Home and Community-based Services (HCS)
and Texas Home Living (TxHmL) Programs

Mental Retardation Authority

User Guide

Department of Aging and Disability Services

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Home and Community-based Services (HCS) & Texas Home Living (TxHmL) Programs Mental Retardation Authority (MRA) User Guide

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Introduction

Overview

About the HCS and TxHmL Programs	The Texas Department Aging and Disability Services (DADS) currently operates two waiver programs for eligible individuals as an alternative to the Intermediate Care Facilities for Persons with Mental Retardation or Related Conditions (ICF/MR). The Home and Community-based Services (HCS) program and the Texas Home Living (TxHmL) program provide community-based services and supports for eligible individuals. The local Mental Retardation Authority (MRA) is responsible for completing all enrollment activities for these individuals prior to the provision of any waiver services. The MRA is also responsible for providing service coordination to all individuals receiving HCS or TxHmL services.
Consumer Directed Services Option	Consumer Directed Services is a service delivery option in which an individual or legally authorized representative (LAR) employs and retains service providers and directs the delivery of program services. An individual who chooses the CDS option is supported by a consumer directed services agency (CDSA) chosen by the individual to provide financial management services, and, at the individual's request, support consultation services if offered by the program in which the individual is enrolled.
Provider-managed Services Option	The traditional agency model (provider-managed) service delivery option is available to provide approved services that the individual/LAR elects not to self-direct. In the traditional agency option, the individual or his or her legally authorized representative (LAR) choose a certified and contracted HCS Program provider capable of delivering the full array of HCS Program service components. The program provider employs and retains service providers, and directs the delivery of program services.
Forms/Written Processes	Forms and written processes can be found in the HCS handbook at http://dadsview.dads.state.tx.us/handbooks/.

Data Entry Functions

The following table displays the CARE on-line data entry functions available to the MRA for the HCS, TxHmL, and CDS (Consumer Directed Services) programs.

Function	HCS	TxHmL	CDS Only
Enter an individual's enrollment Screens 410, W21, 321, 490, L01, C68, C63, L32, L02, L02, L09, L05	X	X	X
Enter an Individual Plan of Care (IPC) Renewal or Revision		X	X
Enter an Enrollment Packet Checklist	X	X	X
Enter Provider Choice	X	X	X
Review IPC and MR/RC Assessment	X		X
Assign a selected provider's local case number	X	X	X
Enter Mental Retardation/Related Condition (MR/RC) assessment information		X	X
Enter MRA/MHA contacts	X	X	X
Enter a permanency plan review	X	X	X
Update an individual's demographics		X	X
Update guardian information		X	X
Transfer an individual to a different contract	X	X	X
Review an individual's termination of services (permanent discharge)	X	X	X
Enter a client assignment		X	X
Initiate/complete an MRA reassignment notification	X	X	X
Assign a Service Coordinator	X	X	X

Inquiry Function

The automated system contains the following on-line inquiry functions.

Function	Description
Inquiry	Using the Authority Inquiry screens, the MRA can view: • consumer transfers • consumer demographic data • an individual's IPC • Medicaid eligibility • consumer discharges • MR/RC assessments - summary • provider information • contract information • provider/contract list • service delivery by IPC • service delivery by provider • enrollment checklist • prior approval • reimbursement authorization • provider/contract roster • MR/RC assessments • provider location list • client assignments • MRA contacts • provider location list • waiver slot counts • waiver slot detail • IPC expiration • MR/RC assessment expiration • consumer roster • WS/C provider review notations • pending MR/RC assessments • Permanency Plan Review approval status

In this Guide

The *Home and Community-based Services (HCS) & Texas Home Living (TxHmL) Programs Mental Retardation Authority User Guide* consists of the Introduction, Procedures, Inquiry, Accessing Reports, Screen Fields, and Glossary sections and includes:

- an overview of the system
- how to access and exit the system
- work procedures
- how to use the **Inquiry** function
- accessing reports
- screen fields/descriptions table
- a glossary
- county codes/county names listing
- a quick reference

Setup, Access, and Support

Introduction

The Texas Department of Aging and Disability Services (DADS) currently operates an automated enrollment and billing system for HCS and TxHmL. This system allows authorities to electronically submit enrollments for individuals, make inquiries, and enter an individual's information.

To have access to this system, the provider must have a PC system. It is the provider's responsibility to have a licensed copy of Windows 3.1 or higher loaded on each machine *and* their modem fully functioning *before* requesting access.

Becoming a VPN or Dial-up User

To become a Virtual Private Network (VPN) or dial-up user, the user must be a contracted provider of HCS services and *be serving an individual*. Although both VPN and dial-up are available, **VPN is the preferred method** and is much faster and more reliable than dial-up. Also, the fees for VPN service are lower than the fees for dial-up.

A provider should contact their DADS Access & Intake, Program Enrollment contact person *as soon as they receive their first individual*. The necessary forms required for being set up to use VPN or dial-up and accessing the automated system will then be sent to the provider. The completed forms, and any required fees ***must* be returned to the provider's DADS contact person for approval before access to any systems will be granted.**

If a provider has CARE access and needs an additional account, the provider must contact the Central Help Desk at 1-888-952-HELP (4357) and tell them what is needed.

DADS provides one free dial-up account per component code. A VPN account or additional dial-up accounts may be obtained for a fee. Contact DADS Community Services Contracts for information on the cost of an additional account. *Fee payments must be sent to DADS, not to ESM.*

Network

After receiving a VPN or Dial-up User ID and Password from Enterprise Security Management (ESM) staff, the provider will need to establish a connection to the HHSC network (HHSCN).

The *VPN Installation Guide* can be obtained at http://vpn.tx.net/. The instructions contained in this guide *must* be completed *prior to* installing the QWS3270 emulation software. The user must log in to VPN before downloading and/or using QWS3270

Information about VPN or dial-up can be obtained by calling the Help Desk. The dial-up set up *must* be completed *prior to* installing the QWS3270 emulation software. The user must log in to dial-up before downloading and/or using QWS3270.

QW3270 Software	After completing the instructions and establishing a connection with the HHSCN, the QWS3270 emulation software can be installed. The QWS3270 installation software is available via download from the ESM Intranet site http://hhscx.hhsc.state.tx.us/tech/security/default.shtml by selecting the **Private Provider Setup and Information** link.
Windows Vista	**The version of QWS3270 that is supported by HHSC is not compatible with Windows Vista. HHSC does not support the version of QWS3270 that is Vista compatible.** Users with Windows Vista must purchase and download a compatible version of QWS3270, which can be found at www.jollygiant.com.
Forms	Once a VPN or dial-up account has been established with HHSCN, forms requesting access to systems and applications may be obtained at the ESM Intranet site by clicking on the **Enterprise Systems and Applications Security Access Forms** link. To request additional access to DADS automated systems, use the Waiver Programs Provider Access Request Form IS090. (Use IS090C for HCS/TxHmL Waiver Programs – CDS Agency) A Security and Privacy Agreement (SPA), EASM-SM-002 form must be submitted by ***all*** users of any DADS system or application.
Support	For questions about installing the QWS3270 emulation software, User ID and Password information, or accessing the mainframe (after a VPN or dial-up connection to HHSCN has been established), you may call the Central Help Desk at 1-888-952-HELP (4357).
Technical Support	To successfully access the dial-up system, you must follow your hardware/ software installation directions precisely and install each item according to the manufacturer's directions. To effectively use the dial-up access system, it is important to have the technical expertise required to install and maintain your hardware and software. DADS will not install and/or maintain the provider's hardware or software. DADS does not take responsibility for installation of your equipment. As there are many combinations of hardware and software that you could be using, DADS cannot resolve every problem you may encounter. You will need to rely on your technical expert for information concerning your hardware, software, and communications setup.

Provider Menus

The system provides menus for authority data entry/update and inquiry functions.

Data Entry Menus

The **L00: Authority Data Entry Menu** displays action codes and data entry/update options. A sample menu is shown below.

```
03-03-10              L00:AUTHORITY DATA ENTRY MENU                VC060160

                ENTER APPROPRIATE NUMBER TO CHOOSE ACTION

L01 - CONSUMER ENROLLMENT              L23 - WAIVER MR/RC ASSESSMENT
L02 - INDIVIDUAL PLAN OF CARE          L26 - CLIENT ASSIGNMENTS
L03 - ENROLLMENT PACKET CHECKLIST      L27 - ASSIGN/IPC RES EXCEPTIONS (HCS)
L05 - PROVIDER CHOICE                  L28 - MRA/MHA CONTACTS
L06 - CONSUMER TRANSFER                L29 - ICF/MR MR/RC ASSESSMENT
L09 - REGISTER CLIENT UPDATE           L30 - MRA ASSIGNMENT NOTIFICATION
L10 - CLIENT CORRESPONDENT UPDATE      L31 - HCS IPC MRA REVIEW (HCS)
L11 - CLIENT NAME UPDATE               L32 - MR/RC ASSESS MRA REVIEW (HCS)
L12 - CLIENT ADDRESS UPDATE            309 - PERMANENCY PLAN REVIEW
L18 - CONSUMER DISCHARGE               490 - CASE MGMT ASSIGNMENT
L20 - GUARDIAN INFORMATION UPDATE

          ACT: ___ (A/MA MAIN MENU, Q/QUIT, HLP(PF1)/SCRN DOC)
```

Inquiry Menu

The **L60: Authority Inquiry Menu** displays action codes and inquiry options. A sample menu is shown below.

```
03-03-10              L60:AUTHORITY INQUIRY MENU                   VC060170

                ENTER APPROPRIATE NUMBER TO CHOOSE ACTION

A63 - CONSUMER TRANSFER                C80 - PROVIDER/CONTRACT ROSTER
C61 - CONSUMER DEMOGRAPHICS            C83 - MR/RC ASSESSMENTS
C62 - INDIVIDUAL PLAN OF CARE (IPC)    C84 - PROVIDER LOCATION
C63 - DHS MEDICAID ELIGIBILITY SEARCH  C85 - CLIENT ASSIGNMENTS
C66 - CONSUMER DISCHARGES              C86 - PROVIDER LOCATION LIST
C68 - MR/RC ASSESSMENTS - SUMMARY      C87 - MRA CONTACTS
C69 - PROVIDER INFORMATION             L61 - WAIVER SLOT COUNTS
C70 - CONTRACT INFORMATION             L62 - WAIVER SLOT DETAIL
C71 - PROVIDER/CONTRACT LIST           L64 - IPC EXPIRATION
C72 - SERVICE DELIVERY BY IPC          L65 - MR/RC ASSESSMENT EXPIRATION
C73 - SERVICE DELIVERY BY PROVIDER     L67 - CONSUMER ROSTER
C74 - CHECKLIST                        L68 - WS/C PROVIDER REVIEW NOTATIONS
C75 - PRIOR APPROVAL                   L82 - PENDING MR/RC ASSESSMENTS
C77 - REIMBURSEMENT AUTHORIZATION      L83 - IPC MRA REVIEW PENDING (HCS)
                                       249 - PPR APPROVAL STATUS

          ACT: ___ (A/MA MAIN MENU, Q/QUIT, HLP(PF1)/SCRN DOC)
```

To access an option, type its action code in the Action field (ACT:) at the bottom of the screen. For example, if you need to access the Consumer Discharge function, type action code **L18** in the Action field (ACT: **L18**) of any screen and press **Enter**.

Header Screens

When you access a data entry or data update option, the first screen displayed requests client-identifying information. This screen is referred to as the ***header*** screen. Header screens may also include the Add/Change/Delete or Add/Correct/Delete direction in the title of the screen.

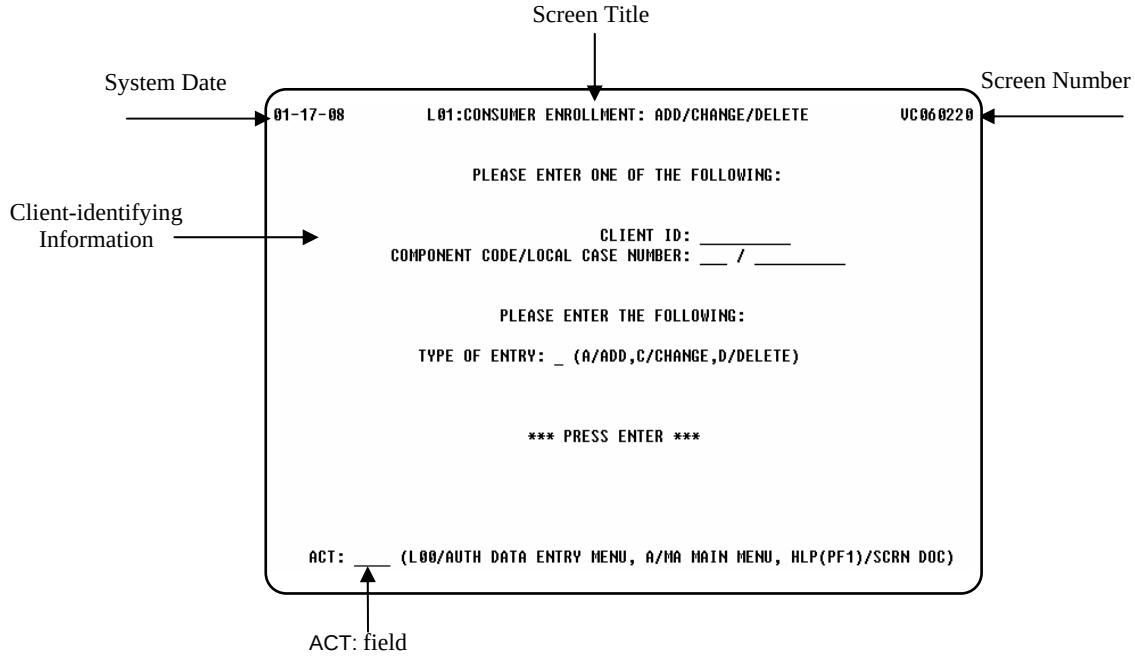
Add/Change/Delete

When using the data entry screens, you will add, change, and delete records.

Use	to…
Add	add a new record.
Change *or* **Correct**	change or correct incorrect information on a record.
Delete	delete a record entered in error.

Screen Structure

A sample header screen for the **L01: Consumer Enrollment** option with its identified structure is shown below.



The above sample shows:

- System Date: **01/17/08**, the current date
- Screen Title: **L01: Consumer Enrollment: Add/Change/Delete**
- Screen Number: **VC060220** - used to identify where you are in the system if you have problems.
- Client-identifying Information fields
- ACT: field - for Action Code entry

Web Addresses

Introduction

Access to Internet and Intranet web sites is available for information, reference, and downloading purposes. These web addresses are sited throughout the *Mental Retardation Authority User Guide.*

Web Addresses

The following web sites (and their corresponding web addresses) are available to providers:

- to access the Private Provider Set-up Information and the Access Request Forms links:
  Enterprise Security Management web site
  http://hhscx.hhsc.state.tx.us/tech/security/default.shtml

- to access the User Guides (MRA, HCS, TxHmL, CDSA):
  HHSC IT Documentation for Legacy MHMR Applications web site
  http://www2.mhmr.state.tx.us/655/cis/training/waiver.html

- to access HCS forms:
  HCS Waiver forms web site
  http://www.dads.state.tx.us/providers/mra/handbooks.html

- to access TxHmL forms:
  TxHmL Waiver forms web site
  http://www.dads.state.tx.us/providers/mra/handbooks.html

- to access the HCS and TxHmL Bill Code Crosswalk for billing information:
  Bill Code Crosswalks website
  http://www.dads.state.tx.us/providers/hipaa/billcodes/index.html#hcs

- to access HIPPA Compliance information:
  http://www.dads.state.tx.us/providers/hipaa/index.html

Procedures

Introduction

The *Procedures* section of the MRA User Guide describes the general steps used for each process.

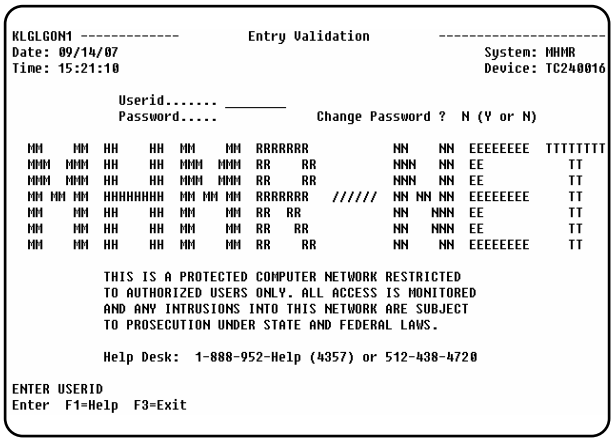
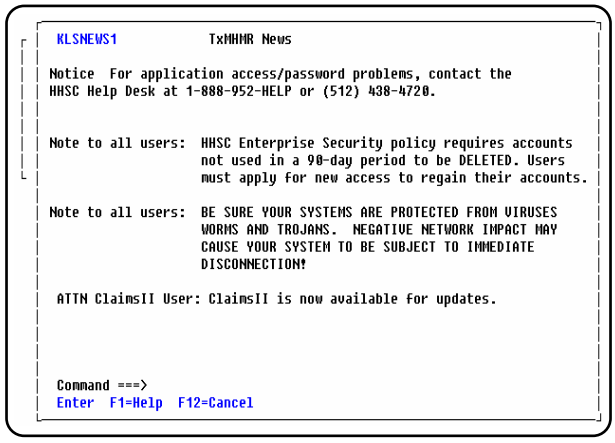
Sample screens in this documentation display fictitious individual information to show the screens used in the procedures you perform.

In this Section

This section contains information on the following processes:

Logon Procedure

The following table describes the steps used to logon to CARE and access the automated system (HCS or TxHmL). The procedure begins at the SuperSession **MHMR-NET** screen.

Step	View	Action
1	A sample SuperSession **MHMR-NET** screen is shown below. 	• Type your User ID in the USERID field. • Tab to the PASSWORD field and type your password. • Press **Enter**. Result: A broadcast message screen is displayed.
2	A sample broadcast message screen is shown below. 	A broadcast message screen is provided to display network information. • Read the screen for messages concerning system availability. • Press **Enter**. Result: The system displays the **CL/SUPERSESSION Main Menu** screen.

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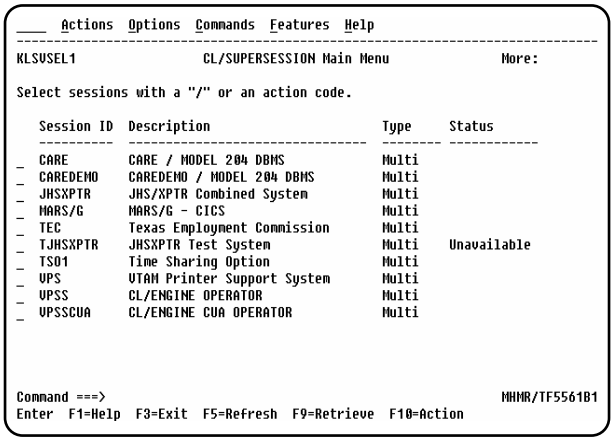
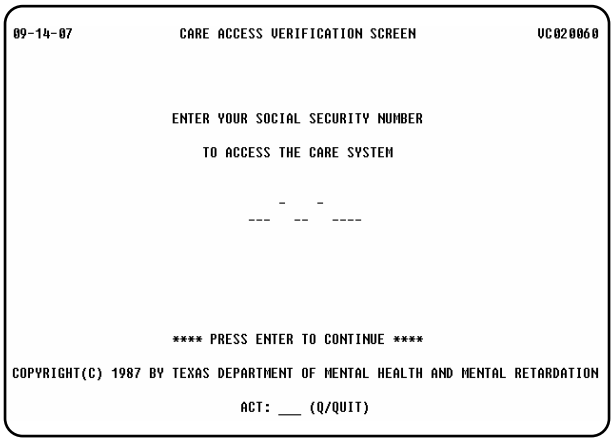
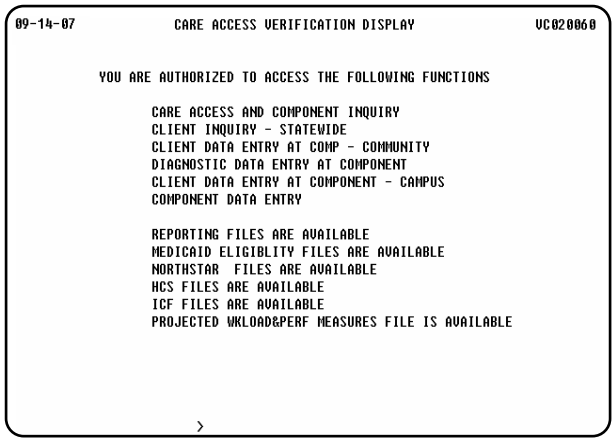
Logon Procedure, continued

Step	View	Action
3	A sample **CL/SUPERSESSION Main Menu** screen is shown below.  ___ Actions Options Commands Features Help KLSVSEL1 CL/SUPERSESSION Main Menu More: Select sessions with a "/" or an action code. Session ID Description Type Status _ CARE CARE / MODEL 204 DBMS Multi _ CAREDEMO CAREDEMO / MODEL 204 DBMS Multi _ JHSXPTR JHS/XPTR Combined System Multi _ MARS/G MARS/G - CICS Multi _ TEC Texas Employment Commission Multi _ TJHSXPTR JHSXPTR Test System Multi Unavailable _ TSO1 Time Sharing Option Multi _ VPS VTAM Printer Support System Multi _ VPSS CL/ENGINE OPERATOR Multi _ VPSSCUA CL/ENGINE CUA OPERATOR Multi Command ===> MHMR/TF5561B1 Enter F1=Help F3=Exit F5=Refresh F9=Retrieve F10=Action	The **CL/SUPERSESSION Main Menu** provides a listing of your menu applications and will vary according to the applications to which you have access. • Review the **CL/SUPERSESSION Main Menu**. • Type **S** (Select) in the field next to **CARE**. Result: The **CARE Access Verification Screen** is displayed.
4	A sample **CARE Access Verification Screen** is shown below.  09-14-07 CARE ACCESS VERIFICATION SCREEN VC020060 ENTER YOUR SOCIAL SECURITY NUMBER TO ACCESS THE CARE SYSTEM - - --- -- ---- **** PRESS ENTER TO CONTINUE **** COPYRIGHT(C) 1987 BY TEXAS DEPARTMENT OF MENTAL HEALTH AND MENTAL RETARDATION ACT: ___ (Q/QUIT)	The **CARE Access Verification Screen** allows you to enter your social security number, which is linked to your User ID number. • Type your social security number. • Press **Enter**. Result: The **CARE Access Verification Display** screen is displayed.
5	A sample **CARE Access Verification Display** screen is shown below.  09-14-07 CARE ACCESS VERIFICATION DISPLAY VC020060 YOU ARE AUTHORIZED TO ACCESS THE FOLLOWING FUNCTIONS CARE ACCESS AND COMPONENT INQUIRY CLIENT INQUIRY - STATEWIDE CLIENT DATA ENTRY AT COMP - COMMUNITY DIAGNOSTIC DATA ENTRY AT COMPONENT CLIENT DATA ENTRY AT COMPONENT - CAMPUS COMPONENT DATA ENTRY REPORTING FILES ARE AVAILABLE MEDICAID ELIGIBLITY FILES ARE AVAILABLE NORTHSTAR FILES ARE AVAILABLE HCS FILES ARE AVAILABLE ICF FILES ARE AVAILABLE PROJECTED WKLOAD&PERF MEASURES FILE IS AVAILABLE ›	The **CARE Access Verification Display** screen lists the functions you are authorized to access. • Press **Enter**. Result: A message screen is displayed.

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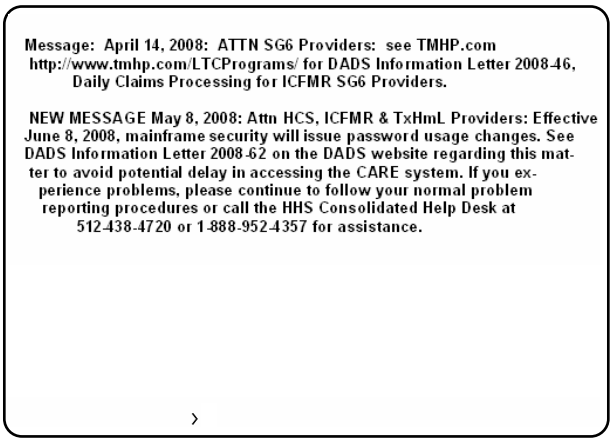
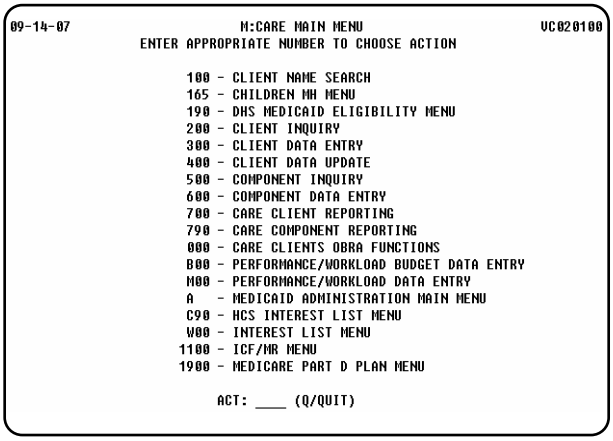
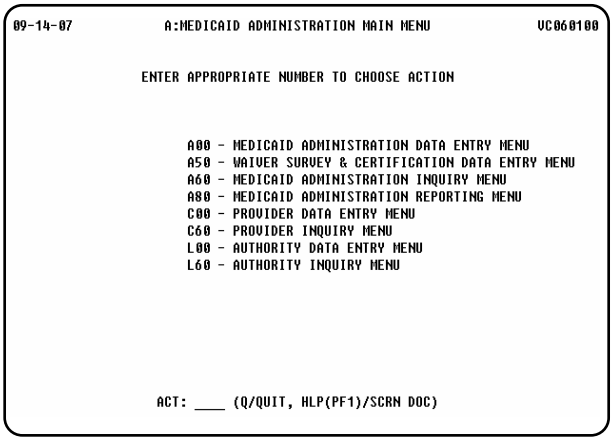
Logon Procedure, continued

Step	View	Action
6	A sample message screen is shown below.  Message: April 14, 2008: ATTN SG6 Providers: see TMHP.com http://www.tmhp.com/LTCPrograms/ for DADS Information Letter 2008-46, Daily Claims Processing for ICFMR SG6 Providers. NEW MESSAGE May 8, 2008: Attn HCS, ICFMR & TxHmL Providers: Effective June 8, 2008, mainframe security will issue password usage changes. See DADS Information Letter 2008-62 on the DADS website regarding this matter to avoid potential delay in accessing the CARE system. If you experience problems, please continue to follow your normal problem reporting procedures or call the HHS Consolidated Help Desk at 512-438-4720 or 1-888-952-4357 for assistance. ›	• Read the screen for messages concerning system or application issues. • Press **Enter** to proceed. Result: The **M: CARE Main Menu** is displayed.
7	A sample **M: CARE Main Menu** is shown below.  09-14-07 M:CARE MAIN MENU VC020100 ENTER APPROPRIATE NUMBER TO CHOOSE ACTION 100 - CLIENT NAME SEARCH 165 - CHILDREN MH MENU 190 - DHS MEDICAID ELIGIBILITY MENU 200 - CLIENT INQUIRY 300 - CLIENT DATA ENTRY 400 - CLIENT DATA UPDATE 500 - COMPONENT INQUIRY 600 - COMPONENT DATA ENTRY 700 - CARE CLIENT REPORTING 790 - CARE COMPONENT REPORTING 800 - CARE CLIENTS OBRA FUNCTIONS B00 - PERFORMANCE/WORKLOAD BUDGET DATA ENTRY M00 - PERFORMANCE/WORKLOAD DATA ENTRY A - MEDICAID ADMINISTRATION MAIN MENU C90 - HCS INTEREST LIST MENU W00 - INTEREST LIST MENU 1100 - ICF/MR MENU 1900 - MEDICARE PART D PLAN MENU ACT: ___ (Q/QUIT)	The **M: CARE Main Menu** displays the action codes and descriptions of the CARE functions. To access the **A: Medicaid Administration Main Menu**: • Type **A** in the ACT: field. • Press **Enter**. Result: The **A: Medicaid Administration Main Menu** is displayed. Note: To select a function listed on this menu: • Type the action code in the ACT: field. • Press **Enter**. Result: The screen containing the menu for the selected function is displayed.
8	A sample **A: Medicaid Administration Main Menu** is shown below.  09-14-07 A:MEDICAID ADMINISTRATION MAIN MENU VC060100 ENTER APPROPRIATE NUMBER TO CHOOSE ACTION A00 - MEDICAID ADMINISTRATION DATA ENTRY MENU A50 - WAIVER SURVEY & CERTIFICATION DATA ENTRY MENU A60 - MEDICAID ADMINISTRATION INQUIRY MENU A80 - MEDICAID ADMINISTRATION REPORTING MENU C00 - PROVIDER DATA ENTRY MENU C60 - PROVIDER INQUIRY MENU L00 - AUTHORITY DATA ENTRY MENU L60 - AUTHORITY INQUIRY MENU ACT: ___ (Q/QUIT, HLP(PF1)/SCRN DOC)	To access the HCS provider data entry menu: • Type **C00** in the ACT: field. • Press **Enter**. Result: The **C00: Provider Data Entry Menu** is displayed. ***or*** To access the HCS provider inquiry menu: • Type **C60** in the ACT: field. • Press **Enter**. Result: The **C60: Provider Inquiry Menu** is displayed.

Exiting the Automated System

Exit Procedure

You can exit the system from any screen. To exit the system:

- Type **Q** in the ACT: field.
- Press **Enter**.
- Type **logoff** at the prompt.
- Press **Enter**.

Result: The **CL/SUPERSESSION Main Menu** is displayed.

- Press **F3** to display the **Exit Menu**.
- Press **F3** to exit the system.

You must also disconnect your HHSCN connection to terminate your dial-up connection.

Changing Your Password

Change Password

You *must* change your *temporary* password. It is recommended that you change it to one that is meaningful to you.

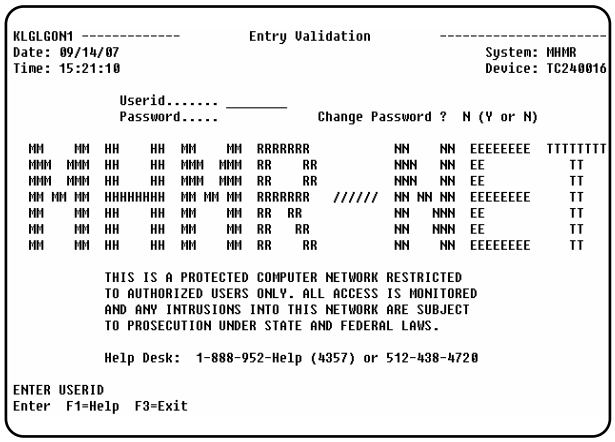
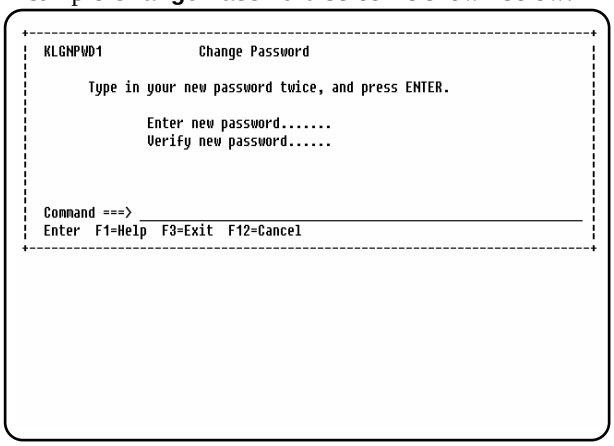
You can change your password as often as you like, but your password *must* be changed *every 90 days* (a prompt will occur).

Your password *must* contain:

- six to eight characters (letters or numbers),
- *no* spaces,
- *no* special characters (#, $, ;),
- *nothing* associated with your user number,
- *no* double characters, and
- passwords *cannot* be reused.

Change Password Procedure

The following table describes how to change your password for use in the system. The procedure begins at the SuperSession **MHMR-NET** screen.

Step	View	Action
1	A sample SuperSession **MHMR-NET** screen is shown below. 	To change your password: • Type your User ID in the USERID field. • Tab to the PASSWORD field and type your password. • Tab to the CHANGE PASSWORD? field. • Type **Y** (Yes). • Press **Enter**. Result: The **Change Password** screen is displayed.
2	A sample **Change Password** screen is shown below. 	• Type your new password in the ENTER NEW PASSWORD field. • Type your password again in the VERIFY NEW PASSWORD field. • Press **Enter**. Result: A message stating that your password has changed is displayed.

Enrollment in a Waiver Program

Introduction

The *Enrollment in a Waiver Program* process allows a Mental Retardation Authority (MRA) to enroll individuals in the Home and Community-based Services (HCS) and Texas Home Living (TxHmL) programs.

Individuals who are to be enrolled in a waiver program must be registered in CARE, the Client Assignment and Registration system.

Enrolling in a Waiver Program

The following table provides a listing of the data entry screens and procedures required for the waiver program enrollment process.

Required screens must be entered in this order, except **490**. However, data must be entered on this screen prior to the individual being enrolled in the waiver program.

Screen	Procedure
410 (Add Case to ID/Demographic Update)	Assign MRA local case number, *if necessary*.
W21 (Interest List - Services)	Change TxHmL status to declined (status code **2**) for TxHmL if individual declines the TxHmL waiver.
490 (Service Coordination Assignment)	Assign Service Coordinator.
L01 (Consumer Enrollment)	Enter individual enrollment.
C63 (DHS Medicaid Eligibility Search)	Check for Medicaid eligibility and ensure accuracy of all data.
C68 (MR/RC Assessments - Summary)	Check for existing Level of Care.
L23 (Waiver MR/RC Assessment)	Enter MR/RC Assessment, *if necessary*.
L02 (Individual Plan of Care)	Enter Initial Individual Plan of Care (IPC).
L03 (Enrollment Packet Checklist)	Enter Enrollment Packet Checklist.
L09 (Register Client Update)	Enter selected provider's local case number, *if necessary*.
L09 (Register Client Update)	Enter selected CDSA's local case number, *if necessary*.
L05 (Provider Choice)	Enter provider choice – provider agency and/or CDSA.

Enrollment in a Waiver Program
Add Case to ID/Demographic Update (410)

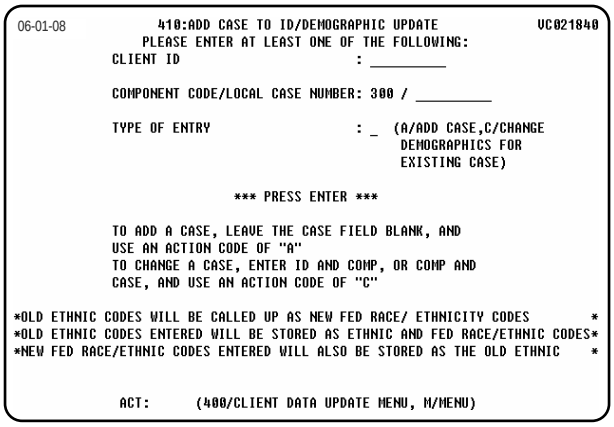
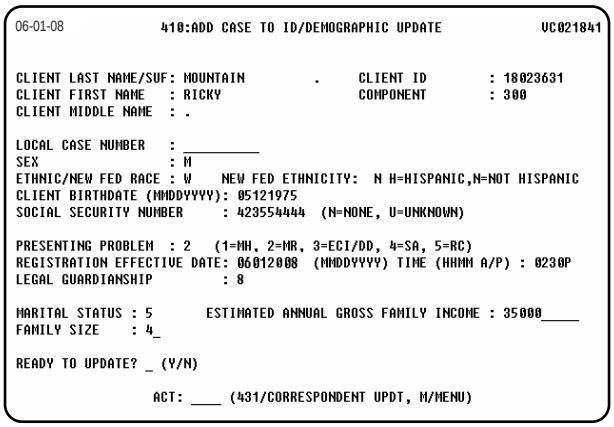
Introduction

The MRA must have assigned a local case number to any individual who is being enrolled in a waiver program. All individuals on an MRA's interest list will already have a local case number assigned for their component.

If an individual is being enrolled who is *not* on the MRA's interest list or is *not* already assigned to the MRA component code, a local case number must be assigned using the *Add Case to ID/Demographic Update* (screen 410) process.

Procedure

The following table describes the steps the MRA will use to add a local case number for the MRA component, if necessary.

Step	View	Action
1	_ _	• Type **410** in the ACT: field of any screen. • Press **Enter**. Result: The **410: Add Case to ID/Demographic Update** header screen is displayed.
2	A sample **410: Add Case to ID/Demographic Update** header screen is shown below. 	• Type the Client ID in the CLIENT ID field. • Type the MRA component code in the COMPONENT CODE field. • Type **A** (Add Case) in the TYPE OF ENTRY field. • Press **Enter**. Result: The **410: Add Case to ID/Demographic Update** screen is displayed.
3	A sample **410: Add Case to ID/Demographic Update** screen is shown below. 	To add a local case number for the MRA component: • Type the local case number for the MRA in the LOCAL CASE NUMBER field. • Type **Y** in the READY TO UPDATE? field to submit the data to the system. • Press **Enter**. Result: The **410: Add Case to ID/Demographic Update** header screen is displayed with the message, *"Case has been Added."*

Continue with the *Interest List - Services* procedure.

Enrollment in a Waiver Program
Interest List - Services (W21)

Introduction

The Interest List is maintained to document the status of individuals who have requested various services. Waiver service is just one of many of these services. If the individual has accepted the waiver slot they were offered, no action is taken on the W21 screen.

For HCS enrollment, the MRA no longer changes the status to **2** (Pending). This is done by the MRA section at DADS and requires no action by the MRA. You will ***only*** use **W21: Interest List - Services** to change the STATUS field to **6** (Can't Contact), or to **8** (Refused Offer) if the individual has signed the *Verification of Freedom of Choice* form.

The MRA will use **W21: Interest List - Services** to change the TXHML STATUS field to **2** (Declined) *only if the individual declines enrollment in TxHmL.* No other action on Interest List is required for TxHmL individuals.

Note: If a person chooses a provider in another MRA service area, the person should be transferred to that MRA.

CARE automatically updates the Interest List if the individual is enrolled, discharged, or denied.

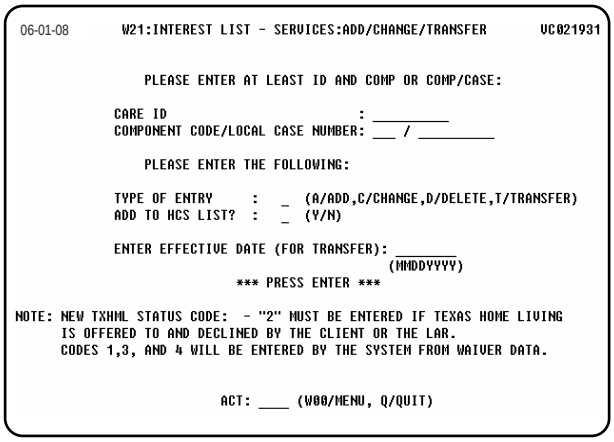
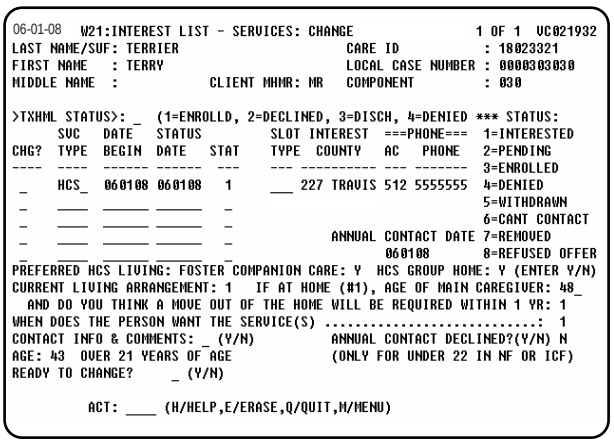
Procedure

The following table describes the steps the MRA will use to change the interest list status to "declined" for TxHmL enrollment.

Step	View	Action
1	_ _	Access **W26: Interest List - Services Inquiry by Person** to determine whether the person is currently on the Interest List.
2	_ _	• Type **W21** in the ACT: field of any screen. • Press **Enter**. Result: The **W21: Interest List - Services: Add/ Change/Transfer** header screen is displayed.

continued on next page

Procedure, continued

Step	View	Action
3	A sample **W21: Interest List - Services: Add/Change/ Transfer** header screen is shown below.  06-01-08 W21:INTEREST LIST - SERVICES:ADD/CHANGE/TRANSFER VC021931 PLEASE ENTER AT LEAST ID AND COMP OR COMP/CASE: CARE ID : _____ COMPONENT CODE/LOCAL CASE NUMBER: ___ / _____ PLEASE ENTER THE FOLLOWING: TYPE OF ENTRY : _ (A/ADD,C/CHANGE,D/DELETE,T/TRANSFER) ADD TO HCS LIST? : _ (Y/N) ENTER EFFECTIVE DATE (FOR TRANSFER): _____ (MMDDYYYY) *** PRESS ENTER *** NOTE: NEW TXHML STATUS CODE: - "2" MUST BE ENTERED IF TEXAS HOME LIVING IS OFFERED TO AND DECLINED BY THE CLIENT OR THE LAR. CODES 1,3, AND 4 WILL BE ENTERED BY THE SYSTEM FROM WAIVER DATA. ACT: ___ (W00/MENU, Q/QUIT)	• Type the requested identifying information in the appropriate fields. Rule: You must enter the Client ID *or* the local case number. • Type the MRA component code in the COMPONENT CODE field. • Type **C** (Change) in the TYPE OF ENTRY field. • Type **Y** (Yes) or **N** (No) in the ADD TO HCS LIST field to indicate whether the individual is to be added to the HCS Interest List. • Press **Enter**. Result: The **W21: Interest List - Services: Change** screen is displayed.
4	A sample **W21: Interest List -Services: Change** screen is shown below.  06-01-08 W21:INTEREST LIST - SERVICES: CHANGE 1 OF 1 VC021932 LAST NAME/SUF: TERRIER CARE ID : 18023321 FIRST NAME : TERRY LOCAL CASE NUMBER : 0000303030 MIDDLE NAME : CLIENT MHMR: MR COMPONENT : 030 >TXHML STATUS>: _ (1=ENROLLD, 2=DECLINED, 3=DISCH, 4=DENIED *** STATUS: SVC DATE STATUS SLOT INTEREST ===PHONE=== 1=INTERESTED CHG? TYPE BEGIN DATE STAT TYPE COUNTY AC PHONE 2=PENDING 3=ENROLLED _ HCS_ 060108 060108 1 ___ 227 TRAVIS 512 5555555 4=DENIED 5=WITHDRAWN 6=CANT CONTACT ANNUAL CONTACT DATE 7=REMOVED 060108 8=REFUSED OFFER PREFERRED HCS LIVING: FOSTER COMPANION CARE: Y HCS GROUP HOME: Y (ENTER Y/N) CURRENT LIVING ARRANGEMENT: 1 IF AT HOME (#1), AGE OF MAIN CAREGIVER: 48_ AND DO YOU THINK A MOVE OUT OF THE HOME WILL BE REQUIRED WITHIN 1 YR: 1 WHEN DOES THE PERSON WANT THE SERVICE(S) .....: 1 CONTACT INFO & COMMENTS: _ (Y/N) ANNUAL CONTACT DECLINED?(Y/N) N AGE: 43 OVER 21 YEARS OF AGE (ONLY FOR UNDER 22 IN NF OR ICF) READY TO CHANGE? _ (Y/N) ACT: ___ (H/HELP,E/ERASE,Q/QUIT,M/MENU)	To change the person's status to declined: • Type **2** (Declined) in the TXHML STATUS field. • Type **Y** in the READY TO CHANGE? field to submit the data to the system. • Press **Enter**. Result: The **W21: Interest List - Services** header screen is displayed with the message, *"Previous Information Changed."*

Continue with the *Community-based Assignment* and *Service Coordination Assignment* procedures.

Enrollment in a Waiver Program
Service Coordination Assignment (490)

Introduction

The *Service Coordination Assignment* process allows the MRA to assign a Service Coordinator for an individual. There *must* be an MRA Service Coordinator assigned for each individual served in the HCS or TxHmL program.

Note: Case Management Units (Action Code **660**) and Case Management Positions (Action Code **670**) for the MRA must have been identified in the CARE system before Service Coordinator assignments can be made.

Procedure

The following table describes the steps the MRA will use to assign a Service Coordinator.

Step	View	Action
1	_ _	• Type **490** in the ACT: field of any screen. • Press **Enter**. Result: The **490: Svc Coordination Assignment: Add/Change/Delete** header screen is displayed.
2	A sample **490: Svc Coordination Assignment: Add/Change/Delete** header screen is shown below. 06-01-08 490:SVC COORDINATION ASSIGNMENT: ADD/CHANGE/DELETE VC021810 PLEASE ENTER ONE OF THE FOLLOWING: CLIENT ID : _____ COMPONENT CODE/LOCAL CASE NUMBER: __ / _____ PLEASE ENTER THE FOLLOWING: TYPE OF ENTRY : _ (A/ADD,C/CHANGE,D/DELETE) *** PRESS ENTER *** ACT: ___ (400/DATA ENTRY MENU, M/MENU)	• Type the requested identifying information in the appropriate fields. Rule: You must enter the Client ID *or* the local case number. • Type the MRA component code in the COMPONENT CODE field. • Type **A** (Add) in the TYPE OF ENTRY field. • Press **Enter**. Result: The **490: Svc Coordination Assignment: Add** screen is displayed.
3	A sample **490: Svc Coordination Assignment: Add** screen is shown below. 06-01-08 490:SVC COORDINATION ASSIGNMENT: ADD VC021811 LAST NAME/SUF: MOUNTAIN CLIENT ID : 18023631 FIRST NAME : RICKY LOCAL CASE NUMBER : 0003006565 MIDDLE NAME : COMPONENT CODE : 300 ASSIGNMENT BEGIN DATE: _____ (MMDDYY) ASSIGNMENT END DATE : _____ (MMDDYY) CASE MANAGER POSITION: ___ CASE MANAGEMENT UNIT : ___ READY TO ADD? : _ (Y/N) ACT: ___ (400/CLIENT ENTRY SCREEN,M/MENU)	• Type the date the assignment begins in the ASSIGNMENT BEGIN DATE field. • Type the code for the Service Coordinator position in the CASE MANAGER POSITION field. • Type the Case Management unit code in the CASE MANAGEMENT UNIT field. • Type **Y** in the READY TO ADD? field. • Press **Enter**. Result: The **490: Svc Coordination Assignment** header screen is displayed with the message, *"Previous Information Added."*

Continue with the *Consumer Enrollment* procedure.

Enrollment in a Waiver Program
Consumer Enrollment (L01)

Introduction

The *Consumer Enrollment* process allows the MRA to enroll an applicant into a waiver program, designate from where the applicant is being admitted and the slot type the applicant will receive, and indicate the county of service.

Procedure

The following table describes the steps the MRA will use to establish a waiver program enrollment for an individual.

Step	View	Action
1	_ _	• Type **L01** in the ACT: field of any screen. • Press **Enter**. Result: The **L01: Consumer Enrollment: Add/ Change/Delete header screen** is displayed.
2	A sample **L01: Consumer Enrollment: Add/Change/ Delete** header screen is shown below. 06-01-08 L01:CONSUMER ENROLLMENT: ADD/CHANGE/DELETE VC060220 PLEASE ENTER ONE OF THE FOLLOWING: CLIENT ID: _____ COMPONENT CODE/LOCAL CASE NUMBER: __ / _____ PLEASE ENTER THE FOLLOWING: TYPE OF ENTRY: _ (A/ADD,C/CHANGE,D/DELETE) *** PRESS ENTER *** ACT: ___ (L00/AUTH DATA ENTRY MENU, A/MA MAIN MENU, HLP(PF1)/SCRN DOC)	• Type the requested identifying information in the appropriate fields. Rule: You must enter the Client ID *or* the local case number. • Type the MRA component code in the COMPONENT CODE field. • Type **A** (Add) in the TYPE OF ENTRY field. • Press **Enter**. Result: The **L01: Consumer Enrollment: Add** screen is displayed.
3	A sample **L01: Consumer Enrollment: Add** screen is shown below. 06-01-08 L01:CONSUMER ENROLLMENT: ADD VC060225 NAME : MOUNTAIN, RICKY CLIENT ID : 18023631 MEDICAID NUMBER: 654565456 LOCAL CASE NUMBER: 0003006565 COMPONENT : 300 ENROLLMENT REQUEST DATE: 06012008 (MMDDYYYY) WAIVER TYPE: _ (1-HCS,4-TXHML) PRIOR DISCHARGE FROM A MEDICAID CERTIFIED NF OR ICF-MR?: _ (Y/N) ADMIT FROM: _ (1=COMM,2=ICF-MR,3=STATE SCH,4=REFINANCE,5=STATE HOSP) ENTER ONE OF THE FOLLOWING: SLOT TYPE : __ (4-ADA WILSON, 7-MDU, 9-ICF-MR, 12-PI, 13-PI4, 18-TXHML/WL, 20-ICFMR#2, 25-PI#3, 29-HOPE, 30-IL REDUCTION, 31-PI-08, 32-PI5, 33-SMICF2, 34-CPS-08, 35-NF-08) SLOT TRACKING NUMBER: _____ MFP DEMO? _ (Y/N) COUNTY OF SERVICE: __ GUARDIAN: LAST NAME : *SELF*_____ SUFFIX : ___ FIRST NAME: _____ MIDDLE INITIAL: _ C/O : _____ PHONE: (__) __ - ___ STREET : _____ CITY : _____ STATE: __ ZIP CODE: ____ ___ READY TO ADD? : _ (Y/N) **MSG: 7547 *WARNING:PLEASE USE 'C12' TO VERIFY PERSON'S ADDRESS. ACT: ___ (L00/AUTH DATA ENTRY MENU, A/MA MAIN MENU, HLP(PF1)/SCRN DOC)	• Type the code for the waiver type in which the applicant is to be enrolled in the WAIVER TYPE field. • Type **Y** (Yes) or **N** (No) in the PRIOR DISCHARGE FROM A MEDICAID CERTIFIED NF OR ICF-MR? field. • Type the code for where the person was living prior to entering the waiver program in the ADMIT FROM field. • Type *either* the Slot Type (for new allocation slots) in the SLOT TYPE field *or* the Slot Tracking Number (for recycled slots) in the SLOT TRACKING NUMBER field. • Type **Y** (Yes) or **N** (No) to indicate whether the person qualifies for the Money Follows the Person Demonstration Project in the MFP DEMO? field. • Type the county code of the county in which the individual will receive services in the COUNTY OF SERVICE field. • Type **Y** in the READY TO ADD? field. • Press **Enter**. Result: The **L01: Consumer Enrollment** header screen is displayed with the message, *"Previous Information Added."*

Continue with the *MR/RC Assessments - Summary* procedure.

Enrollment in a Waiver Program
DHS Medicaid Eligibility Search (C63)

Introduction

One of the eligibility requirements for participating in the HCS and/or TxHmL programs is for the individual or applicant to be financially eligible for Medicaid.

The *DHS Medicaid Eligibility Search* process allows the MRA to confirm Medicaid eligibility and ensure the accuracy of all data.

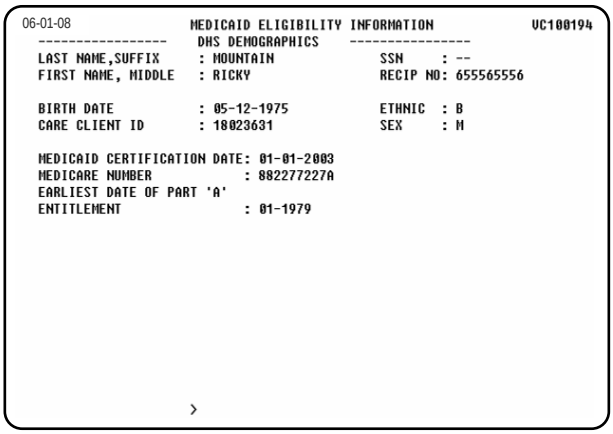
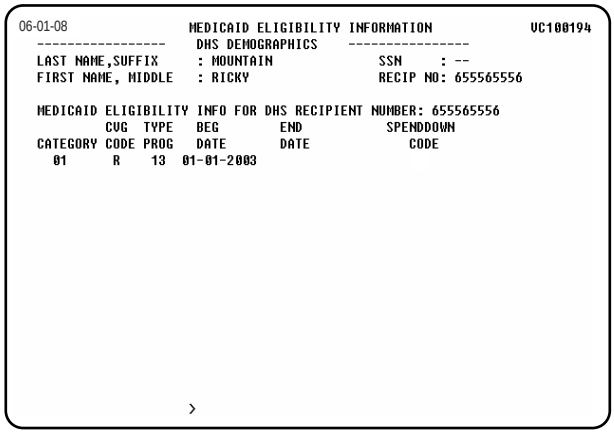
Procedure

The following table describes the steps the MRA will use to confirm Medicaid eligibility.

