS: M = MET, U = UNMET, P = PARTIALLY MET
A. PHYSICIAN          : -
B. SPECIALIZED CONSULTING
  1. PSYCHIATRIC CONSULTING : -    2. NEUROLOGICAL CONSULTING: -
  3. ORTHOPEDIC CONSULTING  : -    4. OTHER                  : -
C. DENTAL SERVICES     : -
READY TO ADD?         _ (Y/N)

ACT: ___ (300/SUBMENU, H/MENU)
    
```

Field Name	Type	Contents
LAST NAME/SUF	D	Person's last name and (optional) suffix. (e.g. Jr, Sr)
FIRST NAME	D	Person's first name.
MIDDLE NAME	D	Person's middle name.
CLIENT ID	D	Person's statewide identification number.
LOCAL CASE NUMBER	D	Person's local case number.
COMPONENT	D	Component code.
LOC CODE	D/O	Location code supplied by CARE if the person is assigned to a location.
STAFFING DATE	D	Date of the annual staffing or interim staffing when a change was determined for the client's care. MMDDYYYY format.

Specialized Therapies

Client's needs in the categories below are: **M=Met**, **U=Unmet**, **P=Partially Met**

A. PHYSICAL THERAPY	O	Indicates the status of the person's need for physical therapy.
B. OCCUPATIONAL THERAPY	O	Indicates the status of the person's need for occupational therapy.
C. ORAL FEEDING THERAPY	O	Indicates the status of the person's need for oral feeding therapy.
D. SPEECH THERAPY	O	Indicates the status of the person's need for speech therapy.

Field Name	Type	Contents
E. COUNSELING	O	Indicates the status of the person's need for counseling.
F. RECREATION THERAPY	O	Indicates the status of the person's need for recreation therapy.
G. ART/DANCE/MUSIC	O	Indicates the status of the person's need for art/dance/music.
H. OTHER	O	Indicates the status of the person's need for other Specialized Therapy.
ICF LEVEL OF CARE	R	One-digit code indicating the person's current ICF-MR level of care. Decode: ICF Level of Care
NEED FOR ADVOCATE	O	One-digit code indicating the person's need for an advocate and the priority group for the receipt of advocacy services. Decode: Need for Advocate

Health Care Services

Client's needs in the categories below are: **M**=Met, **U**=Unmet, **P**=Partially Met

A. PHYSICIAN	O	Indicates the status of the person's need for a physician.
B. SPECIALIZED CONSULTING		
1. PSYCHIATRIC CONSULTING	O	Indicates the status of the person's need for psychiatric consulting.
2. NEUROLOGICAL CONSULTING	O	Indicates the status of the person's need for neurological consulting.
3. ORTHOPEDIC CONSULTING	O	Indicates the status of the person's need for orthopedic consulting.
4. OTHER	O	Indicates the status of the person's need for other Specialized Consulting.
C. DENTAL SERVICES	O	Indicates the status of the person's need for dental services.

MR Needs III (VC021393)

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09-26-03          340:MR NEEDS III: ADD          VC021393

LAST NAME/SUF:           CLIENT ID           :
FIRST NAME   :           LOCAL CASE NUMBER  :
MIDDLE NAME  :           COMPONENT/LOC CODE:
STAFFING DATE (MMDDYYYY): 09262003

HEALTH CARE SERVICES     STATUS: M = MET, U = UNMET, P = PARTIALLY MET

D. NURSING SERVICES      : _      E. AUDIOLOGY                : _
F. VISUAL SCREENING     : _      G. DIET/WEIGHT MAINTENANCE : _
H. PROSTHETICS
  1. HEARING AID         : _      2. DENTAL                    : _
  3. CORRECTIVE LENSES  : _      4. WHEELCHAIR                 : _
  5. WALKER/CANE        : _      6. ORTHOPEDIC SHOES          : _
  7. ORTHOPEDIC APPLIANCES : _    8. SPECIAL POSITIONING EQUIP : _
  9. ADAPTIVE EATING DEVICES: _   10. AUGMENTED COMM DEVICE  : _
 11. OTHER               : _

READY TO ADD?           _ (Y/N)

ACT: ____ (300 SUBMENU, M/MENU)
    
```

Field Name	Type	Contents
LAST NAME/SUF	D	Person's last name and (optional) suffix. (e.g. Jr, Sr)
FIRST NAME	D	Person's first name.
MIDDLE NAME	D	Person's middle name.
CLIENT ID	D	Person's statewide identification number.
LOCAL CASE NUMBER	D	Person's local case number.
COMPONENT	D	Component code.
LOC CODE	D/O	Location code supplied by CARE if the person is assigned to a location.
STAFFING DATE	D	Date of the annual staffing or interim staffing when a change was determined for the client's care. MMDDYYYY format.

Health Care Services

Client's needs in the categories below are: **M**=Met, **U**=Unmet, **P**=Partially Met

D. NURSING SERVICES	O	Indicates the status of the person's need for nursing services.
E. AUDIOLOGY	O	Indicates the status of the person's need for audiology services.
F. VISUAL SCREENING	O	Indicates the status of the person's need for visual screening.
G. DIET/WEIGHT MAINTENANCE	O	Indicates the status of the person's need for diet/weight maintenance.

Field Name	Type	Contents
H. PROSTHETICS		
1. HEARING AID	O	Indicates the status of the person's need for a hearing aid.
2. DENTAL	O	Indicates the status of the person's need for dental services.
3. CORRECTIVE LENSES	O	Indicates the status of the person's need for corrective lenses.
4. WHEELCHAIR	O	Indicates the status of the person's need for a wheelchair.
5. WALKER/CANE	O	Indicates the status of the person's need for a walker/cane.
6. ORTHOPEDIC SHOES	O	Indicates the status of the person's need for orthopedic shoes.
7. ORTHOPEDIC APPLIANCES	O	Indicates the status of the person's need for orthopedic appliances.
8. SPECIAL POSITIONING EQUIP	O	Indicates the status of the person's need for special positioning equipment.
9. ADAPTIVE EATING DEVICES	O	Indicates the status of the person's need for adaptive eating devices.
10. AUGMENTED COMM DEVICE	O	Indicates the status of the person's need for an augmented communication device.
11. OTHER	O	Indicates the status of the person's need for other prosthetics.

MR Needs IV (VC021394)

```

09-26-03                340:MR NEEDS IV: ADD                UC021394
LAST NAME/SUF:                CLIENT ID      :
FIRST NAME  :                LOCAL CASE NUMBER :
MIDDLE NAME :                COMPONENT/LOC CODE:
STAFFING DATE (MMDDYYYY): 09262003

HEALTH CARE AVAILABILITY (1-6): _

RECOMMENDED MOVEMENT (1,2,3,5,7): _

LSA IS OPTIONAL
IF 3 OR 5 ENTERED ABOVE, ENTER PREFERRED LSA IN RANK ORDER

FIRST : _ SECOND: _ THIRD: _

CLIENT`S PREFERENCE (1-3)      : _
PARENT/GUARDIAN/PRIMARY CORRESPONDENT PREFERENCE (1-4): _

READY TO ADD?      _ (Y/N)

ACT: ___ (300/SUBMENU, M/MENU)
    
```

Field Name	Type	Contents
LAST NAME/SUF	D	Person's last name and (optional) suffix. (e.g. Jr, Sr)
FIRST NAME	D	Person's first name.
MIDDLE NAME	D	Person's middle name.
CLIENT ID	D	Person's statewide identification number.
LOCAL CASE NUMBER	D	Person's local case number.
COMPONENT	D	Component code.
LOC CODE	D/O	Location code supplied by CARE if the person is assigned to a location.
STAFFING DATE	D	Date of the annual staffing or interim staffing when a change was determined for the client's care. MMDDYYYY format.
HEALTH CARE AVAILABILITY (1-6)	R	One-digit code to identify the person's need for health care availability. Decode: Health Care Availability
RECOMMENDED MOVEMENT (1, 2, 3, 5, 7)	R	One-digit code indicating a recommended move, if any, for the person. Decode: Recommended Movement <u>Note:</u> If 3 or 5 is entered, enter preferred LSA in rank order.
FIRST (LSA)	O	Two-digit code indicating the Preferred LSA as first in rank order if 3 or 5 was entered for RECOMMENDED MOVEMENT. LSA 01-65. Out of State=99. County Codes and Local Service Areas

Field Name	Type	Contents
SECOND (LSA)	O	Two-digit code to identify the Preferred LSA as second in rank order if 3 or 5 was entered for RECOMMENDED MOVEMENT. LSA 01-65. Out of State=99. County Codes and Local Service Areas
THIRD (LSA)	O	Two-digit code to identify the Preferred LSA as third in rank order if 3 or 5 was entered for RECOMMENDED MOVEMENT. LSA 01-65. Out of State=99. County Codes and Local Service Areas
CLIENT'S PREFERENCE (1-3)	O/R	One-digit code indicating the person's preference, if any, regarding placement in the current or alternate environment. Decode: Client's Environmental Preference
PARENT/GUARDIAN/PRIMARY CORRESPONDENT PREFERENCE (1-4)	O/R	One-digit code indicating the parent's/guardian's/primary correspondent's preference, if any, regarding placement in the current or alternate environment. Decode: Parent's/Guardian's Environmental Preference

MR Needs V (VC021395)

```

09-26-03                340:MR NEEDS U: ADD                UC021395
LAST NAME/SUF:                CLIENT ID                :
FIRST NAME :                LOCAL CASE NUMBER :
MIDDLE NAME :                COMPONENT/LOC CODE:
STAFFING DATE (MMDDYYYY): 09262003

COMPETENCY STATUS (Y = YES, N = NO, X = N/A):
  A. FINANCIAL                : _   B. MEDICAL                : _
  C. PROGRAMMATIC            : _
  FAMILY CONTACT (1-4)        : _

READY TO ADD?                _ (Y/N)

ACT: ____ (300/SUBMENU, H/MENU)
    
```

Field Name	Type	Contents
LAST NAME/SUF	D	Person's last name and (optional) suffix. (e.g. Jr, Sr)
FIRST NAME	D	Person's first name.
MIDDLE NAME	D	Person's middle name.
CLIENT ID	D	Person's statewide identification number.
LOCAL CASE NUMBER	D	Person's local case number.
COMPONENT	D	Component code.
LOC CODE	D/O	Location code supplied by CARE if the person is assigned to a location.
STAFFING DATE	D	Date of the annual staffing or interim staffing when a change was determined for the client's care. MMDDYYYY format.