Step	View	Action
1	_ _	• Type **C63** in the ACT: field of any screen. • Press **Enter**. Result: The **C63: DHS Medicaid Eligibility Search** header screen is displayed.
2	A sample **C63: DHS Medicaid Eligibility Search** header screen is shown below. 06-01-08 C63:DHS MEDICAID ELIGIBILITY SEARCH VC060250 FILL IN ONE OF THE FOLLOWING SECTIONS ENTER CARE IDENTIFIER, AND THE PROGRAM WILL SCAN THE MEDICAID ELIGIBLILITY FILE FOR MATCHES TO THE DEMOGRAPHIC FIELDS ENTERED IN CARE CLIENT ID: _____ COMP/LCL CASE NUMBER : __ / _____ ---- OR ----- ENTER MEDICAID NUMBER AND THE MEDICAID FILE WILL BE SEARCHED DIRECTLY MEDICAID RECIP NO : _____ ---- OR ----- ENTER AT LEAST TWO OF NAME, SSN, AND BIRTH DATE MEDICAID ELIGIBILE CLIENTS THAT MATCH TO AT LEAST TWO OF THOSE FIELDS WILL BE DISPLAYED CLIENT NAME-LAST: _____ FIRST: _____ MIDDLE: _____ SSN : _____ BIRTH DATE(MMDDYYYY) : _____ ACT: ___ (C60/PROV INQUIRY MENU, A/MA MAIN MENU, HLP(PF1)/SCRN DOC)	• Type the Client ID in the CLIENT ID field to scan the Medicaid eligibility file for matches to the demographic fields entered in CARE, ***or*** • Type the Medicaid Number in the MEDICAID RECIP NO field to search the Medicaid file directly, ***or*** • Type *at least two* of Name, SSN, and Birthdate. • Press **Enter**. Result: The **C63: Medicaid Recipient Information** screen is displayed. Note: If the individual does not have Medicaid, the message, *"No matches were found to the Medicaid Eligibility file"* is displayed.
3	A sample **C63: Medicaid Recipient Information** screen is shown below. 06-01-08 C63:MEDICAID RECIPIENT INFORMATION VC100193 INFORMATION ON THIS SCREEN IS FROM THE MEDICAID FILE LINE CARE ID LASTNM FIRSTNM/M SEX ETH BIRTHDATE SSN 1 18023631 MOUNTAIN RICKY M B 05-12-1975 MEDICAID: 655565556 MEDICARE: 882277227A CURRENT SCREEN 1 TOTAL SCREENS: 1 NAMES RETURNED: 1 FOR FURTHER INFORMATION, ENTER A LINE NUMBER: _ (OR MOVE CURSOR TO LINE) DECODE ELIGIBILITY FIELDS (Y/N) : N ******** MSG: PRESS <ENTER> TO RETURN TO REQUEST SCREEN******* ACT: ___ (C63/REQUEST SCREEN,M/MENU)	• View the information from the Medicaid file. • For further information, type a line number (**1** in this example) in the ENTER A LINE NUMBER field. • Press **Enter**. Result: The **Medicaid Eligibility Information** screen is displayed. Note: If multiple names are displayed on this screen, contact the Program Enrollment section of DADS.

continued on next page

Procedure, continued

Step	View	Action
4	A sample **Medicaid Eligibility Information** screen is shown below.  06-01-08 MEDICAID ELIGIBILITY INFORMATION VC100194 DHS DEMOGRAPHICS LAST NAME,SUFFIX : MOUNTAIN SSN : -- FIRST NAME, MIDDLE : RICKY RECIP NO: 655565556 BIRTH DATE : 05-12-1975 ETHNIC : B CARE CLIENT ID : 18023631 SEX : M MEDICAID CERTIFICATION DATE: 01-01-2003 MEDICARE NUMBER : 882277227A EARLIEST DATE OF PART 'A' ENTITLEMENT : 01-1979 ›	• View the DHS Demographics, including the Medicaid Certification date. • Press **Enter**. Result: The **Medicaid Eligibility Information** (Screen 2) is displayed.
5	A sample **Medicaid Eligibility Information** (Screen 2) is shown below.  06-01-08 MEDICAID ELIGIBILITY INFORMATION VC100194 DHS DEMOGRAPHICS LAST NAME,SUFFIX : MOUNTAIN SSN : -- FIRST NAME, MIDDLE : RICKY RECIP NO: 655565556 MEDICAID ELIGIBILITY INFO FOR DHS RECIPIENT NUMBER: 655565556 CVG TYPE BEG END SPENDDOWN CATEGORY CODE PROG DATE DATE CODE 01 R 13 01-01-2003 ›	• View the Medicaid eligibility information for the selected DHS Recipient Number, including the coverage code, type program, and begin date. Note: An individual *must* have one of the following Coverage Codes and Type Programs to be Medicaid eligible for the HCS *or* TxHmL waiver program. If not, contact Program Enrollment. **Waiver** / **Coverage Code** / **Type Program** TxHmL / R / 01, 02, 03, 08, 09, 10, 12, 13, 15, 18, 19, 21, 22, 29, 44, 47, 48, 61 HCS / R / 01, 02, 03 ,07 ,08, 09, 10, 12, 13, 14, 15, 18, 19, 21, 22, 29, 37, 44, 47, 48, 51, 61 • Press **Enter** to display the **C63: Medicaid Recipient Information** screen. • Press **Enter**. Result: The **C63: DHS Medicaid Eligibility Search** header screen is displayed.

Continue with the *Waiver MR/RC Assessment* procedure.

Enrollment in a Waiver Program
MR/RC Assessments - Summary (C68)

Introduction

The *MR/RC Assessments - Summary* process allows the MRA to verify whether an individual has a current MR/RC Assessment with an existing Level of Care (LOC) and Level of Need (LON) once **L01: Consumer Enrollment** has been entered. If the MR/RC Assessment is current (will not expire for 60 days from enrollment) and correct, no MR/RC Assessment is required at this time.

Procedure

The following table describes the steps the MRA will use to verify that an individual has a current MR/RC Assessment with an existing LOC/LON.

Step	View	Action
1	_ _	• Type **C68** in the ACT: field of any screen. • Press **Enter**. Result: The **C68: MR/RC Assessments-Summary** header screen is displayed.
2	A sample **C68: MR/RC Assessments-Summary** header screen is shown below. 06-01-08 C68:MR/RC ASSESSMENTS - SUMMARY VC060560 PLEASE ENTER ONE OF THE FOLLOWING: CLIENT ID: _____ COMPONENT CODE/LOCAL CASE NUMBER: __ / _____ MEDICAID NUMBER: _____ *** PRESS ENTER *** ENTER IF DESIRED PRINTER CODE: _____ (ENTER FOR HARD COPY) ACT: ___ (C60/PROV INQUIRY MENU,A/MA MAIN MENU,HLP(PF1)/SCRN DOC)	• Type the requested identifying information in the appropriate fields. Rule: You must enter the Client ID, the local case number, *or* the Medicaid Number. • Type the MRA component code in the COMPONENT CODE field. • Press **Enter**. Result: The **C68: MR/RC Assessments-Summary** screen is displayed.
3	A sample **C68: MR/RC Assessments-Summary** screen is shown below. 01-18-08 C68:MR/RC ASSESSMENTS - SUMMARY VC060565 NAME : TERRIER, TERRY CLIENT ID: 18023321 LOCAL CASE NUMBER: 0000WTS001 CONTRACT NUMBER : 001007358 COMPONENT: 804 MEDICAID NUMBER / LEVEL OF CARE / LEV CARE BEGIN DT / LEV CARE END DT / PREVIOUS END DT / PURPOSE CODE / LON / LON SOURCE 123456546 1 12-20-07 12-18-08 2 V3 1 TDMHMR PREADM ›	If the **C68: MR/RC Assessments-Summary** screen displays an existing Level of Care in the individual's record that will not expire for 60 days from the enrollment date, and the record is correct, *no MR/RC Assessment is required at this time*. Note: If there is not an existing LOC in the individual's record, the **C68: MR/RC Assessments-Summary** screen is displayed with the message, *"No Records Found."* • See the *Waiver MR/RC Assessment* procedure to complete the MR/RC Assessment. An MR/RC Assessment must be authorized by DADS *before* the entry of **L02: Individual Plan of Care**. Note: If an existing Level of Care/Level of Need is not accurate the MRA must enter the correct information. See *Waiver MR/RC Assessment* procedures.

Continue with the *DHS Medicaid Eligibility Search* procedure.

Enrollment in a Waiver Program
Waiver MR/RC Assessment (L23)

Introduction

The Mental Retardation/Related Condition (MR/RC) Assessment establishes eligibility for the waiver program and designates a Level of Care (LOC) and Level of Need (LON) for the individual.

The MRA uses **C68: MR/RC Assessments - Summary** to verify that a current LOC/LON exists for the individual. The MRA must complete the MR/RC assessment if the:

- individual does *not* have a current LOC/LON, *or*
- current assessment expires within 60 days of the enrollment date, *or*
- existing Level of Need is inaccurate, *or*
- LOC/LON has expired.

The *Waiver MR/RC Assessment* process consists of seven screens that allow the MRA to enter an individual's MR/RC Assessment information, if necessary.

For information on the fields used on these screens, refer to the MR/RC Assessment instructions at http://dadsview.dads.state.tx.us/forms/8578/

continued on next page

Procedure — The following table describes the steps the MRA will use to enter an MR/RC Assessment, if necessary.

Step	View	Action
1	_ _	• Type **L23** in the ACT: field of any screen. • Press **Enter**. Result: The **L23: Waiver MR/RC Assessment: Add/Change/Delete** header screen is displayed.
2	A sample **L23: Waiver MR/RC Assessment: Add/Change/Delete** header screen is shown below. 06-01-08 L23:WAIVER MR/RC ASSESSMENT: ADD/CHG/DEL VC060750 PLEASE ENTER ONE OF THE FOLLOWING: CLIENT ID: _____ COMPONENT CODE/LOCAL CASE NUMBER: __ / _____ MEDICAID NUMBER: _____ PLEASE ENTER THE FOLLOWING: CONTRACT NO : _____ PURPOSE CODE: _ (2/NO CURRENT ASSESSMENT, 3/CONTINUED STAY ASSESSMENT, 4/CHANGE LON ON EXISTING ASSESSMENT, E/GAPS IN ASSESSMENT) TYPE OF ENTRY: _ (A/ADD,C/CHANGE,D/DELETE) REQUESTED BEGIN DATE: _____ (MMDDYYYY, ENTER FOR ADD) REQUESTED END DATE : _____ (MMDDYYYY, ENTER FOR PURPOSE CODE E,ADD) *** PRESS ENTER *** ACT: ___ (L00/AUTH DATA ENTRY MENU, A/MA MAIN MENU, HLP(PF1)/SCRN DOC)	• Type the requested identifying information in the appropriate fields. Rule: You must enter the Client ID, the local case number, *or* the Medicaid Number. • Type the MRA component code in the COMPONENT CODE field. • Type **2** (No Current Assessment) in the PURPOSE CODE field. • Type **A** (Add) in the TYPE OF ENTRY field. • Type the MR/RC Assessment begin date in the REQUESTED BEGIN DATE field.* • Press **Enter**. Result: The **L23: Waiver MR/RC Assessment Purpose Code 2: Add** screen is displayed.

***The Purpose Code 2 MR/RC Assessment must begin on or before the enrollment date. If an MRA fails to enter a Purpose Code 2 by this date, they must enter a comment in the PROVIDER COMMENTS field requesting DADS Program Enrollment staff to backdate the MR/RC to the date of enrollment.**

Step	View	Action
3	A sample **L23: Waiver MR/RC Assessment Purpose Code 2: Add** screen is shown below. 06-01-08 L23:WAIVER MR/RC ASSESSMENT PURPOSE CODE 2: ADD VC060751 PROVIDER NAME: DALLAS METROCARE SERVICES CONTRACT NO. : TXHML ADDRESS : 1380 RIVER BEND DR, DALLAS TX, 75247 CLIENT NAME : MOUNTAIN, RICKY CLIENT ID : 18023631 COMPONENT : 300 LOCAL CASE NO. : 0003006565 MEDICAID NO. : 655565556 HIC/MEDICARE NO: DATE OF BIRTH: 05-12-1975 SSN : 423-55-4444 REQUESTED BEGIN DATE: 06-01-08 12. COMPLETED DATE: _____ (MMDDYYYY) 14. PHYS EXAM DATE: _____ (MMDDYYYY) 15. LEGAL STATUS : _ 16. PREV. RES.: _ 17. REC. LOC : _ 18. REC. LON : _ *DIAGNOSIS 20. PRIMARY DIAG : _____ 21. VERSION: 9 22. ONSET: _____ (MMYYYY) 24. CURRENT MED.DIAG: _____ 25. VERSION: 9 27. PSYCHIATRIC DIAG: _____ 28. VERSION: 4 * PRESS ENTER TO CONTINUE * ACT: ___ (L00/AUTH DATA ENTRY MENU,A/MA MAIN MENU,B(F7)/PREV SCRN)	• Type the date the MR/RC Assessment was completed in the COMPLETED DATE field. • Type the person's legal status in the LEGAL STATUS field. • Type the person's previous residence location before the current enrollment in the PREV. RES. field. • Type the recommended Level of Care in the REC. LOC field. • Type the recommended Level of Need in the REC. LON field. • Type the person's current primary diagnosis code as determined by a physician in the PRIMARY DIAG field. • Type the month and year that the person's disabling condition was originally diagnosed in the ONSET field. • Press **Enter.** Result: The **L23 Waiver MR/RC Assessment Purpose Code 2: Add** (Screen 2) is displayed.

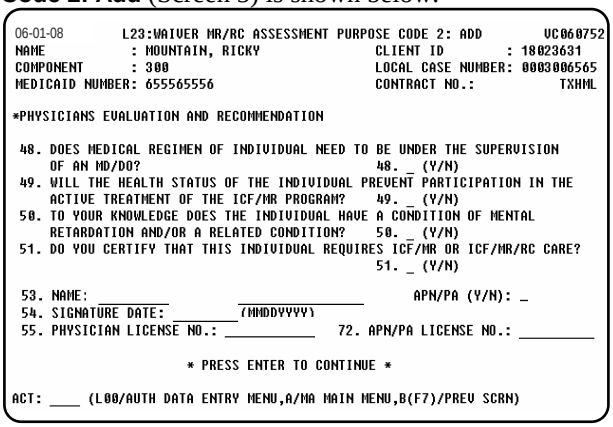
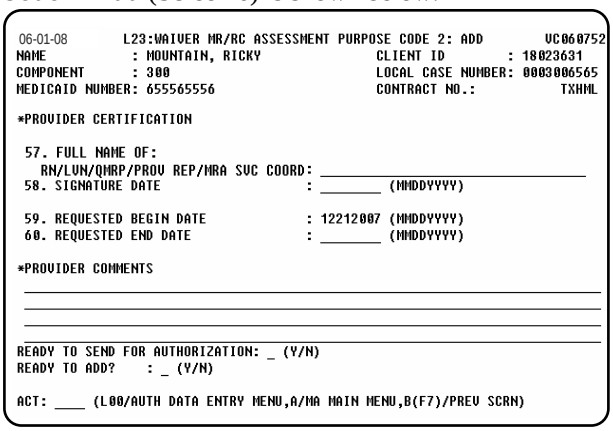
continued on next page

Procedure, continued

Step	View	Action
4	A sample **L23: Waiver MR/RC Assessment Purpose Code 2: Add** (Screen 2) is shown below. 06-01-08 L23:WAIVER MR/RC ASSESSMENT PURPOSE CODE 2: ADD VC060751 **VIEW CLIENT INFO AND MR/RC RECORD INFO** CLIENT COMP/CASE: 300/0003006565 CLIENT NAME : MOUNTAIN, RICKY CLIENT ADDRESS : 100 WEST MAIN, DALLAS TX, 75201 DIAGNOSIS DESCRIPTION FOR CODES ENTERED: PRIMARY DIAGNOSIS: 317 MILD MENTAL RETARDATION MEDICAL DIAGNOSIS: PSYCHIATRIC DIAGNOSIS: *NO MR/RC ASSESSMENT RECORD IN FILE >	• View the client and MR/RC record information. • Verify that the diagnoses are correct (based on the codes entered on screen 1). • Press **Enter** to continue. Result: The **L23: Waiver MR/RC Assessment Purpose Code 2: Add** (Screen 3) is displayed.
5	A sample **L23: Waiver MR/RC Assessment Purpose Code 2: Add** (Screen 3) is shown below. 06-01-08 L23:WAIVER MR/RC ASSESSMENT PURPOSE CODE 2: ADD VC060752 NAME : MOUNTAIN, RICKY CLIENT ID : 18023631 COMPONENT : 300 LOCAL CASE NUMBER: 0003006565 MEDICAID NUMBER: 655565556 CONTRACT NO.: TXHML 18. REC LON : 1 *COGNITIVE FUNCTIONING 29. IQ: ___ 30. ABL: _ *ICAP DATA 31. BROAD INDEPENDENCE ___ 32. GEN. MALADAPTIVE ___ 33. ICAP SERVICE LEVEL _ *BEHAVIORAL STATUS 34. BEHAVIOR PROGRAM _ 35. SELF-INJURY BEHAVIOR _ 36. SERIOUS DISRUP BEH _ 37. AGGRESSIVE BEHAVIOR _ 38. SEX. AGGRESS. BEH. _ *NURSING 39. SERVICE PROVIDER __ 40. FREQUENCY CODE __ * PRESS ENTER TO CONTINUE * ACT: ___ (L00/AUTH DATA ENTRY MENU,A/MA MAIN MENU,B(F7)/PREV SCRN)	• Type information in the appropriate fields**.** Note: *All of the fields* on this screen are required. • Press **Enter.** Result: The **L23 Waiver MR/RC Assessment Purpose Code 2: Add** (Screen 4) is displayed.
6	A sample **L23 Waiver MR/RC Assessment Purpose Code 2: Add** (Screen 4) is shown below. 06-01-08 L23:WAIVER MR/RC ASSESSMENT PURPOSE CODE 2: ADD VC060752 NAME : MOUNTAIN, RICKY CLIENT ID : 18023631 COMPONENT : 300 LOCAL CASE NUMBER: 0003006565 MEDICAID NUMBER: 655565556 CONTRACT NO.: TXHML *DAY SERVICES *NON-VOCATIONAL SETTING: 41. SERVICE __ 42. FREQUENCY CODE __ 43. FUNDING CODE __ *VOCATIONAL SETTING: 44. SERVICE __ 45. FREQUENCY CODE __ 46. FUNDING CODE __ *FUNCTIONAL ASSESSMENT 47. AMBULATION _ * PRESS ENTER TO CONTINUE * ACT: ___ (L00/AUTH DATA ENTRY MENU,A/MA MAIN MENU,B(F7)/PREV SCRN)	• Type information in the appropriate fields**.** Note: *All of the fields* on this screen are required. • Press **Enter.** Result: The **L23 Waiver MR/RC Assessment Purpose Code 2: Add** (Screen 5) is displayed.

continued on next page

Procedure, continued

<table>
<tr><th>Step</th><th>View</th><th>Action</th></tr>
<tr><td>7</td><td>A sample L23: Waiver MR/RC Assessment Purpose Code 2: Add (Screen 5) is shown below.
 
</td><td>The Physician's Evaluation and Recommendation fields are not required for waiver programs.
Note:<table><tr><th>If the physician has…</th><th>then…</th></tr><tr><td>signed the form</td><td>you must complete all fields on the screen.</td></tr><tr><td>not signed the form</td><td>do not enter any data on the screen.</td></tr></table>• Press Enter to continue.
Result: The L23: Waiver MR/RC Assessment Purpose Code 2: Add (Screen 6) is displayed.</td></tr>
<tr><td>8</td><td>A sample L23: Waiver MR/RC Assessment Purpose Code 2: Add (Screen 6) is shown below.
 
</td><td>• Type information in the appropriate fields.
• Type Y (Yes) or N (No) in the READY TO SEND FOR AUTHORIZATION? field to indicate whether or not you are ready to send the MR/RC Assessment to Program Enrollment (PE) at State Office.
• Type Y (Yes) or N (No) in the READY TO ADD? field to indicate whether or not you are ready to add the record. You may want to add the record pending further modifications even if you are not ready to send it for authorization by PE. If you add the record, the system saves the data and you won't have to reenter the information, but you will have to add needed information and send for authorization prior to proceeding further with the enrollment.
• Press Enter.
Result: The L23: Waiver MR/RC Assessment header screen is displayed with the message, "Previous Information Added."</td></tr>
</table>

Note: The MR/RC Assessment must be authorized by Program Enrollment *before* entry of the **L02**. Continue with the *Individual Plan of Care* procedure.

Enrollment in a Waiver Program
Individual Plan of Care (L02) - Initial

Introduction

The *Individual Plan of Care* (IPC) process allows the MRA to enter an *initial* Individual Plan of Care during a waiver program enrollment to identify the type and amount of waiver services the individual will need for the current plan year.

This section describes the steps taken to enter an HCS initial IPC and a TxHmL initial IPC. Sample screens and instructions are provided for entering the initial IPCs.

The screens in this process display service categories and allow the MRA to enter units of service to be provided annually for each category. The dollars for adaptive aids, minor home modification, and dental services may also be specified.

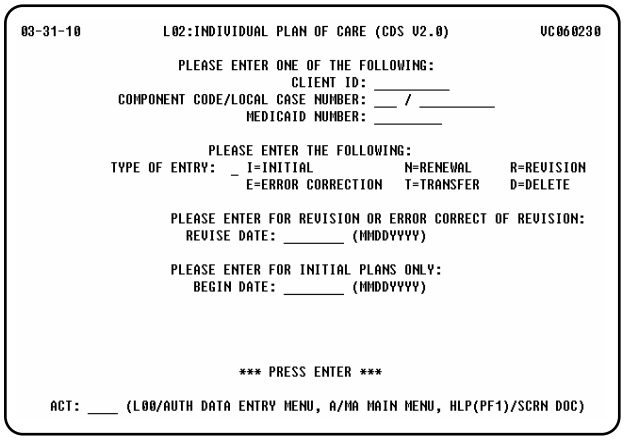
The system calculates and displays the total annual cost on the second screen after service units are specified and the service delivery option is identified.

Consumer Directed Services (CDS)

The consumer directed services option is for those individuals in the own home/family home setting. It is an option that allows individuals or their legally authorized representatives to be the employer of their direct service providers by recruiting, hiring, training, supervising, and terminating their service providers. Services that can be self-directed vary depending on the DADS program. At the time of entry of the initial IPC into the CARE system, the MRA specifies if any services are to be self-directed.

Procedure

The following table describes the steps the MRA will use to enter an HCS initial Individual Plan of Care.

Step	View	Action
1	_ _	• Type **L02** in the ACT: field of any screen. • Press **Enter**. Result: The **L02: Individual Plan of Care** header screen is displayed.
2	A sample **L02: Individual Plan of Care** header screen is shown below.  03-31-10 L02:INDIVIDUAL PLAN OF CARE (CDS V2.0) VC060230 PLEASE ENTER ONE OF THE FOLLOWING: CLIENT ID: _____ COMPONENT CODE/LOCAL CASE NUMBER: __ / _____ MEDICAID NUMBER: _____ PLEASE ENTER THE FOLLOWING: TYPE OF ENTRY: _ I=INITIAL N=RENEWAL R=REVISION E=ERROR CORRECTION T=TRANSFER D=DELETE PLEASE ENTER FOR REVISION OR ERROR CORRECT OF REVISION: REVISE DATE: _____ (MMDDYYYY) PLEASE ENTER FOR INITIAL PLANS ONLY: BEGIN DATE: _____ (MMDDYYYY) *** PRESS ENTER *** ACT: ___ (L00/AUTH DATA ENTRY MENU, A/MA MAIN MENU, HLP(PF1)/SCRN DOC)	• Type the requested identifying information in the appropriate fields. Rule: You must enter the Client ID, the local case number, *or* the Medicaid Number. • Type the MRA component code in the COMPONENT CODE field. • Type **I** (Initial) in the TYPE OF ENTRY field. • Type the date the provider began or will begin providing services in the BEGIN DATE field. Note: The IPC Begin Date cannot be prior to the enrollment request date reflected on screen **L01**. • Press **Enter**. Result: The **L02: Individual Plan of Care Entry: Initial** screen is displayed.

continued on next page

Procedure, continued

Step	View	Action
3	A sample **L02: Individual Plan of Care Entry: Initial** screen is shown below.	• Type the number of units of each service category in the appropriate fields and the dollar amounts in the ADAPTIVE AIDS, MINOR HOME MOD, and DENTAL fields (from page 1 of the IPC). • Type **Y** (Yes) or **N** (No) in the ANY SERVICES SELF DIRECTED? field to indicate whether any of the services will be self-directed. Note 1: If **Y** (Yes) is entered and services are to be self-directed, the FMS MONTHLY FEE is required. You ***must*** enter one unit per month of the IPC in the FMS MONTHLY FEE field. Note 2: If you enter any units in the SUPPORT CONSULTATION field, you ***must*** answer **Y** (Yes). Note 3: Only Supported Home Living and Respite can be self-directed in HCS. • Type the individual's residence type in the RES TYPE field. (2=Foster/Companion Care, 3=Own Home/Family Home, 4=Supervised Living, 5=Residential Support) Note: For CDS the individual ***must*** be in residential type **3** (Own Home/Family Home). • Type **Y** in the READY TO CONTINUE? field. • Press **Enter**. Result:

```
03-31-10   L02:INDIVIDUAL PLAN OF CARE ENTRY (CDS V2.0): INITIAL    VC060232A
NAME: SPANIEL, SAMMY              CLCN: 040 0000WHY098 CLIENT ID: 18026770
BEG DT: 03022010 REV DT:          (MMDDYYYY) END DT: 03012011
SERVICE CATEGORY       UNITS          SERVICE CATEGORY          UNITS
AA    ADAPTIVE AIDS    _______ DOL    AAR   ADAPTIVE AIDS REQ.  _______ DOL
AU    AUDIOLOGY        _______ HRS    PS    BEHAVIORAL SUPPORT  _______ HRS
FC    HCS FOSTER CARE  _______ DAYS   DH    DAY HABILITATION    240____ DAYS
DE    DENTAL           _______ DOL    DER   DENTAL REQ. FEE     _______ DOL
DI    DIETARY          _______ HRS    MHM   MINOR HOME MODS     _______ DOL
MHMR  MINOR HOME MOD R _______ DOL    NUR   NURSING  RN        0.25___ HRS
NUL   NURSING  LVN     4.75___ HRS    NURS  NURSING  SPEC RN   _______ HRS
NULS  NURSING  SPEC LV _______ HRS    OT    OCCUPATIONAL THERAP _______ HRS
PT    PHYSICAL THERAPY _______ HRS    REH   RESPITE HR          _______ HRS
RSS   RES SUPPORT SVC  _______ DAYS   SW    SOCIAL WORK       _______ HRS
SP    SPEECH/LANGUAGE  _______ HRS    SE    SUPPORTED EMP     62_____ HRS
SL    SUPERVISED LIVIN _______ DAYS   SHL   SUPPORTED HOME LIVI 20_____ HRS
FMSV  FMS MONTHLY FEE  12_____ MONS   SCU   SUPPORT CONSULTATIO _______ HRS


ANY SERVICES SELF DIRECTED? Y (Y/N)  RES TYPE: 3 (2-5)  LOCATION:      (UNK)
READY TO CONTINUE?  _ (Y/N)

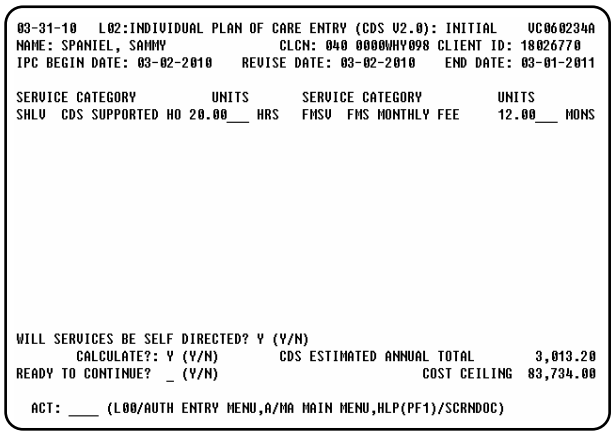
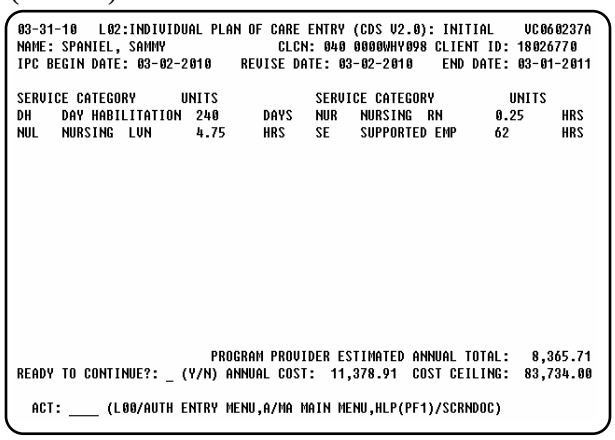
  ACT: ___ (L00/AUTH ENTRY MENU,A/MA MAIN MENU,HLP(PF1)/SCRNDOC)
```

Result:

If you answered…	The…
Y to the question, ANY SERVICES SELF DIRECTED?	**L02: Individual Plan of Care Entry: Initial** CDS screen is displayed.
N to the question, ANY SERVICES SELF DIRECTED?	**L02: Individual Plan of Care Entry: Initial** program provider screen is displayed. *Skip to Step 5.*

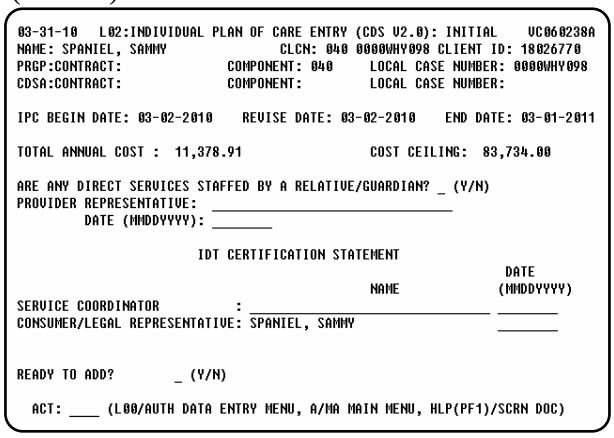
continued on next page

Procedure, continued

Step	View	Action
4	A sample **L02: Individual Plan of Care Entry: Initial** (screen 2) is shown below.  03-31-10 L02:INDIVIDUAL PLAN OF CARE ENTRY (CDS V2.0): INITIAL VC060234A NAME: SPANIEL, SAMMY CLCN: 040 0000WHY098 CLIENT ID: 18026770 IPC BEGIN DATE: 03-02-2010 REVISE DATE: 03-02-2010 END DATE: 03-01-2011 SERVICE CATEGORY UNITS SERVICE CATEGORY UNITS SHLV CDS SUPPORTED HO 20.00___ HRS FMSV FMS MONTHLY FEE 12.00___ MONS WILL SERVICES BE SELF DIRECTED? Y (Y/N) CALCULATE?: Y (Y/N) CDS ESTIMATED ANNUAL TOTAL 3,013.20 READY TO CONTINUE? _ (Y/N) COST CEILING 83,734.00 ACT: ___ (L00/AUTH ENTRY MENU,A/MA MAIN MENU,HLP(PF1)/SCRNDOC)	This screen displays the CDS portion of the IPC. The units for services eligible to be self-directed are displayed **and cannot be changed**. Note: All services that are self-directed contain a V at the end of the service abbreviation on this screen. For example, the service abbreviation for Respite is REH. If that service is self-directed, the abbreviation becomes REHV. • Type **N** in the CALCULATE? field. • Type **Y** in the READY TO CONTINUE? field. • Press **Enter**. Result: The **L02: Individual Plan of Care Entry: Initial** (screen 3) is displayed.
5	A sample **L02: Individual Plan of Care Entry: Initial** (screen 3) is shown below.  03-31-10 L02:INDIVIDUAL PLAN OF CARE ENTRY (CDS V2.0): INITIAL VC060237A NAME: SPANIEL, SAMMY CLCN: 040 0000WHY098 CLIENT ID: 18026770 IPC BEGIN DATE: 03-02-2010 REVISE DATE: 03-02-2010 END DATE: 03-01-2011 SERVICE CATEGORY UNITS SERVICE CATEGORY UNITS DH DAY HABILITATION 240 DAYS NUR NURSING RN 0.25 HRS NUL NURSING LVN 4.75 HRS SE SUPPORTED EMP 62 HRS PROGRAM PROVIDER ESTIMATED ANNUAL TOTAL: 8,365.71 READY TO CONTINUE?: _ (Y/N) ANNUAL COST: 11,378.91 COST CEILING: 83,734.00 ACT: ___ (L00/AUTH ENTRY MENU,A/MA MAIN MENU,HLP(PF1)/SCRNDOC)	This screen displays the program provider portion of the IPC. Services not being self-directed are displayed and cannot be changed. • Type **Y** in the READY TO CONTINUE? field. • Press **Enter**. Result: The **L02: Individual Plan of Care Entry: Initial** (screen 4) is displayed.

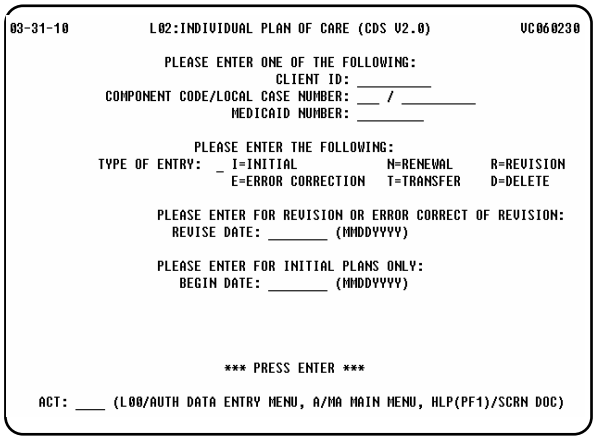
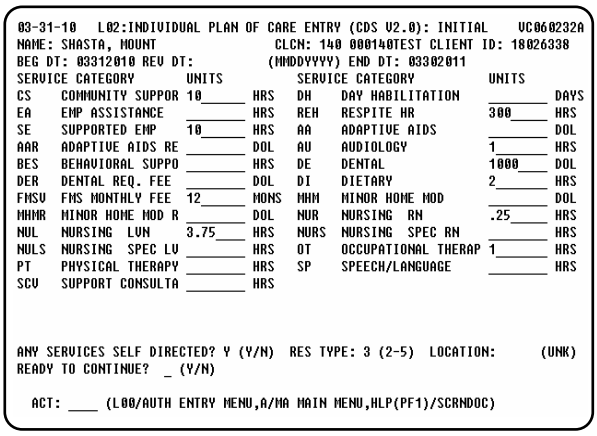
continued on next page

Procedure, continued

Step	View	Action
6	A sample **L02: Individual Plan of Care Entry: Initial** (screen 4) is shown below.  03-31-10 L02:INDIVIDUAL PLAN OF CARE ENTRY (CDS V2.0): INITIAL VC060238A NAME: SPANIEL, SAMMY CLCN: 040 0000WHY098 CLIENT ID: 18026770 PRGP:CONTRACT: COMPONENT: 040 LOCAL CASE NUMBER: 0000WHY098 CDSA:CONTRACT: COMPONENT: LOCAL CASE NUMBER: IPC BEGIN DATE: 03-02-2010 REVISE DATE: 03-02-2010 END DATE: 03-01-2011 TOTAL ANNUAL COST : 11,378.91 COST CEILING: 83,734.00 ARE ANY DIRECT SERVICES STAFFED BY A RELATIVE/GUARDIAN? _ (Y/N) PROVIDER REPRESENTATIVE: _____ DATE (MMDDYYYY): _____ IDT CERTIFICATION STATEMENT NAME DATE (MMDDYYYY) SERVICE COORDINATOR : _____ _____ CONSUMER/LEGAL REPRESENTATIVE: SPANIEL, SAMMY _____ READY TO ADD? _ (Y/N) ACT: ___ (L00/AUTH DATA ENTRY MENU, A/MA MAIN MENU, HLP(PF1)/SCRN DOC)	• Type **Y** (Yes) or **N** (No) to indicate whether any services are staffed by a relative or guardian. • Type the name of the provider representative (individual's name) in the PROVIDER REPRESENTATIVE field and the date the provider representative signed the IPC in the DATE field. • Type the Service Coordinator's name in the SERVICE COORDINATOR field and the date the Service Coordinator signed the IPC in the DATE field. • The name of the individual or legal representative is pre-filled based on whether or not a guardian has been identified (screen L20) in the CONSUMER/LEGAL REPRESENTATIVE field. Type the date the individual or legal representative signed the IPC in the DATE field. Note: Before you enter names in the fields on this screen, signatures *must* be on the IPC in the individual's records. **All data entered into the CARE system should be entered from a paper copy (a hard copy) and match exactly**. • Type **Y** in the READY TO ADD? field to submit the data to the system. • Press **Enter**. Result: The **L02: Individual Plan of Care** header screen is displayed with the message, "*Plan has been Added*."

Enrollment in a Waiver Program
Individual Plan of Care (L02) - TxHmL

Procedure — The following table describes the steps the MRA will use to enter a TxHmL initial Individual Plan of Care.

Step	View	Action
1	_ _	• Type **L02** in the ACT: field of any screen. • Press **Enter**. Result: The **L02: Individual Plan of Care** header screen is displayed.
2	A sample **L02: Individual Plan of Care** header screen is shown below.  03-31-10 L02:INDIVIDUAL PLAN OF CARE (CDS V2.0) VC060230 PLEASE ENTER ONE OF THE FOLLOWING: CLIENT ID: _____ COMPONENT CODE/LOCAL CASE NUMBER: __ / _____ MEDICAID NUMBER: _____ PLEASE ENTER THE FOLLOWING: TYPE OF ENTRY: _ I=INITIAL N=RENEWAL R=REVISION E=ERROR CORRECTION T=TRANSFER D=DELETE PLEASE ENTER FOR REVISION OR ERROR CORRECT OF REVISION: REVISE DATE: _____ (MMDDYYYY) PLEASE ENTER FOR INITIAL PLANS ONLY: BEGIN DATE: _____ (MMDDYYYY) *** PRESS ENTER *** ACT: ___ (L00/AUTH DATA ENTRY MENU, A/MA MAIN MENU, HLP(PF1)/SCRN DOC)	• Type the requested identifying information in the appropriate fields. Rule: You must enter the Client ID, the local case number, *or* the Medicaid Number. • Type the MRA component code in the COMPONENT CODE field. • Type **I** (Initial) in the TYPE OF ENTRY field. • Type the date the provider began or will begin providing services in the BEGIN DATE field. Note: The IPC Begin Date cannot be prior to the enrollment request date reflected on screen **L01**. • Press **Enter**. Result: The **L02: Individual Plan of Care Entry: Initial** screen is displayed.
3	A sample **L02: Individual Plan of Care Entry: Initial** screen is shown below.  03-31-10 L02:INDIVIDUAL PLAN OF CARE ENTRY (CDS V2.0): INITIAL VC060232A NAME: SHASTA, MOUNT CLCN: 140 000140TEST CLIENT ID: 18026338 BEG DT: 03312010 REV DT: (MMDDYYYY) END DT: 03302011 SERVICE CATEGORY UNITS SERVICE CATEGORY UNITS CS COMMUNITY SUPPOR 10_____ HRS DH DAY HABILITATION _____ DAYS EA EMP ASSISTANCE _____ HRS REH RESPITE HR 300____ HRS SE SUPPORTED EMP 10_____ HRS AA ADAPTIVE AIDS _____ DOL AAR ADAPTIVE AIDS RE _____ DOL AU AUDIOLOGY 1_____ HRS BES BEHAVIORAL SUPPO _____ HRS DE DENTAL 1000___ DOL DER DENTAL REQ. FEE _____ DOL DI DIETARY 2_____ HRS FMSV FMS MONTHLY FEE 12_____ MONS MHM MINOR HOME MOD _____ DOL MHMR MINOR HOME MOD R _____ DOL NUR NURSING RN .25____ HRS NUL NURSING LVN 3.75___ HRS NURS NURSING SPEC RN _____ HRS NULS NURSING SPEC LV _____ HRS OT OCCUPATIONAL THERAP 1_____ HRS PT PHYSICAL THERAPY _____ HRS SP SPEECH/LANGUAGE _____ HRS SCU SUPPORT CONSULTA _____ HRS ANY SERVICES SELF DIRECTED? Y (Y/N) RES TYPE: 3 (2-5) LOCATION: (UNK) READY TO CONTINUE? _ (Y/N) ACT: ___ (L00/AUTH ENTRY MENU,A/MA MAIN MENU,HLP(PF1)/SCRNDOC)	• Type the number of units of each service category in the appropriate fields and the dollar amounts in the ADAPTIVE AIDS, MINOR HOME MOD, and DENTAL fields (from the IPC). • Type **Y** (Yes) or **N** (No) in the ANY SERVICES SELF DIRECTED? field to indicate whether any of the services will be self-directed. Note 1: If you enter units in the SUPPORT CONSULTATION or FINANCIAL MANAGEMENT fields, you ***must*** answer **Y** (Yes). Note 2: If **Y** (Yes) is entered and services are to be self-directed, the FMS MONTHLY FEE is required. You must then enter one unit per month of the IPC in the FMS MONTHLY FEE field. Note 3: If units have been entered for Adaptive Aids or Minor Home Modifications, no requisition fee is allowed when self-directing. • Type **3** (Own Home/Family Home) in the RES TYPE field. • Type **Y** in the READY TO CONTINUE? field. • Press **Enter**. Result: **If you answered… / The…** **Y** to the question, ANY SERVICES SELF DIRECTED? — **L02: Individual Plan of Care Entry: Initial** CDS screen is displayed. **N** to the question, ANY SERVICES SELF DIRECTED? — **L02: Individual Plan of Care Entry: Initial** program provider screen is displayed. *Skip to Step 5.*

Procedure, continued

<table>
<tr><th>Step</th><th>View</th><th>Action</th></tr>
<tr><td>4</td><td>A sample L02: Individual Plan of Care Entry: Initial (screen 2) is shown below.
<pre>
03-31-10   L02:INDIVIDUAL PLAN OF CARE ENTRY (CDS V2.0): INITIAL   VC060234A
NAME: SHASTA, MOUNT   CLCN: 140 000140TEST CLIENT ID: 18026338
IPC BEGIN DATE: 03-31-2010   REVISE DATE: 03-31-2010   END DATE: 03-30-2011

SERVICE CATEGORY   UNITS   SERVICE CATEGORY   UNITS
CSV   CDS COMMUNITY SU 10.00___ HRS   REHV CDS RESPITE HR   300.00__ HRS
SEV   CDS SUPPORTED EM 10.00___ HRS   AUV   CDS AUDIOLOGY   1.00___ HRS
DEV   CDS DENTAL   1000.00_ DOL   DIV   CDS DIETARY   2.00___ HRS
FMSV FMS MONTHLY FEE 12.00___ MONS NURV CDS NURSING RN   0.25___ HRS
NULV CDS NURSING LVN 3.75____ HRS   OTV   CDS OCCUPATIONAL TH 1.00___ HRS

WILL SERVICES BE SELF DIRECTED? Y (Y/N)
       CALCULATE?: Y (Y/N)   CDS ESTIMATED ANNUAL TOTAL   9,941.21
READY TO CONTINUE? _ (Y/N)   COST CEILING 15,000.00

  ACT: ___ (L00/AUTH ENTRY MENU,A/MA MAIN MENU,HLP(PF1)/SCRNDOC)
</pre>
The following screen shows the units that have been changed to 0 for each service that is to be provided by the program provider.
<pre>
03-31-10   L02:INDIVIDUAL PLAN OF CARE ENTRY (CDS V2.0): INITIAL   VC060234A
NAME: SHASTA, MOUNT   CLCN: 140 000140TEST CLIENT ID: 18026338
IPC BEGIN DATE: 03-31-2010   REVISE DATE: 03-31-2010   END DATE: 03-30-2011

SERVICE CATEGORY   UNITS   SERVICE CATEGORY   UNITS
CSV   CDS COMMUNITY SU 10.00___ HRS   REHV CDS RESPITE HR   300.00__ HRS
SEV   CDS SUPPORTED EM 0_______ HRS   AUV   CDS AUDIOLOGY   0_______ HRS
DEV   CDS DENTAL   1000.00_ DOL   DIV   CDS DIETARY   0_______ HRS
FMSV FMS MONTHLY FEE 12.00___ MONS NURV CDS NURSING RN   0.25___ HRS
NULV CDS NURSING LVN 3.75____ HRS   OTV   CDS OCCUPATIONAL TH 1.00___ HRS

WILL SERVICES BE SELF DIRECTED? Y (Y/N)
       CALCULATE?: Y (Y/N)   CDS ESTIMATED ANNUAL TOTAL   9,558.28
READY TO CONTINUE? _ (Y/N)   COST CEILING 15,000.00

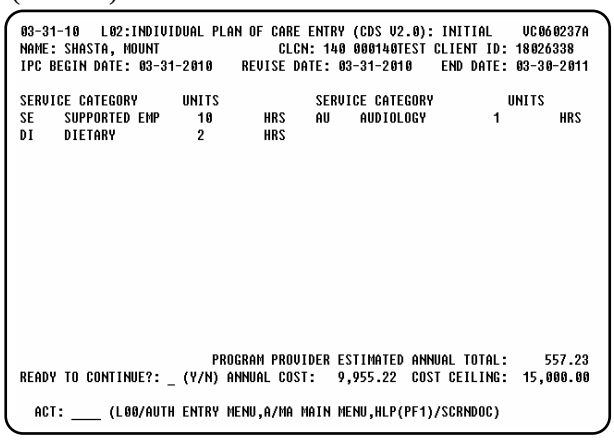
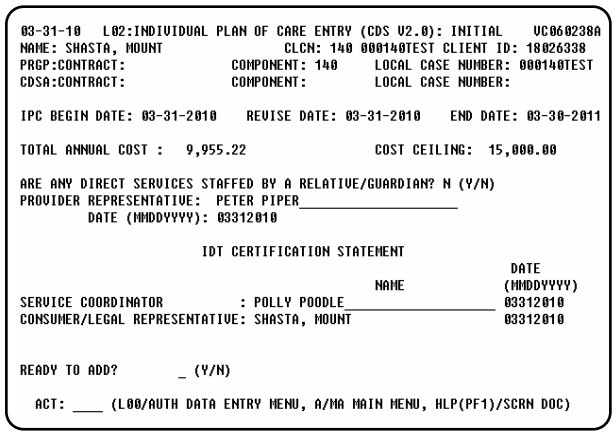
  ACT: ___ (L00/AUTH ENTRY MENU,A/MA MAIN MENU,HLP(PF1)/SCRNDOC)
</pre></td><td>This screen displays the CDS portion of the IPC. The units for all services eligible to be self-directed are displayed. You can edit units for services not being self-directed on this screen by typing 0 (zero) in place of units.

Note 1: Support Consultation and Financial Management Service fee units cannot be changed on this screen.

Note 2: All services that are self-directed contain a V at the end of the service abbreviation on this screen. For example, the service abbreviation for Respite is REH. If that service is self-directed, the abbreviation becomes REHV.
<table>
<tr><th>If you want to …</th><th>Then…</th></tr>
<tr><td>continue to the Program Provider screen (screen 3) after calculating</td><td>• Type N in the CALCULATE? field.
• Type Y in the READY TO CONTINUE? field.
• Press Enter.
• Continue with Step 5.</td></tr>
<tr><td>indicate that some of the services are not to be self - directed, but will be provided by the Program Provider</td><td>• Replace the displayed units of service with 0 (zero) for each service that is to be provided by the Program Provider.
• Press Enter to calculate.
• Type N in the CALCULATE? field.
• Type Y in the READY TO CONTINUE? field.
• Press Enter.
• Continue with Step 5.</td></tr>
</table></td></tr>
</table>

continued on next page

Procedure, continued

Step	View	Action
5	A sample **L02: Individual Plan of Care Entry: Initial** (screen 3) is shown below.  03-31-10 L02:INDIVIDUAL PLAN OF CARE ENTRY (CDS V2.0): INITIAL VC060237A NAME: SHASTA, MOUNT CLCN: 140 000140TEST CLIENT ID: 18026338 IPC BEGIN DATE: 03-31-2010 REVISE DATE: 03-31-2010 END DATE: 03-30-2011 SERVICE CATEGORY UNITS SERVICE CATEGORY UNITS SE SUPPORTED EMP 10 HRS AU AUDIOLOGY 1 HRS DI DIETARY 2 HRS PROGRAM PROVIDER ESTIMATED ANNUAL TOTAL: 557.23 READY TO CONTINUE?: _ (Y/N) ANNUAL COST: 9,955.22 COST CEILING: 15,000.00 ACT: ___ (L00/AUTH ENTRY MENU,A/MA MAIN MENU,HLP(PF1)/SCRNDOC)	This screen displays the program provider portion of the IPC. Services not being self-directed are displayed and cannot be changed. • Type **Y** in the READY TO CONTINUE? field. • Press **Enter**. Result: The **L02: Individual Plan of Care Entry: Initial** (screen 4) is displayed.
6	A sample **L02: Individual Plan of Care Entry: Initial** (screen 4) is shown below.  03-31-10 L02:INDIVIDUAL PLAN OF CARE ENTRY (CDS V2.0): INITIAL VC060238A NAME: SHASTA, MOUNT CLCN: 140 000140TEST CLIENT ID: 18026338 PRGP:CONTRACT: COMPONENT: 140 LOCAL CASE NUMBER: 000140TEST CDSA:CONTRACT: COMPONENT: LOCAL CASE NUMBER: IPC BEGIN DATE: 03-31-2010 REVISE DATE: 03-31-2010 END DATE: 03-30-2011 TOTAL ANNUAL COST : 9,955.22 COST CEILING: 15,000.00 ARE ANY DIRECT SERVICES STAFFED BY A RELATIVE/GUARDIAN? N (Y/N) PROVIDER REPRESENTATIVE: PETER PIPER DATE (MMDDYYYY): 03312010 IDT CERTIFICATION STATEMENT NAME DATE (MMDDYYYY) SERVICE COORDINATOR : POLLY POODLE 03312010 CONSUMER/LEGAL REPRESENTATIVE: SHASTA, MOUNT 03312010 READY TO ADD? _ (Y/N) ACT: ___ (L00/AUTH DATA ENTRY MENU, A/MA MAIN MENU, HLP(PF1)/SCRN DOC)	• Type **Y** (Yes) or **N** (No) to indicate whether any services are staffed by a relative or guardian. • Type the name of the provider representative (individual's name) in the PROVIDER REPRESENTATIVE field and the date the provider representative signed the IPC in the DATE field. • Type the Service Coordinator's name in the SERVICE COORDINATOR field and the date the Service Coordinator signed the IPC in the DATE field. • The name of the individual or legal representative is pre-filled based on whether or not a guardian has been identified (screen **L20**) in the CONSUMER/LEGAL REPRESENTATIVE field. Type the date the individual or legal representative signed the IPC in the DATE field. Note: Before you enter names in the fields on this screen, signatures *must* be on the IPC in the individual's record. **All data entered into the CARE system should be entered from a paper copy (a hard copy) and match exactly**. • Type **Y** in the READY TO ADD? field to submit the data to the system. • Press **Enter**. Result: The **L02: Individual Plan of Care** header screen is displayed with the message, *"Plan has been Added."*

Continue with the *Enrollment Packet Checklist* procedure.

Enrollment in a Waiver Program
Enrollment Packet Checklist (L03)

Introduction

The *Enrollment Packet Checklist* process allows the MRA to document the completion of the necessary forms/processes for waiver program enrollment.

Procedure

The following table describes the steps the MRA will use to enter the enrollment packet checklist.

Step	View	Action
1	_ _	• Type **L03** in the ACT: field of any screen. • Press **Enter**. Result: The **L03: Enrollment Packet Checklist: Add/Change/Delete** header screen is displayed.
2	A sample **L03: Enrollment Packet Checklist: Add/Change/Delete** header screen is shown below. 06-01-08 L03:ENROLLMENT PACKET CHECKLIST: ADD/CHG/DEL VC060360 PLEASE ENTER ONE OF THE FOLLOWING: CLIENT ID: _____ COMPONENT CODE/LOCAL CASE NUMBER: ___ / _____ MEDICAID NUMBER: _____ PLEASE ENTER THE FOLLOWING: TYPE OF ENTRY: _ (A/ADD,C/CHANGE,D/DELETE) *** PRESS ENTER *** ACT: ___ (L00/AUTH DATA ENTRY MENU, A/MA MAIN MENU, HLP(PF1)/SCRN DOC)	• Type the Client ID in the CLIENT ID field. • Type the MRA component code in the COMPONENT CODE field. • Type **A** (Add) in the TYPE OF ENTRY field. • Press **Enter**. Result: The **L03: Enrollment Packet Checklist: Add** screen is displayed.
3	A sample **L03: Enrollment Packet Checklist: Add** screen is shown below. 06-01-08 L03:ENROLLMENT PACKET CHECKLIST: ADD VC060365 NAME : MOUNTAIN, RICKY CLIENT ID : 18023631 MEDICAID NUMBER: 655565556 LOCAL CASE NUMBER: 0003006565 IPC BEGIN DATE : 06-01-2008 COMPONENT : 300 SERVICES BEGIN DATE: _____ (MMDDYYYY) IPC NON WAIVER SERVICES _____ (MMDDYYYY) FREEDOM OF CHOICE FORM _____ (MMDDYYYY) ADAPTIVE AIDS ASSESSMENT/BID _____ (MMDDYYYY) MINOR HOME MODS ASSESSMENT/BID _____ (MMDDYYYY) PERSON DIRECTED PLAN/SMRF COMMUNITY LIVING PLAN _____ (MMDDYYYY) READY TO ADD? _ (Y/N) ACT: ___ (L00/AUTH DATA ENTRY MENU, A/MA MAIN MENU, HLP(PF1)/SCRN DOC)	• Type the date waiver services will begin in the SERVICES BEGIN DATE field. • Type the date the Freedom of Choice form was signed by the individual/legal representative in the FREEDOM OF CHOICE FORM field. • Type the date of the adaptive aids bid or, if unavailable, the date of the assessment in the ADAPTIVE AIDS ASSESSMENT/BID field, if applicable. Note: This date is necessary *only* if the amount of adaptive aids on the IPC exceeds what is approved in the billing guidelines. • Type the date of the minor home modification bid or, if unavailable, the date of the assessment in the MINOR HOME MODS ASSESSMENT/BID fields. Note: This date is necessary *only* if the amount of minor home modifications on the IPC exceeds what is approved in the billing guidelines. • Type the date the Person Directed Plan/SMRF Community Living Plan was completed. • Type **Y** in the READY TO ADD? field. • Press **Enter**. Result: The **L03: Enrollment Packet Checklist** header screen is displayed with the message, *"Previous Information Added."*

Continue with the *Register Client Update* procedure.

Enrollment in a Waiver Program
Register Client Update (L09) – Program Provider

Introduction

The *Register Client Update* process allows the MRA to assign the selected program provider's local case number for a new enrollment.

The program provider is contacted for a local case number for the individual, and the MRA enters that local case number into the CARE system.

Note: You will enter information on L09 twice if both the provider and CDSA are involved.

Procedure

The following table describes the steps the MRA will use to assign the selected provider's local case number.

Step	View	Action
1	_ _	• Type **L09** in the ACT: field of any screen. • Press **Enter**. Result: The **L09: Register Client Update** header screen is displayed.
2	A sample **L09: Register Client Update** header screen is shown below. 06-01-08 L09:REGISTER CLIENT UPDATE VC060420 PLEASE ENTER AT LEAST ONE OF THE FOLLOWING: CLIENT ID: _____ COMPONENT CODE/LOCAL CASE NUMBER: __ / _____ NOTE: TO ASSIGN A PROVIDER'S LOCAL CASE NUMBER FOR NEW ENROLLMENTS USE THE PROVIDERS COMPONENT CODE IN THE ABOVE FIELD. *** PRESS ENTER *** ACT: ___ (L00/AUTH DATA ENTRY MENU, A/MA MAIN MENU, HLP(PF1)/SCRN DOC)	• Type the Client ID in the CLIENT ID field. • Type the **program provider's component code** in the COMPONENT CODE field. • Press **Enter**. Result: The **L09: Register Client Update** screen is displayed. Note: Once an individual has been assigned a local case number by a provider, it is not necessary to assign them another local case number.
3	A sample **L09: Register Client Update** screen is shown below. 06-01-08 L09: REGISTER CLIENT UPDATE VC060425 CLIENT LAST NAME/SUF : MOUNTAIN CLIENT ID : 18023631 CLIENT FIRST NAME : RICKY COMPONENT : 300 CLIENT MIDDLE NAME : LOCAL CASE NUMBER : _____ SEX : M ETHNICITY : W CLIENT BIRTHDATE (MMDDYYYY) : 05121975 SOCIAL SECURITY NUMBER : 423554444 (N=NONE, U=UNKNOWN) MEDICAID NUMBER : 655565556 MEDICARE NUMBER: _____ PRESENTING PROBLEM : 2 (1=MH, 2=MR, 3=ECI/DD, 4=SA, 5=RC) REGISTRATION EFFECTIVE DATE : 060108 (MMDDYY) TIME (HHMM A/P) : 0230P LEGAL GUARDIANSHIP : 8 MARITAL STATUS : 5 ESTIMATED ANNUAL GROSS FAMILY INCOME: 35000____ FAMILY SIZE : 4_ SERVICE PARTICIPANT GROUP : __ (CB, SB, PD, HC, TS, EC, UC) READY TO UPDATE? _ (Y/N) ACT: ___ (L00/AUTH DATA ENTRY MENU, A/MA MAIN MENU, HLP(PF1)/SCRN DOC)	• Type the Local Case Number assigned to the individual by the program provider in the LOCAL CASE NUMBER field. • Review all fields on the screen for accuracy and correctness if necessary. Note: **Do *not* change the Registration Effective Date.** • Type **Y** in the READY TO UPDATE? field. • Press **Enter**. Result: The **L09: Register Client Update** header screen is displayed with the message, *"Previous Information Changed."* Note: You don't have to change a local case number if an individual changes programs and leaves the provider, then later returns to the provider.

Continue with the *CDSA L09* or the *Provider Choice* procedure.

Enrollment in a Waiver Program
Register Client Update (L09) – CDSA

Introduction

The *Register Client Update* process allows the MRA to assign the selected CDSA's local case number for a new enrollment.

The CDSA is contacted for a local case number for the individual, and the MRA enters that local case number into the CARE system.

Note: You will enter information on L09 twice if both the program provider and CDSA are involved.

Procedure

The following table describes the steps the MRA will use to assign the selected CDSA's local case number.

Step	View	Action
1	_ _	• Type **L09** in the ACT: field of any screen. • Press **Enter**. Result: The **L09: Register Client Update** header screen is displayed.
2	A sample **L09: Register Client Update** header screen is shown below. 06-01-08 L09:REGISTER CLIENT UPDATE VC060420 PLEASE ENTER AT LEAST ONE OF THE FOLLOWING: CLIENT ID: _____ COMPONENT CODE/LOCAL CASE NUMBER: __ / _____ NOTE: TO ASSIGN A PROVIDER'S LOCAL CASE NUMBER FOR NEW ENROLLMENTS USE THE PROVIDERS COMPONENT CODE IN THE ABOVE FIELD. *** PRESS ENTER *** ACT: ___ (L00/AUTH DATA ENTRY MENU, A/MA MAIN MENU, HLP(PF1)/SCRN DOC)	• Type the Client ID in the CLIENT ID field. • Type the **CDSA's component code** in the COMPONENT CODE field. • Press **Enter**. Result: The **L09: Register Client Update** screen is displayed. Note: Once an individual has been assigned a local case number by a CDSA, it is not necessary to assign them another local case number.
3	A sample **L09: Register Client Update** screen is shown below. 06-01-08 L09: REGISTER CLIENT UPDATE VC060425 CLIENT LAST NAME/SUF : MOUNTAIN CLIENT ID : 18023631 CLIENT FIRST NAME : RICKY COMPONENT : 300 CLIENT MIDDLE NAME : LOCAL CASE NUMBER : _____ SEX : M ETHNICITY : W CLIENT BIRTHDATE (MMDDYYYY) : 05121975 SOCIAL SECURITY NUMBER : 423554444 (N=NONE, U=UNKNOWN) MEDICAID NUMBER : 655565556 MEDICARE NUMBER: _____ PRESENTING PROBLEM : 2 (1=MH, 2=MR, 3=ECI/DD, 4=SA, 5=RC) REGISTRATION EFFECTIVE DATE : 060108 (MMDDYY) TIME (HHMM A/P) : 0230P LEGAL GUARDIANSHIP : 8 MARITAL STATUS : 5 ESTIMATED ANNUAL GROSS FAMILY INCOME: 35000____ FAMILY SIZE : 4_ SERVICE PARTICIPANT GROUP : _ (CB, SB, PD, HC, TS, EC, UC) READY TO UPDATE? _ (Y/N) ACT: ___ (L00/AUTH DATA ENTRY MENU, A/MA MAIN MENU, HLP(PF1)/SCRN DOC)	• Type the Local Case Number assigned to the individual by the **CDSA** in the LOCAL CASE NUMBER field. • Review all fields on the screen for accuracy and correct if necessary. Note: **Do *not* change the Registration Effective Date.** • Type **Y** in the READY TO UPDATE? field. • Press **Enter**. Result: The **L09: Register Client Update** header screen is displayed with the message, *"Previous Information Changed."* Note: You don't have to change a local case number if an individual changes programs and leaves the provider, then later returns to the provider.

Continue with the *Provider Choice* procedure.

Enrollment in a Waiver Program
Provider Choice (L05)

Introduction

The *Provider Choice* process allows the MRA to enter the choice of program providers made by the individual/LAR and the program provider's contract number and location code.

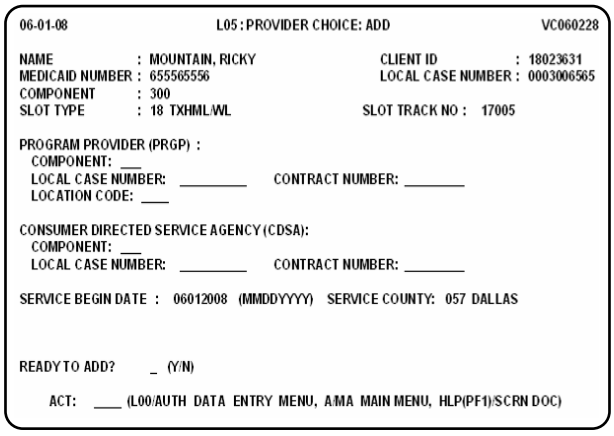
Procedure

The following table describes the steps the MRA will use to enter provider choice.

Step	View	Action
1	_ _	• Type **L05** in the ACT: field of any screen. • Press **Enter**. Result: The **L05: Provider Choice: Add/Delete** header screen is displayed.
2	A sample **L05: Provider Choice: Add/Delete** header screen is shown below. 06-01-08 L05 : PROVIDER CHOICE: ADD/DEL VC060227 PLEASE ENTER ONE OF THE FOLLOWING: CLIENT ID : _____ COMPONENT CODE/LOCAL CASE NUMBER : __/_____ MEDICAID NUMBER : _____ PLEASE ENTER THE FOLLOWING: TYPE OF ENTRY : _ (A/ADD,D/DELETE) *** PRESS ENTER *** ACT : ___ (L00/AUTH DATA ENTRY MENU, A/MA MAIN MENU, HLP(PF1)/SCRN DOC)	• Type the Client ID in the CLIENT ID field. • Type the **MRA** component code in the COMPONENT CODE field. • Type **A** (Add) in the TYPE OF ENTRY field. • Press **Enter**. Result: The **L05: Provider Choice: Add** screen is displayed.

continued on next page

Procedure, continued

Step	View	Action
3	A sample **L05: Provider Choice: Add** screen is shown below.  06-01-08 L05 : PROVIDER CHOICE: ADD VC060228 NAME : MOUNTAIN, RICKY CLIENT ID : 18023631 MEDICAID NUMBER : 655565556 LOCAL CASE NUMBER : 0003006565 COMPONENT : 300 SLOT TYPE : 18 TXHML/WL SLOT TRACK NO : 17005 PROGRAM PROVIDER (PRGP) : COMPONENT: ___ LOCAL CASE NUMBER: _____ CONTRACT NUMBER: _____ LOCATION CODE: ___ CONSUMER DIRECTED SERVICE AGENCY (CDSA): COMPONENT: ___ LOCAL CASE NUMBER: _____ CONTRACT NUMBER: _____ SERVICE BEGIN DATE : 06012008 (MMDDYYYY) SERVICE COUNTY: 057 DALLAS READY TO ADD? _ (Y/N) ACT: ___ (L00/AUTH DATA ENTRY MENU, A/MA MAIN MENU, HLP(PF1)/SCRN DOC)	**Program Provider (PRGP):** • Type the component code of the program provider chosen by the individual in the COMPONENT field. • Type the local case number that the program provider assigned the individual in the LOCAL CASE NUMBER field. • Type the contract number of the program provider chosen by the individual in the CONTRACT NUMBER field. • For TxHmL individuals, type **OHFH** (Own Home/Family Home) in the LOCATION CODE field. For HCS individuals, type the location code provided by the program provider in the LOCATION CODE field. Note: In HCS, when choosing a CDSA, the location code ***must*** be **OHFH**. **Consumer Directed Service Agency (CDSA):** • Type the component code of the CDS Agency in the COMPONENT field. • Type the local case number assigned the individual by the CDS Agency in the LOCAL CASE NUMBER field. • Type the contract number of the CDS Agency in the CONTRACT NUMBER field. • Type **Y** in the READY TO ADD? field. • Press **Enter**. Result: The header screen is displayed with the message, *"Previous Information Added."*

Service Coordination Assignment (490)

Introduction

The *Service Coordination Assignment* process allows the Mental Retardation Authority (MRA) to add, change, or delete a Service Coordinator assignment for an individual.

Note: Case Management Units (Action Code **660**) and Case Management Positions (Action Code **670**) for the MRA must have been identified in the CARE system before Service Coordinator assignments can be made.

Service Coordination Assignment (490): Add

Procedure

The following table describes the steps the MRA will use to add a Service Coordinator assignment for an individual.

The **Add** option is used to add the ***original*** Service Coordinator assignment for an individual **or** to ***change to a different*** Service Coordinator.

Step	View	Action
1	_ _	• Type **490** in the ACT: field of any screen. • Press **Enter**. Result: The **490: Svc Coordination Assignment: Add/Change/Delete header screen** is displayed.
2	A sample **490: Svc Coordination Assignment: Add/Change/Delete** header screen is shown below. 01-04-08 490:SVC COORDINATION ASSIGNMENT: ADD/CHANGE/DELETE VC021810 PLEASE ENTER ONE OF THE FOLLOWING: CLIENT ID : _____ COMPONENT CODE/LOCAL CASE NUMBER: __ / _____ PLEASE ENTER THE FOLLOWING: TYPE OF ENTRY : _ (A/ADD,C/CHANGE,D/DELETE) *** PRESS ENTER *** ACT: ___ (400/DATA ENTRY MENU, M/MENU)	• Type the requested identifying information in the appropriate fields. Rule: You must enter the Client ID *or* the local case number. • Type the MRA component code in the COMPONENT CODE field. • Type **A** (Add) in the TYPE OF ENTRY field. • Press **Enter**. Result: The **490: Svc Coordination Assignment: Add** screen is displayed.
3	A sample **490: Svc Coordination Assignment: Add** screen is shown below. 01-04-08 490:SVC COORDINATION ASSIGNMENT: ADD VC021811 LAST NAME/SUF: JACK CLIENT ID : 37940 FIRST NAME : APPLE LOCAL CASE NUMBER : 0000007206 MIDDLE NAME : COMPONENT CODE : 300 ASSIGNMENT BEGIN DATE: _____ (MMDDYY) ASSIGNMENT END DATE : _____ (MMDDYY) CASE MANAGER POSITION: ___ CASE MANAGEMENT UNIT : ___ READY TO ADD? : _ (Y/N) ACT: ___ (400/CLIENT ENTRY SCREEN,M/MENU)	• Type the date the assignment begins in the ASSIGNMENT BEGIN DATE field. • Type the code for the Service Coordinator position in the CASE MANAGER POSITION field. • Type the Case Management unit code in the CASE MANAGEMENT UNIT field. • Type **Y** in the READY TO ADD? field. Note: You can type **N** in the READY TO ADD? field to take no action and return to the header screen. • Press **Enter**. Result: The **490: Svc Coordination Assignment** header screen is displayed with the message, *"Previous Information Added."*

Service Coordination Assignment (490): Change

Procedure

The following table describes the steps the MRA will use to change an individual's Service Coordinator assignment record ***if an assignment was added in error and it must be corrected***. This option is ***not*** to be used to *change* service coordinators.

Step	View	Action
1	_ _	• Type **490** in the ACT: field of any screen. • Press **Enter**. Result: The **490: Svc Coordination Assignment: Add/Change/Delete** header screen is displayed.
2	A sample **490: Svc Coordination Assignment: Add/Change/Delete** header screen is shown below. 01-04-08 490:SVC COORDINATION ASSIGNMENT: ADD/CHANGE/DELETE VC021810 PLEASE ENTER ONE OF THE FOLLOWING: CLIENT ID : _____ COMPONENT CODE/LOCAL CASE NUMBER: __ / _____ PLEASE ENTER THE FOLLOWING: TYPE OF ENTRY : _ (A/ADD,C/CHANGE,D/DELETE) *** PRESS ENTER *** ACT: ___ (400/DATA ENTRY MENU, M/MENU)	• Type the requested identifying information in the appropriate fields. Rule: You must enter the Client ID *or* the local case number. • Type the MRA component code in the COMPONENT CODE field. • Type **C** (Change) in the TYPE OF ENTRY field. • Press **Enter**. Result: The **490: Svc Coordination Assignment: Change** screen is displayed.
3	A sample **490: Svc Coordination Assignment: Change** screen is shown below. 01-04-08 490:SVC COORDINATION ASSIGNMENT: CHANGE VC021811 REC: 1 OF 1 LAST NAME/SUF: JACK CLIENT ID : 37940 FIRST NAME : APPLE LOCAL CASE NUMBER : 0000007206 MIDDLE NAME : COMPONENT CODE : 300 ASSIGNMENT BEGIN DATE: 120507 (MMDDYY) ASSIGNMENT END DATE : _____ (MMDDYY) CASE MANAGER POSITION: 0153 CASE MANAGEMENT UNIT : 0721 READY TO CHANGE?: _ (Y/N) ACT: ___ (400/CLIENT ENTRY SCREEN,F/FO,B/BK,M/MENU)	• Type changes to the Service Coordination assignment in the appropriate fields. • Type **Y** in the READY TO CHANGE? field. Note: You can type **N** in the READY TO CHANGE? field to take no action and return to the header screen. • Press **Enter**. Result: The **490: Svc Coordinator Assignment** header screen is displayed with the message, *"Previous Information Changed."*

Service Coordination Assignment (490): Delete

Procedure — The following table describes the steps the MRA will use to delete an individual's Service Coordinator assignment record.

Step	View	Action
1	_ _	• Type **490** in the ACT: field of any screen. • Press **Enter**. Result: The **490: Svc Coordination Assignment: Add/Change/Delete** header screen is displayed.
2	A sample **490: Svc Coordinator Assignment: Add/Change/Delete** header screen is shown below. 01-04-08 490:SVC COORDINATION ASSIGNMENT: ADD/CHANGE/DELETE VC021810 PLEASE ENTER ONE OF THE FOLLOWING: CLIENT ID : _____ COMPONENT CODE/LOCAL CASE NUMBER: __ / _____ PLEASE ENTER THE FOLLOWING: TYPE OF ENTRY : _ (A/ADD,C/CHANGE,D/DELETE) *** PRESS ENTER *** ACT: ___ (400/DATA ENTRY MENU, M/MENU)	• Type the requested identifying information in the appropriate fields. Rule: You must enter the Client ID *or* the local case number. • Type the MRA component code in the COMPONENT CODE field. • Type **D** (Delete) in the TYPE OF ENTRY field. • Press **Enter**. Result: The **490: Svc Coordination Assignment: Delete** screen is displayed.
3	A sample **490: Svc Coordination Assignment: Delete** screen is shown below. 01-04-08 490:SVC COORDINATION ASSIGNMENT: DELETE VC021811 REC: 1 OF 1 LAST NAME/SUF: JACK CLIENT ID : 37940 FIRST NAME : APPLE LOCAL CASE NUMBER : 0000007206 MIDDLE NAME : COMPONENT CODE : 300 ASSIGNMENT BEGIN DATE: 120507 (MMDDYY) ASSIGNMENT END DATE : _____ (MMDDYY) CASE MANAGER POSITION: 0153 CASE MANAGEMENT UNIT : 0721 EV TYPE : R01A READY TO DELETE?: _ (Y/N) ACT: ___ (400/CLIENT ENTRY SCREEN,F/FO,B/BK,M/MENU)	• Type **Y** in the READY TO DELETE? field. Note: You can type **N** in the READY TO DELETE? field to take no action and return to the header screen. • Press **Enter**. Result: The **490: Case Management Assignment** header screen is displayed with the message, *"Previous Information Deleted."*

Waiver MR/RC Assessment (L23)

Introduction

The *Waiver MR/RC Assessment* process consists of seven screens that allow the Mental Retardation Authority (MRA) to add, change, or delete MR/RC assessment information for an individual.

Refer to the MR/RC Assessment instructions at http://dadsview.dads.state.tx.us/forms/8578/ for information on the fields used on these screens.

Note: The MRA is responsible for all MR/RC assessments for Purpose Code **2** (No Current Assessment), and Purpose Code **3** (Continued Stay Assessment), Purpose Code **4** (Change LON on Existing Assessment), and Purpose Code **E** (Gaps in LOC/LON) for TxHmL individuals.

The following pages display the **Add** screens for **Purpose Code 3**, **Purpose Code 4**, and **Purpose Code E**. The change and delete functions are not described but are used in the same way as other change and delete functions. However, once a MR/RC assessment has been electronically sent for review, Program Enrollment (PE) staff must electronically "return" it in order for you to access these functions.

There must be a paper (hard) copy of all information entered into the CARE system. This documentation should be kept in the individual's record and match data entered exactly.

Waiver MR/RC Assessment Purpose Code 3 (L23): Add

Procedure — The following table describes the steps the MRA will use to add an MR/RC continued stay assessment (Purpose Code 3) for a TxHmL individual.

Step	View	Action
1	_ _	• Type **L23** in the ACT: field of any screen. • Press **Enter**. Result: The **L23: Waiver MR/RC Assessment**: **Add/Chg/Del** header screen is displayed.
2	A sample **L23: Waiver MR/RC Assessment**: **Add/Chg/Del** header screen is shown below. 03-30-10 L23:WAIVER MR/RC ASSESSMENT: ADD/CHG/DEL VC060750 PLEASE ENTER ONE OF THE FOLLOWING: CLIENT ID: _____ COMPONENT CODE/LOCAL CASE NUMBER: __ / _____ MEDICAID NUMBER: _____ PLEASE ENTER THE FOLLOWING: CONTRACT NO : _____ PURPOSE CODE: _ (2/NO CURRENT ASSESSMENT, 3/CONTINUED STAY ASSESSMENT, 4/CHANGE LON ON EXISTING ASSESSMENT, E/GAPS IN ASSESSMENT) TYPE OF ENTRY: _ (A/ADD,C/CHANGE,D/DELETE) REQUESTED BEGIN DATE: _____ (MMDDYYYY, ENTER FOR ADD) REQUESTED END DATE : _____ (MMDDYYYY, ENTER FOR PURPOSE CODE E,ADD) *** PRESS ENTER *** ACT: ___ (L00/AUTH DATA ENTRY MENU, A/MA MAIN MENU, HLP(PF1)/SCRN DOC) This screen allows you to select the appropriate purpose code and type of entry for the TxHmL individual's data. This documentation describes the procedure for adding a Purpose Code 3 (Continued Stay Assessment).	• Type the requested identifying information in the appropriate fields. Rule: You must enter the Client ID, the local case number, *or* the Medicaid Number. • Type the MRA component code in the COMPONENT CODE field. • Type the contract number under which services are provided to this individual in the CONTRACT NO field. • Type **3** (Continued Stay Assessment) in the PURPOSE CODE field. • Type **A** (Add) in the TYPE OF ENTRY field. • Type the requested begin date in the REQUESTED BEGIN DATE field. (Within 60 days prior to the current expiration date, the begin date can be the day after the expiration date. Other than during this 60-day window, the begin date must be the date of data entry.) • Press **Enter**. Result: The **L23: Waiver MR/RC Assessment Purpose Code 3: Add** screen is displayed.
3	A sample **L23: Waiver MR/RC Assessment Purpose Code 3: Add** screen is shown below. 03-30-10 L23:WAIVER MR/RC ASSESSMENT PURPOSE CODE 3: ADD VC060751 PROVIDER NAME: DALLAS METROCARE SERVICES CONTRACT NO. : TXHML ADDRESS : 1380 RIVER BEND DR, DALLAS TX, 75247 CLIENT NAME : MOUNTAIN, ROCKY CLIENT ID : 18023509 COMPONENT : 804 LOCAL CASE NO. : 0008045555 MEDICAID NO. : 546789123 HIC/MEDICARE NO: DATE OF BIRTH: 05-18-1970 SSN : 423-33-3333 REQUESTED BEGIN DATE: 03-30-2010 12. COMPLETED DATE: _____ (MMDDYYYY) 14. PHYS EXAM DATE: 03152010 (MMDDYYYY) 15. LEGAL STATUS : _ 16. PREV. RES.: _ 17. REC. LOC : _ 18. REC. LON : 6 *DIAGNOSIS 20. PRIMARY DIAG : 317___ 21. VERSION: 9 22. ONSET: 051970 (MMYYYY) 24. CURRENT MED.DIAG: _____ 25. VERSION: 9 27. PSYCHIATRIC DIAG: _____ 28. VERSION: 4 * PRESS ENTER TO CONTINUE * ACT: ___ (L00/AUTH DATA ENTRY MENU,A/MA MAIN MENU,B(F7)/PREV SCRN) If you need to add or change information on these screens, you can page backward to correct any entry on previous screens. Use **F7** (function key) or type **B** in the ACT: field to page backward to the previous screen. You will not lose the information you have already entered.	• Type the date the MR/RC Assessment was completed in the COMPLETED DATE field. • Type in the latest physical examination date in the PHYS EXAM DATE field. • Type additional information in the appropriate fields. Note 1: **All data entered into the CARE system should be entered from a paper copy (a hard copy) and match exactly**. Note 2: The LEGAL STATUS and PREV. RES. fields are required. • Press **Enter**. Result: The **L23: Waiver MR/RC Assessment Purpose Code 3: Add** (Screen 2) is displayed.

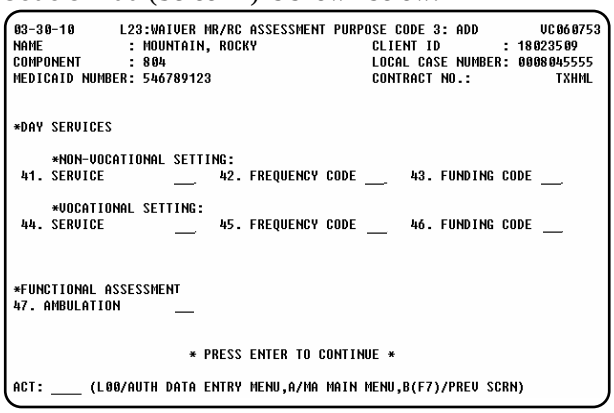
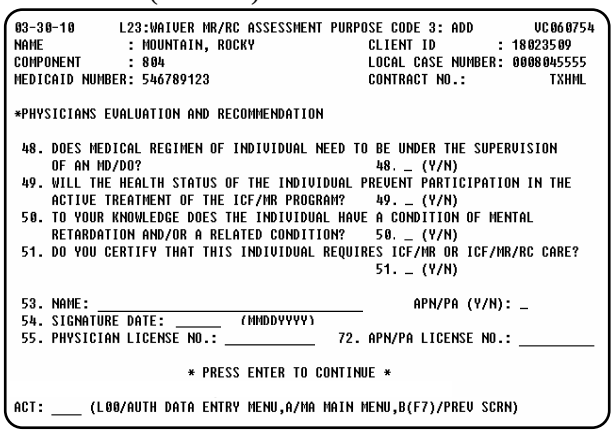
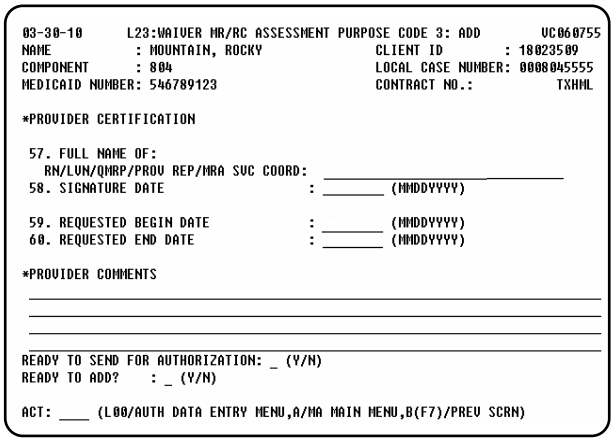
continued on next page

Procedure, continued

Step	View	Action
4	A sample **L23: Waiver MR/RC Assessment Purpose Code 3: Add** (Screen 2) is shown below. 03-30-10 L23:WAIVER MR/RC ASSESSMENT PURPOSE CODE 3: ADD VC060751 **VIEW CLIENT INFO AND MR/RC RECORD INFO** CLIENT COMP/CASE: 804/0008045555 CLIENT NAME : MOUNTAIN, ROCKY CLIENT ADDRESS : 525 OAK STREET, ANYTOWN TX, 78756 DIAGNOSIS DESCRIPTION FOR CODES ENTERED: PRIMARY DIAGNOSIS: 317 MILD MENTAL RETARDATION MEDICAL DIAGNOSIS: PSYCHIATRIC DIAGNOSIS: *INFO FROM THE LATEST 'LOC' RECORD EFF.DATE: 03-24-2010 END DATE: 03-23-2011 LEV.OF CARE: 1 LEV.OF NEED: 6 ›	This screen is a view screen that allows you to view client information and available MR/RC record information. It displays the Client Comp/Case, Client Name, Client Address, and diagnosis descriptions for codes entered for primary, medical, and psychiatric diagnoses. Information from the latest LOC record is also included. This screen also shows the current level of care information. • View and verify the client and MR/RC record information. • Press **Enter** to continue. Result: The **L23: Waiver MR/RC Assessment Purpose Code 3: Add** (Screen 3) is displayed.
5	A sample **L23: Waiver MR/RC Assessment Purpose Code 3: Add** (Screen 3) is shown below. 03-30-10 L23:WAIVER MR/RC ASSESSMENT PURPOSE CODE 3: ADD VC060752 NAME : MOUNTAIN, ROCKY CLIENT ID : 18023589 COMPONENT : 804 LOCAL CASE NUMBER: 0008045555 MEDICAID NUMBER: 546789123 CONTRACT NO.: TXHML 18. REC LON : 6 *COGNITIVE FUNCTIONING 29. IQ: ___ 30. ABL: ___ *ICAP DATA 31. BROAD INDEPENDENCE 32. GEN. MALADAPTIVE ___ 33. ICAP SERVICE LEVEL ___ *BEHAVIORAL STATUS 34. BEHAVIOR PROGRAM __ 35. SELF-INJURY BEHAVIOR __ 36. SERIOUS DISRUP BEH __ 37. AGGRESSIVE BEHAVIOR __ 38. SEX. AGGRESS. BEH. __ *NURSING 39. SERVICE PROVIDER 15 40. FREQUENCY CODE 1_ * PRESS ENTER TO CONTINUE * ACT: ___ (L00/AUTH DATA ENTRY MENU,A/MA MAIN MENU,B(F7)/PREV SCRN)	• Type information in the appropriate fields. Required fields on this screen are IQ, ABL (Adaptive Behavior Level), BROAD INDEPENDENCE, GEN. MALADAPTIVE, ICAP SERVICE LEVEL, BEHAVIOR PROGRAM (**Y**ES OR **N**O), SELF-INJURY BEHAVIOR, SERIOUS DISRUP BEH, AGGRESSIVE BEHAVIOR, and SEX. AGGRESS. BEH. (See MR/RC instructions for codes and how they affect the LON) Note: For the 32. GEN. MALADAPTIVE field, if the number is negative, you *must* use the – (minus) sign just above the alpha section of the keyboard, not the – sign on the 10-key pad. • Press **Enter**. Result: The **L23: Waiver MR/RC Assessment Purpose Code 3: Add** (Screen 4) is displayed.

continued on next page

Procedure, continued

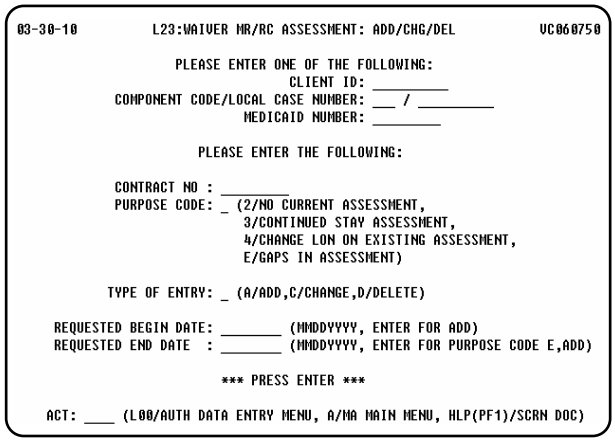
Step	View	Action
6	A sample **L23: Waiver MR/RC Assessment Purpose Code 3: Add** (Screen 4) is shown below.  03-30-10 L23:WAIVER MR/RC ASSESSMENT PURPOSE CODE 3: ADD VC060753 NAME : MOUNTAIN, ROCKY CLIENT ID : 18023509 COMPONENT : 804 LOCAL CASE NUMBER: 0008045555 MEDICAID NUMBER: 546789123 CONTRACT NO.: TXHML *DAY SERVICES *NON-VOCATIONAL SETTING: 41. SERVICE __ 42. FREQUENCY CODE __ 43. FUNDING CODE __ *VOCATIONAL SETTING: 44. SERVICE __ 45. FREQUENCY CODE __ 46. FUNDING CODE __ *FUNCTIONAL ASSESSMENT 47. AMBULATION __ * PRESS ENTER TO CONTINUE * ACT: ___ (L00/AUTH DATA ENTRY MENU,A/MA MAIN MENU,B(F7)/PREV SCRN)	• Type information in the appropriate fields. Note: *All of the fields* on this screen are required. (See instructions for codes) • Press **Enter**. Result: The **L23: Waiver MR/RC Assessment Purpose Code 3: Add** (Screen 5) is displayed.
7	A sample **L23: Waiver MR/RC Assessment Purpose Code 3: Add** (Screen 5) is shown below.  03-30-10 L23:WAIVER MR/RC ASSESSMENT PURPOSE CODE 3: ADD VC060754 NAME : MOUNTAIN, ROCKY CLIENT ID : 18023509 COMPONENT : 804 LOCAL CASE NUMBER: 0008045555 MEDICAID NUMBER: 546789123 CONTRACT NO.: TXHML *PHYSICIANS EVALUATION AND RECOMMENDATION 48. DOES MEDICAL REGIMEN OF INDIVIDUAL NEED TO BE UNDER THE SUPERVISION OF AN MD/DO? 48. _ (Y/N) 49. WILL THE HEALTH STATUS OF THE INDIVIDUAL PREVENT PARTICIPATION IN THE ACTIVE TREATMENT OF THE ICF/MR PROGRAM? 49. _ (Y/N) 50. TO YOUR KNOWLEDGE DOES THE INDIVIDUAL HAVE A CONDITION OF MENTAL RETARDATION AND/OR A RELATED CONDITION? 50. _ (Y/N) 51. DO YOU CERTIFY THAT THIS INDIVIDUAL REQUIRES ICF/MR OR ICF/MR/RC CARE? 51. _ (Y/N) 53. NAME: _____ APN/PA (Y/N): _ 54. SIGNATURE DATE: _____ (MMDDYYYY) 55. PHYSICIAN LICENSE NO.: _____ 72. APN/PA LICENSE NO.: _____ * PRESS ENTER TO CONTINUE * ACT: ___ (L00/AUTH DATA ENTRY MENU,A/MA MAIN MENU,B(F7)/PREV SCRN)	• Type information in the appropriate fields. • If **any** data is entered or shown on this screen, all fields must be correctly entered (not required for waiver programs). Note: The fields (48-55) on this screen are not required to be completed. If you choose to enter information in the fields, **they must be completed completely and accurately**. • Press **Enter**. Result: The **L23: Waiver MR/RC Assessment Purpose Code 3: Add** (Screen 6) is displayed.
8	A sample **L23: Waiver MR/RC Assessment Purpose Code 3: Add** (Screen 6) is shown below.  03-30-10 L23:WAIVER MR/RC ASSESSMENT PURPOSE CODE 3: ADD VC060755 NAME : MOUNTAIN, ROCKY CLIENT ID : 18023509 COMPONENT : 804 LOCAL CASE NUMBER: 0008045555 MEDICAID NUMBER: 546789123 CONTRACT NO.: TXHML *PROVIDER CERTIFICATION 57. FULL NAME OF: RN/LVN/QMRP/PROV REP/MRA SVC COORD: _____ 58. SIGNATURE DATE : _____ (MMDDYYYY) 59. REQUESTED BEGIN DATE : _____ (MMDDYYYY) 60. REQUESTED END DATE : _____ (MMDDYYYY) *PROVIDER COMMENTS READY TO SEND FOR AUTHORIZATION: _ (Y/N) READY TO ADD? : _ (Y/N) ACT: ___ (L00/AUTH DATA ENTRY MENU,A/MA MAIN MENU,B(F7)/PREV SCRN)	• Type information in the appropriate fields. Note: The title of the person listed on the FULL NAME OF field (field 57) **must be on the list** displayed on this screen. • Type **Y** (Yes) or **N** (No) in the READY TO SEND FOR AUTHORIZATION? field to indicate whether or not you are ready to send the MR/RC Assessment to DADS Access & Intake, Program Enrollment (PE). • Type **Y** (Yes) or **N** (No) in the READY TO ADD? field to indicate whether or not you are ready to add the record. You may want to add the record pending further modifications even if you are not ready to send it for authorization by UR. Note: You may type **N** in the READY TO ADD? field to take no action and return to the header screen. **No data entered will be saved.** • Press **Enter**. Result: The **L23: Waiver MR/RC Assessment** header screen is displayed with the message, *"Previous Information Added."*

Waiver MR/RC Assessment Purpose Code 4 (L23): Add

Procedure

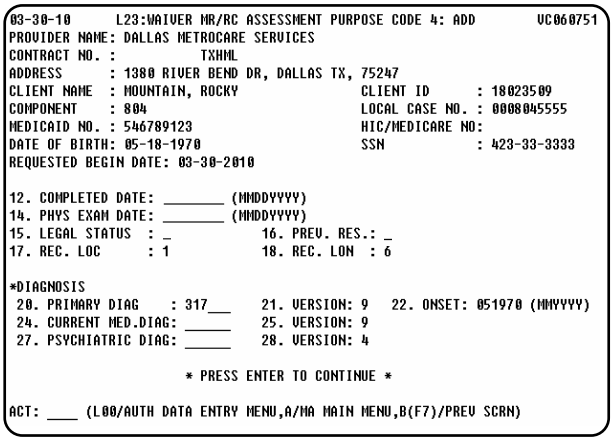
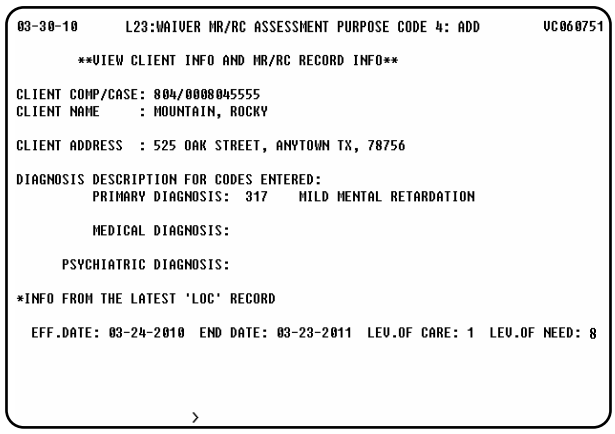
The following table describes the steps a provider will use to reflect information that an individual's skills and/or behaviors have changed to the extent that they warrant a change to the LON (Level of Need) on an existing assessment (Purpose Code 4).

Note: LON changes are not considered in the TxHmL program, as reimbursement is not related to LON. The process described here allows the CARE system to be updated to show that circumstances have changed and that an LON increase is felt to be appropriate. This would only have an impact should the individual enroll in another program where the rate(s) of reimbursement are determined by the LON (i.e. HCS, ICF).

Step	View	Action
1	_ _	• Type **L23** in the ACT: field of any screen. • Press **Enter**. Result: The **L23: Waiver MR/RC Assessment**: **Add/Chg/Del** header screen is displayed.
2	A sample **L23: Waiver MR/RC Assessment**: **Add/Chg/Del** header screen is shown below.  03-30-10 L23:WAIVER MR/RC ASSESSMENT: ADD/CHG/DEL VC060750 PLEASE ENTER ONE OF THE FOLLOWING: CLIENT ID: _____ COMPONENT CODE/LOCAL CASE NUMBER: __ / _____ MEDICAID NUMBER: _____ PLEASE ENTER THE FOLLOWING: CONTRACT NO : _____ PURPOSE CODE: _ (2/NO CURRENT ASSESSMENT, 3/CONTINUED STAY ASSESSMENT, 4/CHANGE LON ON EXISTING ASSESSMENT, E/GAPS IN ASSESSMENT) TYPE OF ENTRY: _ (A/ADD,C/CHANGE,D/DELETE) REQUESTED BEGIN DATE: _____ (MMDDYYYY, ENTER FOR ADD) REQUESTED END DATE : _____ (MMDDYYYY, ENTER FOR PURPOSE CODE E,ADD) *** PRESS ENTER *** ACT: ___ (L00/AUTH DATA ENTRY MENU, A/MA MAIN MENU, HLP(PF1)/SCRN DOC) This screen allows you to select the appropriate purpose code and type of entry for the individual's data. This documentation describes the procedure for adding a Purpose Code 4 (Change LON on Existing Assessment).	• Type the requested identifying information in the appropriate fields. Rule: You must enter the Client ID, the local case number, *or* the Medicaid Number. Note: Your component code is displayed based on your logon account number. • Type the contract number under which services are provided to this individual in the CONTRACT NO field. • Type **4** (Change LON on Existing Assessment) in the PURPOSE CODE field. • Type **A** (Add) in the TYPE OF ENTRY field. • Type the requested begin date in the REQUESTED BEGIN DATE field. Note: For a Purpose Code 4, the begin date *must* equal the date of data entry. The end date will be the date that the current LOC/LON expires. • Press **Enter**. Result: The **L23: Waiver MR/RC Assessment Purpose Code 4: Add** screen is displayed.

continued on next page

Procedure, continued

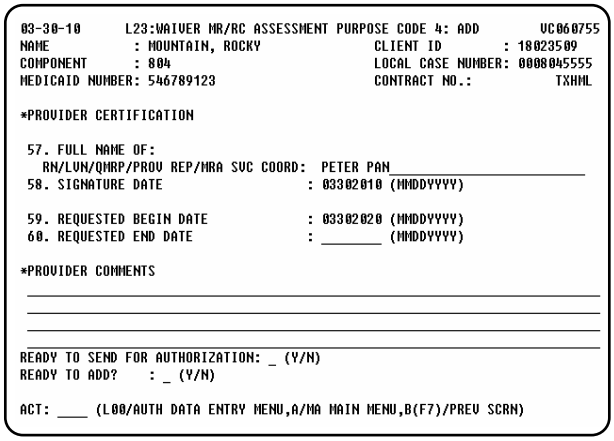
Step	View	Action
3	A sample **L23: Waiver MR/RC Assessment Purpose Code 4: Add** screen is shown below.  If you need to add or change information on these screens, you can page backward to correct any entry on previous screens. Use **F7** (function key) or type **B** in the ACT: field to page backward to the previous screen. You will not lose the information you have already entered.	• Type the date the MR/RC Assessment was completed in the COMPLETED DATE field. • Type the recommended Level of Need (LON) in the REC. LON field. • Type additional information in the appropriate fields. Note: **All data entered into the CARE system should be entered from a paper copy (a hard copy) and match exactly**. • Press **Enter** to continue. Result: The **L23: Waiver MR/RC Assessment Purpose Code 4: Add** (Screen 2) is displayed.
4	A sample **L23: Waiver MR/RC Assessment Purpose Code 4: Add** (Screen 2) is shown below. 	This screen allows you to view client information and available MR/RC record information. It displays the Client Comp/Case, Client Name, Client Address, and diagnosis descriptions for codes entered for primary, medical, and psychiatric diagnoses. This screen also shows the current LOC information. • View the client and MR/RC record information. • Press **Enter** to continue. Result: The **L23: Waiver MR/RC Assessment Purpose Code 4: Add** (Screen 3) is displayed.

continued on next page

Procedure, continued

Step	View	Action
5	A sample **L23: Waiver MR/RC Assessment Purpose Code 4: Add** (Screen 3) is shown below. 03-30-10 L23:WAIVER MR/RC ASSESSMENT PURPOSE CODE 4: ADD VC060752 NAME : MOUNTAIN, ROCKY CLIENT ID : 18023509 COMPONENT : 804 LOCAL CASE NUMBER: 0008045555 MEDICAID NUMBER: 546789123 CONTRACT NO.: TXHML 18. REC LON : 6 *COGNITIVE FUNCTIONING 29. IQ: 50_ 30. ABL: 3 *ICAP DATA 31. BROAD INDEPENDENCE 412 32. GEN. MALADAPTIVE -21 33. ICAP SERVICE LEVEL 1 *BEHAVIORAL STATUS 34. BEHAVIOR PROGRAM Y 35. SELF-INJURY BEHAVIOR 0 36. SERIOUS DISRUP BEH 0 37. AGGRESSIVE BEHAVIOR 0 38. SEX. AGGRESS. BEH. 0 *NURSING 39. SERVICE PROVIDER __ 40. FREQUENCY CODE 1_ * PRESS ENTER TO CONTINUE * ACT: ___ (L00/AUTH DATA ENTRY MENU,A/MA MAIN MENU,B(F7)/PREV SCRN)	• Type information in the appropriate fields. • Press **Enter** to continue. Result: The **L23: Waiver MR/RC Assessment Purpose Code 4: Add** (Screen 4) is displayed.
6	A sample **L23: Waiver MR/RC Assessment Purpose Code 4: Add** (Screen 4) is shown below. 03-30-10 L23:WAIVER MR/RC ASSESSMENT PURPOSE CODE 4: ADD VC060753 NAME : MOUNTAIN, ROCKY CLIENT ID : 18023509 COMPONENT : 804 LOCAL CASE NUMBER: 0008045555 MEDICAID NUMBER: 546789123 CONTRACT NO.: TXHML *DAY SERVICES *NON-VOCATIONAL SETTING: 41. SERVICE 2_ 42. FREQUENCY CODE 1_ 43. FUNDING CODE 1_ *VOCATIONAL SETTING: 44. SERVICE 0_ 45. FREQUENCY CODE 0_ 46. FUNDING CODE 0_ *FUNCTIONAL ASSESSMENT 47. AMBULATION 1 * PRESS ENTER TO CONTINUE * ACT: ___ (L00/AUTH DATA ENTRY MENU,A/MA MAIN MENU,B(F7)/PREV SCRN)	• Type information in the appropriate fields. • Press **Enter** to continue. Result: The **L23: Waiver MR/RC Assessment Purpose Code 4: Add** (Screen 5) is displayed.
7	A sample **L23: Waiver MR/RC Assessment Purpose Code 4: Add** (Screen 5) is shown below. 03-30-10 L23:WAIVER MR/RC ASSESSMENT PURPOSE CODE 4: ADD VC060754 NAME : MOUNTAIN, ROCKY CLIENT ID : 18023509 COMPONENT : 804 LOCAL CASE NUMBER: 0008045555 MEDICAID NUMBER: 546789123 CONTRACT NO.: TXHML *PHYSICIANS EVALUATION AND RECOMMENDATION 48. DOES MEDICAL REGIMEN OF INDIVIDUAL NEED TO BE UNDER THE SUPERVISION OF AN MD/DO? 48. _ (Y/N) 49. WILL THE HEALTH STATUS OF THE INDIVIDUAL PREVENT PARTICIPATION IN THE ACTIVE TREATMENT OF THE ICF/MR PROGRAM? 49. _ (Y/N) 50. TO YOUR KNOWLEDGE DOES THE INDIVIDUAL HAVE A CONDITION OF MENTAL RETARDATION AND/OR A RELATED CONDITION? 50. _ (Y/N) 51. DO YOU CERTIFY THAT THIS INDIVIDUAL REQUIRES ICF/MR OR ICF/MR/RC CARE? 51. _ (Y/N) 53. NAME: _____ APN/PA (Y/N): _ 54. SIGNATURE DATE: _ (MMDDYYYY) 55. PHYSICIAN LICENSE _____ 72. APN/PA LICENSE NO.: _____ * PRESS ENTER TO CONTINUE * ACT: ___ (L00/AUTH DATA ENTRY MENU,A/MA MAIN MENU,B(F7)/PREV SCRN)	• Type information in the appropriate fields. If any information is entered or shown, all fields on this screen must be correctly entered. Note: The fields (48-55) on this screen are not required to be completed. If you choose to enter information in the fields, **they must be completed completely and accurately**. • Press **Enter** to continue. Result: The **L23: Waiver MR/RC Assessment Purpose Code 4: Add** (Screen 6) is displayed.

Procedure, continued

Step	View	Action
8	A sample **L23: Waiver MR/RC Assessment Purpose Code 4: Add** (Screen 6) is shown below.  A paper copy of the MR/RC purpose code 4 must be maintained in the individual's record and exactly match the data entered.	• Type or verify correctness of information in the appropriate fields. Note: The title of the person listed on the FULL NAME OF field (field 57) **must be on the list** displayed on this screen. • Type **Y** (Yes) or **N** (No) in the READY TO SEND FOR AUTHORIZATION? field to indicate whether or not you are ready to send the MR/RC Assessment to DADS Access & Intake, Program Enrollment (PE). • Type **Y** (Yes) or **N** (No) in the READY TO ADD? field to indicate whether or not you are ready to add the record. You may want to add the record pending further modifications even if you are not ready to send it for authorization by PE/UR. Note: You can type **N** in the READY TO ADD? field to take no action and return to the header screen. **No data entered will be saved.** • Press **Enter**. Result: The **L23: Waiver MR/RC Assessment** header screen is displayed with the message, *"Previous Information Added."*

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03-30-10     L23:WAIVER MR/RC ASSESSMENT PURPOSE CODE 4: ADD       VCB60755
NAME          : MOUNTAIN, ROCKY              CLIENT ID       : 18023509
COMPONENT     : 804                          LOCAL CASE NUMBER: 0808045555
MEDICAID NUMBER: 546789123                   CONTRACT NO.:          TXHML

*PROVIDER CERTIFICATION

 57. FULL NAME OF:
   RN/LVN/QMRP/PROV REP/MRA SVC COORD:  PETER PAN_____________________
 58. SIGNATURE DATE                  : 03302010 (MMDDYYYY)

 59. REQUESTED BEGIN DATE            : 03302020 (MMDDYYYY)
 60. REQUESTED END DATE              : _______ (MMDDYYYY)

*PROVIDER COMMENTS
 ____________________________________________________________________
 ____________________________________________________________________
 ____________________________________________________________________
 ____________________________________________________________________
READY TO SEND FOR AUTHORIZATION: _ (Y/N)
READY TO ADD?    : _ (Y/N)