Competency Status: Y=Yes, N=No, X=N/A

A. FINANCIAL	R	Indicates the person's competency for making financial decisions.
B. MEDICAL	R	Indicates the person's competency for making medical decisions.
C. PROGRAMMATIC	R	Indicates the person's competency for making programmatic decisions.
FAMILY CONTACT (1-4)	R	One-digit code indicating the degree of contact which the family maintains with the person and/or staff.

Decode: Family Contact

MH Acute Level of Care Determination (VC021316)

(Action Code 343)

```

07-19-00      343:MH ACUTE LEVEL OF CARE DETERMINATION:ADD      VC021316

LAST NAME/SUF : .                CLIENT ID      :
FIRST NAME   :                   LOCAL CASE NUMBER :
MIDDLE NAME  :                   COMPONENT       :
REVIEW DATE  : _____ (MMDDYYYY)             CUR.ADMISSION DATE:

*CRITERIA (ENTER 'X' IF APPLIES)
A.1.  _   2.  _   3.  _   4A.  _   4B.  _
      5A.  _   5B.  _   5C.  _   5D.  _
      6A.  _   6B.  _   6C.  _   6D.  _   6E.  _
      7A.  _   7B.  _   7C.  _   8.   _
      B.   _
      C.   _           ACUTE(A) OR SUB-ACUTE(S):  _

READY TO ADD? : _ (Y/N)

ACT:  _ (300/CLIENT DATA ENTRY MENU, H/MENU)
  
```

Field Name	Type	Contents
LAST NAME/SUF	D	Person's last name and (optional) suffix. (e.g., Jr, Sr)
FIRST NAME	D	Person's first name.
MIDDLE NAME	D	Person's middle name.
CLIENT ID	D	Person's statewide identification number.
LOCAL CASE NUMBER	D	Person's local case number.
COMPONENT	D	Component code.
CUR. ADMISSION DATE	D	Date of the person's current admission.
REVIEW DATE	R	Date LOC is determined.
CRITERIA	R	X to indicate if the specific criteria applies to the person.
ACUTE (A) OR SUB-ACUTE (S)	R	A (Acute) or S (Sub-acute) to indicate if the person is acute or sub-acute.

MH Bed Allocation Exception (VC021314)

(Action Code 345)

```

07-20-00          345:MH BED ALLOCATION EXCEPTION: ADD          UC021314
                                                           1 OF 1
LAST NAME/SUF:          .          CLIENT ID          :
FIRST NAME  :          LOCAL CASE NUMBER :
MIDDLE NAME :          COMPONENT          :

          BEG DATE          END DATE          REASON

          _____          _____          ---
          _____          _____          ---
          _____          _____          ---
          _____          _____          ---
          _____          _____          ---
          _____          _____          ---
          _____          _____          ---
          _____          _____          ---
          _____          _____          ---
          _____          _____          ---

READY TO ADD?          :  _ (Y/N)

ACT:  ____ (300/DATA ENTRY MENU, H/MENU)
    
```

Field Name	Type	Contents
LAST NAME/SUF	D	Person's last name and (optional) suffix. (e.g., Jr, Sr)
FIRST NAME	D	Person's first name.
MIDDLE NAME	D	Person's middle name.
CLIENT ID	D	Person's statewide identification number.
LOCAL CASE NUMBER	D	Person's local case number.
COMPONENT	D	Component code.
BEG DATE	R	Beginning date of the exception period. MMDDYYYY format.
END DATE	O/R	End date of the exception period. MMDDYYYY format.
REASON	R	Reason code for the exception. 03=Big Spring State Hospital 46.02/46.03 04=Out of Texas TDCJ Commitment 05=VA Project 07=Kerrville State Hospital 46.02/46.03 09=Medicare A 10=Medicaid THSTEPS 11=Medicaid IMD 12=Health Insurance 13=Contract with MHA 14=Contract (Other) 15=Medicaid THSTEPS – Independent Child 16=Consignment from State School 17=Facility as Payor

MH Adult Uniform Assessment for Benefit Design (VC021397)

(Action Code 346)

To be completed by Pilot Sites Only

```

09-23-03          346:MH UA BENEFIT DESIGN: ADD          VC021397
LAST NAME/SUF:          CLIENT ID          :
FIRST NAME  :          LOCAL CASE NUMBER  :
MIDDLE NAME :          COMPONENT          :
ASSESSMENT-PURPOSE: _ DISCH-REASON: _    UA BENEFIT DESIGN REC: 1 OF 1
SECT 1: ADULT-TRAG AND RECOMMENDED LEVEL OF CARE
1. ADULT - TRAG (1 TO 9)
  1. _ 2. _ 3. _ 4. _ 5. _ 6. _ 7. _ 8. _ 9. _
2. RECOMMENDED LEVEL OF CARE - LOC-R: _ CALCULATED LOC-R: _
SECT 2 AUTHORIZED LEVEL OF CARE
1. AUTHORIZED LEVEL OF CARE - LOC-A: _
2. DEV REASON: A--RL _ B--CC _ C--CN _ D--CCG _ E--OTH _
SECT 1/2 DATE(MDDYYVYV): _____
SECT 3: SYMPTOMS DIAGNOSIS          LAST PRINCIPAL DIAG: *****
  A.SCH-PSRS: _ BNSA: _ B.BIPOLAR-BDSS: _ C.MAJ DP-QIDS: _ QV: _
SECT 4: COMMUNITY SCALES
1. MCAS FUNC: _ ADJ TO LV: _ SOC CPT: _ COM/CMPLY: _ SUM: _
2. RES TYPE: _ 3. PD EMP TYPE: _ 4. REASON-OUT OF LABOR FORCE: _
SECTION 3/4 DATE(MDDYYVYV): _____

READY TO ADD?   : _ (Y/N)

ACT: ____ (300/DATA ENTRY MENU, M/MENU)

```

Field Name	Type	Contents
LAST NAME/SUF	D	Person's last name and suffix, if any.
FIRST NAME	D	Person's first name.
MIDDLE NAME	D	Person's middle name.
CLIENT ID	D	Person's statewide identification number assigned by CARE.
LOCAL CASE NUMBER	D	Person's local case number.
COMPONENT	D	Three-digit code of the component to which the person is assigned.
ASSESSMENT PURPOSE	R	Purpose of the assessment (A=Admission, C=Continued Care, or D=Discharge).
DISCH REASON	O/R	If discharge, indicates the code that best describes the discharge reason. C=Level of care services complete, J=Incarcerated in jail or prison, M=Moved out of local service area, N=Never returned for services within authorized service period, not to exceed 6 months, T=Transferred to other community provider in local service area, Z=Other.
SECT 1: ADULT-TRAG AND RECOMMENDED LEVEL OF CARE		
1. ADULT - TRAG (1 TO 9)	R	Indicates the individual rating for each of the Adult-TRAG dimensions 1 through 8, and indicates the rating for 9 if MDD.
2. RECOMMENDED LEVEL OF CARE - LOC-R	R	Indicates the Adult-TRAG Level of Care recommendation (LOC-R).
CALCULATED LOC-R	R	Indicates the calculated Level of Care recommendation (LOC-R).

Field Name	Type	Contents
2. RES TYPE	R	Person's current type of residence. 1=Independent/Dependent in Family Home/Supported Housing 2=Group Home/Assisted Living/Treatment-Training-Rehab Center 3=Nursing Home/Intermediate Care Facility (ICF)/Hospital 4=Homeless 5=Correctional Facility
3. PD EMP TYPE	R	Person's current employment status. 1=Independent/Competitive/Supported/Self-employment 2=Transitional/Sheltered Employment 3=Unemployed but wants or needs to work 4=Not in the labor force
4. REASON-OUT OF LABOR FORCE	O/R	Main reason that the person is not in the labor force. Required if 3. PD EMP TYPE is 4 =Not in the labor force.
SECTION 3/4 DATE	R	Date of the completion of Section 3 and/or Section 4 of the form.