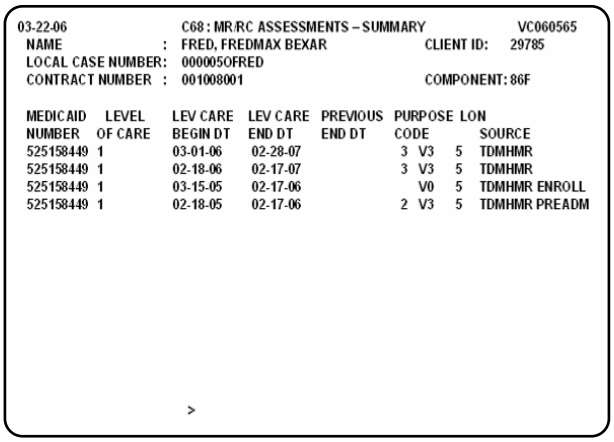
ACT: ___ (L00/AUTH DATA ENTRY MENU,A/MA MAIN MENU,B(F7)/PREV SCRN)
```

Waiver MR/RC Assessment Purpose Code E (L23): Add

Procedure

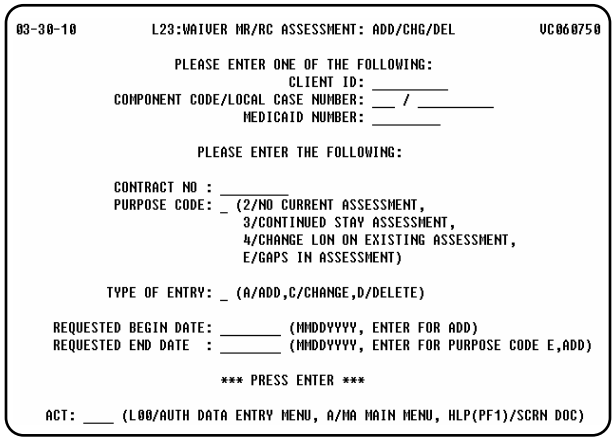
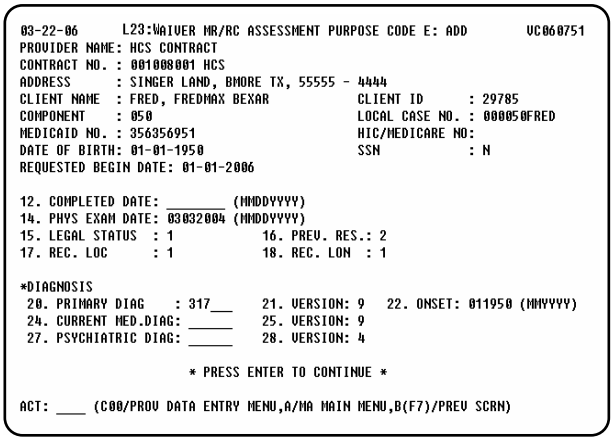
Providers may not request an MR/RC to begin prior to the date of data entry. If a provider fails to renew a LOC/LON prior to the expiration of the current LOC/LON, this will result in a time period for which there is no LOC/LON, referred to as a gap in LOC/LON. A current MR/RC must be authorized in the CARE system. Providers may request an MR/RC assessment, **Purpose Code E**, to cover the gap period, but it may only be requested for a time period no more than **180 days** after the beginning of the gap.

The following table describes the steps a provider will use to add a request for reinstatement of a level of care for a gap in assessment (Purpose Code E).

Step	View	Action
1	_ _	• Type **C68** in the ACT: field of any screen. • Press **Enter**. Result: The **C68: MR/RC Assessments – Summary** header screen is displayed.
2	A sample **C68: MR/RC Assessments – Summary** header screen is shown below. 	The gap begin and end dates are obtained from the **C68: MR/RC Assessments – Summary** screen. Important: **The begin date of the gap is the day after the previous LOC/LON expired, and the end date is the day before the current LOC/LON begins.** • Review information from the two most recent MR/RC Assessments to determine the gap dates.
3	_ _	• Type **L23** in the ACT: field of any screen. • Press **Enter**. Result: The **L23: Waiver MR/RC Assessment**: **Add/Chg/Del** header screen is displayed.

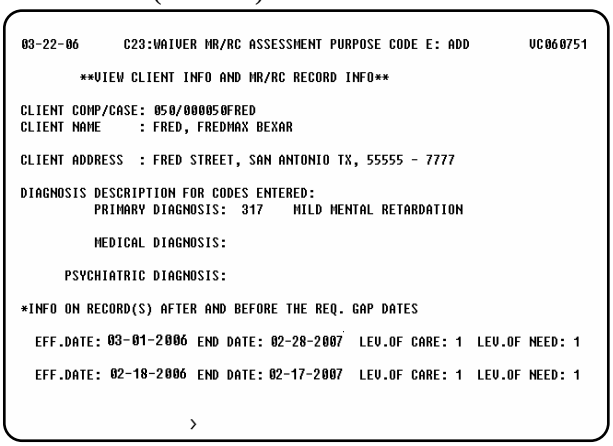
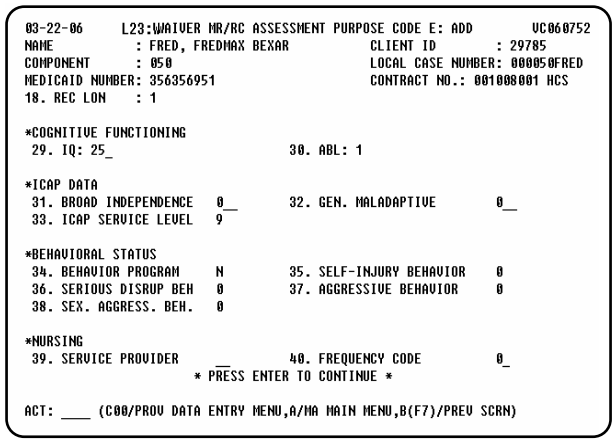
continued on next page

Procedure, continued

Step	View	Action
4	A sample **L23: Waiver MR/RC Assessment**: **Add/Chg/Del** header screen is shown below.  03-30-10 L23:WAIVER MR/RC ASSESSMENT: ADD/CHG/DEL VC060750 PLEASE ENTER ONE OF THE FOLLOWING: CLIENT ID: _____ COMPONENT CODE/LOCAL CASE NUMBER: __ / _____ MEDICAID NUMBER: _____ PLEASE ENTER THE FOLLOWING: CONTRACT NO : _____ PURPOSE CODE: _ (2/NO CURRENT ASSESSMENT, 3/CONTINUED STAY ASSESSMENT, 4/CHANGE LON ON EXISTING ASSESSMENT, E/GAPS IN ASSESSMENT) TYPE OF ENTRY: _ (A/ADD,C/CHANGE,D/DELETE) REQUESTED BEGIN DATE: _____ (MMDDYYYY, ENTER FOR ADD) REQUESTED END DATE : _____ (MMDDYYYY, ENTER FOR PURPOSE CODE E,ADD) *** PRESS ENTER *** ACT: ___ (L00/AUTH DATA ENTRY MENU, A/MA MAIN MENU, HLP(PF1)/SCRN DOC) This screen allows you to select the appropriate purpose code and type of entry for the individual's data. This documentation describes the procedure for adding a Purpose Code E (Gaps in Assessment).	• Type the requested identifying information in the appropriate fields. Rule: You must enter the Client ID, the local case number, *or* the Medicaid Number. Note: Your component code is displayed based on your logon account number. • Type the contract number under which services are provided to this individual in the CONTRACT NO field. • Type **E** (Gaps in Assessment) in the PURPOSE CODE field. • Type **A** (Add) in the TYPE OF ENTRY field. • Type the requested begin date in the REQUESTED BEGIN DATE field. • Type the requested end date in the REQUESTED END DATE field. Note: For Purpose Code E, REQUESTED BEGIN DATE and REQUESTED END DATE are required. • Press **Enter**. Result: The **L23: Waiver MR/RC Assessment Purpose Code E: Add** screen is displayed.
5	A sample **L23: Waiver MR/RC Assessment Purpose Code E: Add** screen is shown below.  03-22-06 L23:WAIVER MR/RC ASSESSMENT PURPOSE CODE E: ADD VC060751 PROVIDER NAME: HCS CONTRACT CONTRACT NO. : 001008001 HCS ADDRESS : SINGER LAND, BMORE TX, 55555 - 4444 CLIENT NAME : FRED, FREDMAX BEXAR CLIENT ID : 29785 COMPONENT : 050 LOCAL CASE NO. : 000050FRED MEDICAID NO. : 356356951 HIC/MEDICARE NO: DATE OF BIRTH: 01-01-1950 SSN : N REQUESTED BEGIN DATE: 01-01-2006 12. COMPLETED DATE: _____ (MMDDYYYY) 14. PHYS EXAM DATE: 03032004 (MMDDYYYY) 15. LEGAL STATUS : 1 16. PREV. RES.: 2 17. REC. LOC : 1 18. REC. LON : 1 *DIAGNOSIS 20. PRIMARY DIAG : 317__ 21. VERSION: 9 22. ONSET: 011950 (MMYYYY) 24. CURRENT MED.DIAG: _____ 25. VERSION: 9 27. PSYCHIATRIC DIAG: _____ 28. VERSION: 4 * PRESS ENTER TO CONTINUE * ACT: ___ (C00/PROV DATA ENTRY MENU,A/MA MAIN MENU,B(F7)/PREV SCRN) If you need to add or change information on these screens, you can page backward to correct any entry on previous screens. Use **F7** (function key) or type **B** in the ACT: field to page backward to the previous screen. You will not lose the information you have already entered.	• Type the date the MR/RC Assessment was completed in the COMPLETED DATE field. Note: The date must be **on or after** the gap end date. • Type the recommended Level of Need (LON) in the REC. LON field. • Type additional information in the appropriate fields. • Press **Enter** to continue. Note: **All data entered into the CARE system should be entered from a paper copy (a hard copy) and match exactly**. Result: The **L23: Waiver MR/RC Assessment Purpose Code E: Add** (Screen 2) is displayed. Note: **An LON increase cannot be authorized on a Purpose Code E.**

continued on next page

Procedure, continued

Step	View	Action
6	A sample **L23: Waiver MR/RC Assessment Purpose Code E: Add** (Screen 2) is shown below.  This screen allows you to view client information and available MR/RC record information. It displays the Client Comp/Case, Client Name, Client Address, and diagnosis descriptions for codes entered for primary, medical, and psychiatric diagnoses.	• View the client and MR/RC record information. • Press **Enter** to continue. Result: The **L23: Waiver MR/RC Assessment Purpose Code E: Add** (Screen 3) is displayed.
7	A sample **L23: Waiver MR/RC Assessment Purpose Code E: Add** (Screen 3) is shown below. 	• Type information in the appropriate fields. • Press **Enter** to continue. Result: The **L23: Waiver MR/RC Assessment Purpose Code E: Add** (Screen 4) is displayed.

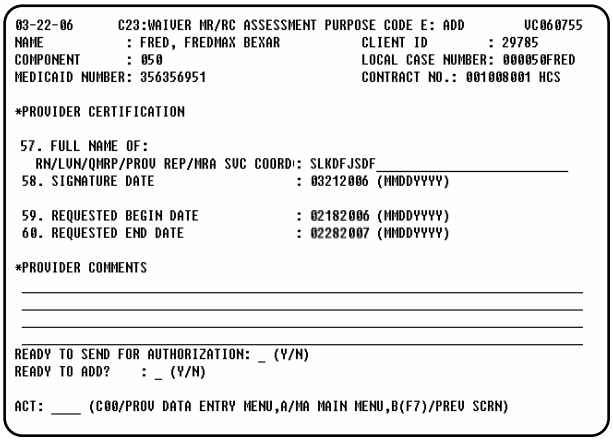
continued on next page

Procedure, continued

Step	View	Action
8	A sample **L23: Waiver MR/RC Assessment Purpose Code E: Add** (Screen 4) is shown below. 03-22-06 L23:WAIVER MR/RC ASSESSMENT PURPOSE CODE E: ADD VC060753 NAME : FRED, FREDMAX BEXAR CLIENT ID : 29785 COMPONENT : 050 LOCAL CASE NUMBER: 000050FRED MEDICAID NUMBER: 356356951 CONTRACT NO.: 001008001 HCS *DAY SERVICES *NON-VOCATIONAL SETTING: 41. SERVICE 0_ 42. FREQUENCY CODE 0_ 43. FUNDING CODE 0_ *VOCATIONAL SETTING: 44. SERVICE 0_ 45. FREQUENCY CODE 0_ 46. FUNDING CODE 0_ *FUNCTIONAL ASSESSMENT 47. AMBULATION 1 * PRESS ENTER TO CONTINUE * ACT: ___ (C00/PROV DATA ENTRY MENU,A/MA MAIN MENU,B(F7)/PREV SCRN)	• Type information in the appropriate fields. • Press **Enter** to continue. Result: The **L23: Waiver MR/RC Assessment Purpose Code E: Add** (Screen 5) is displayed.
9	A sample **L23: Waiver MR/RC Assessment Purpose Code E: Add** (Screen 5) is shown below. 03-22-06 C23:WAIVER MR/RC ASSESSMENT PURPOSE CODE E: ADD VC060754 NAME : FRED, FREDMAX BEXAR CLIENT ID : 29785 COMPONENT : 050 LOCAL CASE NUMBER: 000050FRED MEDICAID NUMBER: 356356951 CONTRACT NO.: 001008001 HCS *PHYSICIANS EVALUATION AND RECOMMENDATION 48. DOES MEDICAL REGIMEN OF INDIVIDUAL NEED TO BE UNDER THE SUPERVISION OF AN MD/DO? 48. Y (Y/N) 49. WILL THE HEALTH STATUS OF THE INDIVIDUAL PREVENT PARTICIPATION IN THE ACTIVE TREATMENT OF THE ICF/MR PROGRAM? 49. N (Y/N) 50. TO YOUR KNOWLEDGE DOES THE INDIVIDUAL HAVE A CONDITION OF MENTAL RETARDATION AND/OR A RELATED CONDITION? 50. Y (Y/N) 51. DO YOU CERTIFY THAT THIS INDIVIDUAL REQUIRES ICF/MR OR ICF/MR/RC CARE? 51. Y (Y/N) 53. NAME: BUGS BUNNY_____ APN/PA (Y/N): _ 54. SIGNATURE DATE: 03212006 (MMDDYYYY) 55. PHYSICIAN LICENSE NO.: LIC2_____ 72. APN/PA LICENSE NO.: _____ * PRESS ENTER TO CONTINUE * ACT: ___ (C00/PROV DATA ENTRY MENU,A/MA MAIN MENU,B(F7)/PREV SCRN)	• Type information in the appropriate fields. Note: The fields (48-55) on this screen are not required to be completed. If you choose to enter information in the fields, **they must be completed completely and accurately**. • Press **Enter**. Result: The **L23: Waiver MR/RC Assessment Purpose Code E: Add** (Screen 6) is displayed.

continued on next page

Procedure, continued

Step	View	Action
10	A sample **L23: Waiver MR/RC Assessment Purpose Code E: Add** (Screen 6) is shown below.  03-22-06 C23:WAIVER MR/RC ASSESSMENT PURPOSE CODE E: ADD VC060755 NAME : FRED, FREDMAX BEXAR CLIENT ID : 29785 COMPONENT : 050 LOCAL CASE NUMBER: 000050FRED MEDICAID NUMBER: 356356951 CONTRACT NO.: 001008001 HCS *PROVIDER CERTIFICATION 57. FULL NAME OF: RN/LVN/QMRP/PROV REP/MRA SVC COORD: SLKDFJSDF 58. SIGNATURE DATE : 03212006 (MMDDYYYY) 59. REQUESTED BEGIN DATE : 02182006 (MMDDYYYY) 60. REQUESTED END DATE : 02282007 (MMDDYYYY) *PROVIDER COMMENTS READY TO SEND FOR AUTHORIZATION: _ (Y/N) READY TO ADD? : _ (Y/N) ACT: ___ (C00/PROV DATA ENTRY MENU,A/MA MAIN MENU,B(F7)/PREV SCRN)	• Type information in the appropriate fields. Note 1: The title of the person listed in the FULL NAME OF field (field 57) **must be on the list** displayed on this screen. Note 2: The signature date must be **on or after** the gap end date. • Type **Y** (Yes) or **N** (No) in the READY TO SEND FOR AUTHORIZATION? field to indicate whether or not you are ready to send the MR/RC Assessment to DADS Access & Intake, Program Enrollment (PE). • Type **Y** (Yes) or **N** (No) in the READY TO ADD? field to indicate whether or not you are ready to add the record. You may want to add the record pending further modifications even if you are not ready to send it for authorization by PE/UR. Note: You can type **N** in the READY TO ADD? field to take no action and return to the header screen. **The Purpose Code E information/changes will not be saved.** • Press **Enter**. • Result: The **L23: Waiver MR/RC Assessment** header screen is displayed with the message, *"Previous Information Added."*

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Service Coordinator Review of MR/RC (L32)

Introduction

Beginning June 2010, the *Service Coordinator Review of MR/RC* screens will be used by the Mental Retardation Authority (MRA) Service Coordinator to review an MR/RC assessment. The Service Coordinator (SC) must either confirm the assessment or return the review to the provider with comments.

Provider's Responsibility

Before the Service Coordinator can review the MR/RC assessment, the provider must access the **C23/L23: Waiver MR/RC Assessment: Add/Chg/Del** screens and enter the MR/RC Assessment information.

The program provider may use the **C82** screen and select STATUS CODE **X – Returned to Provider for More Information** to see if any MR/RC Assessments have been returned by the MRA.

Service Coordinator Review

Once the program provider has entered the information into CARE, the Service Coordinator has seven (7) days to review the LOC/LON information and enter their agreement or disagreement with what was entered.

The MRA may access the **L82: Pending MR/RC MRA SC Reviews: MRA Inquiry** screen which assists the MRA with tracking MR/RCs that need to be reviewed by the Service Coordinator and displays all MR/RCs waiting for the Service Coordinator review. MRAs are expected to review each MR/RC and must determine how frequently they will need to produce the list in order to meet this expectation.

Assessment Not Reviewed in Timely Manner

Program providers will not be prevented from entering billing because a Service Coordinator does not review the MR/RC Assessment in a timely manner. If a Service Coordinator does not review an MR/RC Assessment within seven (7) days of data entry, CARE will automatically send the MR/RC Assessment to DADS for approval. Reports will be available for state office and MRA management staff noting those MR/RC Assessments not reviewed by the Service Coordinator.

LOC/LON Approval/Denial

DADS Program Enrollment (PE) will continue to approve or deny an individual's LOC/LON. The Service Coordinator's agreement or disagreement does not ensure any action will be taken or not taken by DADS PE. The Service Coordinator may be used as an informant if DADS Program Enrollment determines an LON review is necessary.

L32: Service Coordinator Review of MR/RC: Add

Procedure The following table describes the steps taken to review the MR/RC and enter their agreement or disagreement and any comments.

Step	View	Action
1	_ _	• Type **L32** in the ACT: field of any screen. • Press **Enter**. Result: The **L32: Service Coordinator Review of MR/RC** header screen is displayed.
2	A sample **L32: Service Coordinator Review of MR/RC** header screen is shown below. 03-16-10 L32: SERVICE COORDINATOR REVIEW OF MR/RC VC061570 PLEASE ENTER ONE OF THE FOLLOWING: CLIENT ID: _____ COMPONENT CODE/LOCAL CASE NUMBER: __ / _____ MEDICAID NUMBER: _____ TYPE OF ENTRY: A (A/ADD, C/CHANGE, D/DELETE) *** PRESS ENTER *** ACT: ___ (L00/AUTH DATA ENTRY MENU, A/HCS MAIN MENU, HLP(PF1)/SCRN DOC)	• Type the requested identifying information in the appropriate fields. • Press **Enter**. Result: The first **L32: Service Coordinator Review of MR/RC** screen is displayed.
3	A sample **L32: Service Coordinator Review of MR/RC** screen is shown below. ***Screen 1*** 03-16-10 L32:SERVICE COORDINATOR REVIEW OF MR/RC VC061575 REC 1 OF 1 NAME : ROSEMARY, MARY CLIENT ID : 38261 COMPONENT : 8PN LOCAL CASE NUMBER: 00008PN456 1. FACILITY/PROVIDER NAME: 2. CONTRACT NO.: 001008296 LUCKY ENTERPRISE 3. MAILING ADDR : 4510 HORIZON DRIVE, GARLAND TX, 75014 4. CLIENT NAME : ROSEMARY, MARY 5. APPLICANT ADDR: MYSTREET, MYCITY TX, 66666 6. COMPONENT CODE: 8PN 7. CASE NUMBER : 00008PN456 8. MEDICAID NUMBER : 996655441 9. HIC/MEDICARE: 10. DATE OF BIRTH : 01-01-1985 11. SSN : U 12. DATE COMPLETED : 03-15-2010 13. PURPOSE CD : 3 14. DATE PHYS. EXAM: 03-10-2009 15. LEGAL STAT : 1 16. PREV. RES. : 1 17. REC. LOC: 1 18. REC. LON : 1 DIAGNOSIS: 19. PRIN. DIAG : MILD MENTAL RETARDATION 20.CD: 317 21.VERS: 9 22. ONSET : 01-1985 23. CUR MED DIAG: 24.CD: 25.VERS: 26. PSYCH. DIAG : 27.CD: 28.VERS: COGNITIVE FUNCTIONING: 29. IQ: 50 30. ABL: 1 > ***Screen 2*** 03-16-10 L32:SERVICE COORDINATOR REVIEW OF MR/RC VC061575 REC 1 OF 1 NAME : ROSEMARY, MARY CLIENT ID : 38261 COMPONENT : 8PN LOCAL CASE NUMBER: 00008PN456 ICAP DATA: 31. BROAD INDEPENDENCE: 111 32. GEN MALADAPTIVE: 1 33. ICAP SVC LEVEL: 7 BEHAVIORAL STATUS: 34. BEHAVIOR PGM : N 35. SELF-INJURY BEH : 0 36. SERIOUS DISRUP BEH: 0 37. AGGRESSIVE BEH: 0 38. SEX. AGGRESS. BEH: 0 NURSING: 39. SERVICE PROVIDER: 15 40. FREQUENCY CODE: 1 DAY SERVICES - NON-VOCATIONAL SETTING: 41. SERVICE: 1 42. FREQUENCY CODE: 1 43. FUNDING CODE: 1 DAY SERVICES - VOCATIONAL SETTING: 44. SERVICE: 1 45. FREQUENCY CODE: 1 46. FUNDING CODE: 1 FUNCTIONAL ASSESSMENT: 47. AMBULATION: 1 PHYSICIANS EVALUATION AND RECOMMENDATION >	The information that was entered by the program provider will be displayed in the first four screens followed by a screen for the Service Coordinator to enter their agreement or disagreement and add any comments. • Review the data. • Press **Enter** to go to the next screen.

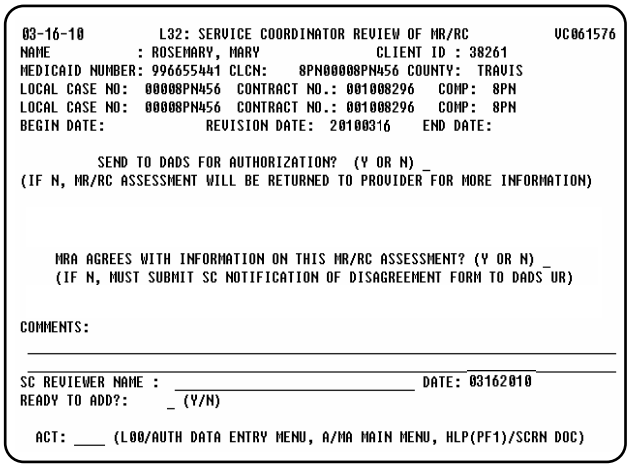
Procedure, continued

Step	View	Action
3, cont.	Sample screens are shown below. ***Screen 3*** 03-16-10 L32:SERVICE COORDINATOR REVIEW OF MR/RC VC061575 REC 1 OF 1 NAME : ROSEMARY, MARY CLIENT ID : 38261 COMPONENT : 8PN LOCAL CASE NUMBER: 00008PN456 48. DOES MEDICAL REGIMEN OF INDIVIDUAL NEED TO BE UNDER THE SUPERVISION OF AN MD/DO? 48. Y (Y/N) 49. WILL THE HEALTH STATUS OF THE INDIVIDUAL PREVENT PARTICIPATION IN THE ACTIVE TREATMENT OF THE ICF/MR PROGRAM? 49. N (Y/N) 50. TO YOUR KNOWLEDGE DOES THE INDIVIDUAL HAVE A CONDITION OF MENTAL RETARDATION AND/OR A RELATED CONDITION? 50. Y (Y/N) 51. DO YOU CERTIFY THAT THIS INDIVIDUAL REQUIRES ICF/MR OR ICF/MR/RC CARE? 51. (Y/N) SIGNATURE: _____ 53. NAME: HANK WILLIAMS 54. SIGNATURE DATE: 03-16-10 55. PHYSICIAN LICENSE NO.: 789789 72. APN/PA LICENSE NO.: > ***Screen 4*** 03-16-10 L32:SERVICE COORDINATOR REVIEW OF MR/RC VC061575 REC 1 OF 1 NAME : ROSEMARY, MARY CLIENT ID : 38261 COMPONENT : 8PN LOCAL CASE NUMBER: 00008PN456 56. SIGNATURE OF RN/LVN/QMRP/PROVIDER REP/MRA SERVICE COORDINATOR _____ 57. FULL NAME OF - RN/LVN/QMRP/PROV REP/MRA SVC COORD: WILLIE NELSON 58. SIGNATURE DATE: 03-16-10 REQUESTED BEGIN/END DATES 59. BEGIN DATE 03-16-10 60. END DATE: FOR DEPARTMENTAL USE ONLY 61. LOC: 62. LON: 1 63. EFFECTIVE DATE : 64. EXPIRATION DATE: 65. REVIEWER NAME : 66. DATE REVIEWED : 67. NAME OF PHYSICIAN: PROVIDER COMMENTS > ***Screen 5*** 03-16-10 L32:SERVICE COORDINATOR REVIEW OF MR/RC VC061575 REC 1 OF 1 NAME : ROSEMARY, MARY CLIENT ID : 38261 COMPONENT : 8PN LOCAL CASE NUMBER: 00008PN456 STATUS: WAITING FOR MRA REVIEW >	• Review the data. • Press **Enter** to review each screen. Screen 5 displays that the status is **Waiting for MRA Review**. • Press **Enter** to display the last screen.

continued on next page

Procedure, continued

Step	View	Action

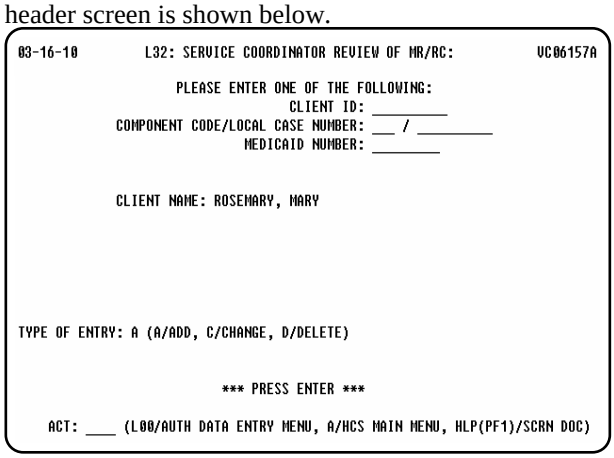
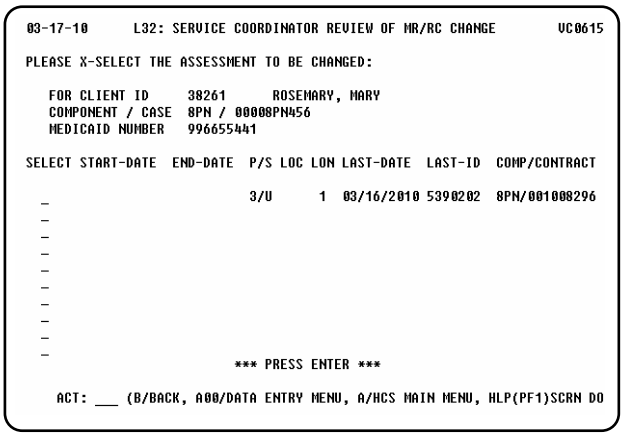
4	A sample screen (***Screen 6***) is shown below.
	 
	03-16-10 L32: SERVICE COORDINATOR REVIEW OF MR/RC VC061576
	NAME : ROSEMARY, MARY CLIENT ID : 38261
	MEDICAID NUMBER: 996655441 CLCN: 8PN00008PN456 COUNTY: TRAVIS
	LOCAL CASE NO: 00008PN456 CONTRACT NO.: 001008296 COMP: 8PN
	LOCAL CASE NO: 00008PN456 CONTRACT NO.: 001008296 COMP: 8PN
	BEGIN DATE: REVISION DATE: 20100316 END DATE:
	SEND TO DADS FOR AUTHORIZATION? (Y OR N) _
	(IF N, MR/RC ASSESSMENT WILL BE RETURNED TO PROVIDER FOR MORE INFORMATION)
	MRA AGREES WITH INFORMATION ON THIS MR/RC ASSESSMENT? (Y OR N) _
	(IF N, MUST SUBMIT SC NOTIFICATION OF DISAGREEMENT FORM TO DADS UR)
	COMMENTS:
	SC REVIEWER NAME : DATE: 03162010
	READY TO ADD?: _ (Y/N)
	ACT: ___ (L00/AUTH DATA ENTRY MENU, A/MA MAIN MENU, HLP(PF1)/SCRN DOC)
		This screen is used by the Service Coordinator to enter their agreement or disagreement and add any comments.
		If the Service Coordinator believes that an error was made in the data entry of the MR/RC Assessment:
		• Type **N** in the SEND TO DADS FOR AUTHORIZATION? field.
		• Type a comment as to why it is being returned to the provider in the COMMENTS section. **Comment is required if returned to provider.**
		Note: SC must call the provider to let them know that they have returned an MR/RC Assessment.
		• Type the Service Coordinator's name in the SC REVIEWER NAME field.
		• Type **Y** in the READY TO ADD? field.
		• Press **Enter**.
		If the Service Coordinator agrees that the information on the assessment is correct and is ready to send it for authorization:
		• Type **Y** in the SEND TO DADS FOR AUTHORIZATION? field.
		• Type **Y** in the MRA AGREES WITH INFORMATION ON THIS MR/RC ASSESSMENT? field.
		• Type the Service Coordinator's name in the SC REVIEWER NAME field.
		• Type **Y** in the READY TO ADD? field.
		• Press **Enter**.
		If the Service Coordinator does not agree that the information is accurate:
		• Type **Y** in the SEND TO DADS FOR AUTHORIZATION? field.
		• Type **N** in the MRA AGREES WITH INFORMATION ON THIS MR/RC ASSESSMENT? field.
		• The Service Coordinator may enter a comment in the COMMENT field.
		• Type the Service Coordinator's name in the SC REVIEWER NAME field.
		• Type **Y** in the READY TO ADD? field.
		• Press **Enter**.
		Note: Any time a disagreement is noted, the Service Coordinator must notify DADS UR and the program provider on the same day as data entry by:
		  • completing a *Notification of SC Disagreement* form (form 8579),
		  • faxing it to DADS Program Enrollment (PE),
		  • and sending a copy to the program provider.
		Errors made on the **L32: Service Coordinator Review of MR/RC** screen may only be corrected during the MRA Review time period (within seven days of the data entry).

continued on next page

L32: Service Coordinator Review of MR/RC: Change

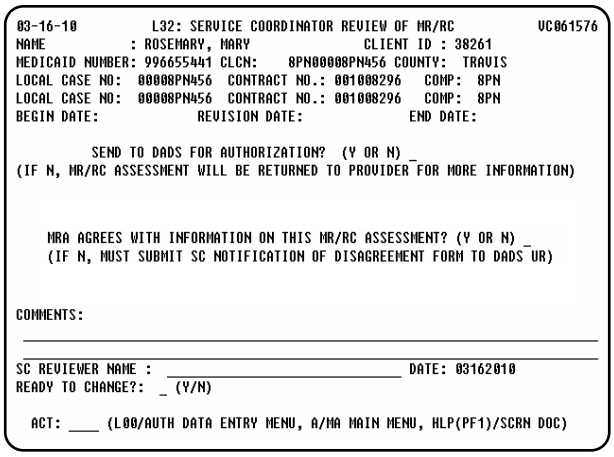
Procedure

The ***change action may only be completed during the 7-day time frame***. The only fields that can be changed are the questions and comments on the last screen. The following table gives a brief description of the steps taken if a change is necessary.

Step	View	Action
1	_ _	• Type **L32** in the ACT: field of any screen. • Press **Enter**. Result: The **L32: Service Coordinator Review of MR/RC** header screen is displayed.
2	A sample **L32: Service Coordinator Review of MR/RC** header screen is shown below.  03-16-10 L32: SERVICE COORDINATOR REVIEW OF MR/RC: VC06157A PLEASE ENTER ONE OF THE FOLLOWING: CLIENT ID: _____ COMPONENT CODE/LOCAL CASE NUMBER: __ / _____ MEDICAID NUMBER: _____ CLIENT NAME: ROSEMARY, MARY TYPE OF ENTRY: A (A/ADD, C/CHANGE, D/DELETE) *** PRESS ENTER *** ACT: ___ (L00/AUTH DATA ENTRY MENU, A/HCS MAIN MENU, HLP(PF1)/SCRN DOC)	• Type the requested identifying information in the appropriate fields. • Type **C** in the TYPE OF ENTRY field. • Press **Enter**. Result: The first **L32: Service Coordinator Review of MR/RC Change** screen is displayed.
3	A sample **L32: Service Coordinator Review of MR/RC Change** is shown below.  03-17-10 L32: SERVICE COORDINATOR REVIEW OF MR/RC CHANGE VC0615 PLEASE X-SELECT THE ASSESSMENT TO BE CHANGED: FOR CLIENT ID 38261 ROSEMARY, MARY COMPONENT / CASE 8PN / 00008PN456 MEDICAID NUMBER 996655441 SELECT START-DATE END-DATE P/S LOC LON LAST-DATE LAST-ID COMP/CONTRACT _ 3/U 1 03/16/2010 5390202 8PN/001008296 *** PRESS ENTER *** ACT: ___ (B/BACK, A00/DATA ENTRY MENU, A/HCS MAIN MENU, HLP(PF1)SCRN DO	• Type **X** in the SELECT column beside the assessment that needs to be changed. • Press **Enter**. Result: The **L32: Service Coordinator Review of MR/RC** screens are displayed. The only fields that can be changed are the questions and comments on the last screen. Press **Enter** to move through the screens.

continued on next page

Procedure, continued

Step	View	Action
4	A sample screen (Screen 6) is shown below.  03-16-10 L32: SERVICE COORDINATOR REVIEW OF MR/RC VC061576 NAME : ROSEMARY, MARY CLIENT ID : 38261 MEDICAID NUMBER: 996655441 CLCN: 8PN00008PN456 COUNTY: TRAVIS LOCAL CASE NO: 00008PN456 CONTRACT NO.: 001008296 COMP: 8PN LOCAL CASE NO: 00008PN456 CONTRACT NO.: 001008296 COMP: 8PN BEGIN DATE: REVISION DATE: END DATE: SEND TO DADS FOR AUTHORIZATION? (Y OR N) _ (IF N, MR/RC ASSESSMENT WILL BE RETURNED TO PROVIDER FOR MORE INFORMATION) MRA AGREES WITH INFORMATION ON THIS MR/RC ASSESSMENT? (Y OR N) _ (IF N, MUST SUBMIT SC NOTIFICATION OF DISAGREEMENT FORM TO DADS UR) COMMENTS: SC REVIEWER NAME : DATE: 03162010 READY TO CHANGE?: _ (Y/N) ACT: ___ (L00/AUTH DATA ENTRY MENU, A/MA MAIN MENU, HLP(PF1)/SCRN DOC)	This screen is used by the Service Coordinator to enter their agreement or disagreement and add any comments. See *Step 4* of the **L32: Service Coordinator Review of MR/RC: Add** procedure for descriptions of the fields on this screen. • Complete the changes to the review by typing the review information in the appropriate fields. • Type **Y** in the READY TO CHANGE? field. • Press **Enter**. Result: The **L32: Service Coordinator Review of MR/RC** header screen is displayed with the message, "*Previous Information Changed*."

L32: Service Coordinator Review of MR/RC: Delete

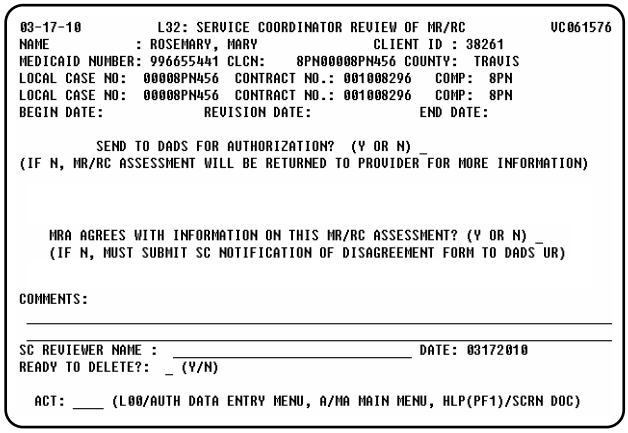
Procedure

The ***delete action may only be completed during the 7-day time frame***. The following table gives a brief description of the steps taken if it is necessary to delete a review.

Note: All MR/RCs that are not reviewed (which would include any that were deleted and not re-entered) will appear on a report showing MR/RCs not reviewed by the MRA.

Step	View	Action
1	_ _	• Type **L32** in the ACT: field of any screen. • Press **Enter**. Result: The **L32: Service Coordinator Review of MR/RC** header screen is displayed.
2	A sample **L32: Service Coordinator Review of MR/RC** header screen is shown below. 03-10-10 L32: SERVICE COORDINATOR REVIEW OF MR/RC VC061570 PLEASE ENTER ONE OF THE FOLLOWING: CLIENT ID: _____ COMPONENT CODE/LOCAL CASE NUMBER: __ / _____ MEDICAID NUMBER: _____ TYPE OF ENTRY: A (A/ADD, C/CHANGE, D/DELETE) *** PRESS ENTER *** ACT: ___ (L00/AUTH DATA ENTRY MENU, A/HCS MAIN MENU, HLP(PF1)/SCRN DOC)	• Type the requested identifying information in the appropriate fields. • Type **D** in the TYPE OF ENTRY field. • Press **Enter**. Result: The first **L32: Service Coordinator Review of MR/RC Change** screen is displayed.
3	A sample **L32: Service Coordinator Review of MR/RC Change** is shown below. 03-17-10 L32: SERVICE COORDINATOR REVIEW OF MR/RC: VC06157A PLEASE X-SELECT THE REVIEW TO BE DELETED: FOR CLIENT ID 38261 ROSEMARY, MARY COMPONENT / CASE 8PN / 00008PN456 MEDICAID NUMBER 996655441 SELECT START-DATE END-DATE P/S LOC LON LAST-DATE LAST-ID COMP/CONTRACT _ 3/U 1 03/16/2010 5390202 8PN/001008296 *** PRESS ENTER *** ACT: ___ (B/BACK, A00/DATA ENTRY MENU, A/HCS MAIN MENU, HLP(PF1)SCRN DOC)	• Type **X** in the SELECT column beside the assessment to be deleted. • Press **Enter**. Result: The **L32: Service Coordinator Review of MR/RC** screens are displayed. • Press **Enter** to move through the screens until you reach the last screen.

Procedure, continued

Step	View	Action
4	A sample **L32: Service Coordinator Review of MR/RC** screen is shown below.  03-17-10 L32: SERVICE COORDINATOR REVIEW OF MR/RC VC061576 NAME : ROSEMARY, MARY CLIENT ID : 38261 MEDICAID NUMBER: 996655441 CLCN: 8PN00008PN456 COUNTY: TRAVIS LOCAL CASE NO: 00008PN456 CONTRACT NO.: 001008296 COMP: 8PN LOCAL CASE NO: 00008PN456 CONTRACT NO.: 001008296 COMP: 8PN BEGIN DATE: REVISION DATE: END DATE: SEND TO DADS FOR AUTHORIZATION? (Y OR N) _ (IF N, MR/RC ASSESSMENT WILL BE RETURNED TO PROVIDER FOR MORE INFORMATION) MRA AGREES WITH INFORMATION ON THIS MR/RC ASSESSMENT? (Y OR N) _ (IF N, MUST SUBMIT SC NOTIFICATION OF DISAGREEMENT FORM TO DADS UR) COMMENTS: SC REVIEWER NAME : DATE: 03172010 READY TO DELETE?: _ (Y/N) ACT: ___ (L00/AUTH DATA ENTRY MENU, A/MA MAIN MENU, HLP(PF1)/SCRN DOC)	To delete the review: • Type **Y** in the READY TO DELETE? field. • Press **Enter**. Result: The **L32: Service Coordinator Review of MR/RC** header screen is displayed with the message, "*Previous Information Deleted*."

Individual Plan of Care (L02)

Introduction

The Mental Retardation Authority (MRA) uses the *Individual Plan of Care* screens to revise, renew, transfer, error correct, and delete an Individual Plan of Care (IPC) as an ongoing responsibility for Texas Home Living (TxHmL) individuals and HCS individuals who have self-directed services only. MRAs will also use the L02 screen to enter Transfer IPCs for HCS individuals.

These screens display service categories and allow the MRA to enter units of service to be provided annually for each category. The dollars for adaptive aids, minor home modification, and dental services must also be specified. The system calculates and displays the total annual cost after service units are entered.

Note: See *Enrollment in a Waiver Program* regarding the entry of an *initial* IPC during enrollment in the waiver programs.

Notes

A transfer IPC cannot be corrected or deleted once the transfer has been authorized. For information about transfers, refer to the Transfer section in this manual.

For revisions, renewals, and transfers:
If an IPC is entered that exceeds the current authorized amount, the message, ***"Warning: Plan cost exceeds the authorized amount"*** is displayed when calculating the IPC cost.

For HCS transfers, the MRA should notify the receiving provider that the IPC exceeds the cost ceiling.

The message, ***"IPC Plan cost category(s) have been exceeded **Warning**"*** is only for TxHmL and will only be displayed if an IPC is entered in which the cost categories have been exceeded and the IPC cost ceiling is *not* exceeded. If this IPC is saved, the increased services will not be billable until approved.

These messages mean that a packet of information regarding the IPC must be sent to PE/UR for review and approval (see the website for cover sheet and information needed).

An MRA can view the current authorized amount by viewing the **C62**, IPC inquiry screen.

IPC Types and Editing Options

The following tables display the types of IPCs, their uses, and editing options.

Note: No IPC can be modified or deleted if the modification or deletion makes the units of the IPC become less than the service delivery units entered against the IPC.

Type	Use
R = Revision IPC	Used to create an amended IPC for currently enrolled TxHmL individuals. A revision IPC can subsequently be revised, transferred, error corrected, or deleted.
N = Renewal IPC	Used to create a new IPC annually (on or up to 60 days prior to the renewal date) for TxHmL individuals. A renewal IPC can subsequently be revised, transferred, error corrected, or deleted.
T = Transfer IPC	Used to create an IPC revision that coincides with the Transfer Effective Date of a TxHmL individual. A transfer IPC can subsequently be revised *once authorized*, error corrected *until authorized*, or deleted *until authorized*.

Editing options for the three types of IPCs:

Type	Use
E = Error Correction	Used to: • correct an *Initial IPC* only if PE/UR has not recommended enrollment • correct a *Revision IPC* • correct a *Renewal IPC* • correct a *Transfer IPC* prior to a transfer authorization by DADS, Program Enrollment unit
D = Delete	Used to: • remove an *Initial IPC* only if the checklist is not present • remove a *Revision IPC*, entered in error, as long as the service units on the previously revised IPC are not less than the units entered (in services delivered) • remove a *Renewal IPC* if no services have been delivered against it and prior to authorization of the transfers • remove a *Transfer IPC* prior to authorization of the transfers

Over Service Category Limit

Introduction

The services and supports available through the Texas Home Living (TxHmL) Program are divided into two service categories. Each service category is made up of several TxHmL Program service components and each has an annual cost limit referred to as a service category limit. This means that the annual cost of one or more service components in a service category must not exceed the service category limit, unless the Department of Aging and Disability Services (DADS) has approved a request to increase a service category limit. Even if DADS approves a request to increase a service category limit, the cost of an individual's Plan of Care (IPC) must not exceed the maximum annual cost ceiling of $15,000 per IPC year. This means that the combined annual cost of all the service components in the two service categories must not exceed $15,000 per IPC year. The service components included in each service category are listed below.

Community Living Service Category

The annual service category limit is $12,000 and includes:

- Community Support
- Day Habilitation
- Employment Assistance
- Supported Employment
- Respite

Professional Technical Service Category

The annual service category limit is $3,000 and includes:

- Skilled Nursing
- Behavioral Support
- Specialized Services
  - Physical and Occupational Therapy (PT, OT)
  - Dietary (DI)
  - Audiology (AU)
  - Speech and Language Pathology (SP)
- Adaptive Aids (AA) (Limited to $6,000 per IPC year)
- AA Requisition Fee
- Minor Home Modifications (MHM) (Limited to a lifetime maximum of $7,500; once that lifetime maximum is reached, $300 per IPC year may be used for additional modifications or repairs of modifications)
- Dental Treatment (Limited to $1,000 per IPC year)

Over Service Category Limit, Continued

Data Entry Warning Message

When data is entered into a TxHmL Initial, Revision, Renewal, or Transfer IPC and one of the Service Category Limits has been exceeded, CARE displays a warning message with the amounts in each category along with the limits. The Service Coordinator must send supporting documentation to Program Enrollment.

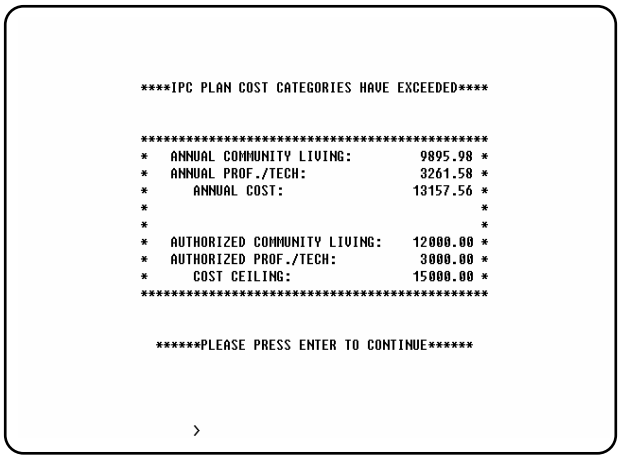
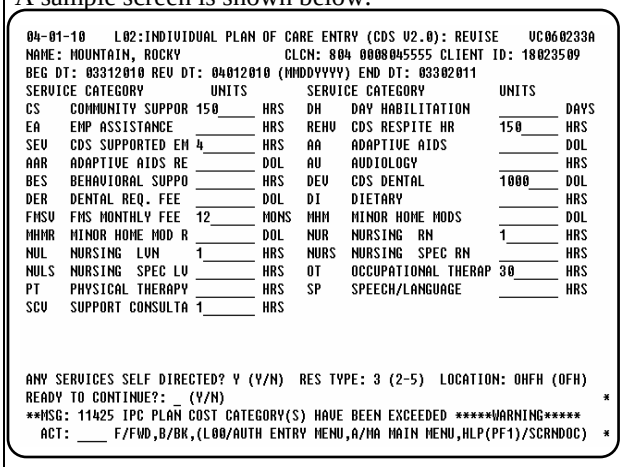
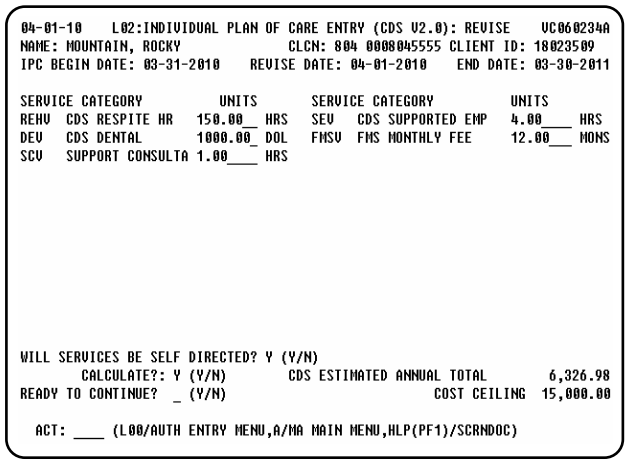
Procedure

The following example shows the warning screens that display when one of the Service Category Limits has been exceeded.

In the example below, an IPC is being revised.

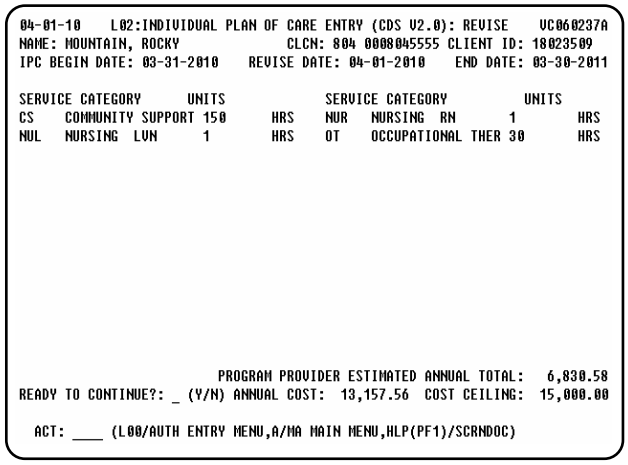
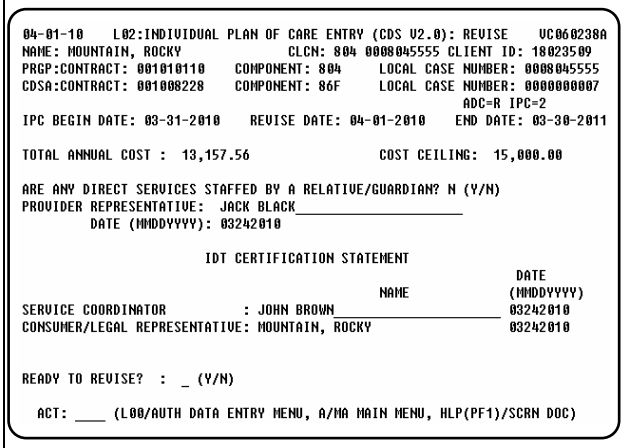
Step	View	Action
1	_ _	• Type **L02** in the ACT: field of any screen. • Press **Enter**. Result: The **L02: Individual Plan of Care** header screen is displayed.
2	A sample **L02: Individual Plan of Care** header screen is shown below. 03-23-10 L02:INDIVIDUAL PLAN OF CARE (CDS V2.0) VC060230 PLEASE ENTER ONE OF THE FOLLOWING: CLIENT ID: _____ COMPONENT CODE/LOCAL CASE NUMBER: ___ / _____ MEDICAID NUMBER: _____ PLEASE ENTER THE FOLLOWING: TYPE OF ENTRY: _ I=INITIAL N=RENEWAL R=REVISION E=ERROR CORRECTION T=TRANSFER D=DELETE PLEASE ENTER FOR REVISION OR ERROR CORRECT OF REVISION: REVISE DATE: _____ (MMDDYYYY) PLEASE ENTER FOR INITIAL PLANS ONLY: BEGIN DATE: _____ (MMDDYYYY) *** PRESS ENTER *** ACT: ___ (L00/AUTH DATA ENTRY MENU, A/MA MAIN MENU, HLP(PF1)/SCRN DOC)	• Type the requested identifying information in the appropriate fields. Rule: You must enter the Client ID, the local case number, *or* the Medicaid Number. • Type the component code of the individual's current component in the COMPONENT CODE field. • Type the type of entry (**R** – Revision was used in this sample) in the TYPE OF ENTRY field. • Type the effective date of the revision to the IPC in the REVISE DATE field. • Press **Enter**.
3	A sample **L02: Individual Plan of Care Entry: Revise** screen is shown below. 04-01-10 L02:INDIVIDUAL PLAN OF CARE ENTRY (CDS V2.0): REVISE VC060233A NAME: MOUNTAIN, ROCKY CLCN: 804 0008045555 CLIENT ID: 18023509 BEG DT: 03312010 REV DT: 04012010 (MMDDYYYY) END DT: 03302011 SERVICE CATEGORY UNITS SERVICE CATEGORY UNITS CS COMMUNITY SUPPOR 150____ HRS DH DAY HABILITATION _____ DAYS EA EMP ASSISTANCE _____ HRS REHU CDS RESPITE HR 150____ HRS SEV CDS SUPPORTED EM 4_____ HRS AA ADAPTIVE AIDS _____ DOL AAR ADAPTIVE AIDS RE _____ DOL AU AUDIOLOGY _____ HRS BES BEHAVIORAL SUPPO _____ HRS DEV CDS DENTAL 1000___ DOL DER DENTAL REQ. FEE _____ DOL DI DIETARY _____ HRS FMSV FMS MONTHLY FEE 12_____ MONS MHM MINOR HOME MODS _____ DOL MHMR MINOR HOME MOD R _____ DOL NUR NURSING RN 1_____ HRS NUL NURSING LVN 1_____ HRS NURS NURSING SPEC RN _____ HRS NULS NURSING SPEC LV _____ HRS OT OCCUPATIONAL THERAP 30_____ HRS PT PHYSICAL THERAPY _____ HRS SP SPEECH/LANGUAGE _____ HRS SCV SUPPORT CONSULTA 1_____ HRS ANY SERVICES SELF DIRECTED? Y (Y/N) RES TYPE: 3 (2-5) LOCATION: OHFH (OFH) READY TO CONTINUE?: _ (Y/N) ACT: ___ F/FWD,B/BK,(L00/AUTH ENTRY MENU,A/MA MAIN MENU,HLP(PF1)/SCRNDOC)	The provider will modify the total plan with the required revisions to service units. You cannot reduce the units where it would leave a current provider without any service authorizations for their service delivery option. • Enter the number of units of each service type in the appropriate fields and the dollar amounts in the ADAPTIVE AIDS, MINOR HOME MOD, and DENTAL fields. • Type **Y** in the READY TO CONTINUE? field. • Press **Enter**. Result: If an IPC is entered that exceeds the current authorized amount, an "*IPC Plan Cost Categories Have Exceeded*" warning screen is displayed when calculating the IPC cost.

Procedure, continued

Step	View	Action
4	A sample warning screen is shown below. 	This error message will display if you have exceeded either service category (community living - $12,000, or professional technical - $3,000) even if the plan has not exceeded the TxHmL waiver cost ceiling of $15,000. • Press **Enter** to continue.
5	A sample screen is shown below. 	If an IPC is entered that exceeds the current authorized amount, message, "*IPC Plan Cost Category(s) Have Been Exceeded*" is displayed when calculating the IPC cost. Providers should continue data entering the IPC as this no longer affects authorizations and billing for services already approved. ***The MRA must submit a packet of information to Program Enrollment (PE) for review*** when this occurs in order to have the new or increased services approved. Note: The person who is entering data for a revision, renewal, etc. should notify the person responsible for submitting a packet. • Type **Y** in the READY TO CONTINUE? field. • Press **Enter**.
6	A sample screen is shown below. 	Services currently being self-directed and new services added to the plan that are eligible to be self-directed are displayed on this screen. The units of new services added to the plan must be changed to zero if they are not being self-directed. Note: The units for services currently being self-directed are displayed **and cannot be changed**. • Type **0** (zero) beside any new service that will not be self-directed. • Press **Enter** to calculate. Result: The system calculates and displays the total annual cost for the IPC, and the message, "*Please verify the new plan cost*" is displayed. Once the system has calculated the IPC • Type **N** in the CALCULATE? field. • Type **Y** in the READY TO CONTINUE? field. • Press **Enter**.

continued on next page

Procedure, continued

Step	View	Action
7	A sample screen is shown below.  04-01-10 L02:INDIVIDUAL PLAN OF CARE ENTRY (CDS V2.0): REVISE VC060237A NAME: MOUNTAIN, ROCKY CLCN: 804 0008045555 CLIENT ID: 18023509 IPC BEGIN DATE: 03-31-2010 REVISE DATE: 04-01-2010 END DATE: 03-30-2011 SERVICE CATEGORY UNITS SERVICE CATEGORY UNITS CS COMMUNITY SUPPORT 150 HRS NUR NURSING RN 1 HRS NUL NURSING LVN 1 HRS OT OCCUPATIONAL THER 30 HRS PROGRAM PROVIDER ESTIMATED ANNUAL TOTAL: 6,830.58 READY TO CONTINUE?: _ (Y/N) ANNUAL COST: 13,157.56 COST CEILING: 15,000.00 ACT: ___ (L00/AUTH ENTRY MENU,A/MA MAIN MENU,HLP(PF1)/SCRNDOC)	This screen displays the program provider portion of the IPC. Services not being self-directed are displayed on this screen and cannot be changed. • Type **Y** in the READY TO CONTINUE? field. • Press **Enter**.
	A sample screen is shown below.  04-01-10 L02:INDIVIDUAL PLAN OF CARE ENTRY (CDS V2.0): REVISE VC060238A NAME: MOUNTAIN, ROCKY CLCN: 804 0008045555 CLIENT ID: 18023509 PRGP:CONTRACT: 001010110 COMPONENT: 804 LOCAL CASE NUMBER: 0008045555 CDSA:CONTRACT: 001008228 COMPONENT: 86F LOCAL CASE NUMBER: 0000000007 ADC=R IPC=2 IPC BEGIN DATE: 03-31-2010 REVISE DATE: 04-01-2010 END DATE: 03-30-2011 TOTAL ANNUAL COST : 13,157.56 COST CEILING: 15,000.00 ARE ANY DIRECT SERVICES STAFFED BY A RELATIVE/GUARDIAN? N (Y/N) PROVIDER REPRESENTATIVE: JACK BLACK_____ DATE (MMDDYYYY): 03242010 IDT CERTIFICATION STATEMENT NAME DATE (MMDDYYYY) SERVICE COORDINATOR : JOHN BROWN_____ 03242010 CONSUMER/LEGAL REPRESENTATIVE: MOUNTAIN, ROCKY 03242010 READY TO REVISE? : _ (Y/N) ACT: ___ (L00/AUTH DATA ENTRY MENU, A/MA MAIN MENU, HLP(PF1)/SCRN DOC)	• Type **Y** (Yes) or **N** (No) to indicate whether any services are staffed by a relative or guardian. • Type the name of the provider representative (individual's name) in the PROVIDER REPRESENTATIVE field and the date the provider representative signed the IPC in the DATE field. • Type or verify the Service Coordinator's name in the SERVICE COORDINATOR field and the date the Service Coordinator signed the IPC in the DATE field. • The name of the individual or legal representative is pre-filled based on whether or not a guardian has been identified (screen **L20**) in the CONSUMER/LEGAL REPRESENTATIVE field. Type the date the individual or legal representative signed the IPC in the DATE field. Note: Before you enter names in the fields on this screen, signatures *must* be on the IPC in the individual's chart. **All data entered into the CARE system should be entered from a paper copy (a hard copy) and must match exactly**. • Type **Y** in the READY TO REVISE? field to submit the data to the system. • Press **Enter**. Result: The **L02: Individual Plan of Care** header screen is displayed with the message, *"Plan has been Revised."*

Individual Plan of Care (L02): Revision

Procedure

The following table describes the steps an MRA will use to enter a revision to an existing IPC for a TxHmL individual.

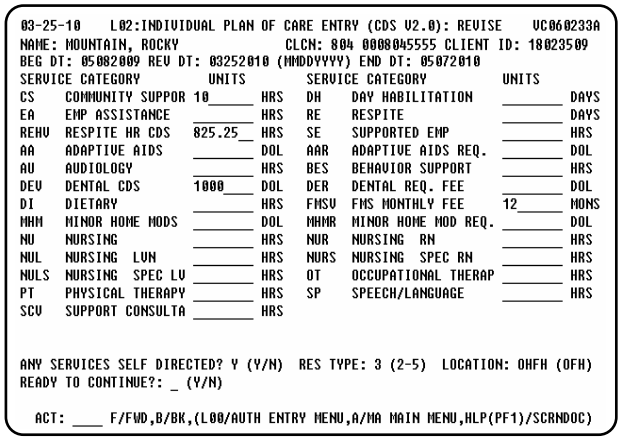
Note**:** There is **one** situation in the TxHmL program when the **L06** screen **must** be completed when a revision or a renewal is done. This occurs when **both** the Program Provider and the CDSA are providing services to the individual and one or more services are moved from one Service Delivery Option (SDO) to the other without moving all services from one SDO to the other, but neither vendor number changes. That means that the same Program Provider and the same CDSA are **both** still providing services, but there has been a change in at least one SDO (no transfer documentation needs to be submitted).

The **L06** Header screen questions **must** be answered **N**, **N**, **Y** for the revision to be completed using the **L06** screen.

Step	View	Action
1	_ _	• Type **L02** in the ACT: field of any screen. • Press **Enter**. Result: The **L02: Individual Plan of Care** header screen is displayed.
2	A sample **L02: Individual Plan of Care** header screen is shown below. 03-23-10 L02:INDIVIDUAL PLAN OF CARE (CDS V2.0) VC060230 PLEASE ENTER ONE OF THE FOLLOWING: CLIENT ID: _____ COMPONENT CODE/LOCAL CASE NUMBER: __ / _____ MEDICAID NUMBER: _____ PLEASE ENTER THE FOLLOWING: TYPE OF ENTRY: _ I=INITIAL N=RENEWAL R=REVISION E=ERROR CORRECTION T=TRANSFER D=DELETE PLEASE ENTER FOR REVISION OR ERROR CORRECT OF REVISION: REVISE DATE: _____ (MMDDYYYY) PLEASE ENTER FOR INITIAL PLANS ONLY: BEGIN DATE: _____ (MMDDYYYY) *** PRESS ENTER *** ACT: ___ (L00/AUTH DATA ENTRY MENU, A/MA MAIN MENU, HLP(PF1)/SCRN DOC)	• Type the requested identifying information in the appropriate fields. Rule: You must enter the Client ID, the local case number, *or* the Medicaid Number. • Type the component code of the individual's current component in the COMPONENT CODE field. • Type **R** (Revision) in the TYPE OF ENTRY field. • Type the revision date in the REVISE field. • Press **Enter**. Result: The **L02: Individual Plan of Care Entry: Revise** screen is displayed.

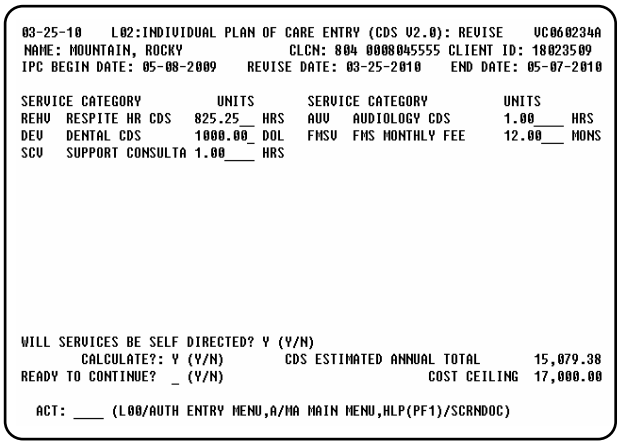
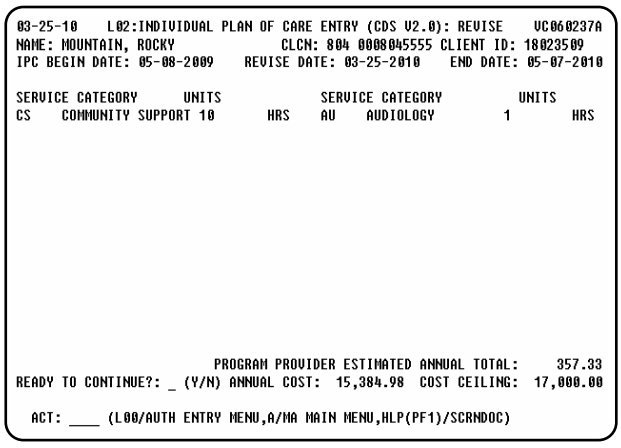
continued on next page

Procedure, continued

Step	View	Action
3	A sample **L02: Individual Plan of Care Entry: Revise** screen is shown below.  Note: The MRA can revise the plan as long as services on the plan are not changed to an amount that is less than what has already been entered for service delivery. For an IPC revision, the units of service are cumulative. The MRA *must* include the number of units previously used *plus* the number of units that will be provided from the revision date through the end of the plan year. If the MRA enters a plan that exceeds a cost ceiling, the increased services are placed on billing hold and the provider will be unable to enter service delivery claims for these increases until the plan no longer exceeds any cost ceiling. If this occurs, the MRA should submit an IPC packet for review to Program Enrollment.	The provider will modify the total plan with the required revisions to service units. You cannot reduce the units where it would leave a current provider without any service authorizations for their service delivery option. • Enter the number of units of each service type in the appropriate fields and the dollar amounts in the ADAPTIVE AIDS, MINOR HOME MOD, and DENTAL fields. • Type **Y** (Yes) or **N** (No) in the ANY SERVICES SELF DIRECTED? field, if necessary. • Type **3** (OHFH) in the RES TYPE field. • Type **Y** in the READY TO CONTINUE? field. • Press **Enter**. Result: The **L02: Individual Plan of Care Entry: Revise** screen (screen 2) is displayed.

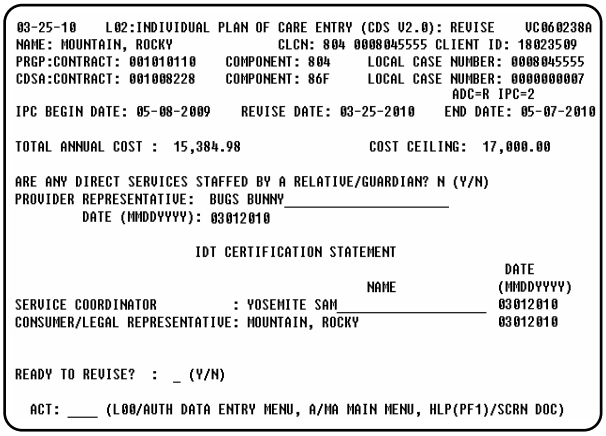
continued on next page

Procedure, continued

Step	View	Action
4	A sample **L02: Individual Plan of Care Entry: Revise** screen (screen 2) is shown below.  03-25-10 L02:INDIVIDUAL PLAN OF CARE ENTRY (CDS V2.0): REVISE VC060234A NAME: MOUNTAIN, ROCKY CLCN: 804 0008045555 CLIENT ID: 18023509 IPC BEGIN DATE: 05-08-2009 REVISE DATE: 03-25-2010 END DATE: 05-07-2010 SERVICE CATEGORY UNITS SERVICE CATEGORY UNITS REHV RESPITE HR CDS 825.25__ HRS AUV AUDIOLOGY CDS 1.00___ HRS DEV DENTAL CDS 1000.00_ DOL FMSV FMS MONTHLY FEE 12.00__ MONS SCV SUPPORT CONSULTA 1.00___ HRS WILL SERVICES BE SELF DIRECTED? Y (Y/N) CALCULATE?: Y (Y/N) CDS ESTIMATED ANNUAL TOTAL 15,079.38 READY TO CONTINUE? _ (Y/N) COST CEILING 17,000.00 ACT: ___ (L00/AUTH ENTRY MENU,A/MA MAIN MENU,HLP(PF1)/SCRNDOC)	Services currently being self-directed and new services added to the plan which are eligible to be self-directed are displayed on this screen. The units of new services added to the plan must be changed to zero if they are not being self-directed. Note 1: The units for services currently being self-directed are displayed **and cannot be changed**. Note 2: All services that are self-directed contain a V at the end of the service abbreviation on this screen. For example, the service abbreviation for Respite is REH. If that service is self-directed, the abbreviation becomes REHV. • Make any necessary changes. • Press **Enter** to calculate. Result: The system calculates and displays the total annual cost for the IPC, and the message, *"Please verify the new plan cost"* is displayed. Once the system has calculated the IPC • Type **N** in the CALCULATE? field. • Type **Y** in the READY TO CONTINUE? field. • Press **Enter**. Result: The **L02: Individual Plan of Care Entry: Revise** screen (screen 3) is displayed.
5	A sample **L02: Individual Plan of Care Entry: Revise** screen (screen 3) is shown below.  03-25-10 L02:INDIVIDUAL PLAN OF CARE ENTRY (CDS V2.0): REVISE VC060237A NAME: MOUNTAIN, ROCKY CLCN: 804 0008045555 CLIENT ID: 18023509 IPC BEGIN DATE: 05-08-2009 REVISE DATE: 03-25-2010 END DATE: 05-07-2010 SERVICE CATEGORY UNITS SERVICE CATEGORY UNITS CS COMMUNITY SUPPORT 10 HRS AU AUDIOLOGY 1 HRS PROGRAM PROVIDER ESTIMATED ANNUAL TOTAL: 357.33 READY TO CONTINUE?: _ (Y/N) ANNUAL COST: 15,384.98 COST CEILING: 17,000.00 ACT: ___ (L00/AUTH ENTRY MENU,A/MA MAIN MENU,HLP(PF1)/SCRNDOC)	This screen displays the program provider portion of the IPC. Services not being self-directed are displayed on this screen and cannot be changed. • Type **Y** in the READY TO CONTINUE? field. • Press **Enter**. Result: The **L02: Individual Plan of Care Entry: Revise** screen (screen 4) is displayed.

continued on next page

Procedure, continued

Step	View	Action
6	A sample **L02: Individual Plan of Care Entry: Revise** screen (Screen 4) is shown below.  03-25-10 L02:INDIVIDUAL PLAN OF CARE ENTRY (CDS V2.0): REVISE VC060238A NAME: MOUNTAIN, ROCKY CLCN: 804 000804555 CLIENT ID: 18023509 PRGP:CONTRACT: 001010110 COMPONENT: 804 LOCAL CASE NUMBER: 0008045555 CDSA:CONTRACT: 001008228 COMPONENT: 86F LOCAL CASE NUMBER: 0000000007 ADC=R IPC=2 IPC BEGIN DATE: 05-08-2009 REVISE DATE: 03-25-2010 END DATE: 05-07-2010 TOTAL ANNUAL COST : 15,384.98 COST CEILING: 17,000.00 ARE ANY DIRECT SERVICES STAFFED BY A RELATIVE/GUARDIAN? N (Y/N) PROVIDER REPRESENTATIVE: BUGS BUNNY DATE (MMDDYYYY): 03012010 IDT CERTIFICATION STATEMENT NAME DATE (MMDDYYYY) SERVICE COORDINATOR : YOSEMITE SAM 03012010 CONSUMER/LEGAL REPRESENTATIVE: MOUNTAIN, ROCKY 03012010 READY TO REVISE? : _ (Y/N) ACT: ___ (L00/AUTH DATA ENTRY MENU, A/MA MAIN MENU, HLP(PF1)/SCRN DOC)	• Type **Y** (Yes) or **N** (No) to indicate whether any services are staffed by a relative or guardian. • Type the name of the provider representative (individual's name) in the PROVIDER REPRESENTATIVE field and the date the provider representative signed the IPC in the DATE field. • Type or verify the Service Coordinator's name in the SERVICE COORDINATOR field and the date the Service Coordinator signed the IPC in the DATE field. • The name of the individual or legal representative is pre-filled based on whether or not a guardian has been identified (screen **L20**) in the CONSUMER/LEGAL REPRESENTATIVE field. Type the date the individual or legal representative signed the IPC in the DATE field. Note: Before you enter names in the fields on this screen, signatures *must* be on the IPC in the individual's chart. **All data entered into the CARE system should be entered from a paper copy (a hard copy) and must match exactly**. • Type **Y** in the READY TO REVISE? field to submit the data to the system. • Press **Enter**. Result: The **L02: Individual Plan of Care** header screen is displayed with the message, *"Plan has been Revised."*

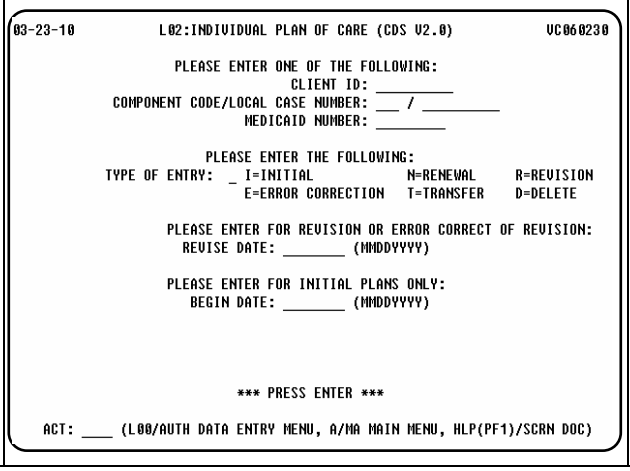
Individual Plan of Care (L02): Renewal

Procedure

Renewal IPCs *must* be entered on or up to 60 days prior to the renewal date (day after expiration of the current IPC) and *cannot* be backdated by the MRA. Submit IPC backdating Request Cover Sheet and information identified on that cover sheet to Program Enrollment to request backdating of the IPC, if necessary.

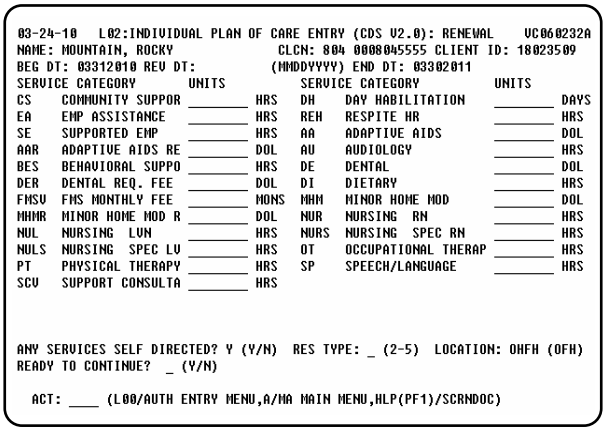
Note: The individual's MR/RC Assessment (LOC/LON) must be in effect on the IPC begin date.

The following table describes the steps an MRA will use to renew an IPC for a TxHmL individual.

Step	View	Action
1	_ _	• Type **L02** in the ACT: field of any screen. • Press **Enter**. Result: The **L02: Individual Plan of Care** header screen is displayed.
2	A sample **L02: Individual Plan of Care** header screen is shown below.  03-23-10 L02:INDIVIDUAL PLAN OF CARE (CDS V2.0) VC060230 PLEASE ENTER ONE OF THE FOLLOWING: CLIENT ID: _____ COMPONENT CODE/LOCAL CASE NUMBER: __ / _____ MEDICAID NUMBER: _____ PLEASE ENTER THE FOLLOWING: TYPE OF ENTRY: _ I=INITIAL N=RENEWAL R=REVISION E=ERROR CORRECTION T=TRANSFER D=DELETE PLEASE ENTER FOR REVISION OR ERROR CORRECT OF REVISION: REVISE DATE: _____ (MMDDYYYY) PLEASE ENTER FOR INITIAL PLANS ONLY: BEGIN DATE: _____ (MMDDYYYY) *** PRESS ENTER *** ACT: ___ (L00/AUTH DATA ENTRY MENU, A/MA MAIN MENU, HLP(PF1)/SCRN DOC)	• Type the requested identifying information in the appropriate fields. Rule: You must enter the Client ID, the local case number, *or* the Medicaid Number. • Type the component code of the individual's current component in the COMPONENT CODE field. • Type **N** (Renewal) in the TYPE OF ENTRY field. • Press **Enter**. Result: The **L02: Individual Plan of Care Entry: Renewal** screen is displayed.

continued on next page

Procedure, continued

<table>
<tr><th>Step</th><th>View</th><th>Action</th></tr>
<tr><td>3</td><td>A sample L02: Individual Plan of Care Entry: Renewal screen is shown below.
 

Note: If the MRA enters a plan that exceeds a cost ceiling, the individual is placed on billing hold and the provider will be unable to enter service delivery until the plan no longer exceeds any cost ceiling. If this occurs, the MRA should submit an IPC packet to Program Enrollment.</td><td>

Type the number of units of each service category in the appropriate fields and the dollar amounts in the ADAPTIVE AIDS, MINOR HOME MOD, and DENTAL fields.
Type Y (Yes) or N (No) in the ANY SERVICES SELF DIRECTED? field to indicate whether any of the services will be self-directed.

Note 1: If you enter units in the SUPPORT CONSULTATION or FINANCIAL MANAGEMENT fields, you ***must*** answer Y (Yes).
Note 2: If Y (Yes) is entered and services are to be self-directed, the FMS MONTHLY FEE is required. You must enter one unit per month of the IPC in the FMS MONTHLY FEE field.

Type 3 (Own Home/Family Home) in the RESIDENTIAL TYPE field.
Type Y in the READY TO CONTINUE? field.
Press Enter.

Result:
<table>
<tr><th>If you answered…</th><th>The…</th></tr>
<tr><td>Y to the question, ANY SERVICES SELF DIRECTED?</td><td>L02: Individual Plan of Care Entry: Renewal CDS screen is displayed.</td></tr>
<tr><td>N to the question, ANY SERVICES SELF DIRECTED?</td><td>L02: Individual Plan of Care Entry: Renewal program provider screen is displayed. Skip to Step 5.</td></tr>
</table>
</td></tr>
</table>

continued on next page

Procedure, continued

<table>
<tr><th>Step</th><th>View</th><th>Action</th></tr>
<tr><td>4</td><td>A sample L02: Individual Plan of Care Entry: Renewal screen (screen 2) is shown below.
<pre>
03-24-10 L02:INDIVIDUAL PLAN OF CARE ENTRY (CDS V2.0): RENEWAL   VC060234A
NAME: MOUNTAIN, ROCKY   CLCN: 804 0008045555 CLIENT ID: 18023509
IPC BEGIN DATE: 03-31-2010   REVISE DATE: 03-31-2010   END DATE: 03-30-2011

SERVICE CATEGORY   UNITS   SERVICE CATEGORY   UNITS
CSV CDS COMMUNITY SU 150.00__ HRS REHV CDS RESPITE HR   150.00__ HRS
SEV CDS SUPPORTED EM 4.00___ HRS   DEV   CDS DENTAL   860.00__ DOL
FMSV FMS MONTHLY FEE 12.00___ MONS NURV CDS NURSING RN   1.00___ HRS
NULV CDS NURSING LVN 1.00___ HRS   OTV   CDS OCCUPATIONAL TH 2.00___ HRS
SCV SUPPORT CONSULTA 1.00___ HRS

WILL SERVICES BE SELF DIRECTED? Y (Y/N)
      CALCULATE?: Y (Y/N)   CDS ESTIMATED ANNUAL TOTAL   10,820.96
READY TO CONTINUE? _ (Y/N)   COST CEILING 15,000.00

  ACT: ___ (L00/AUTH ENTRY MENU,A/MA MAIN MENU,HLP(PF1)/SCRNDOC)
</pre>
The following sample screen displays the way the screen appears when some of the services are not to be self-directed.
<pre>
03-24-10 L02:INDIVIDUAL PLAN OF CARE ENTRY (CDS V2.0): RENEWAL   VC060234A
NAME: MOUNTAIN, ROCKY   CLCN: 804 0008045555 CLIENT ID: 18023509
IPC BEGIN DATE: 03-31-2010   REVISE DATE: 03-31-2010   END DATE: 03-30-2011

SERVICE CATEGORY   UNITS   SERVICE CATEGORY   UNITS
CSV CDS COMMUNITY SU 0_______ HRS REHV CDS RESPITE HR   150.00__ HRS
SEV CDS SUPPORTED EM 4.00___ HRS   DEV   CDS DENTAL   860.00__ DOL
FMSV FMS MONTHLY FEE 12.00___ MONS NURV CDS NURSING RN   0_______ HRS
NULV CDS NURSING LVN 0_______ HRS OTV   CDS OCCUPATIONAL TH 0_______ HRS
SCV SUPPORT CONSULTA 1.00___ HRS

WILL SERVICES BE SELF DIRECTED? Y (Y/N)
      CALCULATE?: Y (Y/N)   CDS ESTIMATED ANNUAL TOTAL   10,820.96
READY TO CONTINUE? _ (Y/N)   COST CEILING 15,000.00

  ACT: ___ (L00/AUTH ENTRY MENU,A/MA MAIN MENU,HLP(PF1)/SCRNDOC)
</pre></td><td>Services currently being self-directed and new services added to the plan which are eligible to be self-directed are displayed on this screen. The units of new services added to the plan must be changed to zero if they are not being self-directed.
Note 1: Support Consultation and Financial Management Service fee units cannot be changed on this screen.
Note 2: All services that are self-directed contain a V at the end of the service abbreviation on this screen. For example, the service abbreviation for Respite is REH. If that service is self-directed, the abbreviation becomes REHV.
<table><tr><th>If you …</th><th>Then…</th></tr><tr><td>want to continue to the program provider screen (screen 3)</td><td>• Verify the new plan cost.
• Type N in the CALCULATE? field.
• Type Y in the READY TO CONTINUE? field.
• Press Enter.
• Continue with Step 5.</td></tr><tr><td>want to indicate that some of the new services are not to be self directed, but will be provided by the program provider</td><td>• Type a zero (0) in the UNITS column for each service that is to be provided by the program provider.
• Press Enter.
• Type N in the CALCULATE? field.