Hospitalization Need of MR Person (VC021438)

(Action Code 357)

```

03-17-94          357:HOSPITALIZATION NEED OF MR PERSON:ADD          UC021438
LAST NAME/SUF:           CLIENT ID           :
FIRST NAME  :           LOCAL CASE NUMBER  :
MIDDLE NAME :           COMPONENT           :

CURRENT ADMISSION DATE: 12-20-93    DISCHARGE DATE:

DETERMINATION DATE (MMDDVV): _____

DOES PERSON NEED FURTHER HOSPITALIZATION? (Y/N): -

READY TO ADD?   : - (Y/N)

ACT: ____ (300/CLIENT DATA ENTRY MENU,M/MAIN MENU)
  
```

Field Name	Type	Contents
LAST NAME/SUF	D	Person's last name and (optional) suffix. (e.g., Jr, Sr)
FIRST NAME	D	Person's first name.
MIDDLE NAME	D	Person's middle name.
CLIENT ID	D	Person's statewide identification number.
LOCAL CASE NUMBER	D	Person's local case number.
COMPONENT	D	Component code.
CURRENT ADMISSION DATE	D	Most current admission date. MMDDYY format.
DISCHARGE DATE	D	Most current discharge date. MMDDYY format.
DETERMINATION DATE	R	Date of determination for person's need for hospitalization. MMDDYY format.
DOES PERSON NEED FURTHER HOSPITALIZATION?	R	Y (Yes) or N (No) to indicate if the person needs further hospitalization.

Death/Separation of Client (VC021455) (Action Code 360)

```

09-03-99          360:DEATH/SEPARATION OF CLIENT:ADD          UC021455

LAST NAME/SUF:          CLIENT ID          :
FIRST NAME  :          LOCAL CASE NUMBER :
MIDDLE NAME :          COMPONENT         :

REASON FOR SEPARATION  : _ (1 = MOVED OUT OF STATE
                        :          2 = DECEASED)

DATE OF SEPARATION (MMDDYYYY) : _____
TIME OF SEPARATION (HHMM A/P) : _____

READY TO ADD?          _ (Y/N)

ACT: _____ (300/CLIENT DATA ENTRY, M/MENU)
  
```

Field Name	Type	Contents
LAST NAME/SUF	D	Person's last name and (optional) suffix. (e.g., Jr, Sr)
FIRST NAME	D	Person's first name.
MIDDLE NAME	D	Person's middle name.
CLIENT ID	D	Person's statewide identification number.
LOCAL CASE NUMBER	D	Person's local case number.
COMPONENT	D	Component code.
REASON FOR SEPARATION	R	Reason person is being separated from CARE. 1=Moved out of state, 2=Deceased.
DATE OF SEPARATION	R	Date of separation. MMDDYYYY format.
TIME OF SEPARATION	R	Time of separation. HHMM A/P format.

New Generation Medication Tracking (VC027775)

(Action Code 375)

```

03-22-06          375:NEW GENERATION MEDICATION TRACKING: ADD          UC027775
                                     1 OF 1
LAST NAME/SUF:          CLIENT ID          :
FIRST NAME   :          LOCAL CASE NUMBER :
MIDDLE NAME  :          COMPONENT         :

DRUG START DATE FUNDING END DATE END      NEXT
TYPE MMDDYYYY  SOURCE MMDDYYYY REASON    COMMENT      COMP
-----
DRUG TYPE          FUNDING SOURCE CODES    REASON FOR ENDING CODES
-----
GC=GENERIC CLOZ    1-HOSPITAL IN-PATNT-74TH/HB1 1-NO OR POOR RESPONSE
C=CLOZARIL        2-STATE CAMPUS FACILITY PAY 2-DECREASED WBC
R=RISPERIDONE     4-OTHER                      3-SIDE EFFECT OTH THAN WBC
O=OLANZAPINE     6-MMR COMMUN ONLY           4-LOSS OF FUNDING
Q=QUETIAPINE     M-OTHER MEDICAID            5-OTHER
Z=ZIPRASIDONE    7-MEDICAID COMMUN ONLY
A=ARIPIPRAZOLE   8-FREE
RC=RISPERDAL CONSTA 9-MEDICARE PART D          D-PART D SELF PAY
READY TO ADD?    : _ (Y/N)

ACT: ___ (300/DATA ENTRY MENU, M/MENU)

```

Field Name	Type	Contents
LAST NAME/SUF	D	Person's last name and (optional) suffix. (e.g., Jr, Sr)
FIRST NAME	D	Person's first name.
MIDDLE NAME	D	Person's middle name.
CLIENT ID	D	Person's statewide identification number.
LOCAL CASE NUMBER	D	Person's local case number.
COMPONENT	D	Three-digit code of the component dispensing the new generation medication.
DRUG TYPE	R	Code indicating the type of new generation medication prescribed for the person.
START DATE	R	Date the person started receiving the new generation medication. MMDDYYYYY format.
FUNDING SOURCE	R	One-digit code indicating the source of funding for the drug therapy for this person. Decode: Funding Source (New Generation Medications)
END DATE	O	Date the person stopped receiving the drug therapy. MMDDYYYYY format. <i>If entered, END REASON must also be entered.</i>

Field Name	Type	Contents
END REASON	O/R	One-digit code that explains why the person has stopped receiving the drug therapy. <i>END REASON is required if END DATE is entered.</i> Decode: Reason for Ending (New Generation Medications)
COMMENT	O	Text (up to 25 characters) to describe the reason for ending the drug therapy. <i>If entered, END DATE must also have been entered.</i>
NEXT COMP	O	Three-digit code of the component to which the person is transferring.

State School Residence Reason (VC021905)

(Action Code 391)

```

05-04-95          391:STATE SCHOOL RESIDENCE REASON          VC021905
                                                                RECORD 1 OF 1
LAST NAME/SUF:          CLIENT ID          :
FIRST NAME  :          COMP/LOCAL CASE NBR:
MIDDLE INIT :          ADM DT:          DISCH DT:

REASON  BEGIN DT      REASON  BEGIN DT      REASON  BEGIN DT  REASONS:
----- (MMDDYY)      ----- (MMDDYY)      ----- (MMDDYY)
1 -      _____  11 -      _____  21 -      _____  S = RESPITE
2 -      _____  12 -      _____  22 -      _____  E = EMERG
3 -      _____  13 -      _____  23 -      _____  O = OPC
4 -      _____  14 -      _____  24 -      _____  R = REGULAR
5 -      _____  15 -      _____  25 -      _____
6 -      _____  16 -      _____  26 -      _____
7 -      _____  17 -      _____  27 -      _____
8 -      _____  18 -      _____  28 -      _____
9 -      _____  19 -      _____  29 -      _____
10 -     _____  20 -      _____  30 -      _____

READY TO UPDATE?: _ (Y/N)

ACT:  _ (300/CLIENT DATA ENTRY MENU, M/MENU)
  
```

Field Name	Type	Contents
RECORD	D	Number of admission episodes. <u>Note:</u> If a person has more than one admission to a state school, the episodes are displayed in descending order. To view prior admission episodes (records), key N in the READY TO UPDATE? field, F (forward) in the ACT field, and press <Enter> .
LAST NAME/SUF	D	Person's last name and (optional) suffix. (e.g., Jr, Sr)
FIRST NAME	D	Person's first name.
MIDDLE INIT	D	Person's middle initial.
CLIENT ID	D	Person's statewide identification number.
COMP/LOCAL CASE NBR	D	Component code/person's local case number.
ADM DT	D	Admission date. MMDDYY format.
DISCH DT	D	Discharge date. MMDDYY format.
REASON	R	One character code to indicate the person's reason for residence in a state school. Decode: Reason (State School Residence) <u>Note:</u> REASON may be added or changed to indicate the reason during intervals in which more than one commitment is in effect.
BEGIN DT	R	Reason begin date. MMDDYY format. First reason date must be same as admission date.

Add Case to ID/Demographic Update (VC021841) (Action Code 410)

```

02-18-99          410:ADD CASE TO ID/DEMOGRAPHIC UPDATE          UC021841

CLIENT LAST NAME/SUF:          CLIENT ID          :
CLIENT FIRST NAME  :          COMPONENT          :
CLIENT MIDDLE NAME :

LOCAL CASE NUMBER  : _____
SEX                : _____
ETHNICITY          : _____
CLIENT BIRTHDATE (MMDDYYYY):
SOCIAL SECURITY NUMBER :          (N=NONE, U=UNKNOWN)

PRESENTING PROBLEM : (1=MH, 2=MR, 3=ECI/DD, 4=SA, 5=RC)
REGISTRATION EFFECTIVE DATE:          (MMDDYYYY) TIME (HHMM A/P) :
LEGAL GUARDIANSHIP : _____
SERVICE PARTICIPANT GROUP: __ (CB, SB, PD, HC, TS, EC, UC)
MARITAL STATUS : _ ESTIMATED ANNUAL GROSS FAMILY INCOME : _____
FAMILY SIZE    : _

READY TO UPDATE? _ (Y/N)

ACT: ____ (431/CORRESPONDENT UPDT, H/MENU)

```

Field Name	Type	Contents
CLIENT LAST NAME/SUF	D	Person's last name and (optional) suffix. (e.g., Jr, Sr)
CLIENT FIRST NAME	D	Person's first name.
CLIENT MIDDLE NAME	D	Person's middle name.
CLIENT ID	D	Person's statewide identification number.
COMPONENT	D	Component code.
LOCAL CASE NUMBER	R	Person's local case number.
SEX	D/R	Person's sex. M=Male, F=Female.
ETHNICITY	D/R	Person's ethnicity. Decode: Ethnicity
CLIENT BIRTHDATE	D/R	Person's date of birth. MMDDYYYY format.
SOCIAL SECURITY NUMBER	D/R	Person's social security number <i>or</i> N=None, U=Unknown.
PRESENTING PROBLEM	D/R	One-digit code to indicate person's presenting problem. Decode: Presenting Problem
REGISTRATION EFFECTIVE DATE	D/R	Date the registration is effective. MMDDYYYY format.
TIME	D/R	Time the registration is effective. HHMM A/P format.
LEGAL GUARDIANSHIP	D/R	Person's legal status. Decode: Legal Status

```

02-18-99          410:ADD CASE TO ID/DEMOGRAPHIC UPDATE          UC021841

CLIENT LAST NAME/SUF:          CLIENT ID          :
CLIENT FIRST NAME   :          COMPONENT         :
CLIENT MIDDLE NAME  :

LOCAL CASE NUMBER  : _____
SEX                :
ETHNICITY          :
CLIENT BIRTHDATE (MMDDYYYY):
SOCIAL SECURITY NUMBER :          (N=NONE, U=UNKNOWN)

PRESENTING PROBLEM : (1=MH, 2=MR, 3=ECI/DD, 4=SA, 5=RC)
REGISTRATION EFFECTIVE DATE: (MMDDYYYY) TIME (HHMM A/P) :
LEGAL GUARDIANSHIP : _
SERVICE PARTICIPANT GROUP: _ (CB, SB, PD, HC, TS, EC, UC)
MARITAL STATUS : _ ESTIMATED ANNUAL GROSS FAMILY INCOME : _____
FAMILY SIZE : _

READY TO UPDATE? _ (Y/N)

ACT: ____ (431/CORRESPONDENT UPDT, M/MENU)

```

Field Name	Type	Contents
SERVICE PARTICIPANT GROUP	O	Person's MR service participant group. Decode: Service Participant Groups (MR)
MARITAL STATUS	O	Person's marital status. Decode: Marital Status
ESTIMATED ANNUAL GROSS FAMILY INCOME	O	Total annual gross income of all family members living with the person, rounded to the nearest thousand. Do not enter commas or decimal points.
FAMILY SIZE	O	Number of persons supported on the person's estimated annual gross family income. Includes the person, number of parent and/or dependent children living in the household, and any other persons dependent on the family for support.

Medicaid/Medicare Number Update (VC021855)

(Action Code 413)

```

09-07-99          413:MEDICAID/MEDICARE NUMBER UPDATE          UC021855
LAST NAME/SUF:          CLIENT ID          :
FIRST NAME  :          LOCAL CASE NUMBER :
MIDDLE NAME :          COMPONENT CODE   :

MEDIKID/RECIPIENT NO.: _____
MEDICARE/HIC NO.      : _____

READY TO UPDATE? _ (Y/N)
ACT: ___ (400/CLIENT DATA UPDATE,M/MENU)
  
```

Field Name	Type	Contents
LAST NAME/SUF	D	Person's last name and (optional) suffix. (e.g., Jr, Sr)
FIRST NAME	D	Person's first name.
MIDDLE NAME	D	Person's middle name.
CLIENT ID	D	Person's statewide identification number.
LOCAL CASE NUMBER	D	Person's local case number.
COMPONENT CODE	D	Component code.
MEDIKID/RECIPIENT NO.	O/R	1 - 9 digit Medicaid/Recipient number.
MEDICARE/HIC No.	O/R	1 - 12 character Medicare/HIC number.

OBRA Client Update (VC021852)

(Action Code 415)

```

02-28-94          OBRA CLIENT UPDATE: ADD          VC021852

CARE ID:          COMP/CASE:  /

  LAST NAME      FIRST NAME MI  OBRA ID      SSN      BIRTH DT  SEX
-----
CARE:
COUNTY:          RECIP NO:          HIC NO:
OBRA:
COUNTY:          RECIP NO:          HIC NO:

          OBRA ID: _____
OBRA START DATE(MMDDVV): _____

DO YOU WANT TO SEE OTHER POSSIBLE MATCHES?  _ (Y/N)
IF NOT, ARE YOU READY TO ADD THIS MATCH?    _ (Y/N)

ACT:  __ (400/CLIENT UPD MENU, M/MENU)
  
```

Field Name	Type	Contents
CARE ID	D	Person's statewide identification number.
COMP/CASE	D	Three-digit component code and local case number assigned by the component.
CARE	D	Demographics of the CARE individual.
OBRA	D	Demographics of the OBRA individual.
LAST NAME	D	Person's last name.
FIRST NAME	D	Person's first name.
MI	D	Person's middle initial.
OBRA ID	D	Person's OBRA identification number.
SSN	D	Person's social security number.
BIRTH DT	D	Person's date of birth. MMDDYYYY format.
SEX	D	Person's sex. M=Male, F=Female.
COUNTY	D	Three-digit code and name of the person's county of residence.
RECIP No	D	The 1 - 9 digit Medicaid/Recipient number.
HIC No	D	The 1 - 12 character Medicare/HIC number.
OBRA ID	D/R	Person's OBRA identification number.

Field Name	Type	Contents
OBRA START DATE	D/R	Date of the letter notifying the authority that the person needs specialized services and is eligible to receive OBRA services. MMDDYY format.
DO YOU WANT TO SEE OTHER POSSIBLE MATCHES?	R	Refer to OBRA/CARE instructions for detailed description.
IF NOT, ARE YOU READY TO ADD THIS MATCH?	R	Refer to OBRA/CARE instructions for detailed description.

Client Name Update (VC021858)

(Action Code 420)

02-18-99
420:CLIENT NAME UPDATE
UC021858

CLIENT LAST NAME :
 CLIENT ID :
 COMPONENT CODE :
 LOCAL CASE NUMBER:

ADD CLIENT NAME

LAST NAME/SUF : _____ .__
 FIRST NAME : _____
 MIDDLE NAME : _____

READY TO ADD? _ (Y/N)

ACT: ____ (400/CLIENT DATA UPDATE MENU, M/MENU)

Field Name	Type	Contents
CLIENT LAST NAME	D	Person's last name.
CLIENT ID	D	Person's statewide identification number.
COMPONENT CODE	D	Component code.
LOCAL CASE NUMBER	D	Person's local case number.
LAST NAME/SUF	O	Person's last name/suffix.
FIRST NAME	O	Person's first name.
MIDDLE NAME	O	Person's middle name.

Client Address Update (VC021868) (Action Code 430)

```

09-18-97                430:CLIENT ADDRESS UPDATE                VC021868

CLIENT LAST NAME :
CLIENT ID       :
COMPONENT CODE  :
LOCAL CASE NUMBER:

CLIENT'S CURRENT ADDRESS

STREET ADDRESS  : _____
CITY            : _____
STATE          : _____
ZIP CODE/SUFFIX : _____
ADDRESS DATE    : _____ (MMDDYY)
CP FUNDING SOURCE: _____
TYPE OF PLACEMENT: _____

READY TO UPDATE? _ (Y/N)

ACT: ____ (400/CLIENT DATA UPDATE MENU, M/MENU)
  
```

Field Name	Type	Contents
CLIENT LAST NAME	D	Person's last name.
CLIENT ID	D	Person's statewide identification number.
COMPONENT CODE	D	Component code.
LOCAL CASE NUMBER	D	Person's local case number.
STREET ADDRESS	O	Person's current street address.
CITY	R	Person's current city of residence.
STATE	R	Person's current state of residence.
ZIP CODE/SUFFIX	O	Up to nine digits to record postal zip code and zip code suffix of person's current residence.
ADDRESS DATE	O	Effective date of the person's current address. MMDDYY format.
CP FUNDING SOURCE	O/R	Two-character code for the funding source used in the transition of consumers to the community. Required for MR community placements. Decode: CP Funding Source
TYPE OF PLACEMENT	O/R	Two-digit code for the type of placement in community. Required for MR community placements. Decode: Type of Placement

Client Correspondent Update (VC021845)

(Action Code 431)

```

01-17-02          431:CLIENT CORRESPONDENT UPDATE          VC021845
LAST NAME/SUF:          CLIENT ID          :
FIRST NAME  :          LOCAL CASE NUMBER :
MIDDLE NAME :          COMPONENT         :

PRIMARY CORRESPONDENT:
CORRES. NAME : _____ CORRES. RELATIONSHIP : __
CORRES. STREET : _____ CORRES. TELEPHONE : ____
CORRES. CITY  : _____ STATE : __ ZIP CODE : ____

SECONDARY CORRESPONDENT:
CORRES. NAME : _____ CORRES. RELATIONSHIP : __
CORRES. STREET : _____ CORRES. TELEPHONE : ____
CORRES. CITY  : _____ STATE : __ ZIP CODE : ____

READY TO UPDATE? _ (Y/N)

ACT: ____ (400/CLIENT DATA UPDATE MENU, M/MENU)
  
```

Field Name	Type	Contents
LAST NAME/SUF	D	Person's last name and (optional) suffix. (e.g., Jr, Sr)
FIRST NAME	D	Person's first name.
MIDDLE NAME	D	Person's middle name.
CLIENT ID	D	Person's statewide identification number.
LOCAL CASE NUMBER	D	Person's local case number.
COMPONENT	D	Component code.
<u>Primary Correspondent:</u>		
CORRES. NAME	R	Name of the first person to contact on behalf of the person in case of an emergency.
CORRES. RELATIONSHIP	O/R	Relationship of the primary correspondent to the person. If the primary correspondent's NAME is entered, this field is required. Decode: Relationship
CORRES. STREET	R	Primary correspondent's current street address.
CORRES. TELEPHONE	O	Primary correspondent's area code and telephone number.
CORRES. CITY	R	Primary correspondent's current city of residence.
STATE	R	Primary correspondent's current state of residence.
ZIP CODE	R	Postal zip code and zip code suffix of the primary correspondent's current residence.