• Type Y in the READY TO CONTINUE? field.
• Press Enter.
• Continue with Step 5.</td></tr></table></td></tr>
<tr><td>5</td><td>A sample L02: Individual Plan of Care Entry: Renewal screen (screen 3) is shown below.
<pre>
03-24-10 L02:INDIVIDUAL PLAN OF CARE ENTRY (CDS V2.0): RENEWAL   VC060237A
NAME: MOUNTAIN, ROCKY   CLCN: 804 0008045555 CLIENT ID: 18023509
IPC BEGIN DATE: 03-31-2010   REVISE DATE: 03-31-2010   END DATE: 03-30-2011

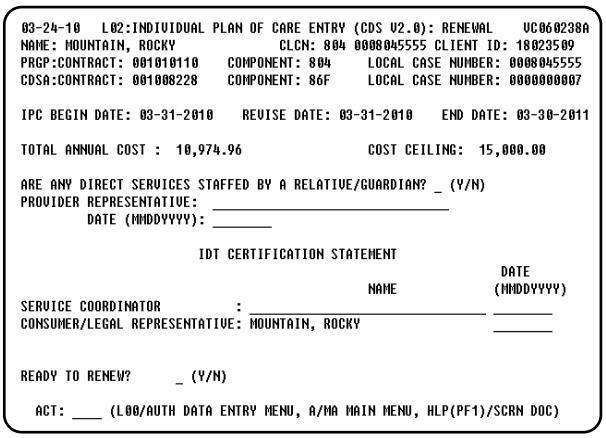
SERVICE CATEGORY   UNITS   SERVICE CATEGORY   UNITS
CS   COMMUNITY SUPPORT 150   HRS   NUR NURSING RN   1   HRS
NUL NURSING LVN   1   HRS   OT   OCCUPATIONAL THER 2   HRS

                          PROGRAM PROVIDER ESTIMATED ANNUAL TOTAL: 4,787.98
READY TO CONTINUE?: _ (Y/N) ANNUAL COST: 10,974.96 COST CEILING: 15,000.00

  ACT: ___ (L00/AUTH ENTRY MENU,A/MA MAIN MENU,HLP(PF1)/SCRNDOC)
</pre></td><td>This screen displays the program provider portion of the IPC. Services not being self-directed are displayed and cannot be changed.
• Type Y in the READY TO CONTINUE? field.
• Press Enter.</td></tr>
</table>

continued on next page

Procedure, continued

Step	View	Action
6	A sample **L02: Individual Plan of Care Entry: Renewal** screen (Screen 4) is shown below.  03-24-10 L02:INDIVIDUAL PLAN OF CARE ENTRY (CDS V2.0): RENEWAL VC0602238A NAME: MOUNTAIN, ROCKY CLCN: 804 0008045555 CLIENT ID: 18023589 PRGP:CONTRACT: 001010110 COMPONENT: 804 LOCAL CASE NUMBER: 0008045555 CDSA:CONTRACT: 001008228 COMPONENT: 86F LOCAL CASE NUMBER: 0000000007 IPC BEGIN DATE: 03-31-2010 REVISE DATE: 03-31-2010 END DATE: 03-30-2011 TOTAL ANNUAL COST : 10,974.96 COST CEILING: 15,000.00 ARE ANY DIRECT SERVICES STAFFED BY A RELATIVE/GUARDIAN? _ (Y/N) PROVIDER REPRESENTATIVE: _____ DATE (MMDDYYYY): _____ IDT CERTIFICATION STATEMENT NAME DATE (MMDDYYYY) SERVICE COORDINATOR : _____ _____ CONSUMER/LEGAL REPRESENTATIVE: MOUNTAIN, ROCKY _____ READY TO RENEW? _ (Y/N) ACT: ___ (L00/AUTH DATA ENTRY MENU, A/MA MAIN MENU, HLP(PF1)/SCRN DOC)	• Type **Y** (Yes) or **N** (No) to indicate whether any services are staffed by a relative or guardian. • Type the name of the provider representative (individual's name) in the PROVIDER REPRESENTATIVE field and the date the provider representative signed the IPC in the DATE field. • Type or verify the Service Coordinator's name in the SERVICE COORDINATOR field and the date the Service Coordinator signed the IPC in the DATE field. • The name of the individual or legal representative is pre-filled based on whether or not a guardian has been identified (screen **L20**) in the CONSUMER/LEGAL REPRESENTATIVE field. Type the date the individual or legal representative signed the IPC in the DATE field. Note: Before you enter names in the fields on this screen, signatures *must* be on the IPC in the individual's chart. **All data entered into the CARE system should be entered from a paper copy (a hard copy) and must match exactly**. • Type **Y** in the READY TO RENEW? field to submit the data to the system. Note: You can type **N** in the READY TO RENEW? field to take no action and return to the header screen. **The renewal IPC will not be saved.** • Press **Enter**. Result: The **L02: Individual Plan of Care** header screen is displayed with the message, *"Previous Information Added."*

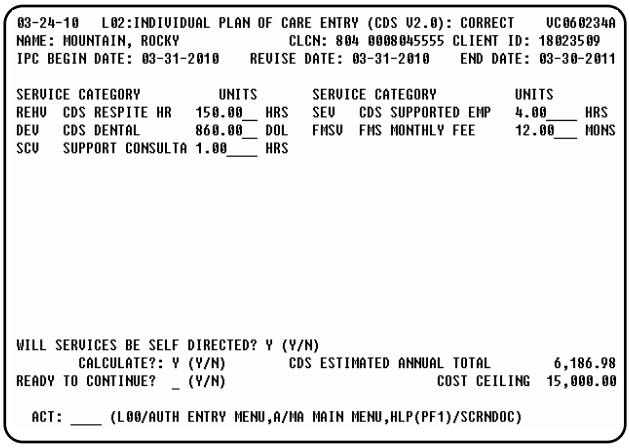
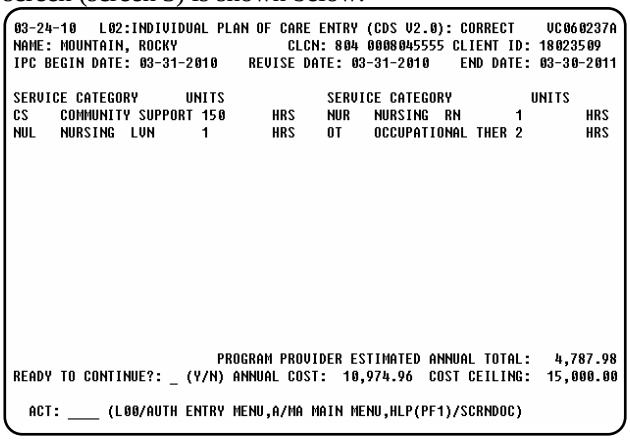
Individual Plan of Care (L02): Error Correction

Procedure — The following table describes the steps an MRA will use to correct data entry errors on a previously entered IPC.

Step	View	Action
1	_ _	• Type **L02** in the ACT: field of any screen. • Press **Enter**. Result: The **L02: Individual Plan of Care** header screen is displayed.
2	A sample **L02: Individual Plan of Care** header screen is shown below. 03-23-10 L02:INDIVIDUAL PLAN OF CARE (CDS V2.0) VC060230 PLEASE ENTER ONE OF THE FOLLOWING: CLIENT ID: _____ COMPONENT CODE/LOCAL CASE NUMBER: ___ / _____ MEDICAID NUMBER: _____ PLEASE ENTER THE FOLLOWING: TYPE OF ENTRY: _ I=INITIAL N=RENEWAL R=REVISION E=ERROR CORRECTION T=TRANSFER D=DELETE PLEASE ENTER FOR REVISION OR ERROR CORRECT OF REVISION: REVISE DATE: _____ (MMDDYYYY) PLEASE ENTER FOR INITIAL PLANS ONLY: BEGIN DATE: _____ (MMDDYYYY) *** PRESS ENTER *** ACT: ___ (L00/AUTH DATA ENTRY MENU, A/MA MAIN MENU, HLP(PF1)/SCRN DOC)	• Type the requested identifying information in the appropriate fields. Rule: You must enter the Client ID, the local case number, *or* the Medicaid Number. • Type the component code of the individual's current component in the COMPONENT CODE field. • Type **E** (Error Correction) in the TYPE OF ENTRY field. • Type the effective date if error correcting a revision to the IPC in the REVISE DATE field. • Press **Enter**. Result: The **L02: Individual Plan of Care Entry: Correct** screen is displayed.
3	A sample **L02: Individual Plan of Care Entry: Correct** screen is shown below. 03-24-10 L02:INDIVIDUAL PLAN OF CARE ENTRY (CDS V2.0): CORRECT VC060233A NAME: MOUNTAIN, ROCKY CLCN: 804 0008045555 CLIENT ID: 18023509 BEG DT: 03312010 REV DT: 03312010 (MMDDYYYY) END DT: 03302011 REC 1 OF 2 SERVICE CATEGORY UNITS SERVICE CATEGORY UNITS CS COMMUNITY SUPPOR 150____ HRS DH DAY HABILITATION _____ DAYS EA EMP ASSISTANCE _____ HRS REHV CDS RESPITE HR 150____ HRS SEV CDS SUPPORTED EM 4_____ HRS AA ADAPTIVE AIDS _____ DOL AAR ADAPTIVE AIDS RE _____ DOL AU AUDIOLOGY _____ HRS BES BEHAVIORAL SUPPO _____ HRS DEV CDS DENTAL 860____ DOL DER DENTAL REQ. FEE _____ DOL DI DIETARY _____ HRS FMSV FMS MONTHLY FEE 12_____ MONS MHM MINOR HOME MODS _____ DOL MHMR MINOR HOME MOD R _____ DOL NUR NURSING RN 1_____ HRS NUL NURSING LVN 1_____ HRS NURS NURSING SPEC RN _____ HRS NULS NURSING SPEC LV _____ HRS OT OCCUPATIONAL THERAP 2_____ HRS PT PHYSICAL THERAPY _____ HRS SP SPEECH/LANGUAGE _____ HRS SCU SUPPORT CONSULTA 1_____ HRS ANY SERVICES SELF DIRECTED? Y (Y/N) RES TYPE: 3 (2-5) LOCATION: OHFH (OFH) READY TO CONTINUE?: _ (Y/N) ACT: ___ F/FWD,B/BK,(L00/AUTH ENTRY MENU,A/MA MAIN MENU,HLP(PF1)/SCRNDOC) Note: If the MRA enters a plan that exceeds the cost ceiling, the increased services are on billing hold and the provider will be unable to receive payment for those increased services until the plan no longer exceeds the cost ceiling. If this occurs, the MRA should submit an IPC packet to Program Enrollment.	• Enter the correct number of units of each service type in the appropriate fields and the dollar amounts in the ADAPTIVE AIDS, MINOR HOME MOD, and DENTAL fields. • Type or verify **Y** in the ANY SERVICES SELF DIRECTED? field, if services are to be self-directed. Note 1: If you enter units in the SUPPORT CONSULTATION or FINANCIAL MANAGEMENT fields, you ***must*** answer **Y** (Yes). Note 2: If **Y** (Yes) is entered and services are to be self-directed, the FMS MONTHLY FEE is required. You must enter one unit per month of the IPC in the FMS MONTHLY FEE field. • Type or verify **3** (Own Home/Family Home) in the RESIDENTIAL TYPE field. • Type **Y** in the READY TO CONTINUE? field. • Press **Enter**. Result: The **L02: Individual Plan of Care Entry: Correct** screen (screen 2) is displayed. Note: To cancel your request to correct data, type **N** in the READY TO CONTINUE? field, and press **Enter** to return to the header screen.

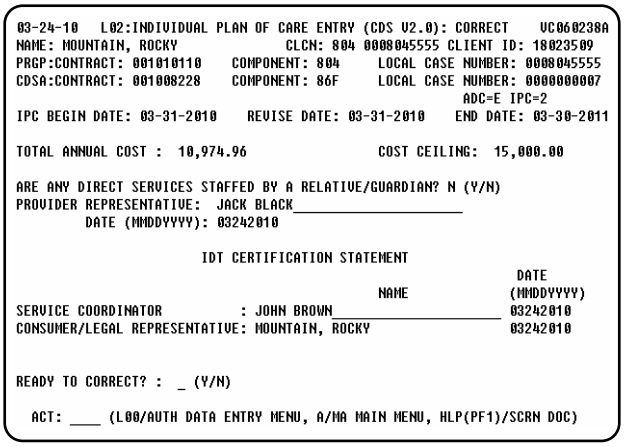
continued on next page

Procedure, continued

Step	View	Action
4	A sample **L02: Individual Plan of Care Entry: Correct** screen (screen 2) is shown below.  03-24-10 L02:INDIVIDUAL PLAN OF CARE ENTRY (CDS V2.0): CORRECT VC060234A NAME: MOUNTAIN, ROCKY CLCN: 804 0008045555 CLIENT ID: 18023509 IPC BEGIN DATE: 03-31-2010 REVISE DATE: 03-31-2010 END DATE: 03-30-2011 SERVICE CATEGORY UNITS SERVICE CATEGORY UNITS REHV CDS RESPITE HR 150.00__ HRS SEV CDS SUPPORTED EMP 4.00___ HRS DEV CDS DENTAL 860.00__ DOL FMSV FMS MONTHLY FEE 12.00__ MONS SCV SUPPORT CONSULTA 1.00___ HRS WILL SERVICES BE SELF DIRECTED? Y (Y/N) CALCULATE?: Y (Y/N) CDS ESTIMATED ANNUAL TOTAL 6,186.98 READY TO CONTINUE? _ (Y/N) COST CEILING 15,000.00 ACT: ___ (L00/AUTH ENTRY MENU,A/MA MAIN MENU,HLP(PF1)/SCRNDOC)	Services currently being self-directed and new services added to the plan which are eligible to be self-directed are displayed on this screen. The units of new services added to the plan must be changed to zero if they are not being self-directed. Note 1: Support Consultation and Financial Management Service fee units ***cannot*** be changed on this screen. Note 2: All services that are self-directed contain a V at the end of the service abbreviation on this screen. For example, the service abbreviation for Respite is RE. If that service is self-directed, the abbreviation becomes REV. • Type **Y** in the CALCULATE? field. • Press **Enter**. Result: The system calculates and displays the total annual cost for this IPC, and the message, *"Please verify the new plan cost"* is displayed. To continue to the program provider screen (screen 3) • Type **N** in the CALCULATE? field. • Type **Y** in the READY TO CONTINUE? field. • Press **Enter**.
5	A sample L02: Individual Plan of Care Entry: Correct screen (screen 3) is shown below.  03-24-10 L02:INDIVIDUAL PLAN OF CARE ENTRY (CDS V2.0): CORRECT VC060237A NAME: MOUNTAIN, ROCKY CLCN: 804 0008045555 CLIENT ID: 18023509 IPC BEGIN DATE: 03-31-2010 REVISE DATE: 03-31-2010 END DATE: 03-30-2011 SERVICE CATEGORY UNITS SERVICE CATEGORY UNITS CS COMMUNITY SUPPORT 150 HRS NUR NURSING RN 1 HRS NUL NURSING LVN 1 HRS OT OCCUPATIONAL THER 2 HRS PROGRAM PROVIDER ESTIMATED ANNUAL TOTAL: 4,787.98 READY TO CONTINUE?: _ (Y/N) ANNUAL COST: 10,974.96 COST CEILING: 15,000.00 ACT: ___ (L00/AUTH ENTRY MENU,A/MA MAIN MENU,HLP(PF1)/SCRNDOC)	This screen displays the program provider portion of the IPC. Services not being self-directed are displayed and cannot be changed. • Type **Y** in the READY TO CONTINUE? field. • Press **Enter**.

continued on next page

Procedure, continued

Step	View	Action
6	A sample **L02: Individual Plan of Care Entry: Correct** screen (Screen 4) is shown below.  03-24-10 L02:INDIVIDUAL PLAN OF CARE ENTRY (CDS V2.0): CORRECT VC060238A NAME: MOUNTAIN, ROCKY CLCN: 804 0008045555 CLIENT ID: 18023509 PRGP:CONTRACT: 001010110 COMPONENT: 804 LOCAL CASE NUMBER: 0008045555 CDSA:CONTRACT: 001008228 COMPONENT: 86F LOCAL CASE NUMBER: 0000000007 ADC=E IPC=2 IPC BEGIN DATE: 03-31-2010 REVISE DATE: 03-31-2010 END DATE: 03-30-2011 TOTAL ANNUAL COST : 10,974.96 COST CEILING: 15,000.00 ARE ANY DIRECT SERVICES STAFFED BY A RELATIVE/GUARDIAN? N (Y/N) PROVIDER REPRESENTATIVE: JACK BLACK DATE (MMDDYYYY): 03242010 IDT CERTIFICATION STATEMENT NAME DATE (MMDDYYYY) SERVICE COORDINATOR : JOHN BROWN 03242010 CONSUMER/LEGAL REPRESENTATIVE: MOUNTAIN, ROCKY 03242010 READY TO CORRECT? : _ (Y/N) ACT: ___ (L00/AUTH DATA ENTRY MENU, A/MA MAIN MENU, HLP(PF1)/SCRN DOC)	• Type **Y** (Yes) or **N** (No) to indicate whether any services are staffed by a relative or guardian. • Type the name of the provider representative (individual's name) in the PROVIDER REPRESENTATIVE field and the date the provider representative signed the IPC in the DATE field. • Type or verify the Service Coordinator's name in the SERVICE COORDINATOR field and the date the Service Coordinator signed the IPC in the DATE field. • The name of the individual or legal representative is pre-filled based on whether or not a guardian has been identified (screen **L20**) in the CONSUMER/LEGAL REPRESENTATIVE field. Type the date the individual or legal representative signed the IPC in the DATE field. Note: Before you enter names in the fields on this screen, signatures *must* be on the IPC in the individual's chart. **All data entered into the CARE system should be entered from a paper copy (a hard copy) and must match exactly**. • Type **Y** in the READY TO CORRECT? field to submit the data to the system. Note: You can type **N** in the READY TO CORRECT? field to take no action and return to the header screen. **Information entered will *not* be saved.** • Press **Enter**. Result: The **L02: Individual Plan of Care** header screen is displayed with the message, *"Plan has been corrected."*

Individual Plan of Care (L02): Delete

Procedure

The following table describes the steps an MRA will use to delete the last IPC (initial or renewal) that was entered.

Note: An IPC can be deleted *only if no billing has been entered or has been deleted*.

Step	View	Action
1	_ _	• Type **L02** in the ACT: field of any screen. • Press **Enter**. Result: The **L02: Individual Plan of Care** header screen is displayed.
2	A sample **L02: Individual Plan of Care** header screen is shown below. 03-23-10 L02:INDIVIDUAL PLAN OF CARE (CDS V2.0) VC060230 PLEASE ENTER ONE OF THE FOLLOWING: CLIENT ID: _____ COMPONENT CODE/LOCAL CASE NUMBER: __ / _____ MEDICAID NUMBER: _____ PLEASE ENTER THE FOLLOWING: TYPE OF ENTRY: _ I=INITIAL N=RENEWAL R=REVISION E=ERROR CORRECTION T=TRANSFER D=DELETE PLEASE ENTER FOR REVISION OR ERROR CORRECT OF REVISION: REVISE DATE: _____ (MMDDYYYY) PLEASE ENTER FOR INITIAL PLANS ONLY: BEGIN DATE: _____ (MMDDYYYY) *** PRESS ENTER *** ACT: ___ (L00/AUTH DATA ENTRY MENU, A/MA MAIN MENU, HLP(PF1)/SCRN DOC)	• Type the requested identifying information in the appropriate fields. Rule: You must enter the Client ID, the local case number, *or* the Medicaid Number. • Type the component code of the individual's current component in the COMPONENT CODE field. • Type **D** (Delete) in the TYPE OF ENTRY field. • Press **Enter**. Result: The **L02: Individual Plan of Care Entry: Delete** screen is displayed.
3	A sample **L02: Individual Plan of Care Entry: Delete** screen is shown below. 03-24-10 L02:INDIVIDUAL PLAN OF CARE ENTRY (CDS V2.0): DELETE VC060233A NAME: MOUNTAIN, ROCKY CLCN: 86F 0000000007 CLIENT ID: 18023509 BEG DT: 03312010 REV DT: 03312010 (MMDDYYYY) END DT: 03302011 REC 1 OF 2 SERVICE CATEGORY UNITS SERVICE CATEGORY UNITS CS COMMUNITY SUPPOR 150____ HRS DH DAY HABILITATION _____ DAYS EA EMP ASSISTANCE _____ HRS REHU CDS RESPITE HR 150____ HRS SEV CDS SUPPORTED EM 4_____ HRS AA ADAPTIVE AIDS _____ DOL AAR ADAPTIVE AIDS RE _____ DOL AU AUDIOLOGY _____ HRS BES BEHAVIORAL SUPPO _____ HRS DEV CDS DENTAL 860____ DOL DER DENTAL REQ. FEE _____ DOL DI DIETARY _____ HRS FMSV FMS MONTHLY FEE 12_____ MONS MHM MINOR HOME MODS _____ DOL MHMR MINOR HOME MOD R _____ DOL NUR NURSING RN 1_____ HRS NUL NURSING LVN 1_____ HRS NURS NURSING SPEC RN _____ HRS NULS NURSING SPEC LV _____ HRS OT OCCUPATIONAL THERAP 2_____ HRS PT PHYSICAL THERAPY _____ HRS SP SPEECH/LANGUAGE _____ HRS SCU SUPPORT CONSULTA 1_____ HRS ANY SERVICES SELF DIRECTED? Y (Y/N) RES TYPE: 3 (2-5) LOCATION: OHFH (OFH) READY TO DELETE? _ (Y/N) ACT: ___ F/FWD,B/BK,(L00/AUTH ENTRY MENU,A/MA MAIN MENU,HLP(PF1)/SCRNDOC)	• Type **Y** in the READY TO DELETE? field. Note: You can type **N** in the READY TO DELETE? field to take no action and return to the header screen. • Press **Enter**. Result: The **L02: Individual Plan of Care** header screen is displayed with the message, *"Previous information deleted."*

Service Coordinator Review of IPC (L31)

Introduction

Beginning June 2010, the *Service Coordinator Review of IPC* screens will be used by the Mental Retardation Authority (MRA) Service Coordinator (SC) to review an IPC and enter their agreement or disagreement and any comments. The Service Coordinator must either confirm the review or return the IPC to the provider with comments. If an individual has more than one IPC pending (a revision to the current IPC and the renewal IPC have been entered, but not yet reviewed) the IPC effective date being reviewed must be entered.

The processes for transmitting a revised IPC to DADS and the Service Coordinator review are the same for revised IPCs as for renewal IPCs.

Note: Since the MRA enters Initial and Transfer IPCs they do not require a Service Coordinator review.

Provider's Responsibility

Before the Service Coordinator can review the IPC, the provider must access the **C02/L02: Individual Plan of Care** screens and enter the IPC renewal or revision.

Note: The program provider may use the **C103: IPC Review Status Provider: Inquiry** screen and select STATUS CODE **X – Returned to Provider for More Information** to see if any IPCs have been returned by the MRA.

Service Coordinator Review

The Service Coordinator is responsible for reviewing the IPC in CARE and entering their name, date of review and whether or not they agree with the information entered within seven (7) calendar days after the program provider enters the IPC in CARE. After the seven-day timeframe, the IPC is available for authorization by DADS regardless of whether the MRA Service Coordinator reviewed it in CARE or agrees or disagrees with the information entered. Before entering a disagreement the Service Coordinator should discuss with the program provider any concerns they have with services contained on the IPC.

The Service Coordinator must agree with the IPC if the Service Coordinator determines that the services on the IPC are:

- not available through other resources, and do not replace existing and natural supports;
- necessary to assure the individual's health and safety and prevent institutionalization; and
- based on the outcomes in the individual's PDP.

continued on next page

Service Coordinator Review, continued	The MRA may access the **L83: Pending IPC MRA Reviews: MRA Inquiry** screen which assists the MRA with tracking IPCs that need to be reviewed by the Service Coordinator and displays all **renewal** and **revised** IPCs waiting for the Service Coordinator review. MRAs are expected to review each IPC and must determine how frequently they will need to produce the list in order to meet this expectation.
Assessment Not Reviewed in Timely Manner	Program providers will not be prevented from entering billing because a Service Coordinator does not review the IPC in a timely manner. If a service coordinator does not review an IPC within seven (7) days of data entry, CARE will automatically send the IPC to DADS for authorization without a Service Coordinator review. Reports will be available for state office and MRA management staff noting those IPCs not reviewed by the Service Coordinator.
DADS Program Enrollment (PE)	DADS Program Enrollment (PE) will continue to authorize, reduce, or deny services on an individual's IPC. The Service Coordinator's agreement or disagreement does not ensure any action will be taken or not taken by DADS PE. The Service Coordinator's agreement or disagreement does not ensure any action will be taken or not taken by DADS PE. The Service Coordinator may be used as an informant if DADS PE determines an LON review is necessary.

L31: Service Coordinator Review of IPC: Add

Procedure — The following table describes the steps the Service Coordinator will use to confirm or reject the IPC.

Step	View	Action
1	_ _	• Type **L31** in the ACT: field of any screen. • Press **Enter**. Result: The **L31: Service Coordinator Review of IPC** header screen is displayed.
2	A sample **L31: Service Coordinator Review of IPC** header screen is shown below. 03-17-10 L31: SERVICE COORDINATOR REVIEW OF IPC VC061560 PLEASE ENTER ONE OF THE FOLLOWING: CLIENT ID: _____ COMPONENT CODE/LOCAL CASE NUMBER: __ / _____ MEDICAID NUMBER: _____ IPC EFFECTIVE DATE: _____ (MMDDYYYY) (REQUIRED IF MORE THAN ONE IPC IS WAITING TO BE REVIEWED) TYPE OF ENTRY: _ A/ADD, C/CHANGE, D/DELETE *** PRESS ENTER *** ACT: ___ (L00/AUTH DATA ENTRY MENU, A/HCS MAIN MENU, HLP(PF1)/SCRN DOC)	• Type the requested identifying information in the appropriate fields. Rule: You must enter the Client ID *or* the local case number. • Type the component code of the individual's current provider component in the COMPONENT CODE field. • Type the IPC effective date in the IPC EFFECTIVE DATE field, if necessary. Note: This field is required if more than one IPC is waiting to be reviewed. • Type **A** in the **Type of Entry** field. • Press **Enter**. Result: The **L31: Service Coordinator Review of IPC** screen is displayed.
3	A sample **L31: Service Coordinator Review of IPC** screen is shown below. ***Screen 1*** 03-17-10 L31:SERVICE COORDINATOR REVIEW OF IPC VC060491 NAME : ROSEMARY, MARY CLIENT ID : 38261 MEDICAID NUMBER: 996655441 CLCN: 804000080445 6 COUNTY: TRAVIS LOCAL CASE NUMBER: 00008044 56 CONTRACT NO: 001007358 COMPONENT: 804 LOCAL CASE NUMBER: 00008PN456 CONTRACT NO: 001008296 CDS COMPONENT: 8PN RESIDENTIAL TYPE : OWN/FAMILY HOME REC 1 OF 1 WAIVER TYPE : HCS LOCATION: OHFH LOC/LON: 1/1 BEGIN DATE: 03-31-2010 REVISION DATE: 03-31-2010 END DATE: 03-30-2011 IPC AWAITING MRA REVIEW SERVICE CATEGORY PROG UNITS SERVICE CATEGORY PROG UNITS AA ADAPTIVE AIDS 500 DOL AU AUDIOLOGY 2 HRS PS BEHAVIORAL SUPPORT 4 HRS DH DAY HABILITATION 250 DAYS DE DENTAL 1000 DOL DI DIETARY 2 HRS NUR NURSING RN 2 HRS NUL NURSING LVN 2 HRS OT OCCUPATIONAL THERAPY 2 HRS PT PHYSICAL THERAPY 3 HRS REHV CDS RESPITE HR 300 HRS SP SPEECH/LANGUAGE 1 HRS SHLV CDS SUPPORTED HOME L 700 HRS FMSV FMS MONTHLY FEE 12 MONS SCV SUPPORT CONSULTATION 10 HRS TOTAL ANNUAL COST: 37,574.28 AUTHORIZED AMOUNT: 83,734.00 ********** CDS SUMMARY ********** FMSV FMS MONTHLY FEE 12 MONS REHV CDS RESPITE HR 300 HRS SCV SUPPORT CONSULTATION 10 HRS SHLV CDS SUPPORTED HOME L 700 HRS >	The information that was entered by the program provider will be displayed in the first three screens followed by a screen for the Service Coordinator to enter their agreement or disagreement and add any comments. • Review the data. • Press **Enter** to go to the next screen.

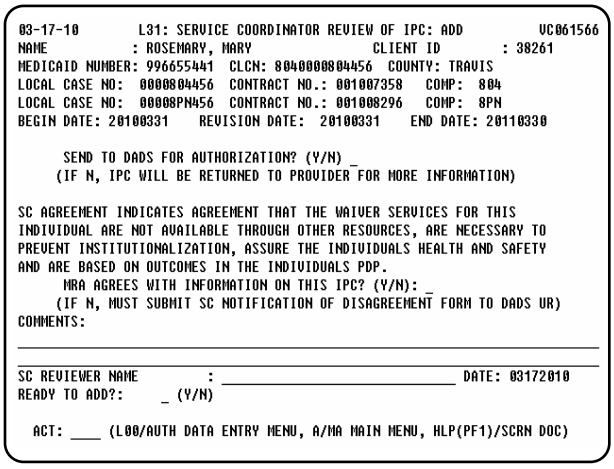
continued on next page

Procedure, continued

Step	View	Action
3, cont.	Sample screens are shown below. ***Screen 2*** 03-17-10 L31:SERVICE COORDINATOR REVIEW OF IPC VC060491 NAME : ROSEMARY, MARY CLIENT ID : 38261 MEDICAID NUMBER: 996655441 CLCN: 8040000804456 COUNTY: TRAVIS LOCAL CASE NUMBER: 0000804456 CONTRACT NO: 001007358 COMPONENT: 804 LOCAL CASE NUMBER: 00008PN456 CONTRACT NO: 001008296 CDS COMPONENT: 8PN RESIDENTIAL TYPE : OWN/FAMILY HOME REC 1 OF 1 WAIVER TYPE : HCS LOCATION: OHFH LOC/LON: 1/1 BEGIN DATE: 03-31-2010 REVISION DATE: 03-31-2010 END DATE: 03-30-2011 IPC AWAITING MRA REVIEW *** CDS ESTIMATED ANNUAL TOTAL: 28,587.00 ********** PROGRAM PROVIDER SUMMARY ********** AA ADAPTIVE AIDS 500 DOL AU AUDIOLOGY 2 HRS DE DENTAL 1000 DOL DH DAY HABILITATION 250 DAYS DI DIETARY 2 HRS NUL NURSING LVN 2 HRS NUR NURSING RN 2 HRS OT OCCUPATIONAL THERAPY 2 HRS PS BEHAVIORAL SUPPORT 4 HRS PT PHYSICAL THERAPY 3 HRS SP SPEECH/LANGUAGE 1 HRS *** PRGP ESTIMATED ANNUAL TOTAL: 8,987.28 ARE ANY SERVICES STAFFED BY A RELATIVE/GUARDIAN? (Y/N): N PROVIDER REPRESENTATIVE : ALAN SHEPHERD 03-17-2010 > ***Screen 3*** 03-17-10 L31:SERVICE COORDINATOR REVIEW OF IPC VC060491 NAME : ROSEMARY, MARY CLIENT ID : 38261 MEDICAID NUMBER: 996655441 CLCN: 8040000804456 COUNTY: TRAVIS LOCAL CASE NUMBER: 0000804456 CONTRACT NO: 001007358 COMPONENT: 804 LOCAL CASE NUMBER: 00008PN456 CONTRACT NO: 001008296 CDS COMPONENT: 8PN RESIDENTIAL TYPE : OWN/FAMILY HOME REC 1 OF 1 WAIVER TYPE : HCS LOCATION: OHFH LOC/LON: 1/1 BEGIN DATE: 03-31-2010 REVISION DATE: 03-31-2010 END DATE: 03-30-2011 IPC AWAITING MRA REVIEW CASE COORDINATOR : BASIL O'BASIL 03-17-2010 CONSUMER/LEGAL REPRESENTATIVE: ROSEMARY, MARY 03-17-2010 CONSUMER INFORMATION CURRENT ADDRESS: MYSTREET BIRTHDATE: 19850101 MYCITY, TX 66666 SS NUMBER: U >	• Review the data. • Press **Enter** to review each screen.

continued on next page

Procedure, continued

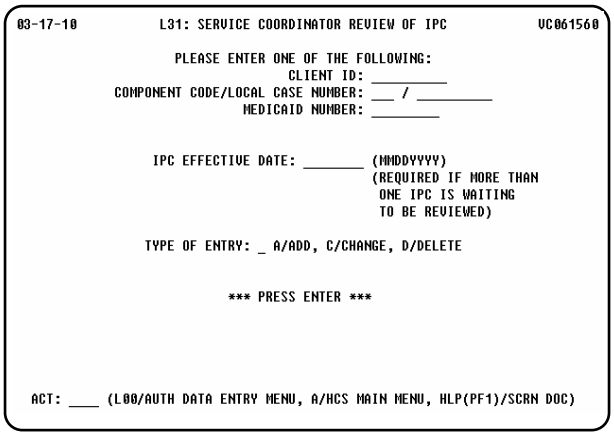
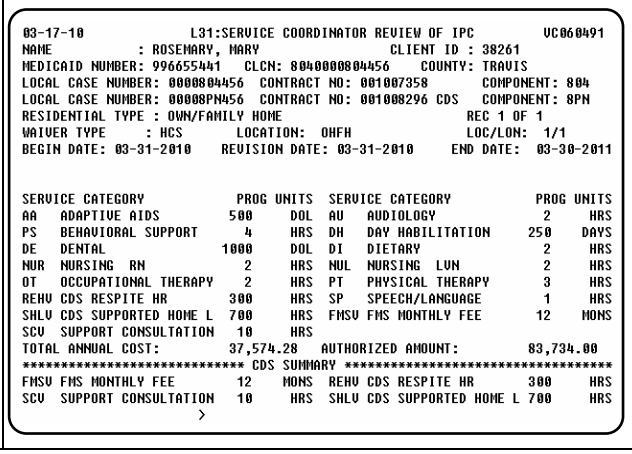
Step	View	Action
4	A sample screen (***Screen 4***) is shown below.  03-17-10 L31: SERVICE COORDINATOR REVIEW OF IPC: ADD VC061566 NAME : ROSEMARY, MARY CLIENT ID : 38261 MEDICAID NUMBER: 996655441 CLCN: 8040000804456 COUNTY: TRAVIS LOCAL CASE NO: 0000804456 CONTRACT NO.: 001007358 COMP: 804 LOCAL CASE NO: 00008PN456 CONTRACT NO.: 001008296 COMP: 8PN BEGIN DATE: 20100331 REVISION DATE: 20100331 END DATE: 20110330 SEND TO DADS FOR AUTHORIZATION? (Y/N) _ (IF N, IPC WILL BE RETURNED TO PROVIDER FOR MORE INFORMATION) SC AGREEMENT INDICATES AGREEMENT THAT THE WAIVER SERVICES FOR THIS INDIVIDUAL ARE NOT AVAILABLE THROUGH OTHER RESOURCES, ARE NECESSARY TO PREVENT INSTITUTIONALIZATION, ASSURE THE INDIVIDUALS HEALTH AND SAFETY AND ARE BASED ON OUTCOMES IN THE INDIVIDUALS PDP. MRA AGREES WITH INFORMATION ON THIS IPC? (Y/N): _ (IF N, MUST SUBMIT SC NOTIFICATION OF DISAGREEMENT FORM TO DADS UR) COMMENTS: SC REVIEWER NAME : DATE: 03172010 READY TO ADD?: _ (Y/N) ACT: ___ (L00/AUTH DATA ENTRY MENU, A/MA MAIN MENU, HLP(PF1)/SCRN DOC)	This screen is used by the Service Coordinator to enter their agreement or disagreement and to add any comments. *If the Service Coordinator believes that an error was made in the data entry of the IPC (return to provider):* • Type **N** in the SEND TO DADS FOR AUTHORIZATION? field. • Type a comment as to why it is being returned to the provider in the COMMENTS section. ***Comment is required if returned to provider.*** **Note: SC must call the provider to let them know that they have returned an IPC.** • Type the Service Coordinator's name in the SC REVIEWER NAME field. • Type **Y** in the READY TO ADD? field. • Press **Enter**. *If the Service Coordinator agrees with the statement and is ready to send for authorization:* • Type **Y** in the SEND TO DADS FOR AUTHORIZATION? field. • Type **Y** in the MRA AGREES WITH INFORMATION ON THIS IPC? field. • Type the Service Coordinator's name in the SC REVIEWER NAME field. • Type **Y** in the READY TO ADD? field. • Press **Enter**. *If the Service Coordinator does not agree with the statement:* • Type **Y** in the Send to DADS FOR AUTHORIZATION? field. • Type **N** in the MRA AGREES WITH INFORMATION ON THIS IPC? field. • The Service Coordinator may enter a comment in the COMMENT field. • Type the Service Coordinator's name in the SC REVIEWER NAME field. • Type **Y** in THE READY TO ADD? field. • Press **Enter**. Note: Any time a disagreement is noted, the Service Coordinator must notify DADS UR and the program provider on the same day as data entry by: • completing a Notification of SC Disagreement form (form 8579), • faxing it to DADS Program Enrollment (PE), • and sending a copy to the program provider. Errors made on the **L31: Service Coordinator Review of IPC** screen may only be corrected during the MRA Review time period (within seven days of the data entry).

continued on next page

L31: Service Coordinator Review of IPC: Change

Procedure

The ***change action may only be completed during the 7-day time frame***. The only fields that can be changed are the questions and comments on the last screen. The following table gives a brief description of the steps taken if a change is necessary.

Step	View	Action
1	_ _	• Type **L31** in the ACT: field of any screen. • Press **Enter**. Result: The **L31: Service Coordinator Review of IPC** header screen is displayed.
2	A sample **L31: Service Coordinator Review of IPC** header screen is shown below.  03-17-10 L31: SERVICE COORDINATOR REVIEW OF IPC VC061560 PLEASE ENTER ONE OF THE FOLLOWING: CLIENT ID: _____ COMPONENT CODE/LOCAL CASE NUMBER: __ / _____ MEDICAID NUMBER: _____ IPC EFFECTIVE DATE: _____ (MMDDYYYY) (REQUIRED IF MORE THAN ONE IPC IS WAITING TO BE REVIEWED) TYPE OF ENTRY: _ A/ADD, C/CHANGE, D/DELETE *** PRESS ENTER *** ACT: ___ (L00/AUTH DATA ENTRY MENU, A/HCS MAIN MENU, HLP(PF1)/SCRN DOC)	• Type the requested identifying information in the appropriate fields. Rule: You must enter the Client ID *or* the local case number. • Type the component code of the individual's current component in the COMPONENT CODE field. • Type **C** in the TYPE OF ENTRY field. • Press **Enter**. Result: The first **L31: Service Coordinator Review of IPC** screen is displayed.
3	A sample **L31: Service Coordinator Review of IPC** is shown below.  03-17-10 L31:SERVICE COORDINATOR REVIEW OF IPC VC060491 NAME : ROSEMARY, MARY CLIENT ID : 38261 MEDICAID NUMBER: 996655441 CLCN: 8040000804456 COUNTY: TRAVIS LOCAL CASE NUMBER: 0000804456 CONTRACT NO: 001007358 COMPONENT: 804 LOCAL CASE NUMBER: 00008PN456 CONTRACT NO: 001008296 CDS COMPONENT: 8PN RESIDENTIAL TYPE : OWN/FAMILY HOME REC 1 OF 1 WAIVER TYPE : HCS LOCATION: OHFH LOC/LON: 1/1 BEGIN DATE: 03-31-2010 REVISION DATE: 03-31-2010 END DATE: 03-30-2011 SERVICE CATEGORY PROG UNITS SERVICE CATEGORY PROG UNITS AA ADAPTIVE AIDS 500 DOL AU AUDIOLOGY 2 HRS PS BEHAVIORAL SUPPORT 4 HRS DH DAY HABILITATION 250 DAYS DE DENTAL 1000 DOL DI DIETARY 2 HRS NUR NURSING RN 2 HRS NUL NURSING LVN 2 HRS OT OCCUPATIONAL THERAPY 2 HRS PT PHYSICAL THERAPY 3 HRS REHV CDS RESPITE HR 300 HRS SP SPEECH/LANGUAGE 1 HRS SHLV CDS SUPPORTED HOME L 700 HRS FMSV FMS MONTHLY FEE 12 MONS SCV SUPPORT CONSULTATION 10 HRS TOTAL ANNUAL COST: 37,574.28 AUTHORIZED AMOUNT: 83,734.00 ********** CDS SUMMARY ********** FMSV FMS MONTHLY FEE 12 MONS REHV CDS RESPITE HR 300 HRS SCV SUPPORT CONSULTATION 10 HRS SHLV CDS SUPPORTED HOME L 700 HRS >	The only fields that can be changed are the questions and comments on the last screen. • Press **Enter** to move through the screens.

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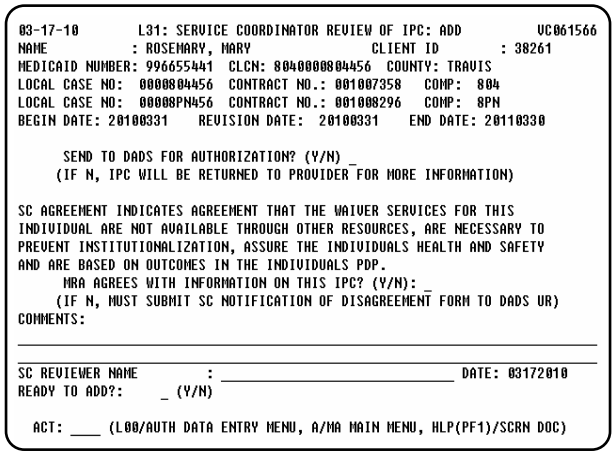
Procedure, continued

Step	View	Action
4	A sample screen is shown below.  03-17-10 L31: SERVICE COORDINATOR REVIEW OF IPC: ADD VC061566 NAME : ROSEMARY, MARY CLIENT ID : 38261 MEDICAID NUMBER: 996655441 CLCN: 804000808456 COUNTY: TRAVIS LOCAL CASE NO: 0000804456 CONTRACT NO.: 001007358 COMP: 804 LOCAL CASE NO: 00008PN456 CONTRACT NO.: 001008296 COMP: 8PN BEGIN DATE: 20100331 REVISION DATE: 20100331 END DATE: 20110330 SEND TO DADS FOR AUTHORIZATION? (Y/N) _ (IF N, IPC WILL BE RETURNED TO PROVIDER FOR MORE INFORMATION) SC AGREEMENT INDICATES AGREEMENT THAT THE WAIVER SERVICES FOR THIS INDIVIDUAL ARE NOT AVAILABLE THROUGH OTHER RESOURCES, ARE NECESSARY TO PREVENT INSTITUTIONALIZATION, ASSURE THE INDIVIDUALS HEALTH AND SAFETY AND ARE BASED ON OUTCOMES IN THE INDIVIDUALS PDP. MRA AGREES WITH INFORMATION ON THIS IPC? (Y/N): _ (IF N, MUST SUBMIT SC NOTIFICATION OF DISAGREEMENT FORM TO DADS UR) COMMENTS: SC REVIEWER NAME : _____ DATE: 03172010 READY TO ADD?: _ (Y/N) ACT: ___ (L00/AUTH DATA ENTRY MENU, A/MA MAIN MENU, HLP(PF1)/SCRN DOC)	This screen is used by the Service Coordinator to enter their agreement or disagreement and to add any comments. See *Step 4* of the **L31: Service Coordinator Review of IPC** procedure for descriptions of the fields on this screen. • Complete the changes to the review by typing the review information in the appropriate fields. • Type **Y** in the READY TO CHANGE? field. • Press **Enter**. Result: The **L31: Service Coordinator Review of IPC** header screen is displayed with the message, "*Previous Information Changed*."

L31: Service Coordinator Review of IPC: Delete

Procedure

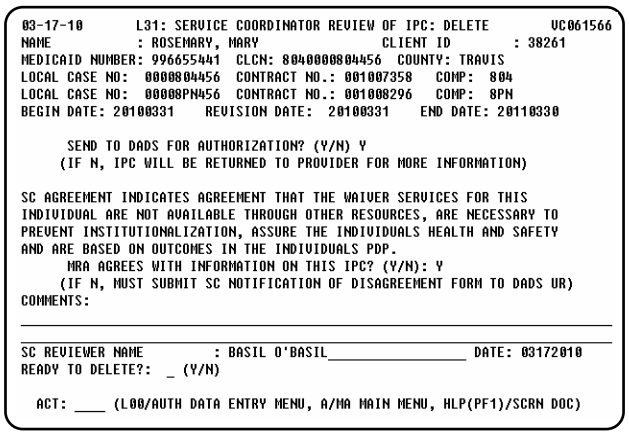
The ***delete action may only be completed during the 7-day time frame***. The following table gives a brief description of the steps taken if it is necessary to delete a review.

Note: All IPCs that are not reviewed (which would include any that were deleted and not re-entered) will appear on a report showing IPCs not reviewed by the MRA.

Step	View	Action
1	_ _	• Type **L31** in the ACT: field of any screen. • Press **Enter**. Result: The **L31: Service Coordinator Review of IPC** header screen is displayed.
2	A sample **L31: Service Coordinator Review of IPC** header screen is shown below. 03-17-10 L31: SERVICE COORDINATOR REVIEW OF IPC VC061560 PLEASE ENTER ONE OF THE FOLLOWING: CLIENT ID: _____ COMPONENT CODE/LOCAL CASE NUMBER: __ / _____ MEDICAID NUMBER: _____ IPC EFFECTIVE DATE: _____ (MMDDYYYY) (REQUIRED IF MORE THAN ONE IPC IS WAITING TO BE REVIEWED) TYPE OF ENTRY: _ A/ADD, C/CHANGE, D/DELETE *** PRESS ENTER *** ACT: ___ (L00/AUTH DATA ENTRY MENU, A/HCS MAIN MENU, HLP(PF1)/SCRN DOC)	• Type the requested identifying information in the appropriate fields. Rule: You must enter the Client ID *or* the local case number. • Type the component code of the individual's current component in the COMPONENT CODE field. • Type **D** in the TYPE OF ENTRY field. • Press **Enter**. Result: The first **L31: Service Coordinator Review of IPC** screen is displayed.
3	A sample **L31: Service Coordinator Review of IPC** is shown below. 03-17-10 L31:SERVICE COORDINATOR REVIEW OF IPC VC060491 NAME : ROSEMARY, MARY CLIENT ID : 38261 MEDICAID NUMBER: 996655441 CLCN: 8040000804456 COUNTY: TRAVIS LOCAL CASE NUMBER: 0000804456 CONTRACT NO: 001007358 COMPONENT: 804 LOCAL CASE NUMBER: 00008PN456 CONTRACT NO: 001008296 CDS COMPONENT: 8PN RESIDENTIAL TYPE : OWN/FAMILY HOME REC 1 OF 1 WAIVER TYPE : HCS LOCATION: OHFH LOC/LON: 1/1 BEGIN DATE: 03-31-2010 REVISION DATE: 03-31-2010 END DATE: 03-30-2011 SERVICE CATEGORY PROG UNITS SERVICE CATEGORY PROG UNITS AA ADAPTIVE AIDS 500 DOL AU AUDIOLOGY 2 HRS PS BEHAVIORAL SUPPORT 4 HRS DH DAY HABILITATION 250 DAYS DE DENTAL 1000 DOL DI DIETARY 2 HRS NUR NURSING RN 2 HRS NUL NURSING LVN 2 HRS OT OCCUPATIONAL THERAPY 2 HRS PT PHYSICAL THERAPY 3 HRS REHV CDS RESPITE HR 300 HRS SP SPEECH/LANGUAGE 1 HRS SHLV CDS SUPPORTED HOME L 700 HRS FMSV FMS MONTHLY FEE 12 MONS SCV SUPPORT CONSULTATION 10 HRS TOTAL ANNUAL COST: 37,574.28 AUTHORIZED AMOUNT: 83,734.00 ********** CDS SUMMARY ********** FMSV FMS MONTHLY FEE 12 MONS REHV CDS RESPITE HR 300 HRS SCV SUPPORT CONSULTATION 10 HRS SHLV CDS SUPPORTED HOME L 700 HRS >	The READY TO DELETE option is on the last screen. • Press **Enter** to move through the screens.

continued on next page

Procedure, continued

Step	View	Action
4	A sample **L31: Service Coordinator Review of IPC** screen is shown below.  03-17-10 L31: SERVICE COORDINATOR REVIEW OF IPC: DELETE VC061566 NAME : ROSEMARY, MARY CLIENT ID : 38261 MEDICAID NUMBER: 99665544I CLCN: 804000080445G COUNTY: TRAVIS LOCAL CASE NO: 0000804456 CONTRACT NO.: 001007358 COMP: 804 LOCAL CASE NO: 00008PN456 CONTRACT NO.: 001008296 COMP: 8PN BEGIN DATE: 20100331 REVISION DATE: 20100331 END DATE: 20110330 SEND TO DADS FOR AUTHORIZATION? (Y/N) Y (IF N, IPC WILL BE RETURNED TO PROVIDER FOR MORE INFORMATION) SC AGREEMENT INDICATES AGREEMENT THAT THE WAIVER SERVICES FOR THIS INDIVIDUAL ARE NOT AVAILABLE THROUGH OTHER RESOURCES, ARE NECESSARY TO PREVENT INSTITUTIONALIZATION, ASSURE THE INDIVIDUALS HEALTH AND SAFETY AND ARE BASED ON OUTCOMES IN THE INDIVIDUALS PDP. MRA AGREES WITH INFORMATION ON THIS IPC? (Y/N): Y (IF N, MUST SUBMIT SC NOTIFICATION OF DISAGREEMENT FORM TO DADS UR) COMMENTS: SC REVIEWER NAME : BASIL O'BASIL DATE: 03172010 READY TO DELETE?: _ (Y/N) ACT: ___ (L00/AUTH DATA ENTRY MENU, A/MA MAIN MENU, HLP(PF1)/SCRN DOC)	To delete the review: • Type **Y** in the READY TO DELETE? field. • Press **Enter**. Result: The **L31: Service Coordinator Review of IPC** header screen is displayed with the message, "*Previous Information Deleted*."

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MRA Assignment Notification (L30)

Introduction

The *MRA Assignment Notification* process tracks that the ***sending*** MRA has notified the ***receiving*** MRA when an individual moves from one MRA service area to another within a Waiver Contract Area. ***This process should be done on or after the date of the move***.

Entering the **L30** screen is *not* the method of notification. The ***sending*** MRA service coordinator must complete the MRA Reassignment form and fax it to the ***receiving*** MRA ***prior*** to an individual moving to a different MRA's service area and ***without transferring to a new waiver contract***.

The **L30: MRA Assignment Notification** screen ensures that coordination between the MRAs has taken place. Unless this screen is completed, the *receiving* MRA will *not* be able to enter the client assignment in **L26: Client Assignments**.

If the date of the move is in the future (no more than 30 days), the *receiving* MRA will complete **L26** *on the date of the move* to complete the assignment. The assignment *cannot* be done for a future date.

If the date of the move is today or in the past, the *receiving* MRA is automatically moved to **L26** to complete the assignment.

Procedure

The following table describes the steps the ***sending*** MRA will use to initiate the MRA assignment notification process.

Note: The ***sending*** service coordinator should contact the program provider to obtain the location code and county where the individual will be moving.

Sending MRA

Step	View	Action
1	_ _	• Type **L30** in the ACT: field of any screen. • Press **Enter**. Result: The **L30: MRA Assignment Notification: Add/Change/Delete header screen** is displayed.
2	A sample **L30: MRA Assignment Notification: Add/Change/Delete** header screen is shown below. 10-03-07 L30:MRA ASSIGNMENT NOTIFICATION: ADD/CHANGE/DELETE VC061290 PLEASE ENTER ONE OF THE FOLLOWING: CLIENT ID: _____ COMPONENT CODE/LOCAL CASE NUMBER: __ / _____ MEDICAID NUMBER: _____ MRA: __ PLEASE ENTER THE FOLLOWING: TYPE OF ENTRY: _ (A/ADD,C/CHANGE,D/DELETE) *** PRESS ENTER *** ACT: ___ (L00/AUTH DATA ENTRY MENU, A/HCS MAIN MENU, HLP(PF1)/SCRN DOC)	• Type the requested identifying information in the appropriate fields. Rule: You must enter the Client ID, the local case number, *or* the Medicaid number. • Type the provider's component code in the COMPONENT CODE field. • Type the ***sending*** MRA's code in the MRA field. • Type **A** (Add) in the TYPE OF ENTRY field. • Press **Enter**. Result: The **L30: MRA Assignment Notification: Add** screen is displayed.
3	A sample **L30: MRA Assignment Notification: Add s**creen is shown below. 10-03-07 L30:MRA ASSIGNMENT NOTIFICATION: ADD VC061295 CLIENT NAME : AMERICA, EDUCARE CLIENT ID : 38032 CONTRACT NUMBER: 001007035 CDS LOCAL CASE NUMBER: 0000013119 COMPONENT: 804 CURRENT LOCATION: OHFH OWN HOME/FAMILY HOME COUNTY: 060 DELTA MOVE TO LOCATION: ___ COUNTY: __ (OHFH ONLY) MOVE DATE: _____ (MMDDYYYY) SENDING AUTHORITY 480 LAKES REGIONAL MHMR CENTER CONTACT NAME : _____ PHONE : (__) __ - ___ DATE: _____ (MMDDYYYY) RECEIVING AUTHORITY ACCEPTED BY : _____ DATE: _____ (MMDDYYYY) READY TO ADD? _ (Y/N) ACT: ___ (L00/AUTH DATA ENTRY MENU, A/MA MAIN MENU, HLP(PF1)/SCRN DOC)	• Type the location code in the MOVE TO LOCATION field. • Type the county code of the new location in the COUNTY field. Note: For TxHmL, the Move to Location must be **OHFH** and the MOVE TO LOCATION and COUNTY code fields are required. • Type the date of the move in the MOVE DATE field. In the **Sending Authority** section of the screen: • Type the name of the MRA contact person in the CONTACT NAME field. • Type the contact person's area code and telephone number in the PHONE fields. • Type the date the data is entered in the DATE field. • Type **Y** in the READY TO ADD? field. Note: You can type **N** in the READY TO ADD? field to take no action and return to the header screen. • Press **Enter**. Result: The **L30: MRA Assignment Notification** header screen is displayed with the message, *"Previous Information Added."*

Procedure — The following table describes the steps the ***receiving*** MRA will use to continue and complete the MRA assignment notification process.

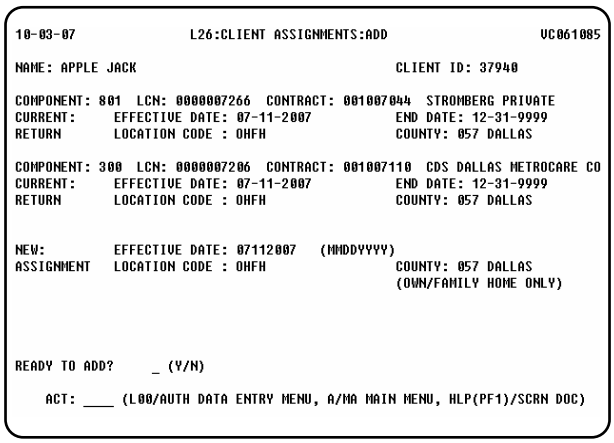
Receiving MRA

Step	View	Action
1	_ _	• Type **L30** in the ACT: field of any screen. • Press **Enter**. Result: The **L30: MRA Assignment Notification: Add/Change/Delete header screen** is displayed.
2	A sample **L30: MRA Assignment Notification: Add/Change/Delete** header screen is shown below. 10-03-07 L30:MRA ASSIGNMENT NOTIFICATION: ADD/CHANGE/DELETE VC061290 PLEASE ENTER ONE OF THE FOLLOWING: CLIENT ID: 30121____ COMPONENT CODE/LOCAL CASE NUMBER: 804 / _____ MEDICAID NUMBER: _____ MRA: 190 PLEASE ENTER THE FOLLOWING: TYPE OF ENTRY: C (A/ADD,C/CHANGE,D/DELETE) *** PRESS ENTER *** **MSG: 1939 PREVIOUS INFORMATION ADDED ACT: ___ (L00/AUTH DATA ENTRY MENU, A/HCS MAIN MENU, HLP(PF1)/SCRN DOC)	• Type the requested identifying information in the appropriate fields. Rule: You must enter the Client ID, the local case number, *or* the Medicaid number. • Type the provider's component code in the COMPONENT CODE field. • Type the ***receiving*** MRA's code in the MRA field. • Type **C** (Change) in the TYPE OF ENTRY field. • Press **Enter**. Result: The **L30: MRA Assignment Notification: Change** screen is displayed.
3	A sample **L30: MRA Assignment Notification: Change** screen is shown below. 10-03-07 L30:MRA ASSIGNMENT NOTIFICATION: CHANGE VC061295 CLIENT NAME : AMERICA, EDUCARE CLIENT ID : 38032 CONTRACT NUMBER: 001007035 CDS LOCAL CASE NUMBER: 0000013119 COMPONENT: 804 CURRENT LOCATION: OHFH OWN HOME/FAMILY HOME COUNTY: 060 DELTA MOVE TO LOCATION: OHFH COUNTY: 234 (OHFH ONLY) MOVE DATE: 07112007(MMDDYYYY) SENDING AUTHORITY 480 LAKES REGIONAL MHMR CENTER CONTACT NAME : JAMES JONES_____ PHONE : (555) 555 - 5555 DATE: 09272007 (MMDDYYYY) RECEIVING AUTHORITY 190 ANDREWS CENTER ACCEPTED BY : JOHN JOHNSON_____ DATE: 09272007 (MMDDYYYY) READY TO CHANGE? _ (Y/N) ACT: ___ (L00/AUTH DATA ENTRY MENU, A/MA MAIN MENU, HLP(PF1)/SCRN DOC)	In the **Receiving Authority** section of the screen: • Type the name of the MRA contact person in the ACCEPTED BY field. • Type the date the data is entered in the DATE field. • Type **Y** in the READY TO CHANGE? field. Note: You can type **N** in the READY TO CHANGE? field to take no action and return to the header screen. • Press **Enter**. If the date of the move is *today's date or in the past*, the **L26: Client Assignments: Add** screen is displayed. *Continue with Step 4.* *- or -* If the date of the move is *in the future*, a message screen is displayed stating that because the movement date is in the future you will not be able to enter the client movement until that date. • Press **Enter**. Result: The **L30: MRA Assignment Notification** header screen is displayed with the message *"Previous Information Changed."* The receiving MRA will complete **L26: Client Assignments** *on the date of the move* to complete the assignment. If the move date is *in the future*, the receiving MRA ***must wait*** until the date of the move to complete the assignment.

continued on next page

Procedure, continued

Receiving MRA

Step	View	Action
4	A sample **L26: Client Assignments: Add** screen is shown below.  10-03-07 L26:CLIENT ASSIGNMENTS:ADD VC061085 NAME: APPLE JACK CLIENT ID: 37940 COMPONENT: 801 LCN: 0000007266 CONTRACT: 001007044 STROMBERG PRIVATE CURRENT: EFFECTIVE DATE: 07-11-2007 END DATE: 12-31-9999 RETURN LOCATION CODE : OHFH COUNTY: 057 DALLAS COMPONENT: 300 LCN: 0000007206 CONTRACT: 001007110 CDS DALLAS METROCARE CO CURRENT: EFFECTIVE DATE: 07-11-2007 END DATE: 12-31-9999 RETURN LOCATION CODE : OHFH COUNTY: 057 DALLAS NEW: EFFECTIVE DATE: 07112007 (MMDDYYYY) ASSIGNMENT LOCATION CODE : OHFH COUNTY: 057 DALLAS (OWN/FAMILY HOME ONLY) READY TO ADD? _ (Y/N) ACT: ___ (L00/AUTH DATA ENTRY MENU, A/MA MAIN MENU, HLP(PF1)/SCRN DOC)	• Type **Y** in the READY TO ADD? field to add the client assignment. • Press **Enter**. Result: The **L30: MRA Assignment Notification** header screen is displayed with the message, *"Previous Information Added."*

Client Assignments (L26)

Introduction

The Mental Retardation Authority (MRA) must enter a client assignment for a Texas Home Living (TxHmL) individual living in his/her own home/family home (OHFH) or an HCS individual who has self-directed services *only* and if the individual moves to a different county.

Client assignments are also created when individuals are:

- enrolled into the waiver program by the MRA,
- transferred between service provider contracts, and
- returned from a temporary discharge status.

Any errors made on client assignments using these other screens must be corrected using the same screen where the assignment was created.

The *Client Assignments* process allows the MRA to add, correct, or delete a client assignment record.

Client Assignments (L26): Add

Procedure

The following table describes the steps the MRA will use to add a new client assignment record for a TxHmL individual or an HCS individual who has self-directed services *only* and if the individual moves to a different county.

Step	View	Action
1	_ _	• Type **L26** in the ACT: field of any screen. • Press **Enter**. Result: The **L26: Client Assignments: Add/ Correct/Delete** header screen is displayed.
2	A sample **L26: Client Assignments: Add/Correct/ Delete** header screen is shown below. 01-04-08 L26:CLIENT ASSIGNMENTS: ADD/CORRECT/DELETE VC061080 PLEASE ENTER ONE OF THE FOLLOWING: CLIENT ID: _____ COMPONENT CODE/LOCAL CASE NUMBER: __ / _____ MEDICAID NUMBER: _____ PLEASE ENTER THE FOLLOWING: TYPE OF ENTRY: _ (A/ADD,C/CORRECT,D/DELETE) "C" TO CORRECT ERRORS ON EXISTING ASSIGNMENTS ONLY. USE "A" TO ADD A NEW ASSIGNMENT. (MOVING A CLIENT FROM ONE HOUSE TO ANOTHER IS A NEW ASSIGNMENT, AND MUST BE AN ADD) *** PRESS ENTER *** ACT: ___ (L00/AUTH DATA ENTRY MENU, A/MA MAIN MENU, HLP(PF1)/SCRN DOC)	• Type the requested identifying information in the appropriate fields. Rule: You must enter the Client ID, the local case number, *or* the Medicaid Number. • Type the provider's Component Code in the COMPONENT CODE field. • Type **A** (Add) in the TYPE OF ENTRY field. • Press **Enter**. Result: The **L26: Client Assignments: Add** screen is displayed.
3	A sample **L26: Client Assignments: Add** screen is shown below. 09-24-07 L26:CLIENT ASSIGNMENTS:ADD VC061085 NAME: CHEF BOYARDEE CLIENT ID: 40657 COMPONENT: 020 LCN: 1234569116 CONTRACT: 001007035 CDS SWBT TXHML CDS CONT CURRENT: EFFECTIVE DATE: 01-10-2007 END DATE: 12-31-9999 ASSIGNMENT LOCATION CODE : OHFH COUNTY: 033 CARSON NEW: EFFECTIVE DATE: 01102007 (MMDDYYYY) ASSIGNMENT LOCATION CODE : OHFH COUNTY: 033 CARSON (OWN/FAMILY HOME ONLY) READY TO ADD? _ (Y/N) ACT: ___ (L00/AUTH DATA ENTRY MENU, A/MA MAIN MENU, HLP(PF1)/SCRN DOC) The screen displays current enrollment information.	• Type the effective date of the new assignment in the EFFECTIVE DATE field. • Type **OHFH** (Own Home/Family Home) in the LOCATION CODE field. • Type the county code of the new assignment in the COUNTY field. • Type **Y** in the READY TO ADD? field to submit the data to the system. Note: You can type **N** in the READY TO ADD? field to take no action and return to the header screen. • Press **Enter**. Result: The header screen is displayed with the message, *"Previous Information Added."*

Client Assignments (L26): Correct

Procedure

The following table describes the steps the MRA will use to correct errors on existing TxHmL assignments, i.e., incorrect assignment date, location code, or county.

Note: You may only correct the most current assignment. If a previous assignment is incorrect, each assignment created after the error must be deleted and then re-entered after the correction is made.

Step	View	Action
1	_ _	• Type **L26** in the ACT: field of any screen. • Press **Enter**. Result: The **L26: Client Assignments: Add/ Correct/Delete** header screen is displayed.
2	A sample **L26: Client Assignments: Add/Correct/ Delete** header screen is shown below. 01-04-08 L26:CLIENT ASSIGNMENTS: ADD/CORRECT/DELETE VC061080 PLEASE ENTER ONE OF THE FOLLOWING: CLIENT ID: _____ COMPONENT CODE/LOCAL CASE NUMBER: __ / _____ MEDICAID NUMBER: _____ PLEASE ENTER THE FOLLOWING: TYPE OF ENTRY: _ (A/ADD,C/CORRECT,D/DELETE) "C" TO CORRECT ERRORS ON EXISTING ASSIGNMENTS ONLY. USE "A" TO ADD A NEW ASSIGNMENT. (MOVING A CLIENT FROM ONE HOUSE TO ANOTHER IS A NEW ASSIGNMENT, AND MUST BE AN ADD) *** PRESS ENTER *** ACT: ___ (L00/AUTH DATA ENTRY MENU, A/MA MAIN MENU, HLP(PF1)/SCRN DOC)	• Type the requested identifying information in the appropriate fields. Rule: You must enter the Client ID, the local case number, *or* the Medicaid Number. • Type the provider's Component Code in the COMPONENT CODE field. • Type **C** (Correct) in the TYPE OF ENTRY field. • Press **Enter**. Result: The **L26: Client Assignments: Correct** screen is displayed.
3	A sample **L26: Client Assignments: Correct** screen is shown below. 09-24-07 L26:CLIENT ASSIGNMENTS:CORRECT VC061085 NAME: CHEF BOYARDEE CLIENT ID: 40657 COMPONENT: 020 LCN: 1234569116 CONTRACT: 001007035 CDS SWBT TXHML CDS CONT PREVIOUS: EFFECTIVE DATE: 01-01-2007 END DATE: 01-09-2007 ENROLLMENT LOCATION CODE : OHFH COUNTY: 056 DALLAM CURRENT: EFFECTIVE DATE: 01102007 (MMDDYYYY) ASSIGNMENT LOCATION CODE : OHFH COUNTY: 033 CARSON (OWN/FAMILY HOME ONLY) READY TO CHANGE? _ (Y/N) ACT: ___ (L00/AUTH DATA ENTRY MENU, A/MA MAIN MENU, HLP(PF1)/SCRN DOC) The screen displays previous enrollment and current assignment information.	• Type corrections to errors in the *current assignment* in the appropriate fields. • Type **Y** in the READY TO CHANGE? field to submit the data to the system. Note: You can type **N** in the READY TO CHANGE? field to take no action and return to the header screen. • Press **Enter**. Result: The header screen is displayed with the message, *"Previous Information Changed."*

Client Assignments (L26): Delete

Procedure

The following table describes the steps the MRA will use to delete a client assignment record for TxHmL individuals.

Step	View	Action
1	_ _	• Type **L26** in the ACT: field of any screen. • Press **Enter**. Result: The **L26: Client Assignments: Add/ Correct/Delete** header screen is displayed.
2	A sample **L26: Client Assignments: Add/Correct/ Delete** header screen is shown below. 01-04-08 L26:CLIENT ASSIGNMENTS: ADD/CORRECT/DELETE VC061080 PLEASE ENTER ONE OF THE FOLLOWING: CLIENT ID: _____ COMPONENT CODE/LOCAL CASE NUMBER: __ / _____ MEDICAID NUMBER: _____ PLEASE ENTER THE FOLLOWING: TYPE OF ENTRY: _ (A/ADD,C/CORRECT,D/DELETE) "C" TO CORRECT ERRORS ON EXISTING ASSIGNMENTS ONLY. USE "A" TO ADD A NEW ASSIGNMENT. (MOVING A CLIENT FROM ONE HOUSE TO ANOTHER IS A NEW ASSIGNMENT, AND MUST BE AN ADD) *** PRESS ENTER *** ACT: ___ (L00/AUTH DATA ENTRY MENU, A/MA MAIN MENU, HLP(PF1)/SCRN DOC)	• Type the requested identifying information in the appropriate fields. Rule: You must enter the Client ID, the local case number, *or* the Medicaid Number. • Type the provider's Component Code in the COMPONENT CODE field. • Type **D** (Delete) in the TYPE OF ENTRY field. • Press **Enter**. Result: The **L26: Client Assignments: Delete** screen is displayed.
3	A sample **L26: Client Assignments: Delete** screen is shown below. 09-24-07 L26:CLIENT ASSIGNMENTS:DELETE VC061085 NAME: CHEF BOYARDEE CLIENT ID: 40657 COMPONENT: 020 LCN: 1234569116 CONTRACT: 001007035 CDS SWBT TXHML CDS CONT PREVIOUS: EFFECTIVE DATE: 01-01-2007 END DATE: 01-09-2007 ENROLLMENT LOCATION CODE : OHFH COUNTY: 056 DALLAM COMPONENT: 020 LCN: 1234569116 CONTRACT: 001007035 CDS SWBT TXHML CDS CONT CURRENT: EFFECTIVE DATE: 01-10-2007 END DATE: 12-31-9999 ASSIGNMENT LOCATION CODE : OHFH COUNTY: 033 CARSON READY TO DELETE? _ (Y/N) ACT: ___ (L00/AUTH DATA ENTRY MENU, A/MA MAIN MENU, HLP(PF1)/SCRN DOC)	• Type **Y** in the READY TO DELETE? field to submit the data to the system. Note: You can type **N** in the READY TO DELETE? field to take no action and return to the header screen. • Press **Enter**. Result: The header screen is displayed with the message, *"Previous Information Deleted."*

Consumer Demographic Update

Introduction

The Mental Retardation Authority (MRA) has the responsibility of updating an individual's demographics during the enrollment process for the HCS and/or TxHmL programs, and that responsibility is ongoing for *all* Texas Home Living individuals and those individuals in HCS who have self-directed services *only*.

The *Consumer Demographic Update* process allows the MRA to update the data in an individual's electronic record regarding name, address, correspondent, and guardian information.

Access Consumer Demographic Update Screens

CARE Action Codes may be entered in the ACT: field to access the data entry screens for the consumer demographic update procedures. Entering either a CARE Action Code *or* an Authority Action Code will result in accessing the same screen for client name, client address, and client correspondent updates.

The consumer demographic update process includes the following data entry screens and procedures:

Screen	Authority Code	CARE Code	Procedure
Client Name Update	**L11**	**420**	Add, change, or delete individual's name information
Client Address Update	**L12**	**430**	Update individual's address information
Client Correspondent Update	**L10**	**431**	Update individual's correspondent information
Guardian Information Update	**L20**	– –	Update individual's guardian information

Consumer Demographic Update
Client Name Update (L11)

Introduction

The *Client Name Update* process allows the MRA to update an individual's name record.

Use the following types of entry to add, change, or delete name information:

- The **Add** option is used when an individual's name has legally changed so that a record of the name history is kept.
- The **Change** option is used if the name was entered incorrectly by your MRA.
- The **Delete** option is used if a name update was entered in error by your MRA.

Consumer Demographic Update
Client Name Update (L11): Add

Procedure

The following table describes the steps the MRA will use to add information to an individual's name record.

Step	View	Action
1	_ _	• Type **L11** in the ACT: field of any screen. • Press **Enter**. Result: The **L11: Client Name Update** header screen is displayed.
2	A sample **L11: Client Name Update** header screen is shown below. 02-04-04 L11:CLIENT NAME UPDATE VC060440 PLEASE ENTER AT LEAST ONE OF THE FOLLOWING: CLIENT ID: _____ COMPONENT CODE/LOCAL CASE NUMBER: __ / _____ PLEASE ENTER THE FOLLOWING: TYPE OF ENTRY : _ (A/ADD,C/CHANGE,D/DELETE) *** PRESS ENTER *** ACT: ___ (L00/AUTH DATA ENTRY MENU, A/MA MAIN MENU, HLP(PF1)/SCRN DOC)	• Type the requested identifying information in the appropriate fields. Rule: You must enter the Client ID *or* the local case number. • Type the component code of the individual's current component in the COMPONENT CODE field. • Type **A** (Add) in the TYPE OF ENTRY field. • Press **Enter**. Result: The **L11: Client Name Update** screen is displayed.
3	A sample **L11: Client Name Update** screen is shown below. 02-04-04 L11:CLIENT NAME UPDATE VC060445 CLIENT LAST NAME : MOUNTAIN CLIENT ID : 33006 COMPONENT CODE : 020 ADD CLIENT NAME LAST NAME/SUF : MOUNTAIN_____ ._ FIRST NAME : ROCKY_____ MIDDLE NAME : ._____ READY TO ADD? _ (Y/N) ACT: ___ (L00/AUTH DATA ENTRY MENU, A/MA MAIN MENU, HLP(PF1)/SCRN DOC)	• Type the information you are updating (last name/suffix, first name, middle name) in the appropriate **Add Client Name** fields. • Type **Y** in the READY TO ADD? field to submit the data to the system. Note: You can type **N** in the READY TO ADD? field to take no action and return to the header screen. • Press **Enter**. Result: The **L11: Client Name Update** header screen is displayed with the message, *"Previous Information Added."*

Consumer Demographic Update
Client Name Update (L11): Change

Procedure

The following table describes the steps used to change name information that was entered incorrectly by your MRA.

Step	View	Action