Field Name	Type	Contents
<u>Secondary Correspondent:</u>		
CORRES. NAME	O	Name of the person to contact on behalf of the person in case of an emergency if the primary correspondent cannot be reached.
CORRES. RELATIONSHIP	O	Relationship of the secondary correspondent to the person. Decode: Relationship
CORRES. STREET	O	Secondary correspondent's current street address.
CORRES. TELEPHONE	O	Secondary correspondent's area code and telephone number.
CORRES. CITY	O	Secondary correspondent's current city of residence.
STATE	O	Secondary correspondent's current state of residence.
ZIP CODE	O	Postal zip code and zip code suffix of the secondary correspondent's current residence.

Client's County of Residence Update (VC021878) (Action Code 440)

```

08-28-95          CLIENT'S COUNTY OF RESIDENCE UPDATE          UC021878

      LAST NAME      :
      CLIENT ID      :
      COMPONENT CODE :
      LOCAL CASE NUMBER:
      CURRENT CNTY RES :      COUNTY DATE:

      PLEASE ENTER THE FOLLOWING:

      RESIDENTIAL COUNTY CODE      _
      EFFECTIVE DATE (MMDDYY)      _
      HAS COUNTY CHANGE BEEN COORDINATED
      WITH THE RECEIVING AUTHORITY? (Y/N) _

      TO SEE CLIENT'S COUNTY OF RESIDENCE HISTORY,
      ENTER AN ACTION CODE OF 220 (DETAIL CLIENT HISTORY).

READY TO UPDATE?  _ (Y/N)

      ACT:  _ (400/REGISTER CLIENT UPDATE MENU, M/MENU)
  
```

Field Name	Type	Contents
LAST NAME	D	Person's last name.
CLIENT ID	D	Person's statewide identification number.
COMPONENT CODE	D	Component code.
LOCAL CASE NUMBER	D	Person's local case number.
CURRENT CNTY RES	D	Three-digit code of the person's current county of residence.
COUNTY DATE	D	Effective date of the person's county of residence.
RESIDENTIAL COUNTY CODE	R	Three-digit code of the person's county of residence change.
EFFECTIVE DATE	R	Effective date of the person's county of residence change. MMDDYY format.
HAS COUNTY CHANGE BEEN COORDINATED WITH THE RECEIVING AUTHORITY?	R	Y (Yes) or N (No) to indicate whether the county of residence change has been coordinated with the receiving authority.

Maintain Destination Assignments (VC027605)

(Action Code 450)

LOCAL			ASSIGNMENT	ASSIGNING	END
CASE NUMBER	CLIENT ID	LAST NAME	BEGIN DATE	COMPONENT	(N/Y)
000005011	2615	MESQUITE	08-24-89	656	N
0000072331	30384	ALOEVERA	08-08-89	677	N
0000015359	30384	ALOEVERA	08-08-89	678	N
0000001686	5789	ASH	01-01-90	677	N

DESTINATION ASSIGNMENTS OPEN MORE THAN 30 DAYS:

READY TO CHANGE? _ (Y/N)

ACT: ___ (400/CLIENT DATA UPDATE, M/MENU)

Field Name	Type	Contents
LOCAL CASE NUMBER	D	Local case number of person with a destination assignment open for more than 30 days.
CLIENT ID	D	Person's statewide identification number.
LAST NAME	D	Person's last name.
ASSIGNMENT BEGIN DATE	D	Date the destination assignment began.
ASSIGNING COMPONENT	D	Three-digit code to identify the component that made the destination assignment.
END ASSIGN (N/Y)	O/R	N (No) or Y (Yes) to indicate if the assignment has ended.

Independent Employment (VC021835)

(Action Code 469)

```

01-07-97          469:INDEPENDENT EMPLOYMENT:ADD          VC021835
                                                           1 OF 1
LAST NAME/SUF:          CLIENT ID          :
FIRST NAME  :          LOCAL CASE NUMBER :
MIDDLE NAME :          COMPONENT/LOC CODE:

                BEGIN   END
                DATE    DATE
                _____
                _____

READY TO ADD?      _ (Y/N)
ACT:  ___ (H/HELP, E/ERASE, Q/QUIT, M/MENU)
    
```

Field Name	Type	Contents
LAST NAME/SUF	D	Person's last name and (optional) suffix. (e.g., Jr, Sr)
FIRST NAME	D	Person's first name.
MIDDLE NAME	D	Person's middle name.
CLIENT ID	D	Person's statewide identification number.
LOCAL CASE NUMBER	D	Person's local case number.
COMPONENT/LOC CODE	D	Component code/location code.
BEGIN DATE	R	Date independent employment services begin.
END DATE	O/R	Date independent employment services end.

Case Management Assignment (VC021811)

(Action Code 490)

```

02-19-99          490:CASE MANAGEMENT ASSIGNMENT: ADD          UC021811
LAST NAME/SUF:          CLIENT ID          :
FIRST NAME  :          LOCAL CASE NUMBER :
MIDDLE NAME :          COMPONENT CODE   :

ASSIGNMENT BEGIN DATE: ____ (MMDDYY)
ASSIGNMENT END DATE  : ____ (MMDDYY)
CASE MANAGER POSITION: ____
CASE MANAGEMENT UNIT : ____
SERVICE TYPE       : ____ (R011 = MR CASE MANAGEMENT,
                           H011 = ADULT MH CASE MANAGEMENT)

READY TO ADD?   : _ (Y/N)
ACT: ____ (400/CLIENT ENTRY SCREEN,M/MENU)

```

Field Name	Type	Contents
LAST NAME/SUF	D	Person's last name and (optional) suffix. (e.g. Jr, Sr)
FIRST NAME	D	Person's first name.
MIDDLE NAME	D	Person's middle name.
CLIENT ID	D	Person's statewide identification number.
LOCAL CASE NUMBER	D	Person's local case number.
COMPONENT CODE	D	Component code.
ASSIGNMENT BEGIN DATE	R	Date assignment begins. MMDDYY format.
ASSIGNMENT END DATE	O/R	Date assignment ends. MMDDYY format. Required when assignment ends.
CASE MANAGER POSITION	O/R	One- to four-digit alphanumeric position code. Must be a valid case manager position for the case management unit during the assignment period.
CASE MANAGEMENT UNIT	O/R	Four-digit case management unit code. Must be a valid case management unit for the component.
SERVICE TYPE	O/R	Case management service type determined by the case management unit's caseload. (R011 for MR unit caseload, H011 for Adult MH unit caseload, either code for MHMR unit caseload)

Aftercare/Brief Intervention (VC021891) (Action Code 495)

```

08-28-95          495:AFTERCARE/BRIEF INTERVENTION: ADD          UC021891
                                     PAGE: 1 OF 1
LAST NAME/SUF:          CLIENT ID          :
FIRST NAME  :          LOCAL CASE NUMBER :
MIDDLE NAME :          COMPONENT CODE   :

PLEASE ENTER THE FOLLOWING:

SERVICE TYPE: ____

DATE OF SERVICE: ____ (MMDDYY)

READY TO ADD?  : _ (Y/N)

ACT: ____ (495/REQ SCRIN, F#/PG FORWARD, B#/PG BACK, 400/CLI SUBMENU, M/MENU)
    
```

Field Name	Type	Contents
LAST NAME/SUF	D	Person's last name and (optional) suffix. (e.g. Jr, Sr)
FIRST NAME	D	Person's first name.
MIDDLE NAME	D	Person's middle name.
CLIENT ID	D	Person's statewide identification number.
LOCAL CASE NUMBER	D	Person's local case number.
COMPONENT CODE	D	Component code.
SERVICE TYPE	R	Type of service provided. Decode: Service Type - <u>Aftercare</u>
DATE OF SERVICE	R	Date of the service provided. MMDDYY format.

Component (VC026015)

(Action Code 605)

```

10-01-01                605:COMPONENT: ADD RECORDS                VC026015

COMP CODE:  NAME      : _____
             SHORT NAME : _____
             ADDRESS   : _____
             CITY      : _____ ZIP : ____
             COUNTY    : _____
             PHONE     : _____ STS NUMBER : _____

OPEN DATE   : _____ (MMDDYYYY)  CLOSE DATE   : _____ (MMDDYYYY)
CONTACT PERSON : _____ CONTACT TITLE : _____
(EXEC. DIRECTOR/SUPERINTENDENT)
MH CONTACT   : _____ MR CONTACT : _____
MH CHILD CONTACT: _____
COUNTY CHANGE CONTACT(MH): _____
COUNTY CHANGE CONTACT(MR): _____
CAMP PROGRAM CLIENT DATA COORDINATOR: _____
COMM PROGRAM CLIENT DATA COORDINATOR: _____
COMPONENT TYPE: - MH REGIONAL COUNCIL : ____
FACILITY BEDS:  _ MR REGIONAL COUNCIL : ____
READY TO ADD?  _ (Y/N)

ACT: ____ (600/COMPONENT DATA ENTRY, M/MENU)

```

Field Name	Type	Contents
COMP CODE	D	Component code.
NAME	R	Name of component.
SHORT NAME	R	Up to 5 digits to record short name of component. Component Codes/LSAs
ADDRESS	R	Street address of component.
CITY	R	City where component is located.
ZIP	R	Up to 9 digits to record postal zip code and zip code suffix. The suffix (last 4 digits) is optional.
COUNTY	R	3-digit code for the county where the component is located. County Codes and Local Service Areas
PHONE	O	Area code and local telephone number of component.
STS NUMBER	O	STS telephone number of component.
OPEN DATE	R	Date component opened. MMDDYYYY format.
CLOSE DATE	O	Date component closed. MMDDYYYY format.
CONTACT PERSON	R	Name of person to contact with regards to component. Usually the Executive Director or Superintendent.
CONTACT TITLE	R	Title of the person named as the contact.
MH CONTACT	O	Name of person in charge of MH services at the component.
MR CONTACT	O	Name of person in charge of MR services at the component.