1	_ _	• Type **L11** in the ACT: field of any screen. • Press **Enter**. Result: The **L11: Client Name Update** header screen is displayed.
2	A sample **L11: Client Name Update** header screen is shown below. 02-04-04 L11:CLIENT NAME UPDATE VC060440 PLEASE ENTER AT LEAST ONE OF THE FOLLOWING: CLIENT ID: _____ COMPONENT CODE/LOCAL CASE NUMBER: __ / _____ PLEASE ENTER THE FOLLOWING: TYPE OF ENTRY : _ (A/ADD,C/CHANGE,D/DELETE) *** PRESS ENTER *** ACT: ___ (L00/AUTH DATA ENTRY MENU, A/MA MAIN MENU, HLP(PF1)/SCRN DOC)	• Type the requested identifying information in the appropriate fields. Rule: You must enter the Client ID *or* the local case number. • Type the component code of the individual's current component in the COMPONENT CODE field. • Type **C** (Change) in the TYPE OF ENTRY field. • Press **Enter**. Result: The **L11: Client Name Update** screen is displayed.
3	A sample **L11: Client Name Update** screen is shown below. 02-04-04 L11:CLIENT NAME UPDATE VC060445 REC 1 OF 2 CLIENT LAST NAME : MOUNTAIN CLIENT ID : 33006 COMPONENT CODE : 020 CHANGE CLIENT NAME LAST NAME/SUF : MOUNTAIN_____ ._ FIRST NAME : ROCKY_____ MIDDLE NAME : L_____ READY TO CHANGE? _ (Y/N) ACT: ___ (L00/AUTH DATA ENTRY MENU, A/MA MAIN MENU, HLP(PF1)/SCRN DOC)	• Type the information you are updating (last name/suffix, first name, middle name) in the appropriate **Change Client Name** fields. • Type **Y** in the READY TO CHANGE? field to submit the data to the system. Note: You can type **N** in the READY TO CHANGE? field to take no action and return to the header screen. • Press **Enter**. Result: The **L11: Client Name Update** header screen is displayed with the message, *"Previous Information Changed."*

Consumer Demographic Update
Client Name Update (L11): Delete

Procedure

The following table describes the steps used to delete a name update that was entered in error by your MRA.

Step	View	Action
1	_ _	• Type **L11** in the ACT: field of any screen. • Press **Enter**. Result: The **L11: Client Name Update** header screen is displayed.
2	A sample **L11: Client Name Update** header screen is shown below. 02-04-04 L11:CLIENT NAME UPDATE VC060440 PLEASE ENTER AT LEAST ONE OF THE FOLLOWING: CLIENT ID: _____ COMPONENT CODE/LOCAL CASE NUMBER: __ / _____ PLEASE ENTER THE FOLLOWING: TYPE OF ENTRY : _ (A/ADD,C/CHANGE,D/DELETE) *** PRESS ENTER *** ACT: ___ (L00/AUTH DATA ENTRY MENU, A/MA MAIN MENU, HLP(PF1)/SCRN DOC)	• Type the requested identifying information in the appropriate fields. Rule: You must enter the Client ID *or* the local case number. • Type the component code of the individual's current component in the COMPONENT CODE field. • Type **D** (Delete) in the TYPE OF ENTRY field. • Press **Enter**. Result: The **L11: Client Name Update** screen is displayed.
3	A sample **L11: Client Name Update** screen is shown below. 02-04-04 L11:CLIENT NAME UPDATE VC060445 REC 1 OF 2 CLIENT LAST NAME : MOUNTAIN CLIENT ID : 33006 COMPONENT CODE : 020 DELETE CLIENT NAME LAST NAME/SUF : MOUNTAIN_____ .__ FIRST NAME : ROCKY_____ MIDDLE NAME : L_____ READY TO DELETE? _ (Y/N) ACT: ___ (L00/AUTH DATA ENTRY MENU, A/MA MAIN MENU, HLP(PF1)/SCRN DOC)	Note: If there is more than one name update record, the system displays the most recent name update record. • Type **Y** in the READY TO DELETE? field to delete the record displayed. • Press **Enter**. Result: The next record is displayed with the message, *"Previous Information Deleted."* • Repeat the action to delete the record displayed ***or*** • Type **N** in the READY TO DELETE? field to take no action and return to the header screen. • Press **Enter**. Result: The **L11: Client Name Update** header screen is displayed.

Consumer Demographic Update
Client Address Update (L12)

Introduction

The *Client Address Update* process allows the MRA to update an individual's address record.

Note: All waiver program individuals must have a current address or a current guardian address.

Procedure

The following table describes the steps the MRA will use to update an individual's address information.

Step	View	Action
1	_ _	• Type **L12** in the ACT: field of any screen. • Press **Enter**. Result: The **L12: Client Address Update** header screen is displayed.
2	A sample **L12: Client Address Update** header screen is shown below. 02-04-04 L12:CLIENT ADDRESS UPDATE VC060450 PLEASE ENTER AT LEAST ONE OF THE FOLLOWING: CLIENT ID: _____ COMPONENT CODE/LOCAL CASE NUMBER: __ / _____ *** PRESS ENTER *** ACT: ___ (L00/AUTH DATA ENTRY MENU, A/MA MAIN MENU, HLP(PF1)/SCRN DOC)	• Type the requested identifying information in the appropriate fields. Rule: You must enter the Client ID *or* the local case number. • Type the component code of the individual's current component in the COMPONENT CODE field. • Press **Enter**. Result: The **L12: Client Address Update** screen is displayed.
3	A sample **L12: Client Address Update** screen is shown below. 09-24-07 L12:CLIENT ADDRESS UPDATE VC060455 CLIENT LAST NAME : WEBTEST CLIENT ID : 34240 COMPONENT CODE : 020 LOCAL CASE NUMBER: 0200000001 CLIENT`S CURRENT ADDRESS STREET ADDRESS : ANYSTREET_____ CITY : AUSTIN_____ STATE : TX ZIP CODE/SUFFIX : 77777 ____ ADDRESS DATE : 071007 (MMDDYY) TYPE OF PLACEMENT: 05 (PRESS PF1 TO SEE CODES/DESC) READY TO UPDATE? _ (Y/N) ACT: ___ (L00/AUTH DATA ENTRY MENU, A/MA MAIN MENU, HLP(PF1)/SCRN DOC)	• Type the information you are updating (street address, city, state, zip code) in the appropriate **Client's Current Address** fields. • Type the date the individual's address record is being updated in the ADDRESS DATE field. • Type **Y** in the READY TO UPDATE? field to submit the data to the system. Note: You can type **N** in the READY TO UPDATE? field to take no action and return to the header screen. • Press **Enter**. Result: The **L12: Client Address Update** header screen is displayed with the message, *"Previous Information Changed."*

Consumer Demographic Update
Client Correspondent Update (L10)

Introduction

The *Client Correspondent Update* process allows the MRA to update an individual's correspondent information.

Note: A client's primary correspondent is the first person to contact on behalf of an individual in case of an emergency. The secondary correspondent is the person to contact on behalf of an individual if the primary correspondent cannot be reached.

Procedure

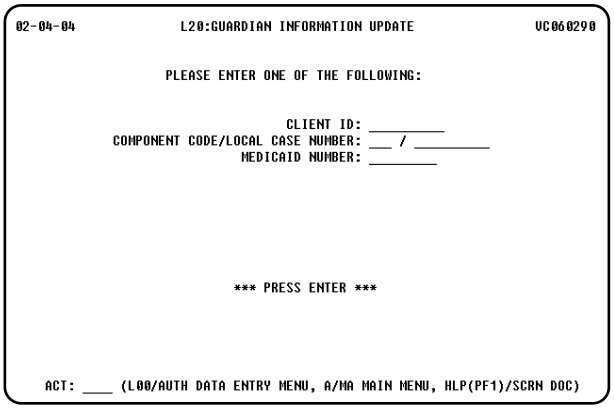
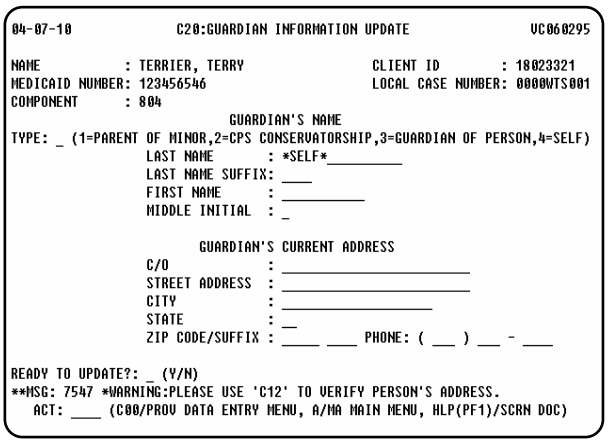
The following table describes the steps the MRA will use to update an individual's correspondent information.

Step	View	Action
1	_ _	• Type **L10** in the ACT: field of any screen. • Press **Enter**. Result: The **L10: Client Correspondent Update** header screen is displayed.
2	A sample **L10: Client Correspondent Update** header screen is shown below. 06-01-08 L10: CLIENT CORRESPONDENT UPDATE VC060430 PLEASE ENTER AT LEAST ONE OF THE FOLLOWING: CLIENT ID : _____ COMPONENT CODE/LOCAL CASE NUMBER : __ / _____ *** PRESS ENTER *** ACT: ___ (L00/AUTH DATA ENTRY MENU, A/MA MAIN MENU, HLP(PF1)/SCRN DOC)	• Type the requested identifying information in the appropriate fields. Rule: You must enter the Client ID *or* the local case number. • Type the component code of the individual's current component in the COMPONENT CODE field. • Press **Enter**. Result: The **L10: Client Correspondent Update** screen is displayed.
3	A sample **L10: Client Correspondent Update** screen is shown below. 02-04-04 L10:CLIENT CORRESPONDENT UPDATE VC060435 LAST NAME/SUF: MOUNTAIN CLIENT ID : 33006 FIRST NAME : ROCKY LOCAL CASE NUMBER : 0005011952 MIDDLE NAME : L COMPONENT : 020 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: ___ (L00/AUTH DATA ENTRY MENU, A/MA MAIN MENU, HLP(PF1)/SCRN DOC)	• Type Primary Correspondent and/or Secondary Correspondent information (name, relationship, street, telephone, city, state, zip code) in the appropriate PRIMARY CORRESPONDENT and/or SECONDARY CORRESPONDENT fields. Note: If you enter a name in the CORRES. NAME field, you *must* enter a code for the correspondent's relationship in the CORRES. RELATIONSHIP field. (Refer to the *Screen Fields* section in the back of this guide for Correspondent Relationship codes.) • Type **Y** in the READY TO UPDATE? field to submit the data to the system. Note: You can type **N** in the READY TO UPDATE? field to take no action and return to the header screen. • Press **Enter**. Result: The **L10: Client Correspondent Update** header screen is displayed with the message, *"Previous Information Changed."*

Consumer Demographic Update
Guardian Information Update (L20)

Introduction — The *Guardian Information Update* process allows the MRA to update information about an individual's guardian.

Procedure — The following table describes the steps the MRA will use to update information about an individual's guardian.

Step	View	Action
1	_ _	• Type **L20** in the ACT: field of any screen. • Press **Enter**. Result: The **L20: Guardian Information Update** header screen is displayed.
2	A sample **L20: Guardian Information Update** header screen is shown below.  02-04-04 L20:GUARDIAN INFORMATION UPDATE VC060290 PLEASE ENTER ONE OF THE FOLLOWING: CLIENT ID: _____ COMPONENT CODE/LOCAL CASE NUMBER: ___ / _____ MEDICAID NUMBER: _____ *** PRESS ENTER *** ACT: ___ (L00/AUTH DATA ENTRY MENU, A/MA MAIN MENU, HLP(PF1)/SCRN DOC)	• Type the requested identifying information in the appropriate fields. Rule: You must type the Client ID, Local Case Number, *or* Medicaid Number. • Type the component code of the individual's current component in the COMPONENT CODE field. • Press **Enter**. Result: The **L20: Guardian Information Update** screen is displayed.
3	A sample **L20: Guardian Information Update** screen is shown below.  04-07-10 C20:GUARDIAN INFORMATION UPDATE VC060295 NAME : TERRIER, TERRY CLIENT ID : 18023321 MEDICAID NUMBER: 123456546 LOCAL CASE NUMBER: 0000WTS001 COMPONENT : 804 GUARDIAN'S NAME TYPE: _ (1=PARENT OF MINOR,2=CPS CONSERVATORSHIP,3=GUARDIAN OF PERSON,4=SELF) LAST NAME : *SELF*_____ LAST NAME SUFFIX: ___ FIRST NAME : _____ MIDDLE INITIAL : _ GUARDIAN'S CURRENT ADDRESS C/O : _____ STREET ADDRESS : _____ CITY : _____ STATE : _ ZIP CODE/SUFFIX : ____ ___ PHONE: (__) __ - ___ READY TO UPDATE?: _ (Y/N) **MSG: 7547 *WARNING:PLEASE USE 'C12' TO VERIFY PERSON'S ADDRESS. ACT: ___ (C00/PROV DATA ENTRY MENU, A/MA MAIN MENU, HLP(PF1)/SCRN DOC)	In the **Guardian's Name** section: • The system displays the guardian's name if the individual has a guardian. Update the guardian's name in the name fields, if appropriate. • The system displays ***SELF*** in the LAST NAME field if the individual does *not* have a guardian. Rule: If ***SELF*** is displayed, the individual *must* have an address on file in the system. Use **L12**: **Client Address Update** to verify the individual's address. • Type the guardian code in the TYPE field. *If the guardian is someone other than the individual:* • Type the guardian's name in the LAST NAME, LAST NAME SUFFIX, FIRST NAME, and MIDDLE INITIAL fields. • Type the guardian's current address in the STREET ADDRESS, CITY, STATE, and ZIP CODE fields. • Type the guardian's telephone number in the PHONE field. • Type **Y** in the READY TO UPDATE? field to submit the data to the system. Note: You can type **N** in the READY TO UPDATE? field to take no action and return to the header screen. • Press **Enter**. Result: The **L20: Guardian Information Update** header screen is displayed with the message, *"Previous Information Changed."*

Consumer Transfer (L06)

Introduction

The *Consumer Transfer* process describes the procedures involved when transferring an individual. An individual may transfer from a Program Provider and/or CDSA to another Program Provider and/or CDSA ***or*** from contract to contract within the same Program Provider's and/or CDSA's component code. A transfer occurs when a contract number associated with an individual is added, ended, or changed.

The Mental Retardation Authority (MRA) is responsible for the coordination of a transfer.

If more than one MRA is involved in the transfer, the ***transferring*** MRA is responsible for completing ***all*** of the data entry screens.

Before an individual can transfer, he/she must:

- have a current Level of Care,
- have a current IPC, and
- not be on hold status

MRA Reassignment

If an individual is moving to a new MRA's service area within the same Waiver Contract Area, and is staying with the same provider agency, this is not a transfer. See the *MRA Assignment Notification* documentation for more information.

Suspension of Waiver Services

An individual currently on suspension of waiver services (formerly temporary discharge) may be transferred directly to a new contract without ending the suspension record.

In this Section

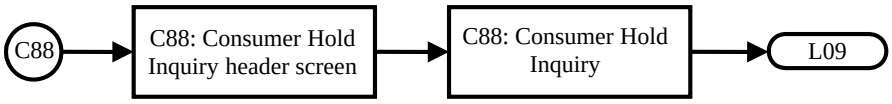
The *Transfer* section has been divided into the following:

- ***Transfers Involving a Program Provider Only*** - describes the procedures involved when transferring an individual from one Program Provider another Program Provider ***or*** from contract to contract within a Program Provider's component code. ***No services are or will be self-directed.***
- ***Transfers Involving a CDSA*** - describes the procedures involved when transferring an individual from one Program Provider and/or CDSA to another Program Provider and/or CDSA ***or*** from contract to contract within a Program Provider's and/or CDSA's component code. ***At least one service is or will be self-directed.***

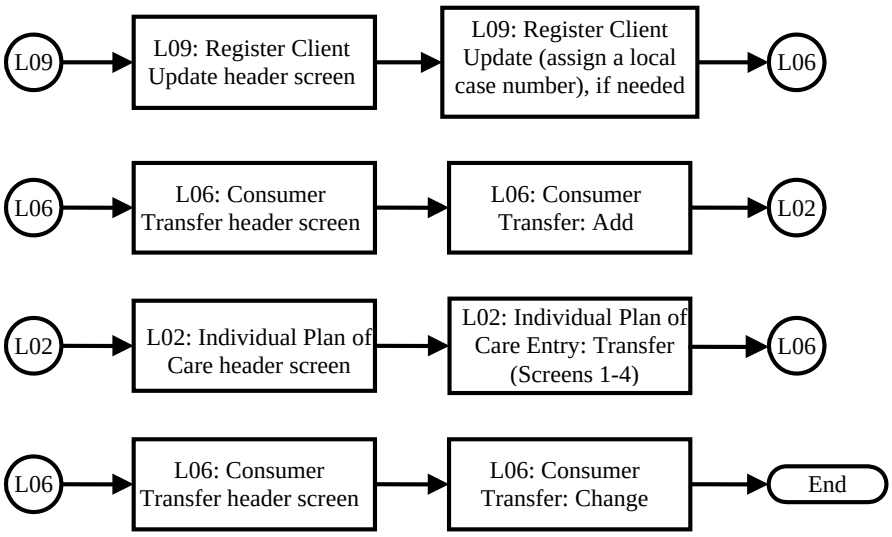
MRA Transfer Entry

The following chart displays the process used when an individual transfers from one Program Provider another Program Provider *or* from contract to contract within a Program Provider's component code.

Note: An individual cannot be transferred while on hold. The reason for the hold must be resolved and the hold must be removed before beginning data entry of a transfer.



Note: The MRA must use **L09: Register Client Update** to add a local case number for the Program Provider and/or the CDSA. If the individual had previously been assigned to the program provider and/or CDSA, he/she will have already been assigned a local case number for that program provider and/or CDSA and this data entry step may not be necessary.



Completing a transfer requires answering three initial questions on the **L06: Consumer Transfer** header screen and then, based on those answers, possibly responding to follow-up questions.

L06: Consumer Transfer Header Screen Questions/Follow-up Questions & Answers

Introduction

A response to the three initial questions in the **L06: Consumer Transfer** header screen will always be required and based on the answers to those questions, follow-up question may be asked. The three initial questions on the **L06: Consumer Transfer** header screen are:

1. **Changing Program Provider (PRGP) or Consumer Directed Services (CDS) Agency?**
2. **Adding a Program Provider or CDS Agency?**
3. **Changing Service Delivery Option?**

The following tables are intended to provide guidance for answering the three initial questions on the **L06: Consumer Transfer** header screen and the follow-up questions for each possible transfer scenario.

To use the tables below, first determine which of the three scenarios describe the individual's current service delivery options, then determine which specific action will be taken and follow the instructions for that specific action.

Note: Answering **N** (No) to the **Statement Confirming the Requested Action** will return you to the **L06: Consumer Transfer** header screen. Check your answers and begin again by making the necessary changes.

Scenario A **Individual has a PRGP Only**			
Specific Action:	**Answers to Initial Questions on the L06 Consumer Transfer Header Screen:**	**Follow-up Question(s) and Answer(s):**	**Statement Confirming the Requested Action and Answer:**
Change the PRGP contract	Y,N,N	NA	NA
Keep the current PRGP contract and add a CDSA contract	N,Y,Y (if REH and/or SHL is already on the IPC) N,Y,N (if REH and/or SHL is **NOT** already on the IPC)	NA	Based on your answers, the PRGP contract is not changing, a CDSA contract is being added, and at least 1 service will be self-directed. Continue? **Y**
Change the PRGP contract and add a CDSA contract	Y,Y,Y (if REH and/or SHL is already on the IPC) Y,Y,N (if REH and/or SHL is **NOT** already on the IPC)	Are all PRGP services ending? **N**	Based on your answers, the PRGP contract is changing, a CDSA contract is being added, and at least 1 service will be self-directed. Continue? **Y**

continued on next page

L06: Consumer Transfer Header Screen Questions/Follow-up Questions & Answers, Continued

Introduction, continued

Scenario A , continued **Individual has a PRGP Only**			
Specific Action:	**Answers to Initial Questions on the L06 Consumer Transfer Header Screen:**	**Follow-up Question(s) and Answer(s):**	**Statement Confirming the Requested Action and Answer:**
End all PRGP services & add a CDSA contract	Y,Y,Y (if REH and/or SHL is already on the IPC) Y,Y,N (if REH and/or SHL is **NOT** already on the IPC)	Are all PRGP services ending? **Y**	Based on your answers, the PRGP services are ending, a CDSA contract is being added, and all services will be self-directed. Continue? **Y**

Scenario B **Individual has a CDSA Only**			
Specific Action:	**Answers to Initial Questions on the L06 Consumer Transfer Header Screen:**	**Follow-up Question(s) and Answer(s):**	**Statement Confirming the Requested Action and Answer:**
Change the CDSA contract	Y,N,N	NA	NA
Add a PRGP contract and keep the current CDSA contract	N,Y,Y (if REH or SHL will no longer be self-directed) N,Y,N (if REH and/or SHL will continue to be self-directed)	NA	Based on your answers, a PRGP contract is being added, the CDSA contract is not changing, and at least 1 service will be self-directed. Continue? **Y**
Add a PRGP contract and change the CDSA contract	Y,Y,Y	Are all CDSA services ending? **N**	Based on your answers, a PRGP contract is being added, the CDSA contract is changing, and at least 1 service will be self-directed. Continue? **Y**
Add a PRGP contract and end the CDSA contract	Y,Y,Y	Are all CDSA services ending? **Y**	Based on your answers, a PRGP contract is being added, the CDSA services are ending, and no services will be self-directed. Continue? **Y**

L06: Consumer Transfer Header Screen Questions/Follow-up Questions & Answers, Continued

Introduction, continued

Scenario C **Individual has a PRGP & CDSA**			
Specific Action:	**Answers to Initial Questions on the L06 Consumer Transfer Header Screen:**	**Follow-up Question(s) and Answer(s):**	**Statement Confirming the Requested Action and Answer**
Change the PRGP contract and keep the CDSA contract	Y, N, N	Are you transferring to a different PRGP contract? **Y** Are you transferring to a different CDSA contract? **N** Are you ending the CDSA contract? **N**	Based on your answers, the PRGP contract is changing, the CDSA contract is not changing, and at least 1 service will be self-directed. Continue? **Y**
Keep the PRGP contract and change the CDSA contract	Y, N, N	Are you transferring to a different PRGP contract? **N** Are you transferring to a different CDSA contract? **Y** Are you ending the PRGP contract? **N**	Based on your answers, the PRGP contract is not changing, the CDSA contract is changing, and at least 1 service will be self-directed. Continue? **Y**
Change the PRGP contract and change the CDSA contract	Y, N, N	Are you transferring to a different PRGP contract? **Y** Are you transferring to a different CDSA contract? **Y**	Based on your answers, the PRGP contract is changing, the CDSA contract is changing, and at least 1 service will be self-directed. Continue? **Y**
End all PGRP services and keep the CDSA contract	Y, N, N	Are you transferring to a different PRGP contract? **N** Are you transferring to a different CDSA contract? **N** Are you ending the PRGP contract? **Y** Are all CDSA services ending? **N**	Based on your answers, the PRGP services are ending, the CDSA contract is not changing, and all services will be self-directed. Continue? **Y**
End all PRGP services and change the CDSA contract	Y, N, Y	Are you transferring to a different PRGP contract? **N** Are you transferring to a different CDSA contract? **Y** Are you ending the PRGP contract? **Y**	Based on your answers, the PRGP services are ending, the CDSA contract is changing, and all services will be self-directed. Continue? **Y**

L06: Consumer Transfer Header Screen Questions/Follow-up Questions & Answers, Continued

Introduction, continued

Scenario C, continued **Individual has a PRGP & CDSA**			
Specific Action:	**Answers to Initial Questions on the L06 Consumer Transfer Header Screen**	**Follow-up Question(s) and Answer(s):**	**Statement Confirming the Requested Action and Answer**
Change the PRGP contract and end the CDSA contract	Y,N,Y	Are you transferring to a different PRGP contract? **Y** Are you transferring to a different CDSA contract? **N** Are you ending the CDSA contract? Y	Based on your answers, the PRGP contract is changing, the CDSA services are ending, and no services will be self-directed. Continue? **Y**
Keep the PRGP and CDSA contracts but change a Service Delivery Option (SDO)	N,N,Y	NA	Based on your answers, the PRGP contract is not changing, the CDSA contract is not changing, and at least 1 service will be self-directed. Continue? **Y**

Transfers Involving a Program Provider Only (L06)

Introduction

This part of the *Transfer* section describes the procedure involved when transferring an individual from a Program Provider another Program Provider ***or*** from contract to contract within a Program Provider's component code. A transfer occurs when a contract number associated with an individual is added, ended, or changed. ***No services are or will be self-directed.***

Important: If more than one MRA is involved in the transfer, the ***transferring*** MRA is responsible for completing ***all*** of the data entry screens.

Before an individual can transfer, he/she must have:

- a current Level of Care *and*
- a current IPC

Procedure

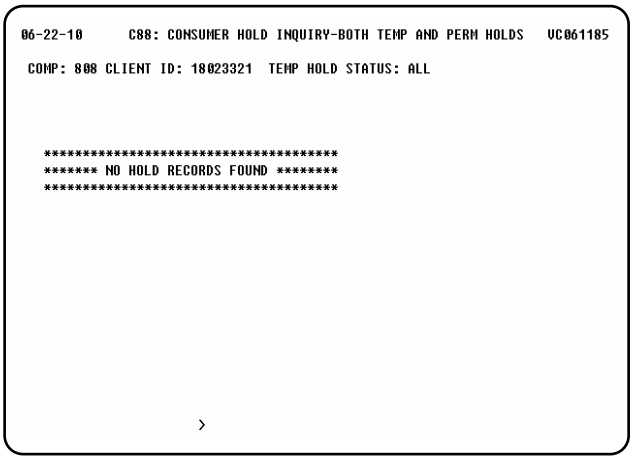
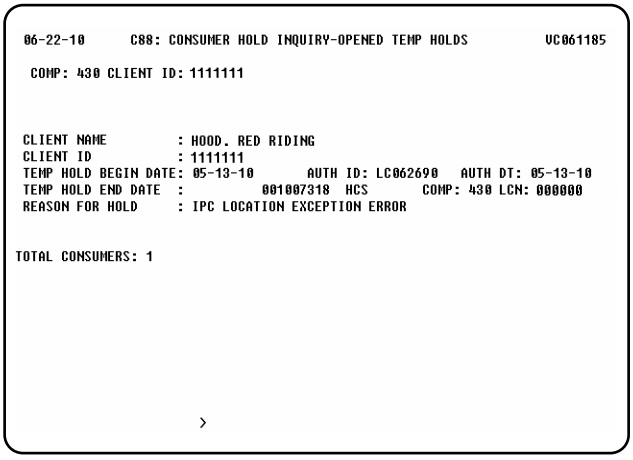
The following table describes the steps the MRA will use to transfer an individual.

Note: In this example, the individual is being transferred from one program provider to another program provider with no CDS services.

Step	View	Action
1	_ _	You cannot transfer an individual if she/he is currently on hold status. Before you begin the transfer process, you should access the **C88: Consumer Hold Inquiry** screen to see if the individual has been placed on Hold. • Type **C88** in the ACT: field of any screen. • Press **Enter**. Result: The **C88: Consumer Hold Inquiry** header screen is displayed.
2	A sample **C88: Consumer Hold Inquiry** screen is shown below. 06-14-10 C88:CONSUMER HOLD INQUIRY VC061180 PLEASE ENTER AT LEAST ONE OF THE FOLLOWING: CLIENT ID: _____ COMPONENT CODE/LOCAL CASE NUMBER: __ / _____ MEDICAID NUMBER: _____ CONTRACT NUMBER: _____ PLEASE ENTER THE FOLLOWING: HOLD TYPE: _ (T=TEMP, P=PERM, A=ALL) (TEMP ONLY) HOLD STATUS: _ (O=OPEN, C=CLOSED, A=ALL) (PERM ONLY) OVERRIDES: _ (Y=YES, BLANK=ALL HOLDS) (PERM ONLY) DATE RANGE: BEGIN: _____ (MMDDYYYY) (OPTIONAL) END: _____ (MMDDYYYY) PRINTER CODE: _____ (ENTER FOR HARD COPY) *** PRESS ENTER *** ACT: ___ (C88/HCS INQUIRY MENU, A/HCS MAIN MENU, HLP(PF1)/SCRN DOC)	• Type the requested identifying information in the appropriate fields. Rule: You must enter the Client ID, the local case number, *or* the Medicaid Number. • Type the transferring provider's component code in the COMPONENT CODE field. • Type **T** in the HOLD TYPE field. • Type **O** in the HOLD STATUS field. • Leave the OVERRIDES field blank. Note: Permanent Holds cannot be corrected. • Press **Enter**. Result: The **C88: Consumer Hold Inquiry** screen is displayed.

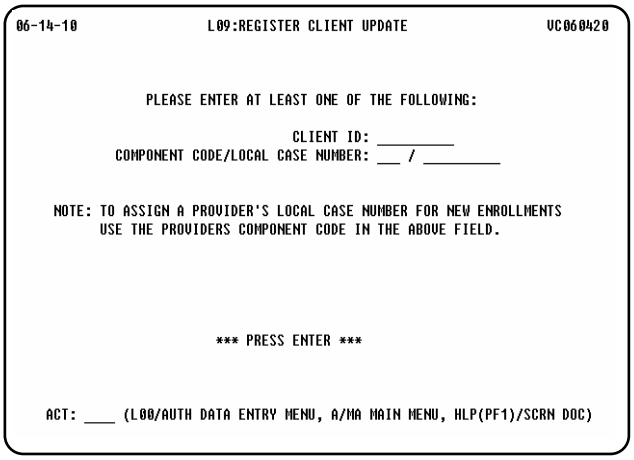
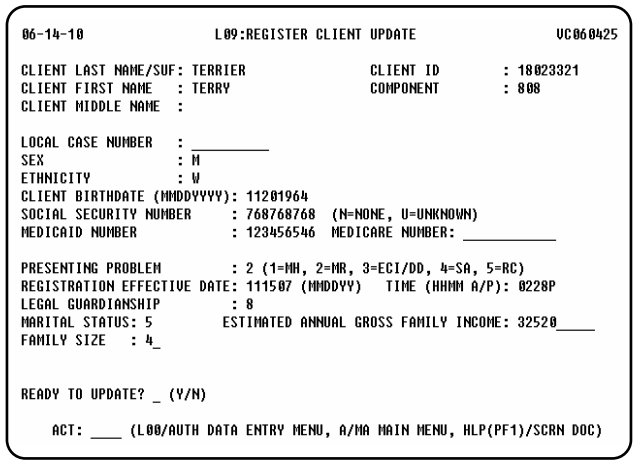
continued on next page

Procedure, continued

<table>
<tr><th>Step</th><th>View</th><th>Action</th></tr>
<tr><td>3</td><td>Sample C88: Consumer Hold Inquiry screens are shown below.
The following screen is displayed when no hold records are found.
 
06-22-10 C88: CONSUMER HOLD INQUIRY-BOTH TEMP AND PERM HOLDS VC061185
COMP: 808 CLIENT ID: 18023321 TEMP HOLD STATUS: ALL
****
******* NO HOLD RECORDS FOUND ********
****
›
The following screen is displayed when a hold record is found.
 
06-22-10 C88: CONSUMER HOLD INQUIRY-OPENED TEMP HOLDS VC061185
COMP: 430 CLIENT ID: 1111111
CLIENT NAME : HOOD, RED RIDING
CLIENT ID : 1111111
TEMP HOLD BEGIN DATE: 05-13-10 AUTH ID: LC062690 AUTH DT: 05-13-10
TEMP HOLD END DATE : 001007318 HCS COMP: 430 LCN: 000000
REASON FOR HOLD : IPC LOCATION EXCEPTION ERROR
TOTAL CONSUMERS: 1
›</td><td>• View the data displayed.
<table><tr><th>If…</th><th>Then…</th></tr><tr><td>The message, “No Hold Records Found” is displayed</td><td>Proceed with the transfer.</td></tr><tr><td>The individual has been placed on Hold,</td><td>You must correct the error before you proceed with the transfer.</td></tr></table>• Once the errors have been corrected, access the C88 screen again to verify that there are no current holds. If all errors have been corrected, the message, “No Hold Records Found” is displayed.
• Continue with the transfer process.</td></tr>
<tr><td>4</td><td>_ _</td><td>• Type L09 in the ACT: field of any screen.
• Press Enter.
Result: The L09: Register Client Update header screen is displayed.</td></tr>
</table>

continued on next page

Procedure, continued

Step	View	Action
5	A sample **L09: Register Client Update** header screen is shown below.  06-14-10 L09:REGISTER CLIENT UPDATE VC060420 PLEASE ENTER AT LEAST ONE OF THE FOLLOWING: CLIENT ID: _____ COMPONENT CODE/LOCAL CASE NUMBER: __ / _____ NOTE: TO ASSIGN A PROVIDER'S LOCAL CASE NUMBER FOR NEW ENROLLMENTS USE THE PROVIDERS COMPONENT CODE IN THE ABOVE FIELD. *** PRESS ENTER *** ACT: ___ (L00/AUTH DATA ENTRY MENU, A/MA MAIN MENU, HLP(PF1)/SCRN DOC)	The MRA must assign a local case number for the receiving Program Provider. • Type the Client ID in the CLIENT ID field. • Type the ***Component Code of the receiving*** provider in the COMPONENT CODE field. • Press **Enter**. Result: The **L09: Register Client Update** screen is displayed. This screen is used to assign a local case number and update individual information. Note: ***DO NOT enter the local case number that you are assigning on the Header screen***.
6	A sample **L09: Register Client Update** screen is shown below.  06-14-10 L09:REGISTER CLIENT UPDATE VC060425 CLIENT LAST NAME/SUF: TERRIER CLIENT ID : 18023321 CLIENT FIRST NAME : TERRY COMPONENT : 808 CLIENT MIDDLE NAME : LOCAL CASE NUMBER : _____ SEX : M ETHNICITY : W CLIENT BIRTHDATE (MMDDYYYY): 11201964 SOCIAL SECURITY NUMBER : 768768768 (N=NONE, U=UNKNOWN) MEDICAID NUMBER : 123456546 MEDICARE NUMBER: _____ PRESENTING PROBLEM : 2 (1=MH, 2=MR, 3=ECI/DD, 4=SA, 5=RC) REGISTRATION EFFECTIVE DATE: 111507 (MMDDYY) TIME (HHMM A/P): 0228P LEGAL GUARDIANSHIP : 8 MARITAL STATUS: 5 ESTIMATED ANNUAL GROSS FAMILY INCOME: 32520____ FAMILY SIZE : 4_ READY TO UPDATE? _ (Y/N) ACT: ___ (L00/AUTH DATA ENTRY MENU, A/MA MAIN MENU, HLP(PF1)/SCRN DOC)	• Type the individual's local case number ***obtained from the receiving Program Provider*** in the LOCAL CASE NUMBER field. Note: The LOCAL CASE NUMBER field *cannot* be blank. • Type updated information in the appropriate fields, if necessary. • Type **Y** in the READY TO UPDATE? field to submit the data to the system. • Press **Enter**. Result: The **L09: Register Client Update** header screen is displayed with the message, *"Previous Information Changed."*

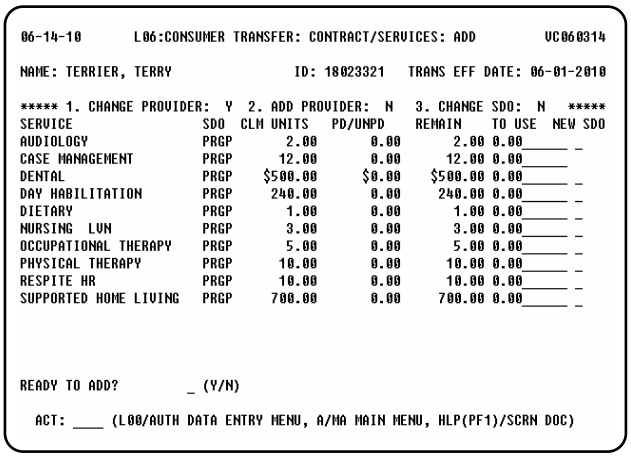
continued on next page

Procedure, continued

Step	View	Action
7	_ _	The MRA must now access the **L06: Consumer Transfer** screen to add the transfer record. On the **L09: Register Client Update** header screen: • Type **L06** in the ACT: field. • Press **Enter**. Result: The **L06: Consumer Transfer: Contract Services: A/C/D** header screen is displayed.
8	A sample **L06: Consumer Transfer: A/C/D** header screen is shown below. 04-05-10 L06:CONSUMER TRANSFER: CONTRACT SERVICES: A/C/D (CDS) VC060311 PLEASE ENTER ONE OF THE FOLLOWING: CLIENT ID: _____ COMPONENT CODE/LOCAL CASE NUMBER: __ / _____ MEDICAID NUMBER: _____ PLEASE ENTER THE FOLLOWING: CONTRACT NUMBER: _____ TRANSFER EFFECTIVE DATE: _____ TYPE OF ENTRY: _ (A/ADD,C/CHANGE,D/DELETE) FOR ADD ONLY: 1. CHANGING PROGRAM PROVIDER OR CDS AGENCY? _ (Y/N) 2. ADDING A PROGRAM PROVIDER OR CDS AGENCY? _ (Y/N) 3. CHANGING SERVICE DELIVERY OPTIONS? _ (Y/N) *** PRESS ENTER *** ACT: ___ (L00/AUTH DATA ENTRY MENU, A/MA MAIN MENU, HLP(PF1)/SCRN DOC)	• Type the requested identifying information in the appropriate fields. Rule: You must enter the Client ID, the local case number, *or* the Medicaid Number. • Type the Component Code of the ***transferring*** (current) Program Provider in the COMPONENT CODE field. • Type the contract number in the CONTRACT field. • Type the transfer effective date in the TRANSFER EFFECTIVE DATE field. • Type **A** (Add) in the TYPE OF ENTRY field. • Type **Y** (Yes) as the answer to question 1. CHANGING A PROGRAM PROVIDER OR CDS AGENCY? • Type **N** (No) as the answer to question 2. ADDING A PROGRAM PROVIDER OR CDS AGENCY? • Type **N** (No) as the answer to question 3. CHANGING SERVICE DELIVERY OPTIONS? • Press **Enter**. Result: The **L06: Consumer Transfer: Contract/Services: Add** screen is displayed.

continued on next page

Procedure, continued

Step	View	Action
9	A sample **L06: Consumer Transfer: Contract/Services: Add** screen is shown below.  06-14-10 L06:CONSUMER TRANSFER: CONTRACT/SERVICES: ADD VC060314 NAME: TERRIER, TERRY ID: 18023321 TRANS EFF DATE: 06-01-2010 ***** 1. CHANGE PROVIDER: Y 2. ADD PROVIDER: N 3. CHANGE SDO: N ***** SERVICE SDO CLM UNITS PD/UNPD REMAIN TO USE NEW SDO AUDIOLOGY PRGP 2.00 0.00 2.00 0.00_____ _ CASE MANAGEMENT PRGP 12.00 0.00 12.00 0.00_____ DENTAL PRGP $500.00 $0.00 $500.00 0.00_____ _ DAY HABILITATION PRGP 240.00 0.00 240.00 0.00_____ _ DIETARY PRGP 1.00 0.00 1.00 0.00_____ _ NURSING LVN PRGP 3.00 0.00 3.00 0.00_____ _ OCCUPATIONAL THERAPY PRGP 5.00 0.00 5.00 0.00_____ _ PHYSICAL THERAPY PRGP 10.00 0.00 10.00 0.00_____ _ RESPITE HR PRGP 10.00 0.00 10.00 0.00_____ _ SUPPORTED HOME LIVING PRGP 700.00 0.00 700.00 0.00_____ _ READY TO ADD? _ (Y/N) ACT: ___ (L00/AUTH DATA ENTRY MENU, A/MA MAIN MENU, HLP(PF1)/SCRN DOC)	This screen displays services listed on the current IPC, the current service delivery option for each service, the authorized IPC units for the plan year, the total of all paid and unpaid services to the transfer effective date, and any units remaining on IPC to the transfer effective date. Note: Press the **PF1** key to view column definitions. Note 2: The transferring Program Provider calculates the amount of units/dollars to be reserved for services that will be provided by them prior to the transfer effective date and/or have been provided by them but not yet claimed and indicates those units/dollars on Form 3617. • Type the units/dollars to be reserved in the appropriate field for each service under the TO USE column. Note 1: If no units/dollars are entered in the fields of the TO USE column, the transferring Program Provider will be prevented from entering any additional claims for the individual. Note 2: If no units/dollars need to be reserved, enter zeroes in the fields of the TO USE column. Typing a number greater than 0 represents the amount of units/dollars reserved for the transferring program provider to claim. • Type **Y** in the READY TO ADD? field. • Press **Enter**. Result: The **L06: Consumer Transfer: Add** screen is displayed.

continued on next page

Procedure, continued

Step	View	Action
10	A sample **L06: Consumer Transfer: Add** screen is shown below. 06-14-10 L06:CONSUMER TRANSFER: ADD VC060316 NAME : TERRIER, TERRY CLIENT ID: 18023321 TRANSFER EFFECTIVE DATE: 06-01-2010 TRANSFERRING: SERVICE COUNTY: 227 LOCATION CODE: OHFH OWN HOME/FAMILY PRGP: COMP/LCN: 804 / 0000WTS001 CONTRACT NUMBER: 001007358 CDSA: COMP/LCN: / CONTRACT NUMBER: RECEIVING: ENTER ONLY IF CHANGING/ADDING PROVIDER(S) SERVICE COUNTY: __ LOCATION CODE: ____ RESIDENTIAL TYPE: 3 PRGP: COMP/LCN: __ / _____ CONTRACT NUMBER: _____ CDSA: COMP/LCN: __ / _____ CONTRACT NUMBER: _____ DOLLAR AMTS: AA MHM DENTAL OTHER SVCS TO BE PROV NOW TO TRANS DT: 0.00 0.00 0.00 0.00 TRANSFER ACCEPTED? _ (Y/N) BY: _____ DATE: _____ READY TO ADD? _ (Y/N) ACT: ___ (C00/HCS DATA ENTRY MENU, A/HCS MAIN MENU, HLP(PF1)/SCRN DOC	• Type the new service county code in the SERVICE COUNTY field. • Type the location code in the LOCATION CODE field. • Type the residential type in the RESIDENTIAL TYPE field, if necessary. ***Complete the following fields as they apply to the receiving provider.*** • Type the component code of the new Program Provider in the COMP field. • Type the local case number in the LCN field. • Type the contract number of the new Program Provider in the CONTRACT NUMBER field, • Type **Y** in the READY TO ADD? field. • Press **Enter**. Result: A screen containing the transfer effective date is displayed. If the date is incorrect, do not proceed. You must delete the transfer record and begin again. • Press **Enter**. Result: The **L06: Consumer Transfer: Contract/Services: A/C/D** header screen is displayed with the message *"Previous Information Added."*
11	_ _	The MRA must now access the **L02: Individual Plan of Care** screen to enter a transfer IPC for the individual. On the **L06: Consumer Transfer** header screen: • Type **L02** in the ACT: field. • Press **Enter**. Result: The **L02: Individual Plan of Care** header screen is displayed.

continued on next page

Procedure, continued

Step	View	Action
12	A sample **L02: Individual Plan of Care** header screen is shown below. 06-14-10 L02:INDIVIDUAL PLAN OF CARE (CDS V2.0) VC060230 PLEASE ENTER ONE OF THE FOLLOWING: CLIENT ID: _____ COMPONENT CODE/LOCAL CASE NUMBER: __ / _____ MEDICAID NUMBER: _____ PLEASE ENTER THE FOLLOWING: TYPE OF ENTRY: T I=INITIAL N=RENEWAL R=REVISION E=ERROR CORRECTION T=TRANSFER D=DELETE PLEASE ENTER FOR REVISION OR ERROR CORRECT OF REVISION: REVISE DATE: _____ (MMDDYYYY) PLEASE ENTER FOR INITIAL PLANS ONLY: BEGIN DATE: _____ (MMDDYYYY) *** PRESS ENTER *** ACT: ___ (L00/AUTH DATA ENTRY MENU, A/MA MAIN MENU, HLP(PF1)/SCRN DOC)	• Type the requested identifying information in the appropriate fields. Rule: You *must* enter the Client ID, the local case number, or the Medicaid Number. • Type the Component Code of the ***receiving*** provider in the COMPONENT CODE field. • Type **T** (Transfer) in the TYPE OF ENTRY field. • Press **Enter**. Result: The **L02: Individual Plan of Care Entry: Transfer** screen is displayed.
13	A sample **L02: Individual Plan of Care Entry: Transfer** screen is shown below. 06-14-10 L02:INDIVIDUAL PLAN OF CARE ENTRY (CDS V2.0): TRANSFER VC060233A NAME: TERRIER, TERRY CLCN: 808 0008085555 CLIENT ID: 18023321 BEG DT: 03192010 REV DT: 06012010 (MMDDYYYY) END DT: 03182011 SERVICE CATEGORY UNITS SERVICE CATEGORY UNITS CMM CASE MANAGEMENT 12_____ MONS AA ADAPTIVE AIDS _____ DOL AAR ADAPTIVE AIDS RE _____ DOL AU AUDIOLOGY 2_____ HRS PS BEHAVIORAL SUPPO _____ HRS FC HCS FOSTER CARE _____ DAYS DH DAY HABILITATION 240____ DAYS DE DENTAL 500____ DOL DER DENTAL REQ. FEE _____ DOL DI DIETARY 1_____ HRS MHM MINOR HOME MODS _____ DOL MHMR MINOR HOME MOD REQ. _____ DOL NUR NURSING RN _____ HRS NUL NURSING LVN 3_____ HRS NURS NURSING SPEC RN _____ HRS NULS NURSING SPEC LVN _____ HRS OT OCCUPATIONAL THE 5_____ HRS PT PHYSICAL THERAPY 10_____ HRS REH RESPITE HR 10_____ HRS RSS RES SUPPORT SVC _____ DAYS SW SOCIAL WORK _____ HRS SP SPEECH/LANGUAGE _____ HRS SE SUPPORTED EMP _____ HRS SL SUPERVISED LIVING _____ DAYS SHL SUPPORTED HOME L 700____ HRS FMSV FMS MONTHLY FEE _____ MONS SCV SUPPORT CONSULTA _____ HRS ANY SERVICES SELF DIRECTED? N (Y/N) RES TYPE: 3 (2-5) LOCATION: OHFH (OFH) READY TO CONTINUE?: _ (Y/N) ACT: ___ F/FWD,B/BK,(L00/AUTH ENTRY MENU,A/MA MAIN MENU,HLP(PF1)/SCRNDOC) Note: The service units/dollars are cumulative for each IPC year. Therefore, the receiving provider must have an accurate account of the units/dollars for each service that has already been claimed and include those units/dollars on the transfer IPC. Example: If 3 units of NUR have been claimed and the receiving provider plans to provide 6 units of NUR, you would need 9 units for NUR on the transfer IPC.	You can use this screen to make the adjustments to the IPC that were agreed upon in the Transfer IPC meeting. Note: You cannot reduce services below what has already been claimed. • Type **Y** in the READY TO CONTINUE? field. • Press **Enter**. Result: The **L02: Individual Plan of Care Entry: Transfer** screen (screen 2) is displayed.

continued on next page

Procedure, continued

Step	View	Action
14	A sample **L02: Individual Plan of Care Entry: Transfer** screen (screen 2) is shown below. 06-14-10 L02:INDIVIDUAL PLAN OF CARE ENTRY (CDS V2.0): TRANSFER VC060237A NAME: TERRIER, TERRY CLCN: 808 0008085555 CLIENT ID: 18023321 IPC BEGIN DATE: 03-19-2010 REVISE DATE: 06-01-2010 END DATE: 03-18-2011 SERVICE CATEGORY UNITS SERVICE CATEGORY UNITS AU AUDIOLOGY 2 HRS DH DAY HABILITATION 240 DAYS DE DENTAL 500 DOL DI DIETARY 1 HRS NUL NURSING LVN 3 HRS OT OCCUPATIONAL THER 5 HRS PT PHYSICAL THERAPY 10 HRS REH RESPITE HR 10 HRS SHL SUPPORTED HOME LI 700 HRS PROGRAM PROVIDER ESTIMATED ANNUAL TOTAL: 30,192.76 READY TO CONTINUE?: _ (Y/N) ANNUAL COST: 30,192.76 COST CEILING: 83,734.00 ACT: ___ (L00/AUTH ENTRY MENU,A/MA MAIN MENU,HLP(PF1)/SCRNDOC)	This screen displays the Program Provider portion of the IPC. Services are ***displayed and cannot be changed***. • Type **Y** in the READY TO CONTINUE? field. • Press **Enter**. Result: The **L02: Individual Plan of Care Entry: Transfer** screen (screen 3) is displayed.
15	A sample **L02: Individual Plan of Care Entry: Transfer** screen (screen 3) is shown below. 06-14-10 L02:INDIVIDUAL PLAN OF CARE ENTRY (CDS V2.0): TRANSFER VC060238A NAME: TERRIER, TERRY CLCN: 808 0008085555 CLIENT ID: 18023321 PRGP:CONTRACT: 001007388 COMPONENT: 808 LOCAL CASE NUMBER: 0008085555 CDSA:CONTRACT: COMPONENT: LOCAL CASE NUMBER: ADC=T IPC=T IPC BEGIN DATE: 03-19-2010 REVISE DATE: 06-01-2010 END DATE: 03-18-2011 TOTAL ANNUAL COST : 30,192.76 COST CEILING: 83,734.00 ARE ANY DIRECT SERVICES STAFFED BY A RELATIVE/GUARDIAN? N (Y/N) PROVIDER REPRESENTATIVE: BIG ROOSTER_____ DATE (MMDDYYYY): 06012010 IDT CERTIFICATION STATEMENT DATE NAME (MMDDYYYY) SERVICE COORDINATOR : RED HEN_____ 06012010 CONSUMER/LEGAL REPRESENTATIVE: TERRIER, TERRY 06012010 READY TO TRANSFER?: _ (Y/N) ACT: ___ (L00/AUTH DATA ENTRY MENU, A/MA MAIN MENU, HLP(PF1)/SCRN DOC)	• Type **Y** (Yes) or **N** (No) to indicate whether any services are staffed by a relative or guardian. • You must change the date in the DATE fields. The dates must be after the previous REVISE DATE and on or before the current TRANSFER date. • Change the names if necessary. • Type **Y** in the READY TO TRANSFER? field to submit the data to the system. • Press **Enter**. Result: You are informed that the transfer IPC has been entered and that you must return to the **L06** screen to complete the transfer. • Press **Enter**. The **L02: Individual Plan of Care** header screen is displayed with the message, "*Transfer Plan has been Added*."
16	_ _	The MRA must now access the **L06: Consumer Transfer** screen to accept the transfer data entry. On the **L02: Individual Plan of Care** header screen: • Type **L06** in the ACT: field. • Press **Enter**. Result: The **L06: Consumer Transfer: Contract Services: A/C/D** header screen is displayed.

continued on next page

Procedure, continued

Step	View	Action
17	A sample **L06: Consumer Transfer** header screen is shown below. 06-14-10 L06:CONSUMER TRANSFER: CONTRACT SERVICES: A/C/D (CDS) VC060311 PLEASE ENTER ONE OF THE FOLLOWING: CLIENT ID: _____ COMPONENT CODE/LOCAL CASE NUMBER: 808 / _____ MEDICAID NUMBER: _____ PLEASE ENTER THE FOLLOWING: CONTRACT NUMBER: _____ TRANSFER EFFECTIVE DATE: _____ TYPE OF ENTRY: _ (A/ADD,C/CHANGE,D/DELETE) FOR ADD ONLY: 1. CHANGING/ENDING PROGRAM PROVIDER OR CDS AGENCY? _ (Y/N) 2. ADDING A PROGRAM PROVIDER OR CDS AGENCY? _ (Y/N) 3. CHANGING SERVICE DELIVERY OPTIONS? _ (Y/N) *** PRESS ENTER *** ACT: ___ (L00/AUTH DATA ENTRY MENU, A/MA MAIN MENU, HLP(PF1)/SCRN DOC)	• Type the requested identifying information in the appropriate fields. Rule: You must enter the Client ID, the local case number, *or* the Medicaid Number. • Type the Component Code of the ***receiving*** provider in the COMPONENT CODE field. • Type the contract number in the CONTRACT field. • Type the transfer effective date in the TRANSFER EFFECTIVE DATE field. • Type **C** (Change) in the TYPE OF ENTRY field. Note: ***DO NOT*** attempt to answer the three questions on the header screen for this action. *Leave the fields blank.* • Press **Enter**. Result: The **L06: Consumer Transfer: Change** screen is displayed.
18	A sample **L06: Consumer Transfer: Change** screen is shown below. 06-14-10 L06:CONSUMER TRANSFER: CHANGE VC060316 NAME : TERRIER, TERRY CLIENT ID: 18023321 TRANSFER EFFECTIVE DATE: 06-01-2010 TRANSFERRING: SERVICE COUNTY: 227 LOCATION CODE: OHFH OWN HOME/FAMILY PRGP: COMP/LCN: 804 / 0000WTS001 CONTRACT NUMBER: 001007358 CDSA: COMP/LCN: / CONTRACT NUMBER: RECEIVING: ENTER ONLY IF CHANGING/ADDING PROVIDER(S) SERVICE COUNTY: 227 LOCATION CODE: OHFH RESIDENTIAL TYPE: 3 PRGP: COMP/LCN: 808 / 0008085555 CONTRACT NUMBER: 001007388 CDSA: COMP/LCN: __ / _____ CONTRACT NUMBER: _____ DOLLAR AMTS: AA MHH DENTAL OTHER SVCS TO BE PROV NOW TO TRANS DT: 0.00 0.00 0.00 0.00 TRANSFER ACCEPTED? _ (Y/N) BY: _____ DATE: _____ READY TO CHANGE? _ (Y/N) ACT: ___ (C00/HCS DATA ENTRY MENU, A/HCS MAIN MENU, HLP(PF1)/SCRN DOC	• Type **Y** in the TRANSFER ACCEPTED field. • Type the name of the person accepting the transfer data entry in the BY field. • If the: - Transfer will occur in the *future*, type the date of data entry in the DATE field. - Transfer occurred in the *past*, type the date of the transfer in the Date field. • Type **Y** in the READY TO CHANGE? field. • Press **Enter**. Result: A screen containing the transfer effective date is displayed. If the date is incorrect, the entire transfer record must be deleted and the transfer must be re-entered. • Press **Enter**. Result: The sample **L06: Consumer Transfer: Contract Services: A/C/D** header screen is displayed with the message, *"Previous Information Changed."*

Reminder: A transfer is not complete until authorized by Program Enrollment.
After all of the data entry is complete, the MRA must send the signed Form 3617 Request for Transfer of Waiver Program Services and the ***receiving provider's*** transfer IPC to Program Enrollment for authorization. Do not send any documentation until **all** of the data entry is complete.

Service claims cannot be entered by the receiving program provider until the transfer has been authorized and the individual is listed as active on the receiving program provider's Consumer Roster (**C67**/**L67**).

Use the **A63** screen to view the status of the transfer.

Transfers Involving a CDSA

Introduction

This part of the *Transfer* section describes the procedure involved when transferring an individual from a Program Provider and/or CDSA to another Program Provider and/or CDSA ***or*** from contract to contract within a Program Provider's and/or CDSA's component code. ***At least one service is or will be self-directed.***

Important: If more than one MRA is involved in the transfer, the ***transferring*** MRA is responsible for completing ***all*** of the data entry screens.

Before an individual can transfer, he/she must have:

- a current Level of Care *and*
- a current IPC

Procedure

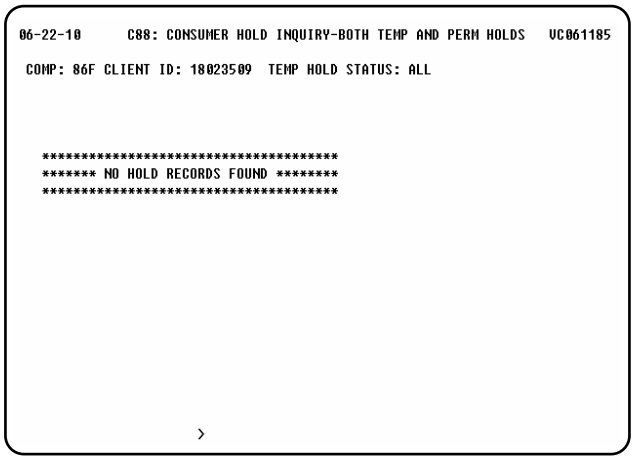
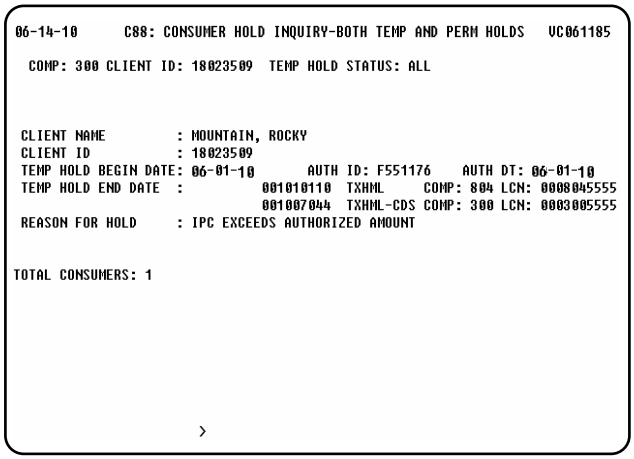
The following table describes the steps the MRA will use to transfer an individual.

Note: In this example, the individual is being transferred from one CDSA to another CDSA.

Step	View	Action
1	_ _	You cannot transfer an individual if s/he is currently on hold status. Before you begin the transfer process, you should access the **C88: Consumer Hold Inquiry** screen to see if the individual has been placed on Hold. • Type **C88** in the ACT: field of any screen. • Press **Enter**. Result: The **C88: Consumer Hold Inquiry** header screen is displayed.
2	A sample **C88: Consumer Hold Inquiry** screen is shown below. 06-22-10 C88:CONSUMER HOLD INQUIRY VC061180 PLEASE ENTER AT LEAST ONE OF THE FOLLOWING: CLIENT ID: _____ COMPONENT CODE/LOCAL CASE NUMBER: __ / _____ MEDICAID NUMBER: _____ CONTRACT NUMBER: _____ PLEASE ENTER THE FOLLOWING: HOLD TYPE: _ (T=TEMP, P=PERM, A=ALL) (TEMP ONLY) HOLD STATUS: _ (O=OPEN, C=CLOSED, A=ALL) (PERM ONLY) OVERRIDES: _ (Y=YES, BLANK=ALL HOLDS) (PERM ONLY) DATE RANGE: BEGIN: _____ (MMDDYYYY) (OPTIONAL) END: _____ (MMDDYYYY) PRINTER CODE: _____ (ENTER FOR HARD COPY) *** PRESS ENTER *** ACT: ___ (C88/HCS INQUIRY MENU, A/HCS MAIN MENU, HLP(PF1)/SCRN DOC)	• Type the requested identifying information in the appropriate fields. Rule: You must enter the Client ID, the local case number, *or* the Medicaid Number. • Type the transferring provider's component code in the COMPONENT CODE field. • Type **T** in the HOLD TYPE field. • Type **O** in the HOLD STATUS field. • Leave the OVERRIDES field blank. Note: Permanent Holds cannot be corrected. • Press **Enter**. Result: The **C88: Consumer Hold Inquiry** screen is displayed.

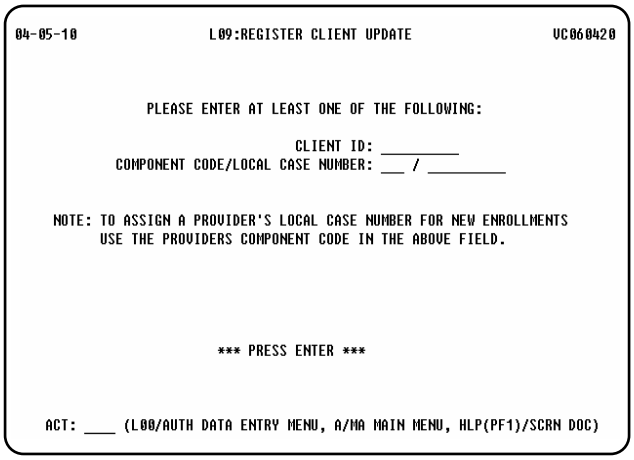
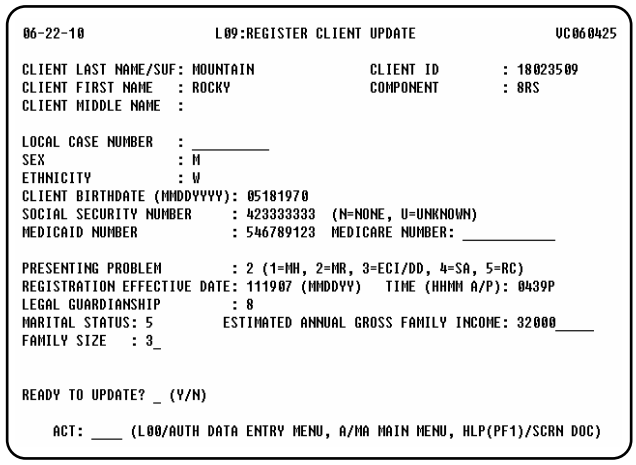
continued on next page

Procedure, continued

<table>
<tr><th>Step</th><th>View</th><th>Action</th></tr>
<tr><td>3</td><td>Sample C88: Consumer Hold Inquiry screens are shown below.
The following screen is displayed when no hold records are found.
 
06-22-10 C88: CONSUMER HOLD INQUIRY-BOTH TEMP AND PERM HOLDS VC061185
COMP: 86F CLIENT ID: 18023509 TEMP HOLD STATUS: ALL
****
******* NO HOLD RECORDS FOUND ********
****
›
The following screen is displayed when a hold record is found.
 
06-14-10 C88: CONSUMER HOLD INQUIRY-BOTH TEMP AND PERM HOLDS VC061185
COMP: 300 CLIENT ID: 18023509 TEMP HOLD STATUS: ALL
CLIENT NAME : MOUNTAIN, ROCKY
CLIENT ID : 18023509
TEMP HOLD BEGIN DATE: 06-01-10 AUTH ID: F551176 AUTH DT: 06-01-10
TEMP HOLD END DATE : 001010110 TXHML COMP: 804 LCN: 0008045555
001007044 TXHML-CDS COMP: 300 LCN: 0003005555
REASON FOR HOLD : IPC EXCEEDS AUTHORIZED AMOUNT
TOTAL CONSUMERS: 1
›</td><td>• View the data displayed.<table><tr><th>If…</th><th>Then…</th></tr><tr><td>The message, “No Hold Records Found” is displayed</td><td>Proceed with the transfer.</td></tr><tr><td>The individual has been placed on Hold,</td><td>You must correct the error before you proceed with the transfer.</td></tr></table>• Once the errors have been corrected, access the C88 screen again to verify that there are no current holds. If all errors have been corrected, the message, “No Hold Records Found” is displayed.
• Continue with the transfer process.</td></tr>
<tr><td>4</td><td>_ _</td><td>• Type L09 in the ACT: field of any screen.
• Press Enter.
Result: The L09: Register Client Update header screen is displayed.</td></tr>
</table>

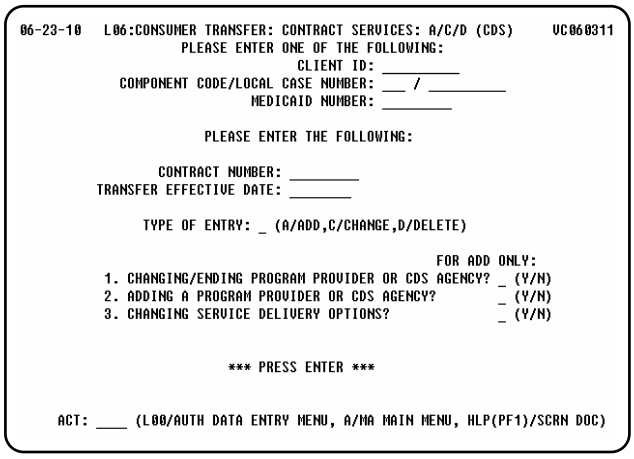
continued on next page

Procedure, continued

Step	View	Action
5	A sample **L09: Register Client Update** header screen is shown below.  04-05-10 L09:REGISTER CLIENT UPDATE VC060420 PLEASE ENTER AT LEAST ONE OF THE FOLLOWING: CLIENT ID: _____ COMPONENT CODE/LOCAL CASE NUMBER: __ / _____ NOTE: TO ASSIGN A PROVIDER'S LOCAL CASE NUMBER FOR NEW ENROLLMENTS USE THE PROVIDERS COMPONENT CODE IN THE ABOVE FIELD. *** PRESS ENTER *** ACT: ___ (L00/AUTH DATA ENTRY MENU, A/MA MAIN MENU, HLP(PF1)/SCRN DOC)	The MRA must assign a local case number for the receiving Program Provider and/or CDSA. • Type the Client ID in the CLIENT ID field. • Type the Component Code of the ***receiving*** provider in the COMPONENT CODE field. • Press **Enter**. Result: The **L09: Register Client Update** screen is displayed. This screen is used to assign a local case number and update information, if necessary. Note 1: ***DO NOT enter the local case number that you are assigning on the header screen.*** Note 2: You must **repeat this step** for each receiving Program Provider and/or CDSA.
6	A sample **L09: Register Client Update** screen is shown below.  06-22-10 L09:REGISTER CLIENT UPDATE VC060425 CLIENT LAST NAME/SUF: MOUNTAIN CLIENT ID : 18023509 CLIENT FIRST NAME : ROCKY COMPONENT : 8RS CLIENT MIDDLE NAME : LOCAL CASE NUMBER : _____ SEX : M ETHNICITY : W CLIENT BIRTHDATE (MMDDYYYY): 05181970 SOCIAL SECURITY NUMBER : 423333333 (N=NONE, U=UNKNOWN) MEDICAID NUMBER : 546789123 MEDICARE NUMBER: _____ PRESENTING PROBLEM : 2 (1=MH, 2=MR, 3=ECI/DD, 4=SA, 5=RC) REGISTRATION EFFECTIVE DATE: 111907 (MMDDYY) TIME (HHMM A/P): 0439P LEGAL GUARDIANSHIP : 8 MARITAL STATUS: 5 ESTIMATED ANNUAL GROSS FAMILY INCOME: 32000____ FAMILY SIZE : 3_ READY TO UPDATE? _ (Y/N) ACT: ___ (L00/AUTH DATA ENTRY MENU, A/MA MAIN MENU, HLP(PF1)/SCRN DOC)	• Type the individual's local case number ***obtained from the receiving provider and/or CDSA*** in the LOCAL CASE NUMBER field. Note: The LOCAL CASE NUMBER field *cannot* be blank. • Type updated information in the appropriate fields, if necessary. • Type **Y** in the READY TO UPDATE? field to submit the data to the system. • Press **Enter**. Result: The **L09: Register Client Update** header screen is displayed with the message, *"Previous Information Changed."* Note: You must **repeat this step** for each receiving **Program Provider and/or CDSA**.

continued on next page

Procedure, continued

Step	View	Action
7	_ _	The MRA must now access the **L06: Consumer Transfer** screen to add the transfer record. On the **L09: Register Client Update** header screen: • Type **L06** in the ACT: field. • Press **Enter**. Result: The **L06: Consumer Transfer: Contract Services: A/C/D** header screen is displayed.
8	A sample **L06: Consumer Transfer: A/C/D** header screen is shown below.  06-23-10 L06:CONSUMER TRANSFER: CONTRACT SERVICES: A/C/D (CDS) VC060311 PLEASE ENTER ONE OF THE FOLLOWING: CLIENT ID: _____ COMPONENT CODE/LOCAL CASE NUMBER: __ / _____ MEDICAID NUMBER: _____ PLEASE ENTER THE FOLLOWING: CONTRACT NUMBER: _____ TRANSFER EFFECTIVE DATE: _____ TYPE OF ENTRY: _ (A/ADD,C/CHANGE,D/DELETE) FOR ADD ONLY: 1. CHANGING/ENDING PROGRAM PROVIDER OR CDS AGENCY? _ (Y/N) 2. ADDING A PROGRAM PROVIDER OR CDS AGENCY? _ (Y/N) 3. CHANGING SERVICE DELIVERY OPTIONS? _ (Y/N) *** PRESS ENTER *** ACT: ___ (L00/AUTH DATA ENTRY MENU, A/MA MAIN MENU, HLP(PF1)/SCRN DOC)	• Type the requested identifying information in the appropriate fields. Rule: You must enter the Client ID, the local case number, *or* the Medicaid Number. • Type the Component Code of the ***transferring*** (current) Program Provider or CDSA in the COMPONENT CODE field. • Type the contract number in the CONTRACT field. • Type the transfer effective date in the TRANSFER EFFECTIVE DATE field. • Type **A** (Add) in the TYPE OF ENTRY field. • Type **Y** (Yes) or **N** (No) to answer each of the following three questions, as appropriate: 1. CHANGING PROGRAM PROVIDER OR CDS AGENCY? 2. ADDING A PROGRAM PROVIDER OR CDS AGENCY? 3. CHANGING SERVICE DELIVERY OPTIONS? ***Refer to the charts in this section for help in answering the questions correctly.*** • Press **Enter**. Result: A screen containing follow up questions is displayed.

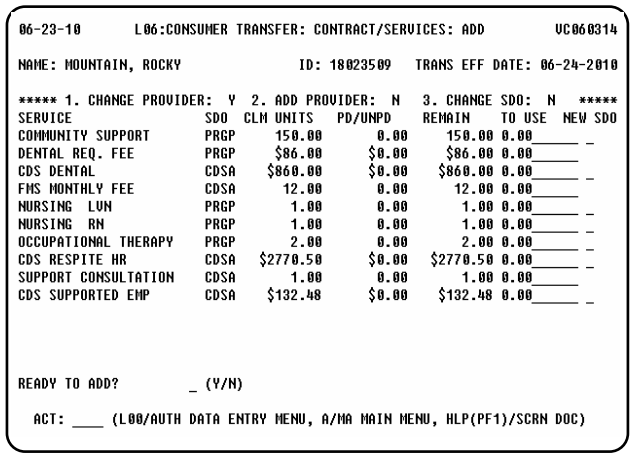
continued on next page

Procedure, continued

<table>
<tr><th>Step</th><th>View</th><th>Action</th></tr>
<tr><td>9</td><td>A sample screen is shown below. In this example, the individual is changing CDSAs and the questions on the header screen were answered Y N N.
<pre>$$ARE YOU TRANSFERRING TO A DIFFERENT PROGRAM PROVIDER CONTRACT? Y/N
N
$$ARE YOU TRANSFERRING TO A DIFFERENT CDSA CONTRACT? Y/N
Y
$$ARE ALL PROGRAM PROVIDER SERVICES ENDING? Y/N
N
BASED ON YOUR ANSWERS, THE PROGRAM PROVIDER'S CONTRACT IS NOT CHANGING, THE CDS-
A CONTRACT IS CHANGING, AND AT LEAST 1 SERVICE WILL BE SELF DIRECTED
$$CONTINUE? Y/N
> Y</pre></td><td>• Answer Y or N to each question and press Enter after each question.
Refer to the charts in this section for help in answering the questions correctly.
• Verify that the last statement is correct.
<table><tr><th>If the statement is…</th><th>Then…</th></tr><tr><td>Correct</td><td>• Type Y.
• Press Enter.
Result: The L06: Consumer Transfer: Contract/Services: Add screen is displayed. Continue with Step 10.</td></tr><tr><td>Incorrect</td><td>• Type N.
• Press Enter.
Result: The L06: Consumer Transfer: A/C/D header screen is displayed with the information you just entered.
• Check the information and make any necessary changes.
• Press Enter.
• Repeat this step.</td></tr></table></td></tr>
</table>

continued on next page

Procedure, continued

Step	View	Action
10	A sample **L06: Consumer Transfer: Contract/Services: Add** screen is shown below. 	This screen displays services listed on the current IPC, the current service delivery option for each service, the authorized IPC units for the plan year, the total of all paid and unpaid services to the transfer effective date, and any units remaining on IPC to the transfer effective date. Note: Press the **PF1** key to view column definitions. Note 2: The transferring program provider and/or CDSA calculates the amount of units/dollars to be reserved for services that will be provided by them prior to the transfer effective date and/or have been provided by them but not yet claimed and indicates those units/dollars on Form 3617. • Type the units/dollars to be reserved in the appropriate field for each service under the TO USE column. Enter **NA** if the service is not impacted by the transfer. Note 1: If no units/dollars are entered in the fields of the TO USE column, the transferring Program Provider and/or CDSA will be prevented from entering any additional service claims for the individual. Note 2: If no unit/dollars need to be reserved, enter zeroes in the fields of the TO USE column. Typing: - **0** indicates that this service is being transferred to a new contract or changing to a new SDO and no units/dollars are being reserved. - ***A number greater than 0*** represents the amount of units/dollars reserved for the transferring program provider and/or CDSA to claim. - **NA** indicates that the service is not included in the transfer. • Type the ***receiving*** Program Provider and/or CDSA's service delivery option (**P** - Program Provider or **C** - CDSA) for the service after the transfer in the NEW SDO field. Note: You may require two screens to list all services. CDS services will list units and dollars. • Type **Y** in the READY TO ADD? field. • Press **Enter**. Result: The **L06: Consumer Transfer: Add** screen is displayed.