Field Name	Type	Contents
MH CHILD CONTACT	O	Name of person in charge of MH children's services at the component.
COUNTY CHANGE CONTACT (MH)	O	Name of the contact person at the MHA for county of residence changes.
COUNTY CHANGE CONTACT (MR)	O	Name of the contact person at the MRA for county of residence changes.
CAMP PROGRAM CLIENT DATA COORDINATOR	O	Name of the campus program client data coordinator.
COMM PROGRAM CLIENT DATA COORDINATOR	O	Name of the community program client data coordinator.
COMPONENT TYPE	R	One-digit code for type of component. H=Hospital, S=School, D=State Center, C=Community Center.
FACILITY BEDS	O	Number of beds at the facility.
MH REGIONAL COUNCIL	O	Three-digit component code of the MH regional council. Component Codes/LSAs
MR REGIONAL COUNCIL	O	Three-digit component code of the MR regional council. Component Codes/LSAs

Non-Residential Services (VC026025) (Action Code 610)

03-01-94	610:NON-RESIDENTIAL SERVICES: ADD	VC026025
COMPONENT CODE :		
SERVICE CODE : ____ SERVICE NAME: _____		
CITY(S) SERVICE LOCATED IN: _____		

CNTY(S) SERVICE LOCATED IN: __ _		
__ _		
__ _		
DESCRIPTION:		

READY TO ADD? _ (Y/N)		
ACT ____ (600/COMPONENT DATA ENTRY, M/MENU)		

Field Name	Type	Contents
COMPONENT CODE	D	Component code.
SERVICE CODE	D	Three-digit service code.
SERVICE NAME	R	Name of service.
CITY(S) SERVICE LOCATED IN	R	Up to 18 fields for recording city(s) service located in. At least one city is required.
CNTY(S) SERVICE LOCATED IN	R	Up to 18 fields for recording three-digit code of county in which service is located. At least one county code is required. County Codes and Local Service Areas
DESCRIPTION	R	Description of service.

Campus-based Residential Ward/Dorm (VC026035)

(Action Code 615)

```

07-19-00      615:CAMPUS-BASED RESIDENTIAL WARD/DORM: ADD      UC026035

COMPONENT CODE      : ---
WARD/DORM CODE      :
WARD/DORM NAME      : _____

UNIT TYPE           : ___
OPEN DATE           : _____
CLOSE DATE          : _____
STATUS              : _ (1=OPEN,2=CLOSED)
AGE RANGE           : ___ TO ___      SEX : _ (M,F,C=COED)

TOTAL NUMBER OF FUNDED BEDS: 0_
NUMBER OF ICF-MR BEDS   : 0_
NUMBER OF MEDICARE BEDS : 0_
NUMBER OF IMD BEDS     : 0_

SQUARE FOOTAGE       : _____

READY TO ADD?       : _ (Y/N)

ACT: ___ (600/COMPONENT DATA ENTRY, M/MENU)
    
```

Field Name	Type	Contents
COMPONENT CODE	D	Component code.
WARD/DORM CODE	D	Ward or dorm code.
WARD/DORM NAME	R	Name of the ward or dorm.
UNIT TYPE	O/R	Unit type of the ward or dorm. Required for state hospitals. Decode: Unit Type
OPEN DATE	R	Date ward or dorm opened. MMDDYYYY format.
CLOSE DATE	O	Date ward or dorm closed. MMDDYYYY format.
STATUS	O	Status of ward or dorm. 1=Open, 2=Closed.
AGE RANGE	O/R	Range of ages of the persons housed in the ward or dorm. Required for state hospitals.
SEX	O/R	Sex of the persons housed in the ward or dorm. Required for state hospitals. (M=Male, F=Female, C=Coed)
TOTAL NUMBER OF FUNDED BEDS	R	Total number of funded beds on the ward or dorm.
NUMBER OF ICF-MR BEDS	O	Number of ICF-MR beds on the ward or dorm.
NUMBER OF MEDICARE BEDS	O	Number of Medicare beds on the ward or dorm.
NUMBER OF IMD BEDS	O	Number of IMD (Institute for Mental Disease) beds on the ward or dorm.
SQUARE FOOTAGE	O/R	Total square footage of living space for persons at the ward or dorm. Required for all current on-campus locations for state schools and for state center mental retardation units.

MH Community-based Residential Program (VC026045)

(Action Code 620)

```

01-07-97      620:MH COMMUNITY-BASED RESIDENTIAL PROGRAM:ADD      VC026045
COMP CODE/NAME : ___ / _____
RES LOC CODE/NAME: ___ / _____
ADDRESS : _____
CITY : _____ ZIP: _____ COUNTY: ___
OPEN DATE: _____ CLOSE DATE: _____ VENDOR NO.: _____

=====

RELATIONSHIP TO COMPONENT: _ TYPE OF LIVING SITUATION: _
C=CONTRACTED BY          FOR CHILD/ADOLESCENT   FOR ADULT
O=OPERATED BY            07 HOSPITAL SERVICES/   19 TREATMENT/TRAINING
P=OTHER                  CRISIS STAB. UNITS   20 OTHER ASSTD LIVING
                        09 THERAP. FOSTER CARE  22 HOSPITAL SERVICES
TYPE OF PLACEMENT: _    16 FOSTER GROUP HOME  23 CRISIS STAB. UNITS
                        17 OTHER RESIDENTIAL    24 CRIS RES/IN-HOME SUC
TOTAL NUMBER OF BEDS : ___ 25 FORENSIC TRANS.PGM.
READY TO ADD?           _ (Y/N) 26 ADULT FOSTER CARE
                        27 LIC.PERS.CARE HOME

ACT: ___ (600/COMPONENT DATA ENTRY, M/MENU)

```

Field Name	Type	Contents
COMP CODE	D	Component code.
COMP NAME	D	Name of component.
RES LOC CODE	D	Residential location code.
RES LOC NAME	R	Name of residential location. If name is not entered, residential location code defaults as the name.
ADDRESS	R	Street address of residential location.
CITY	R	City where residential program is located.
ZIP	R	Up to 9 digits to record postal zip code and zip code suffix. The suffix (last 4 digits) is optional.
COUNTY	R	3-digit code for the county where the residential program is located. County Codes and Local Service Areas
OPEN DATE	R	Date the residential location opened. MMDDYY format.
CLOSE DATE	O	Date residential program closed. MMDDYY format. CLOSE DATE cannot be entered if there are open assignments at the location.
VENDOR NO.	O/R	Four-digit vendor number assigned by TDHS. Required if TYPE OF PLACEMENT is 07-Nursing Home .

Field Name	Type	Contents
------------	------	----------

For Changes Only: These fields are displayed only when you use the change function.

REASON FOR MODIFICATION OF THE FOLLOWING ITEM(S)	R	A one-digit code to indicate the reason for modification of any of the following items. (1=Error Correction, 2=Change of Description)
IF 2 (CHANGE OF DESCRIPTION) EFFECTIVE DATE OF CHANGE	O/R	Effective date of change. MMDDYY format. Required if 2 is entered for REASON FOR MODIFICATION OF THE FOLLOWING ITEM(S).
LATEST EFFECTIVE DATE OF CHANGE	D	Latest effective date of change.
RELATIONSHIP TO COMPONENT	R	C = Contracted By, O = Operated By, P = Other.
TYPE OF LIVING SITUATION	O/R	Two-digit code for the type of living situation (for child/adolescent <i>or</i> for adult). Required if RELATIONSHIP TO COMPONENT is C or O . Decode: Type of Living Situation (MH)
TYPE OF PLACEMENT	R	Type of community placement. Decode: Type of Placement
TOTAL NUMBER OF BEDS	R	Up to 4 digits to record the total number of beds in the residential program.

MR Community-based Residential Program (VC026039)

(Action Code 623)

```

08-05-93      623:MR COMMUNITY-BASED RESIDENTIAL PROGRAM:ADD      VC026039
COMP CODE/NAME : ___ / _____
RES LOC CODE/NAME: ___ / _____
ADDRESS : _____
CITY : _____ ZIP: _____ COUNTY: ___
OPEN DATE: _____ CLOSE DATE: _____ VENDOR NO.: _____

=====

RELATIONSHIP TO COMPONENT: _      TYPE OF RESIDENTIAL SERVICE: ___
C=CONTRACTED BY      R031=FAMILY LIVING
O=OPERATED BY      R032=RESIDENTIAL LIVING
P=OTHER      R033=CONTRACTED SPEC. RESIDENCES
      D030=OTHER

TYPE OF PLACEMENT: ___ TOTAL NUMBER OF BEDS: ___ SQUARE FEET: _____
IF ICF-MR, NUMBER OF ICF-MR BEDS: ___
READY TO ADD?      _ (Y/N)

ACT: ___ (600/COMPONENT DATA ENTRY, M/MENU)
    
```

Field Name	Type	Contents
COMP CODE	D	Component code.
COMP NAME	D	Name of component.
RES LOC CODE	D	Residential location code.
RES LOC NAME	R	Name of residential location. If name is not entered, residential location code defaults as the name.
ADDRESS	R	Street address of residential location.
CITY	R	City where residential program is located.
ZIP	R	Up to 9 digits to record postal zip code and zip code suffix. The suffix (last 4 digits) is optional.
COUNTY	R	3-digit code for the county where the residential program is located. County Codes and Local Service Areas
OPEN DATE	R	Date the residential location opened. MMDDYY format.
CLOSE DATE	O	Date residential program closed. MMDDYY format. CLOSE DATE <i>cannot</i> be entered if there are open assignments at the location.
VENDOR NO.	O/R	Four-digit vendor number assigned by TDHS. Required if TYPE OF PLACEMENT is 07 -Nursing Home.

Field Name	Type	Contents
------------	------	----------

For Changes Only: These fields are displayed only when you use the change function.

REASON FOR MODIFICATION OF THE FOLLOWING ITEM(S)	R	A one-digit code to indicate the reason for modification of any of the following items. (1=Error Correction, 2=Change of Description)
IF 2 (CHANGE OF DESCRIPTION), EFFECTIVE DATE OF CHANGE	O/R	Effective date of change. MMDDYY format. Required if 2 is entered for REASON FOR MODIFICATION OF THE FOLLOWING ITEM(S).
THE LATEST EFFECTIVE DATE OF CHANGE	D	Latest effective date of change.
RELATIONSHIP TO COMPONENT	R	C = Contracted by, O = Operated by, P = Other.
TYPE OF RESIDENTIAL SERVICE	R	MR residential service code. (R031=Family Living, R032=Residential Living, R033=Contracted Specialized Residences, D030=Other)
TYPE OF PLACEMENT	R	Type of community placement. Decode: Type of Placement
TOTAL NUMBER OF BEDS	R	Up to 4 digits to record the total number of beds in the residential program.
SQUARE FEET	O/R	Total square footage of living space for persons at the residential location. Required for all current MR community-based residential locations contracted or operated by TXMHMR components.
IF ICF-MR, NUMBER OF ICF-MR BEDS	O/R	Number of ICF-MR beds. Required if TYPE OF PLACEMENT is 08, 09, 10, or 15.

MH & MR Authority (VC026055)

(Action Code 625)

```

09-18-97          625:MH & MR AUTHORITY:ADD          VC026055
                                                         1 OF 1
LOCAL SERVICE AREA :
      MENTAL HEALTH AUTHORITY   COMP          COMP
      NAME                     SERVING   MENTAL RETARDATION AUTH   SERVING
                               AS MHA    NAME                               AS MRA

_____          _____          _____          _____
MH SHORT NAME: _____      MR SHORT NAME: _____
MH ABBREV NAME: _____      MR ABBREV NAME: _____
BEGIN DATE MMDDYYYY: _____  END DATE MMDDYYYY: _____

READY TO ADD?          : _ (Y/N)

ACT: ___ (600/COMPONENT DATA ENTRY MENU, M/MENU)
    
```

Field Name	Type	Contents
LOCAL SERVICE AREA	D	Service area code.
MENTAL HEALTH AUTHORITY NAME	R	Name of the Mental Health Authority.
COMP SERVING AS MHA	R	Component code of the component serving as the Mental Health Authority.
MENTAL RETARDATION AUTHORITY NAME	R	Name of the Mental Retardation Authority.
COMP SERVING AS MRA	R	Component code of the component serving as the Mental Retardation Authority.
MH SHORT NAME	R	Short name of the Mental Health Authority. Component Codes/LSAs
MR SHORT NAME	R	Short name of the Mental Retardation Authority. Component Codes/LSAs
MH ABBREV NAME	R	Abbreviated name of the Mental Health Authority.
MR ABBREV NAME	R	Abbreviated name of the Mental Retardation Authority
BEGIN DATE	R	Begin date for the MHA/MRA. MMDDYYYY format.
END DATE	O/R	End date for the MHA/MRA. MMDDYYYY format.

Accounting Code (VC026085)

(Action Code 640)

03-01-94	640:ACCOUNTING CODE: ADD	VC026085 1 OF 1
COMPONENT CODE :		
ACCOUNTING CODE	ACCOUNTING CODE NAME	
_____	_____	
_____	_____	
_____	_____	
_____	_____	
_____	_____	
_____	_____	
_____	_____	
_____	_____	
_____	_____	
_____	_____	
_____	_____	
READY TO ADD? : _ (Y/N)		
ACT: ___ (600/COMPONENT DATA ENTRY MENU, M/MENU)		

Field Name	Type	Contents
COMPONENT CODE	D	Component code and component name.
ACCOUNTING CODE	R	Accounting code.
ACCOUNTING CODE NAME	R	Accounting code name.

Case Management Position Reassignments (VC02625)

(Action Code 675)

```

11-21-89          CASE MANAGEMENT POSITION REASSIGNMENTS          UC026125
                                                           1 OF 1
COMPONENT CODE/NAME : 660 / DENTON STATE SCHOOL
CASE MGMT UNIT CODE/NAME: 122 / PELICAN HALL
CASE MGMT SUPVR CODE/NM : 111 / MAPLE, JOE

NEW SUPVR  POSITION  TYPE
CODE       NBR     (S/C) %  BEG DT  END DT  CASE MANAGER NAME
-----
   _____ 2323   C   30_  100189  _____ APPLE, DON_____
   _____ 5432   C   20_  110189  _____ ORANGE, LON_____
   _____ 7989   C   50_  092589  _____ GRAPE, LARRY_____

READY TO CHANGE? : _ (Y/N)

ACT: ___ (F/PAGE FORWARD,600/COMP ENTRY,H/HELP,E/ERASE)
    
```

Field Name	Type	Contents
COMPONENT CODE/NAME	R	Component code and name.
CASE MGMT UNIT CODE/ NAME	R	Four-digit Case Management Unit Code and Case Management Unit Name.
CASE MGMT SUPVR CODE/ NM	R	Case management supervisor code and name.
NEW SUPERVISOR CODE	R	One- to four-digit alphanumeric code.
POSITION NUMBER	R	One- to four-digit alphanumeric position code.
TYPE—S/C	R	Type of position. S=Supervisor, C=Case Manager.
%	R	Numeric percentage for the position.
BEG DT	R	Beginning date of the position. MMDDYY format. Must be within the unit's open/close range.
END DT	R	Ending date of the position is entered when the position closes. MMDDYY format. There can be no open case management assignments for that position. The end date must be within the unit's open/close date.
CASE MANAGER NAME	O	Case manager name, up to 28 characters.

Client & Family Support Program (VC026059)

(Action Code 680)

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03-23-93          680:CLIENT & FAMILY SUPPORT PROGRAM: ADD          VC026059

COMP CODE/NAME : ___ / _____
LOC CODE/NAME  : ___ / _____
ADDRESS       : _____
CITY         : _____
ZIP          : ____ ____
COUNTY      : ____
PHONE        : ( ___ ) _____
CONTACT      : _____

OPEN DATE : ____   CLOSE DATE : ____

READY TO ADD?   _ (Y/N)

ACT: ___ (600/COMPONENT DATA ENTRY, M/MENU)
  
```

Field Name	Type	Contents
COMP CODE	D	Component code.
NAME	D	Component name.
LOC CODE	D	Location code.
NAME	O	Location name.
ADDRESS	R	Location address.
CITY	R	Location city.
ZIP	R	Location zip code.
COUNTY	R	Three-digit county code of the location.
PHONE	O	Telephone number of the location.
CONTACT	O	Name of a contact person at the location.
OPEN DATE	R	Date the location opened. MMDDYY format.
CLOSE DATE	O	Date the location closed. MMDDYY format.

Note: If a close date is entered, there can be no open assignments to this location.

Living Options Process (VC140741A)

(Action Code 1121)

To be completed by Community ICF/MR Facilities Only

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01-17-02          1121:LIVING OPTIONS PROCESS: ADD          UC140741A
LAST NAME/SUF:          CLIENT ID          :
FIRST NAME  :          LOCAL CASE NUMBER :
MIDDLE NAME :          COMPONENT         :

>====> BELOW TO BE FILLED IN BY COMMUNITY ICF/MR ONLY

ENTER THE DATE OF THE MOST RECENT LIVING OPTIONS PROCESS : _____

DID THE MOST CURRENT LIVING OPTIONS PROCESS RESULT IN EITHER
A NEW REFERRAL TO THE MRA OR A CONTINUATION OF A REFERRAL
MADE PREVIOUSLY?                                          : _

IF CLIENT IS UNDER 22, HAS PERMANENCY PLANNING BEEN DONE (Y/N): N
ENTER THE DATE OF THE MOST RECENT PERMANENCY PLANNING   : _____
( AGE OF CONSUMER IS 29 )

READY TO ADD?      : _ (Y/N)

ACT: ____ (1100/DATA ENTRY MENU, H/MENU, PF1/DOC)
    
```

Field Name	Type	Contents
LAST NAME/SUF	D	Person's last name and (optional) suffix. (e.g., Jr, Sr)
FIRST NAME	D	Person's first name.
MIDDLE NAME	D	Person's middle name.
CLIENT ID	D	Person's statewide identification number.
LOCAL CASE NUMBER	D	Person's local case number.
COMPONENT	D	Component code.
ENTER THE DATE OF THE MOST RECENT LIVING OPTIONS PROCESS	R	Date of the person's most recent living options process.
DID THE MOST CURRENT LIVING OPTIONS PROCESS RESULT IN EITHER A NEW REFERRAL TO THE MRA OR A CONTINUATION OF A REFERRAL MADE PREVIOUSLY?	R	Y (Yes) or N (No) to indicate whether the most current living options process resulted in a new referral to the MRA or a continuation of a referral made previously.
IF CLIENT IS UNDER 22, HAS PERMANENCY PLANNING BEEN DONE?	R	If the client is under 22, Y (Yes) or N (No) to indicate whether permanency planning has been done.
ENTER THE DATE OF THE MOST RECENT PERMANENCY PLANNING	R	If permanency planning has been done, date of the most recent permanency planning.