```
06-23-10       L06:CONSUMER TRANSFER: CONTRACT/SERVICES: ADD          VC060314

NAME: MOUNTAIN, ROCKY               ID: 18023509   TRANS EFF DATE: 06-24-2010

***** 1. CHANGE PROVIDER:  Y  2. ADD PROVIDER:  N   3. CHANGE SDO:  N   *****
SERVICE                SDO  CLM UNITS   PD/UNPD    REMAIN    TO USE  NEW SDO
COMMUNITY SUPPORT      PRGP     150.00       0.00     150.00 0.00_____ _
DENTAL REQ. FEE        PRGP      $86.00      $0.00      $86.00 0.00_____
CDS DENTAL             CDSA     $860.00      $0.00     $860.00 0.00_____ _
FMS MONTHLY FEE        CDSA      12.00       0.00      12.00 0.00_____
NURSING  LVN           PRGP       1.00       0.00       1.00 0.00_____ _
NURSING  RN            PRGP       1.00       0.00       1.00 0.00_____ _
OCCUPATIONAL THERAPY   PRGP       2.00       0.00       2.00 0.00_____ _
CDS RESPITE HR         CDSA    $2770.50      $0.00    $2770.50 0.00_____ _
SUPPORT CONSULTATION   CDSA       1.00       0.00       1.00 0.00_____
CDS SUPPORTED EMP      CDSA     $132.48      $0.00     $132.48 0.00_____ _




READY TO ADD?         _ (Y/N)

  ACT: ___ (L00/AUTH DATA ENTRY MENU, A/MA MAIN MENU, HLP(PF1)/SCRN DOC)
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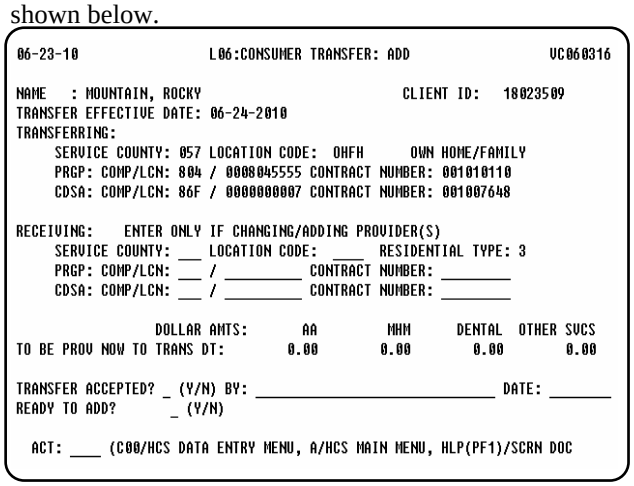
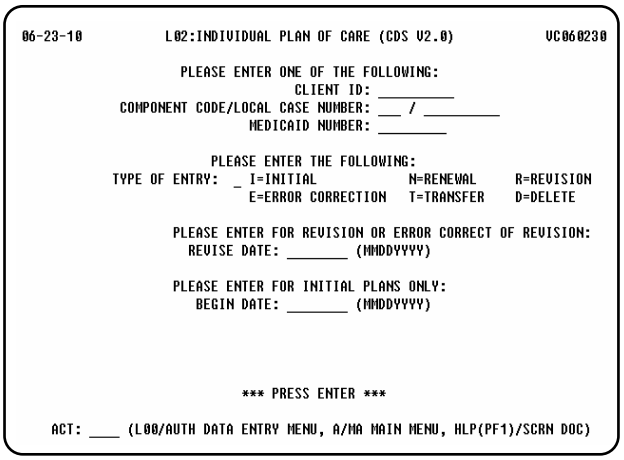
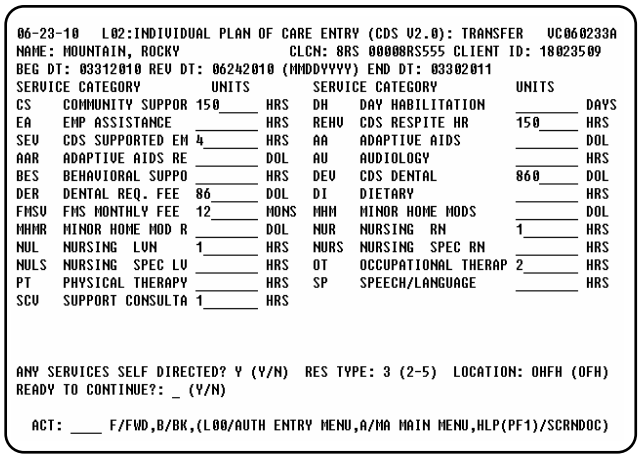
continued on next page

Procedure, continued

Step	View	Action
11	A sample **L06: Consumer Transfer: Add** screen is shown below.  06-23-10 L06:CONSUMER TRANSFER: ADD VC060316 NAME : MOUNTAIN, ROCKY CLIENT ID: 18023509 TRANSFER EFFECTIVE DATE: 06-24-2010 TRANSFERRING: SERVICE COUNTY: 057 LOCATION CODE: OHFH OWN HOME/FAMILY PRGP: COMP/LCN: 804 / 0008045555 CONTRACT NUMBER: 001010110 CDSA: COMP/LCN: 86F / 0000000007 CONTRACT NUMBER: 001007648 RECEIVING: ENTER ONLY IF CHANGING/ADDING PROVIDER(S) SERVICE COUNTY: ___ LOCATION CODE: ___ RESIDENTIAL TYPE: 3 PRGP: COMP/LCN: ___ / _____ CONTRACT NUMBER: _____ CDSA: COMP/LCN: ___ / _____ CONTRACT NUMBER: _____ DOLLAR AMTS: AA MHM DENTAL OTHER SVCS TO BE PROV NOW TO TRANS DT: 0.00 0.00 0.00 0.00 TRANSFER ACCEPTED? _ (Y/N) BY: _____ DATE: _____ READY TO ADD? _ (Y/N) ACT: ___ (C00/HCS DATA ENTRY MENU, A/HCS MAIN MENU, HLP(PF1)/SCRN DOC	• Type the new service county code in the SERVICE COUNTY field. • Type the location code in the LOCATION CODE field. • Type the residential type in the RESIDENTIAL TYPE field. Complete the following fields as they apply to the receiving provider(s). *If the individual is transferring to a different Program Provider or adding a Program Provider:* • Type the component code of the new Program Provider in the COMP field. • Type the local case number in the LCN field. • Type the contract number of the new Program Provider in the CONTRACT NUMBER field, *If the individual is transferring to a different CDSA or adding a CDSA:* • Type the component code of the new CDSA in the COMP field. • Type the local case number in the LCN field. • Type the contract number of the new CDSA in the CONTRACT NUMBER field. • Type **Y** in the READY TO ADD? field. • Press **Enter**. Result: A screen containing the transfer effective date is displayed. If the date is incorrect, do not proceed. You must delete the transfer record and begin again. • Press **Enter**. Result: The **L06: Consumer Transfer: Contract/Services: A/C/D** header screen is displayed with the message *"Previous Information Added."*
12	_ _	The MRA must now access the **L02: Individual Plan of Care** screen to enter a transfer IPC for the individual. On the **L06: Consumer Transfer** header screen: • Type **L02** in the ACT: field. • Press **Enter**. Result: The **L02: Individual Plan of Care** header screen is displayed.