Living Options Process (VC140741B)

(Action Code 1121)

To be completed by State Mental Retardation Facilities Only

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01-17-02          1121:LIVING OPTIONS PROCESS: ADD          UC140741B

LAST NAME/SUF:          .          CLIENT ID          :
FIRST NAME  :          LOCAL CASE NUMBER :
MIDDLE NAME :          COMPONENT          :

>====> BELOW TO BE FILLED IN BY STATE MENTAL RETARDATION FACILITIES ONLY

ENTER THE DATE OF THE MOST RECENT LIVING OPTIONS PROCESS      : _____ *
DID THE MRA PARTICIPATE IN LIVING OPTIONS PROCESS? (Y/N) : _ *

IF CLIENT IS UNDER 22, HAS PERMANENCY PLANNING BEEN DONE (Y/N): N
ENTER THE DATE OF THE MOST RECENT PERMANENCY PLANNING          : _____
( AGE OF CONSUMER IS 51 )

READY TO ADD?          : _ (Y/N)
'
ACT: ____ (1100/DATA ENTRY MENU, M/MENU, PF1/DOC)          *
```

Field Name	Type	Contents
LAST NAME/SUF	D	Person's last name and (optional) suffix. (e.g., Jr, Sr)
FIRST NAME	D	Person's first name.
MIDDLE NAME	D	Person's middle name.
CLIENT ID	D	Person's statewide identification number.
LOCAL CASE NUMBER	D	Person's local case number.
COMPONENT	D	Component code.
ENTER THE DATE OF THE MOST RECENT LIVING OPTIONS PROCESS	R	Date of the person's most recent living options process.
DID THE MRA PARTICIPATE IN LIVING OPTIONS PROCESS?	R	Y (Yes) or N (No) to indicate whether the MRA participated in the living options process.
IF CLIENT IS UNDER 22, HAS PERMANENCY PLANNING BEEN DONE?	R	If the client is under 22, Y (Yes) or N (No) to indicate whether permanency planning has been done.
ENTER THE DATE OF THE MOST RECENT PERMANENCY PLANNING	R	If permanency planning has been done, date of the most recent permanency planning.

Field Name	Type	Contents
REQUIRED REPORTING FOR MR	R	Code of the current living arrangement; if at home, age of main caregiver and whether a move out of the home will be required within 1 year; and code to indicate when the person wants the service(s).
PREFERRED HCS LIVING FOSTER COMPANION CARE HCS GROUP HOME (SL OR RSS)	O/R	If HCS is included in the Service Type column, the Preferred HCS Living questions must be answered, each with either Y (Yes) or N (no).
ANNUAL CONTACT DECLINED? (ONLY FOR UNDER 22 IN NF OR ICFMR)	O/R	<i>(Applies only to individuals under age 22 living in ICFMR or NF.)</i> Y (Yes) or N (No) to indicate the annual contact preference of the LAR for clients under the age of 22 or the service recipient between 18-21 without an LAR.
CONTACT INFO & COMMENTS	O	Current contact information to reach the primary correspondent as well as clarifying comments and/or notes.

Travis Questionnaire Entry (VC061505)

(Action Code W27)

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08-30-07          W27:TRAVIS QUESTIONNAIRE ENTRY: ADD          UC061505
CLIENT LAST NAME:          FIRST NAME:          SSN:
BIRTHDATE:                CLIENT ID:          AGENCY:
LOCAL CASE NO:            COMPLETED BY: _____
DATE: (MMDDYYYY)         INFORMANT NAME: _____
RELATIONSHIP: ___ (PF1 FOR CODES) PHONE:  ___ - ___ - ___
MAILING ADDRESS: _____
DID INFORMANT DECLINE TO ANSWER QUESTIONNAIRE ITEMS? (Y/N) _
IF YES, ENTER NOTES: _____

1. IS HELP NEEDED WITH: (ENTER Y FOR EACH TYPE OF HELP NEEDED)
- PERSONAL CARE?          - COMMUNICATING?
- LEARNING OR REMEMBERING THINGS?  - WALKING OR GETTING AROUND?
- LIVING INDEPENDENTLY?    - UNKNOWN?
- SKILLS TRAINING?        - DECLINE TO ANSWER
EXPLAIN: _____
PREVIOUS ASSISTANCE RECEIVED: _____
_____
_____

* PRESS ENTER TO CONTINUE *

ACT: ___ (W00/MENU, PF1(HLP)/SCRND0C)
  
```

Field Name	Type	Contents
CLIENT LAST NAME	D	Person's last name.
FIRST NAME	D	Person's first name.
SSN	D	Person's social security number.
BIRTHDATE	D	Person's date of birth.
CLIENT ID	D	Person's statewide identification number.
AGENCY	D	"MRA" component code
LOCAL CASE NUMBER	D	Person's local case number.
COMPLETED BY	R	Name of the DADS/MRA staff who collected the information on the form.
DATE	R	Date the questions were asked and responses were received from the informant.
INFORMANT NAME	R	Name of the person providing the information for the questionnaire, if other than the individual who will potentially receive services.
RELATIONSHIP	R	Code that identifies the relationship between the person providing the information for the CARE individual and the CARE individual.
PHONE	R	Informant's telephone number.
MAILING ADDRESS	R	Informant's mailing address. (Include street, city, state, and zip code.)
DID INFORMATION DECLINE TO ANSWER QUESTIONNAIRE ITEMS?	R	Y (Yes, declined to answer) or N (No, did not decline to answer).
IF YES, ENTER NOTES	O	Any comments about the informant not answering the question. Example: Declines because information is unknown, etc.
1. IS HELP NEEDED WITH	O	Y indicates each type of service with which the individual needs help.
EXPLAIN	O	If Y (Yes) is entered in the SKILLS TRAINING? field, more information must be provided.

Travis Questionnaire Entry (VC061506)

(Action Code W27)

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08-31-07          W27:TRAVIS QUESTIONNAIRE ENTRY: ADD          UC061506
CLIENT NAME:                SSN:
BIRTHDATE:                  CLIENT ID:

2. HAS A DIAGNOSIS BEEN GIVEN FOR MENTAL RETARDATION?  _
      Y(ES), (N)O, U(NKNOWN), D(ECLINED)
IF YES, WAS THE DIAGNOSIS BEFORE THE AGE OF 18?      -
OR HAS ANY OTHER DIAGNOSIS BEEN GIVEN?              -
IF YES, LIST DIAGNOSIS: _____
WHAT YEAR WAS THE DIAGNOSIS GIVEN?  ____ (YYYY)

3. IS THE CONSUMER ON AN INTEREST LIST FOR ANY OTHER SERVICES?
   (ENTER Y FOR ALL THAT APPLY)
- NONE                - CLASS
- CBA                  - MRA INTEREST LIST
- HCS                  - OTHER DADS INTEREST LIST
- MDCP                 - UNKNOWN
- DBMD                 - DECLINED TO ANSWER

* PRESS ENTER TO CONTINUE *

ACT:  ____ (V00/MENU, PF7/BACKWARD, PF1(HLP)/SCRND0C)

```

Field Name	Type	Contents
CLIENT NAME	D	Person's name.
SSN	D	Person's social security number.
BIRTHDATE	D	Person's date of birth.
CLIENT ID	D	Person's statewide identification number.
2. HAS A DIAGNOSIS BEEN GIVEN FOR MENTAL RETARDATION?	O	Y (Yes), N (No), U (Unknown), or D (Declined)
IF YES, WAS THE DIAGNOSIS BEFORE THE AGE OF 18?	O	Y (Yes) or N (No). Required if HAS A DIAGNOSIS BEEN GIVEN FOR MENTAL RETARDATION? is answered Y (Yes).
OR HAS ANY OTHER DIAGNOSIS BEEN GIVEN?	O	Y (Yes) or N (No) to indicate if other diagnosis has been given.
IF YES, LIST DIAGNOSIS	O	Indicates other diagnosis, if applicable.
WHAT YEAR WAS THE DIAGNOSIS GIVEN?	O	Year other diagnosis was given, if applicable. (YYYY format)
3. IS THE CONSUMER ON AN INTEREST LIST FOR ANY OTHER SERVICES? (ENTER ALL THAT APPLY)	O	Y beside a service indicates whether the consumer is on an interest list for that service. (The informant may not know or may choose to decline to answer this question. If Y (Yes) is entered for UNKNOWN or DECLINE TO ANSWER, no other responses to this question are accepted.)