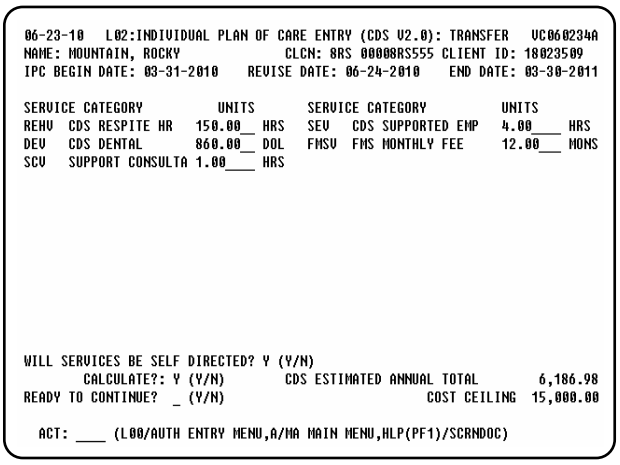
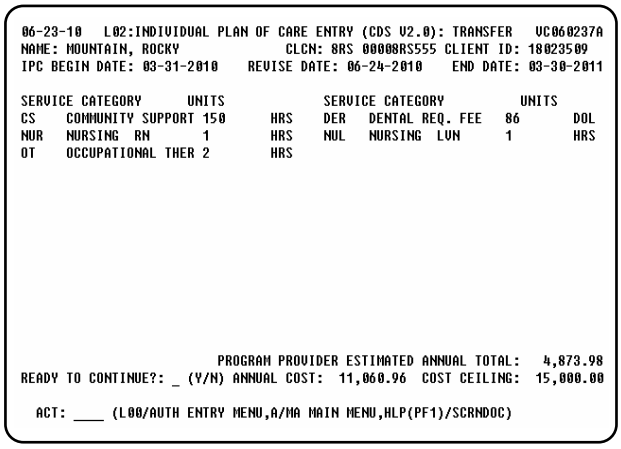
continued on next page

Procedure, continued

Step	View	Action
13	A sample **L02: Individual Plan of Care** header screen is shown below.  06-23-10 L02:INDIVIDUAL PLAN OF CARE (CDS V2.0) VC060230 PLEASE ENTER ONE OF THE FOLLOWING: CLIENT ID: _____ COMPONENT CODE/LOCAL CASE NUMBER: __ / _____ MEDICAID NUMBER: _____ PLEASE ENTER THE FOLLOWING: TYPE OF ENTRY: _ I=INITIAL N=RENEWAL R=REVISION E=ERROR CORRECTION T=TRANSFER D=DELETE PLEASE ENTER FOR REVISION OR ERROR CORRECT OF REVISION: REVISE DATE: _____ (MMDDYYYY) PLEASE ENTER FOR INITIAL PLANS ONLY: BEGIN DATE: _____ (MMDDYYYY) *** PRESS ENTER *** ACT: ___ (L00/AUTH DATA ENTRY MENU, A/MA MAIN MENU, HLP(PF1)/SCRN DOC)	• Type the requested identifying information in the appropriate fields. Rule: You *must* enter the Client ID, the local case number, or the Medicaid Number. • Type the Component Code of the receiving provider in the COMPONENT CODE field. • Type **T** (Transfer) in the TYPE OF ENTRY field. • Press **Enter**. Result: The **L02: Individual Plan of Care Entry: Transfer** screen is displayed.
14	A sample **L02: Individual Plan of Care Entry: Transfer** screen is shown below.  06-23-10 L02:INDIVIDUAL PLAN OF CARE ENTRY (CDS V2.0): TRANSFER VC060233A NAME: MOUNTAIN, ROCKY CLCN: 8RS 00008RS555 CLIENT ID: 18023509 BEG DT: 03312010 REV DT: 06242010 (MMDDYYYY) END DT: 03302011 SERVICE CATEGORY UNITS SERVICE CATEGORY UNITS CS COMMUNITY SUPPOR 150____ HRS DH DAY HABILITATION _____ DAYS EA EMP ASSISTANCE _____ HRS REHV CDS RESPITE HR 150____ HRS SEV CDS SUPPORTED EM 4_____ HRS AA ADAPTIVE AIDS _____ DOL AAR ADAPTIVE AIDS RE _____ DOL AU AUDIOLOGY _____ HRS BES BEHAVIORAL SUPPO _____ HRS DEV CDS DENTAL 860____ DOL DER DENTAL REQ. FEE 86_____ DOL DI DIETARY _____ HRS FMSV FMS MONTHLY FEE 12_____ MONS MHM MINOR HOME MODS _____ DOL MHMR MINOR HOME MOD R _____ DOL NUR NURSING RN 1_____ HRS NUL NURSING LVN 1_____ HRS NURS NURSING SPEC RN _____ HRS NULS NURSING SPEC LV _____ HRS OT OCCUPATIONAL THERAP 2_____ HRS PT PHYSICAL THERAPY _____ HRS SP SPEECH/LANGUAGE _____ HRS SCU SUPPORT CONSULTA 1_____ HRS ANY SERVICES SELF DIRECTED? Y (Y/N) RES TYPE: 3 (2-5) LOCATION: OHFH (OFH) READY TO CONTINUE?: _ (Y/N) ACT: ___ F/FWD,B/BK,(L00/AUTH ENTRY MENU,A/MA MAIN MENU,HLP(PF1)/SCRNDOC) Note: The service units/dollars are cumulative for each IPC year. Therefore, the receiving provider must have an accurate account of the units/dollars for each service that has already been claimed and include those units/dollars on the transfer IPC. Example: If 3 units of NUR have been claimed and the receiving provider plans to provide 6 units of NUR you would need 9 units of NUR on the transfer IPC.	You can use this screen to make the adjustments to the IPC that were agreed upon in the Transfer IPC meeting. Note: You cannot reduce services below what has already been claimed. • Type **Y** in the READY TO CONTINUE? field. • Press **Enter**. Result: The **L02: Individual Plan of Care Entry: Transfer** screen (screen 2) is displayed.

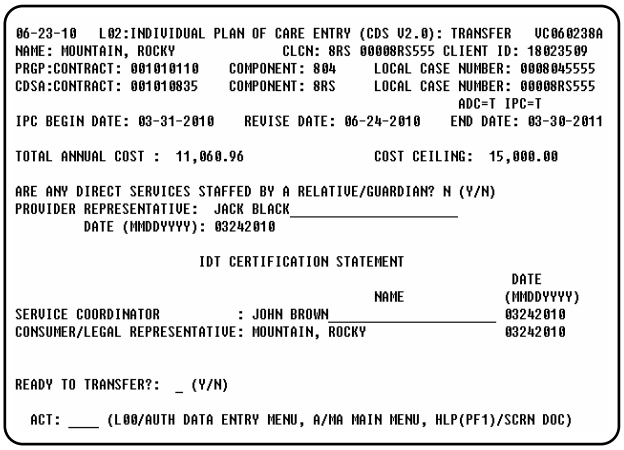
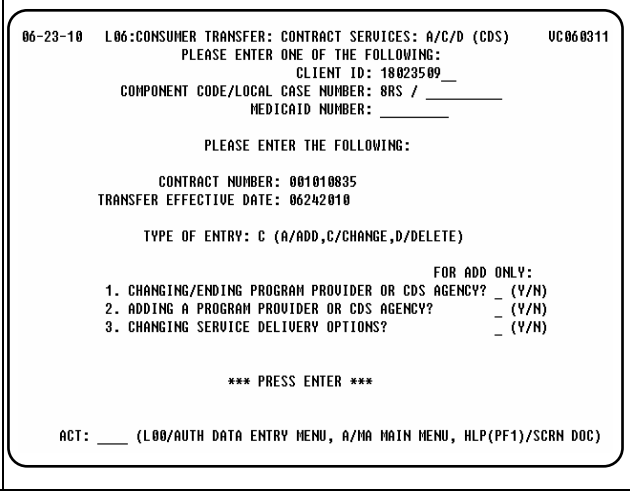
continued on next page

Procedure, continued

Step	View	Action
15	A sample **L02: Individual Plan of Care Entry: Transfer** screen (screen 2) is shown below.  06-23-10 L02:INDIVIDUAL PLAN OF CARE ENTRY (CDS V2.0): TRANSFER VC060234A NAME: MOUNTAIN, ROCKY CLCN: 8RS 00008RS555 CLIENT ID: 18023509 IPC BEGIN DATE: 03-31-2010 REVISE DATE: 06-24-2010 END DATE: 03-30-2011 SERVICE CATEGORY UNITS SERVICE CATEGORY UNITS REHV CDS RESPITE HR 150.00__ HRS SEV CDS SUPPORTED EMP 4.00___ HRS DEV CDS DENTAL 860.00__ DOL FMSV FMS MONTHLY FEE 12.00__ MONS SCV SUPPORT CONSULTA 1.00___ HRS WILL SERVICES BE SELF DIRECTED? Y (Y/N) CALCULATE?: Y (Y/N) CDS ESTIMATED ANNUAL TOTAL 6,186.98 READY TO CONTINUE? _ (Y/N) COST CEILING 15,000.00 ACT: ___ (L00/AUTH ENTRY MENU,A/MA MAIN MENU,HLP(PF1)/SCRNDOC)	This screen displays the CDS portion of the IPC. Services currently being self-directed and new services added to the plan which are eligible to be self-directed are displayed on this screen. Note: All services that are self-directed contain a V at the end of the service abbreviation on this screen. For example, the service abbreviation for Respite is RE. If that service is self-directed, the service abbreviation becomes REV. • Type **N** in the CALCULATE? field. • Type **Y** in the READY TO CONTINUE? field. • Press **Enter**. Result: The **L02: Individual Plan of Care Entry: Transfer** screen (screen 3) is displayed.
16	A sample **L02: Individual Plan of Care Entry: Transfer** screen (screen 3) is shown below.  06-23-10 L02:INDIVIDUAL PLAN OF CARE ENTRY (CDS V2.0): TRANSFER VC060237A NAME: MOUNTAIN, ROCKY CLCN: 8RS 00008RS555 CLIENT ID: 18023509 IPC BEGIN DATE: 03-31-2010 REVISE DATE: 06-24-2010 END DATE: 03-30-2011 SERVICE CATEGORY UNITS SERVICE CATEGORY UNITS CS COMMUNITY SUPPORT 150 HRS DER DENTAL REQ. FEE 86 DOL NUR NURSING RN 1 HRS NUL NURSING LVN 1 HRS OT OCCUPATIONAL THER 2 HRS PROGRAM PROVIDER ESTIMATED ANNUAL TOTAL: 4,873.98 READY TO CONTINUE?: _ (Y/N) ANNUAL COST: 11,060.96 COST CEILING: 15,000.00 ACT: ___ (L00/AUTH ENTRY MENU,A/MA MAIN MENU,HLP(PF1)/SCRNDOC)	This screen displays the Program Provider portion of the IPC. Services not being self-directed are ***displayed and cannot be changed***. • Type **Y** in the READY TO CONTINUE? field. • Press **Enter**. Result: The **L02: Individual Plan of Care Entry: Transfer** screen (screen 4) is displayed.

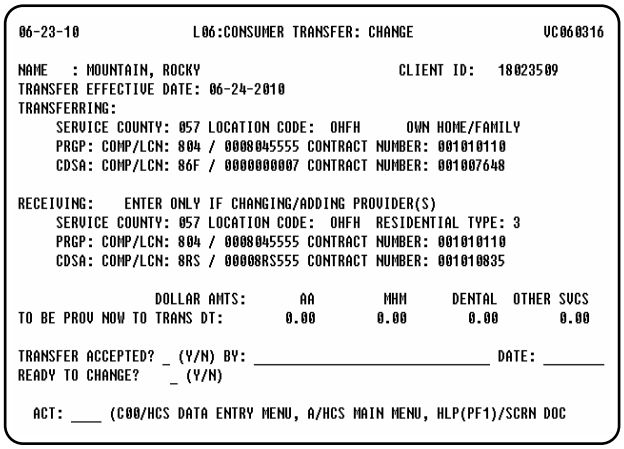
continued on next page

Procedure, continued

Step	View	Action
17	A sample **L02: Individual Plan of Care Entry: Transfer** screen (screen 4) is shown below.  06-23-10 L02:INDIVIDUAL PLAN OF CARE ENTRY (CDS V2.0): TRANSFER VC060238A NAME: MOUNTAIN, ROCKY CLCN: 8RS 00008RS555 CLIENT ID: 18023509 PRGP:CONTRACT: 001010110 COMPONENT: 804 LOCAL CASE NUMBER: 0008045555 CDSA:CONTRACT: 001010835 COMPONENT: 8RS LOCAL CASE NUMBER: 00008RS555 ADC=T IPC=T IPC BEGIN DATE: 03-31-2010 REVISE DATE: 06-24-2010 END DATE: 03-30-2011 TOTAL ANNUAL COST : 11,060.96 COST CEILING: 15,000.00 ARE ANY DIRECT SERVICES STAFFED BY A RELATIVE/GUARDIAN? N (Y/N) PROVIDER REPRESENTATIVE: JACK BLACK DATE (MMDDYYYY): 03242010 IDT CERTIFICATION STATEMENT NAME DATE (MMDDYYYY) SERVICE COORDINATOR : JOHN BROWN 03242010 CONSUMER/LEGAL REPRESENTATIVE: MOUNTAIN, ROCKY 03242010 READY TO TRANSFER?: _ (Y/N) ACT: ___ (L00/AUTH DATA ENTRY MENU, A/MA MAIN MENU, HLP(PF1)/SCRN DOC)	• Type **Y** (Yes) or **N** (No) to indicate whether any services are staffed by a relative or guardian. • You must change the date in the DATE fields. The dates must be after the previous Revise Date and on or before the current Transfer date. • Change the names if necessary. • Type **Y** in the READY TO TRANSFER? field to submit the data to the system. • Press **Enter**. Result: You are informed that the transfer IPC has been entered and that you must return to the L06 screen to complete the transfer. • Press **Enter**. The **L02: Individual Plan of Care** header screen is displayed with the message, "*Transfer Plan has been Added*."
18	_ _	The MRA must now access the **L06: Consumer Transfer** screen to accept the transfer data entry. On the **L02: Individual Plan of Care** header screen: • Type **L06** in the Act: field. • Press **Enter**. Result: The **L06: Consumer Transfer: Contract Services: A/C/D** header screen is displayed.
19	A sample **L06: Consumer Transfer** header screen is shown below.  06-23-10 L06:CONSUMER TRANSFER: CONTRACT SERVICES: A/C/D (CDS) VC060311 PLEASE ENTER ONE OF THE FOLLOWING: CLIENT ID: 18023509_ COMPONENT CODE/LOCAL CASE NUMBER: 8RS / _____ MEDICAID NUMBER: _____ PLEASE ENTER THE FOLLOWING: CONTRACT NUMBER: 001010835 TRANSFER EFFECTIVE DATE: 06242010 TYPE OF ENTRY: C (A/ADD,C/CHANGE,D/DELETE) FOR ADD ONLY: 1. CHANGING/ENDING PROGRAM PROVIDER OR CDS AGENCY? _ (Y/N) 2. ADDING A PROGRAM PROVIDER OR CDS AGENCY? _ (Y/N) 3. CHANGING SERVICE DELIVERY OPTIONS? _ (Y/N) *** PRESS ENTER *** ACT: ___ (L00/AUTH DATA ENTRY MENU, A/MA MAIN MENU, HLP(PF1)/SCRN DOC)	• Type the requested identifying information in the appropriate fields. Rule: You must enter the Client ID, the local case number, *or* the Medicaid Number. • Type the Component Code of the ***receiving*** provider in the COMPONENT CODE field. • Type the contract number in the CONTRACT field. • Type the transfer effective date in the TRANSFER EFFECTIVE DATE field. • Type **C** (Change) in the TYPE OF ENTRY field. Note: ***DO NOT*** attempt to answer the three questions on the header screen for this action. *Leave the fields blank.* • Press **Enter**. Result: The **L06: Consumer Transfer: Change** screen is displayed.

continued on next page

Procedure, continued

Step	View	Action
20	A sample **L06: Consumer Transfer: Change** screen is shown below.  06-23-10 L06:CONSUMER TRANSFER: CHANGE VC060316 NAME : MOUNTAIN, ROCKY CLIENT ID: 18023509 TRANSFER EFFECTIVE DATE: 06-24-2010 TRANSFERRING: SERVICE COUNTY: 057 LOCATION CODE: OHFH OWN HOME/FAMILY PRGP: COMP/LCN: 804 / 0008045555 CONTRACT NUMBER: 001010110 CDSA: COMP/LCN: 86F / 0000000007 CONTRACT NUMBER: 001007648 RECEIVING: ENTER ONLY IF CHANGING/ADDING PROVIDER(S) SERVICE COUNTY: 057 LOCATION CODE: OHFH RESIDENTIAL TYPE: 3 PRGP: COMP/LCN: 804 / 0008045555 CONTRACT NUMBER: 001010110 CDSA: COMP/LCN: 8RS / 00008RS555 CONTRACT NUMBER: 001010835 DOLLAR AMTS: AA MHM DENTAL OTHER SVCS TO BE PROV NOW TO TRANS DT: 0.00 0.00 0.00 0.00 TRANSFER ACCEPTED? _ (Y/N) BY: _____ DATE: _____ READY TO CHANGE? _ (Y/N) ACT: ___ (C00/HCS DATA ENTRY MENU, A/HCS MAIN MENU, HLP(PF1)/SCRN DOC	• Type **Y** in the TRANSFER ACCEPTED field. • Type the name of the person accepting the transfer data entry in the BY field. • If the: - Transfer will occur in the future, type the date of data entry in the DATE field. - Transfer occurred in the past, type the date of the transfer in the Date field. • Type **Y** in the READY TO CHANGE? field. • Press **Enter**. Result: A screen containing the transfer effective date is displayed. If the date is incorrect, the entire transfer record must be deleted and the transfer must be re-entered. • Press **Enter**. Result: The sample **L06: Consumer Transfer: Contract Services: A/C/D** header screen is displayed with the message, *"Previous Information Changed."*

Reminder: A transfer is not complete until authorized by Program Enrollment. After all of the data entry is complete, the MRA must send the signed Form 3617 Request for Transfer of Waiver Services and the ***receiving provider's*** Transfer IPC to Program Enrollment for authorization. Do not send any documentation until **all** of the data entry is complete.

Service claims cannot be entered by the receiving program provider and/or CDSA until the transfer has been authorized and the individual is listed as active on the receiving provider's and/or CDSA's Consumer Roster (**C67**/**L67**).

Use the **A63** screen to view the status of the transfer.

Critical Incident Data (686) – HCS

Introduction

The *Critical Incident Data* process allows a provider to add, change, or delete critical incident data.

The entry of critical incident data is required on a monthly basis for *all* of the contracts administered by a provider of MRA General Revenue, HCS, TxHmL, and ICF/MR services. Critical incident data must be entered *no later than* 30 days from the end of the month being reported. For example, the data reported in the month of September will reflect data that was entered in August.

When adding critical incident data, the fields on the **686: Critical Incident Data: Add** screen will clear to allow for multiple entries of the contracts for your component, and the number of contracts entered is displayed.

Note: HCS information that was previously entered in WebCARE must be entered in CARE beginning September 1, 2009.

Reportable Data

The following information provides terms and definitions used on the Critical Incident Data screens.

Term	Definition
Medication Error	A medication error is reported when there is a discrepancy between what a physician prescribes and what an individual actually takes and the individual self-administers medication under supervision of the Program Provider or has medication administered by the Program Provider. A medication error occurs in one of three ways: • **Wrong medication** - an individual takes medication that is not prescribed for that individual. This includes taking medication after it has been discontinued or taking the incorrect medication because it was inappropriately labeled. • **Wrong dose** - an individual takes a dose of medication other than the dose prescribed. • **Omitted dose** - an individual does not take a prescribed dose of medication within one hour before or one hour after the prescribed time, except an omitted dose does not include an individual's refusal to take medication.
Serious Injury	A serious physical injury is reported, regardless of the cause or setting in which it occurred, when an individual sustains: • a fracture; • a dislocation of any joint; • an internal injury; • a contusion larger than 2½ inches in diameter; • a concussion; • a second or third degree burn; • a laceration requiring sutures; or • an injury determined serious by a physician, physician assistant, registered nurse, or a vocational nurse.

continued on next page

Reportable Data, continued

Term	Definition
Behavior Intervention Plan Authorizing Restraint	A behavior intervention plan is reported if it authorizes a personal, mechanical or psychoactive medication, as defined below, for an individual. • **Personal restraint** - the application of pressure, except physical guidance or prompting of brief duration that restricts the free movement of part or all of an individual's body. • **Mechanical restraint** - the use of a device that restricts the free movement of part or all of an individual's body. Such a device includes an anklet, a wristlet, a camisole, a helmet with fasteners, a mitt with fasteners, a posey, a waist strap, a head strap, and a restraining sheet. Such a device does not include one used to provide support for functional body position or proper balance, such as a wheelchair belt, or one used for medical treatment, such as a helmet to prevent injury during a seizure. • **Psychoactive medication** - the use of a chemical, including a pharmaceutical, through topical application, oral administration, injection, or other means, to control an individual's activity and which is not a standard treatment for the individual's medical or psychiatric condition.
Emergency Personal Restraint	An emergency personal restraint is reported when the Program Provider uses a personal restraint, as defined above, and such restraint is not authorized in a written behavior intervention plan approved by the individual's IDT.
Emergency Mechanical Restraint	An emergency mechanical restraint is reported when the Program Provider uses a mechanical restraint, as defined above, and such restraint is not authorized in a written behavior intervention plan approved by the individual's IDT.
Emergency Psychoactive Medication	An emergency psychoactive medication is reported when the Program Provider uses a psychoactive medication, as defined above and such restraint is not authorized in a written behavior intervention plan approved by the individual's IDT.
Individual Requiring Emergency Restraint	An individual is reported as requiring emergency restraint if the individual is restrained (by either personal or mechanical restraint or psychoactive medication) at least once during a calendar month. If an individual is restrained more than once during a calendar month, the individual is reported only once for that month.
Restraint Related Injury	A restraint related injury is a serious injury sustained by an individual that is clearly related to the application of a personal restraint, an emergency mechanical restraint, or an emergency psychoactive medication administered to an individual. Reportable injuries in this category are not due to self-injury that occurred prior to the application of restraint. Serious injuries sustained during the application of a restraint that are investigated by DFPS as an allegation of abuse, neglect or exploitation must be included in CIRS reporting for this category.

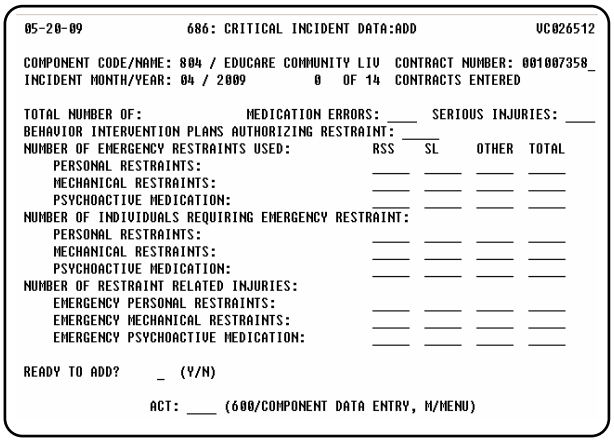
Critical Incident Data (686): Add – HCS

Procedure The following table describes the steps a provider will use to enter critical incident data for a specified reporting month.

Step	View	Action
1	_ _	• Type **686** in the ACT: field of any screen. • Press **Enter**. Result: The **686: Critical Incident Data: Add/ Change/Delete** header screen is displayed.
2	A sample **686: Critical Incident Data: Add/Change/ Delete** header screen is shown below. 05-20-09 686:CRITICAL INCIDENT DATA : ADD/CHANGE/DELETE VC026510 PLEASE ENTER THE FOLLOWING: COMPONENT CODE : __ MONTH AND YEAR (MMYYYY) : _____ CONTRACT NUMBER : _____ TYPE OF ENTRY : _ (A/ADD,C/CHANGE,D/DELETE) *** PRESS ENTER *** ACT: ___ (600/COMPONENT DATA ENTRY, M/MENU)	Your component code is displayed based on your logon account number. • Type the month and year being reported in the MONTH AND YEAR field. (MMYYYY format) • Type the contract number in the CONTRACT NUMBER field. • Type **A** (Add) in the TYPE OF ENTRY field. • Press **Enter**. Result: The **686: Critical Incident Data: Add** screen is displayed.

continued on next page

Procedure, continued

Step	View	Action
3	A sample **686: Critical Incident Data: Add** screen is shown below.  05-20-09 686: CRITICAL INCIDENT DATA:ADD VC026512 COMPONENT CODE/NAME: 804 / EDUCARE COMMUNITY LIV CONTRACT NUMBER: 001007358_ INCIDENT MONTH/YEAR: 04 / 2009 0 OF 14 CONTRACTS ENTERED TOTAL NUMBER OF: MEDICATION ERRORS: ___ SERIOUS INJURIES: ___ BEHAVIOR INTERVENTION PLANS AUTHORIZING RESTRAINT: ____ NUMBER OF EMERGENCY RESTRAINTS USED: RSS SL OTHER TOTAL PERSONAL RESTRAINTS: ____ ____ ____ ____ MECHANICAL RESTRAINTS: ____ ____ ____ ____ PSYCHOACTIVE MEDICATION: ____ ____ ____ ____ NUMBER OF INDIVIDUALS REQUIRING EMERGENCY RESTRAINT: PERSONAL RESTRAINTS: ____ ____ ____ ____ MECHANICAL RESTRAINTS: ____ ____ ____ ____ PSYCHOACTIVE MEDICATION: ____ ____ ____ ____ NUMBER OF RESTRAINT RELATED INJURIES: EMERGENCY PERSONAL RESTRAINTS: ____ ____ ____ ____ EMERGENCY MECHANICAL RESTRAINTS: ____ ____ ____ ____ EMERGENCY PSYCHOACTIVE MEDICATION: ____ ____ ____ ____ READY TO ADD? _ (Y/N) ACT: ___ (600/COMPONENT DATA ENTRY, M/MENU) The top of the screen displays the component code and name, the contract number for which you are reporting incidents, and the incident month and year. In this example, *0 of 14 Contracts Entered* is displayed at the top of the screen. As data is entered for each contract, the screen displays the total number of contracts for the component and the number of that total that has been entered. The middle portion of the screen provides fields for you to enter the number of errors, injuries, and restraint information. This section includes RSS (Residential Support Services), SL (Supervised Living), OTHER (Foster/Companion care and individual living in own home or family home), and TOTAL fields. You will enter the following information: **Number Of Emergency Restraints Used:** These fields include the total number of times a restraint was used in each category. You must manually add the numbers and enter the total in the TOTAL fields. **Number Of Individuals Requiring Emergency Restraint:** These fields include the total number of individuals who were restrained in each category. You must manually add the numbers and enter the total in the TOTAL fields. **Number Of Restraint Related Injuries:** These fields include the total number of injuries that were related to a restraint incident in each category. You must manually add the numbers and enter the total in the TOTAL fields. *See the note and example on the following page.*	The contract number that was entered on the header screen is displayed but can be changed. • Type the contract number in the CONTRACT NUMBER field, if the contract for which you are entering data is other than the one entered on the header screen. • Type the number of medication errors during the report month for every person served in your contract in the MEDICATION ERRORS field. • Type the number of serious injuries during the report month for every person served in your contract in the SERIOUS INJURIES field. • Type the number of behavior intervention plans authorizing personal, mechanical, or psychoactive medication restraint during the report month in the BEHAVIOR INTERVENTION PLANS AUTHORIZING RESTRAINT field. **Number Of Emergency Restraints Used** • Type the number of emergency restraints used by category during the report month in the PERSONAL RESTRAINTS, MECHANICAL RESTRAINTS, and PSYCHOACTIVE MEDICATION fields. • Type the total number of emergency restraints used in the TOTAL field. **Number Of Individuals Requiring Emergency Restraint** • Type the number of individuals requiring emergency restraint during the report month in the PERSONAL RESTRAINTS, MECHANICAL RESTRAINTS, and PSYCHOACTIVE MEDICATION fields. • Type the total number of individuals requiring emergency restraints in the TOTAL field. **Number Of Restraint Related Injuries** • Type the number of restraint related injuries during the report month in the EMERGENCY PERSONAL RESTRAINTS, EMERGENCY MECHANICAL RESTRAINTS, and EMERGENCY PSYCHOACTIVE MEDICATION fields. • Type the total number of restraint related injuries in the TOTAL field. • Type **Y** in the READY TO ADD? field. • Press **Enter**. Result: The screen is redisplayed with cleared fields to allow for the entry of data for additional contracts, and the message, *"Previous Information Added"* is displayed. • Repeat this step for all contracts.

continued on next page

Procedure, continued

Step	View	Action
3 cont.	**Note: Zeroes *must* be entered in the fields on this screen when there is no reportable data for that month. *Data must be entered monthly*.** Example screen: 06-10-09 686: CRITICAL INCIDENT DATA:ADD VC026512 COMPONENT CODE/NAME: 804 / EDUCARE COMMUNITY LIV CONTRACT NUMBER: 001007358_ INCIDENT MONTH/YEAR: 05 / 2009 0 OF 14 CONTRACTS ENTERED TOTAL NUMBER OF: MEDICATION ERRORS: 2___ SERIOUS INJURIES: 1___ BEHAVIOR INTERVENTION PLANS AUTHORIZING RESTRAINT: 5___ NUMBER OF EMERGENCY RESTRAINTS USED: RSS SL OTHER TOTAL PERSONAL RESTRAINTS: 4___ 2___ 0___ 6___ MECHANICAL RESTRAINTS: 2___ 0___ 0___ 2___ PSYCHOACTIVE MEDICATION: 0___ 0___ 0___ 0___ NUMBER OF INDIVIDUALS REQUIRING EMERGENCY RESTRAINT: PERSONAL RESTRAINTS: 1___ 1___ 0___ 2___ MECHANICAL RESTRAINTS: 1___ 0___ 0___ 1___ PSYCHOACTIVE MEDICATION: 0___ 0___ 0___ 0___ NUMBER OF RESTRAINT RELATED INJURIES: EMERGENCY PERSONAL RESTRAINTS: 1___ 0___ 0___ 1___ EMERGENCY MECHANICAL RESTRAINTS: 0___ 0___ 0___ 0___ EMERGENCY PSYCHOACTIVE MEDICATION: 0___ 0___ 0___ 0___ READY TO ADD? Y (Y/N) ACT: ___ (600/COMPONENT DATA ENTRY, M/MENU)	When all contracts have been entered, type **N** in the READY TO ADD? field and press **Enter** to return to the header screen. Example: The following describes the data displayed on the sample screen on the left side of the page. **Number of Emergency Restraints** section: • John is in Residential Support Services and has had four personal restraints in a month. You would type **4** in the PERSONAL RESTRAINTS: RSS field. • Sally is in Supervised Living and has had two personal restraints in a month. You would type **2** in the PERSONAL RESTRAINTS: SL field, and • Type **6** in the TOTAL field. • Bob is in Residential Support Services and has had two mechanical restraints in a month. You would type **2** in the MECHANICAL RESTRAINTS: RSS field and **2** in the TOTAL field. **Number of Individuals Requiring Emergency Restraint** section: • Even though John has had 4 and Sally has had 2 personal restraints, this field is counting individuals, so you would type **1** in the PERSONAL RESTRAINTS: RSS field, **1** in the SL field, and **2** in the TOTAL field. Bob has had two mechanical restraints, but you would type **1** in the MECHANICAL RESTRAINTS: RSS field and **1** in the TOTAL field. **Number of Restraint Related Injuries** section: • One of Bob's restraints resulted in a restraint related injury, so you would type **1** in the MECHANICAL RESTRAINTS: RSS field and **1** in the TOTAL field. ***Important*: Remember that you must type zeroes in all fields that have no critical incident data to be reported.**

Critical Incident Data (686): Change – HCS

Procedure

The following table describes the steps a provider will use to change critical incident data that has been entered incorrectly.

Step	View	Action
1	_ _	• Type **686** in the ACT: field of any screen. • Press **Enter**. Result: The **686: Critical Incident Data: Add/ Change/Delete** header screen is displayed.
2	A sample **686: Critical Incident Data: Add/Change/ Delete** header screen is shown below. 05-20-09 686:CRITICAL INCIDENT DATA : ADD/CHANGE/DELETE VC026510 PLEASE ENTER THE FOLLOWING: COMPONENT CODE : __ MONTH AND YEAR (MMYYYY) : _____ CONTRACT NUMBER : _____ TYPE OF ENTRY : _ (A/ADD,C/CHANGE,D/DELETE) *** PRESS ENTER *** ACT: ___ (600/COMPONENT DATA ENTRY, M/MENU)	Your component code is displayed based on your logon account number. • Type the month and year being reported in the MONTH AND YEAR field. (MMYYYY format) • Type the contract number in the CONTRACT NUMBER field. • Type **C** (Change) in the TYPE OF ENTRY field. • Press **Enter**. Result: The **686: Critical Incident Data: Change** screen is displayed.
3	A sample **686: Critical Incident Data: Change** screen is shown below. 06-11-09 686: CRITICAL INCIDENT DATA:CHANGE VC026512 COMPONENT CODE/NAME: 804 / EDUCARE COMMUNITY LIV CONTRACT NUMBER: 001007358_ INCIDENT MONTH/YEAR: 05 / 2009 1 OF 14 CONTRACTS ENTERED TOTAL NUMBER OF: MEDICATION ERRORS: 2__ SERIOUS INJURIES: 1__ BEHAVIOR INTERVENTION PLANS AUTHORIZING RESTRAINT: 5___ NUMBER OF EMERGENCY RESTRAINTS USED: RSS SL OTHER TOTAL PERSONAL RESTRAINTS: 4___ 2___ 0___ 6___ MECHANICAL RESTRAINTS: 2___ 0___ 0___ 2___ PSYCHOACTIVE MEDICATION: 0___ 0___ 0___ 0___ NUMBER OF INDIVIDUALS REQUIRING EMERGENCY RESTRAINT: PERSONAL RESTRAINTS: 1___ 1___ 0___ 2___ MECHANICAL RESTRAINTS: 1___ 0___ 0___ 1___ PSYCHOACTIVE MEDICATION: 0___ 0___ 0___ 0___ NUMBER OF RESTRAINT RELATED INJURIES: EMERGENCY PERSONAL RESTRAINTS: 1___ 0___ 0___ 1___ EMERGENCY MECHANICAL RESTRAINTS: 0___ 0___ 0___ 0___ EMERGENCY PSYCHOACTIVE MEDICATION: 0___ 0___ 0___ 0___ READY TO CHANGE? Y (Y/N) ACT: ___ (600/COMPONENT DATA ENTRY, M/MENU)	• Type changes to the critical incident data in the appropriate fields. • Type **Y** in the READY TO CHANGE? field to submit the data to the system. • Press **Enter**. Result: The header screen is displayed with the message, *"Previous Information Changed."*

Critical Incident Data (686): Delete – HCS

Procedure

The following table describes the steps a provider will use to delete critical incident data that has been entered in error.

Step	View	Action
1	_ _	• Type **686** in the ACT: field of any screen. • Press **Enter**. Result: The **686: Critical Incident Data: Add/ Change/Delete** header screen is displayed.
2	A sample **686: Critical Incident Data: Add/Change/ Delete** header screen is shown below. 05-20-09 686:CRITICAL INCIDENT DATA : ADD/CHANGE/DELETE VC026510 PLEASE ENTER THE FOLLOWING: COMPONENT CODE : __ MONTH AND YEAR (MMYYYY) : _____ CONTRACT NUMBER : _____ TYPE OF ENTRY : _ (A/ADD,C/CHANGE,D/DELETE) *** PRESS ENTER *** ACT: ___ (600/COMPONENT DATA ENTRY, M/MENU)	Your component code is displayed based on your logon account number. • Type the month and year being reported in the MONTH AND YEAR field. (MMYYYY format) • Type the contract number in the CONTRACT NUMBER field. • Type **D** (Delete) in the TYPE OF ENTRY field. • Press **Enter**. Result: The **686: Critical Incident Data: Delete** screen is displayed.
3	A sample **686: Critical Incident Data: Delete** screen is shown below. 06-11-09 686: CRITICAL INCIDENT DATA:DELETE VC026512 COMPONENT CODE/NAME: 804 / EDUCARE COMMUNITY LIV CONTRACT NUMBER: 001007358_ INCIDENT MONTH/YEAR: 05 / 2009 1 OF 14 CONTRACTS ENTERED TOTAL NUMBER OF: MEDICATION ERRORS: 2__ SERIOUS INJURIES: 1__ BEHAVIOR INTERVENTION PLANS AUTHORIZING RESTRAINT: 5___ NUMBER OF EMERGENCY RESTRAINTS USED: RSS SL OTHER TOTAL PERSONAL RESTRAINTS: 4___ 2___ 0___ 6___ MECHANICAL RESTRAINTS: 2___ 0___ 0___ 2___ PSYCHOACTIVE MEDICATION: 0___ 0___ 0___ 0___ NUMBER OF INDIVIDUALS REQUIRING EMERGENCY RESTRAINT: PERSONAL RESTRAINTS: 1___ 1___ 0___ 2___ MECHANICAL RESTRAINTS: 1___ 0___ 0___ 1___ PSYCHOACTIVE MEDICATION: 0___ 0___ 0___ 0___ NUMBER OF RESTRAINT RELATED INJURIES: EMERGENCY PERSONAL RESTRAINTS: 1___ 0___ 0___ 1___ EMERGENCY MECHANICAL RESTRAINTS: 0___ 0___ 0___ 0___ EMERGENCY PSYCHOACTIVE MEDICATION: 0___ 0___ 0___ 0___ READY TO DELETE? Y (Y/N) ACT: ___ (600/COMPONENT DATA ENTRY, M/MENU)	• Type **Y** in the READY TO DELETE? field to submit the data to the system. • Press **Enter**. Result: The header screen is displayed with the message, *"Previous Information Deleted."*

Critical Incident Data: Inquiry (286) – HCS

Introduction

The **Critical Incident Data: Inquiry** option is used to view critical incident data based on the information reported on the **686: Critical Incident Data** screens.

The report can be displayed in one of three ways. You can:

- Request a complete report that includes both the summary of incidents reported for each contract and a list of contracts for which incidents were not reported.
- Request a report that includes only the summary.
- Request a report that includes a list of contracts for which incidents were not reported.

Requesting Reports

When you request a report and enter only the Component Code and Month and Year on the header screen:

- The first screen(s) will display critical incidents for each contract
- The second screen will display contracts that did not report
- The third screen will display the Total Number of Critical Incidents for all contracts that reported

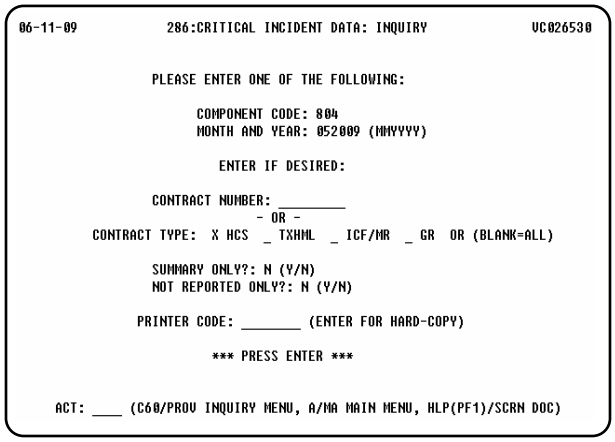
If you enter the Component Code, Month and Year, and a specific Contract Number on the header screen and:

- If the contract ***reported*** incidents for the Component Code and Month and Year:
  - The first screen will display critical incidents for the contract
  - The second screen will display 0 number of contracts did not report
  - The third screen will display the **total number** of Critical Incidents for that contract
- If the contract ***did not report*** for the Component Code and Month and Year:
  - The first screen will not be displayed
  - The second screen will display that the contract did not report
  - The third screen will display the 0 totals for Critical Incidents for that contract

continued on next page

Procedure

The table below displays the steps taken to access the **286: Critical Incident Data: Inquiry** screen.

Step	View	Action
1	_ _	• Type **286** in the ACT: field of any screen. • Press **Enter**. Result: The **286: Critical Incident Data: Inquiry** header screen is displayed.
2	A sample **286: Critical Incident Data: Inquiry** header screen is shown below.  06-11-09 286:CRITICAL INCIDENT DATA: INQUIRY VC026530 PLEASE ENTER ONE OF THE FOLLOWING: COMPONENT CODE: 804 MONTH AND YEAR: 052009 (MMYYYY) ENTER IF DESIRED: CONTRACT NUMBER: _____ - OR - CONTRACT TYPE: X HCS _ TXHML _ ICF/MR _ GR OR (BLANK=ALL) SUMMARY ONLY?: N (Y/N) NOT REPORTED ONLY?: N (Y/N) PRINTER CODE: _____ (ENTER FOR HARD-COPY) *** PRESS ENTER *** ACT: ___ (C60/PROV INQUIRY MENU, A/MA MAIN MENU, HLP(PF1)/SCRN DOC)	Your component code is displayed based on your logon account number. • Type the month and year in the MONTH AND YEAR field. (MMYYYY format) • Type the contract number in the CONTRACT NUMBER field, or • Type an **X** beside the appropriate contract type. (HCS, TxHmL, ICF/MR, or GR) • Type **Y** in the SUMMARY ONLY field if you want a summary *only*. • Type **Y** in the NOT REPORTED ONLY field if you want a list of contracts for which incidents were not reported *only*. • Press **Enter**. Result: The **286: Critical Incident Data Inquiry** screen is displayed.

Procedure, continued

Step	View	Action
3	A sample **286: Critical Incident Data Inquiry** screen is shown below. The following sample screens display a complete report that includes a summary of total incidents reported, a list of contracts for which no incidents were reported, and a summary for the contract for which data was reported in our example. The system displays data entered for each contract.	The screen displays the data that was entered for each contract on the **686: Critical Incident Data** screens. This screen is accessed when you leave **N** (No) in the SUMMARY ONLY and the NOT REPORTED ONLY fields on the header screen.

```
06-17-09            286:CRITICAL INCIDENT DATA INQUIRY            VC026532

COMPONENT CODE/NAME: 804/EDUCARE COMMUNITY LIVING CORPORATION - TEXAS
INCIDENT MONTH/YEAR: 05/2009   DATE REPORTED: 06/10/2009   STATUS: ON TIME

       CONTRACT NUMBER: HCS 001007358 EDUCARE COMMUNITY LIVING CORPORATION-TEX

         BEHAVIOR INTERVENTION PLANS AUTHORIZING RESTRAINT:               5
                        TOTAL NUMBER OF MEDICATION ERRORS:                2
                           TOTAL NUMBER OF SERIOUS INJURIES:              1
                                                    RSS     SL    OTH  TOTAL
NBR. EMER. RESTRAINTS USED:      PERS. RESTRAINTS:    4      2      0      6
                                 MECH. RESTRAINTS:    2      0      0      2
                                PSYCH. RESTRAINTS:    0      0      0      0
NBR. INDIV. REQ. EMERG.RESTRNT:  PERS. RESTRAINTS:    1      1      0      2
                                 MECH. RESTRAINTS:    1      0      0      1
                                PSYCH. RESTRAINTS:    0      0      0      0
NBR. SER. INJ. DUE TO:     EMER. PERS. RESTRAINTS:    1      0      0      1
                           EMER. MECH. RESTRAINTS:    0      0      0      0
                          EMER. PSYCH. RESTRAINTS:    0      0      0      0

                     >
```

```
06-17-09             286:CRITICAL INCIDENT DATA INQUIRY             VC026532
                        CONTRACTS NOT REPORTED - HCS ONLY

 COMPONENT CODE/NAME: 804 / EDUCARE COMMUNITY LIVING CORPORATION - TEXAS
 INCIDENT MONTH/YEAR: 05/2009

             001007102  HCS     EDUCARE COMMUNITY LIVING CORPORATION-TEX
             001007162  HCS     EDUCARE COMMUNITY LIVING CORPORATION-TEX
             001007479  HCS     EDUCARE COMMUNITY LIVING CORPORATION-TEX
             001007518  HCS     EDUCARE COMMUNITY LIVING CORPORATION-TEX

  TOTAL NUMBER OF CONTRACTS NOT REPORTED:   4

                      >
```

```
06-17-09             286:CRITICAL INCIDENT DATA INQUIRY             VC026532
                             SUMMARY - HCS ONLY

COMPONENT CODE/NAME: 804/EDUCARE COMMUNITY LIVING CORPORATION - TEXAS
INCIDENT MONTH/YEAR: 05/2009          1 OF 5 CONTRACTS REPORTED

          BEHAVIOR INTERVENTION PLANS AUTHORIZING RESTRAINT:               5
                         TOTAL NUMBER OF MEDICATION ERRORS:                2
                            TOTAL NUMBER OF SERIOUS INJURIES:              1
                                                     RSS     SL    OTH  TOTAL
NBR. EMER. RESTRAINTS USED:      PERS. RESTRAINTS:    4      2      0      6
                                 MECH. RESTRAINTS:    2      0      0      2
                                PSYCH. RESTRAINTS:    0      0      0      0
NBR. INDIV. REQ. EMERG.RESTRNT:  PERS. RESTRAINTS:    1      1      0      2
                                 MECH. RESTRAINTS:    1      0      0      1
                                PSYCH. RESTRAINTS:    0      0      0      0
NBR. SER. INJ. DUE TO:     EMER. PERS. RESTRAINTS:    1      0      0      1
                           EMER. MECH. RESTRAINTS:    0      0      0      0
                          EMER. PSYCH. RESTRAINTS:    0      0      0      0

                     >
```

Procedure, continued

Step	View	Action
3, cont.	The following sample screen displays a report that includes only the summary.	This screen is accessed when you type **Y** (Yes) in the SUMMARY ONLY field and **N** (No) in the NOT REPORTED ONLY fields on the header screen.

```
06-17-09            286:CRITICAL INCIDENT DATA INQUIRY            VC026532
                            SUMMARY - HCS ONLY

COMPONENT CODE/NAME: 804/EDUCARE COMMUNITY LIVING CORPORATION - TEXAS
INCIDENT MONTH/YEAR: 05/2009          1 OF 5 CONTRACTS REPORTED

         BEHAVIOR INTERVENTION PLANS AUTHORIZING RESTRAINT:               5
                        TOTAL NUMBER OF MEDICATION ERRORS:                2
                           TOTAL NUMBER OF SERIOUS INJURIES:              1
                                                    RSS     SL    OTH  TOTAL
NBR. EMER. RESTRAINTS USED:      PERS. RESTRAINTS:    0      0      0      6
                                  MECH. RESTRAINTS:    0      0      0      2
                                 PSYCH. RESTRAINTS:    0      0      0      0
NBR. INDIV. REQ. EMERG.RESTRNT:  PERS. RESTRAINTS:    0      0      0      2
                                  MECH. RESTRAINTS:    0      0      0      1
                                 PSYCH. RESTRAINTS:    0      0      0      0
NBR. SER. INJ. DUE TO:     EMER. PERS. RESTRAINTS:    0      0      0      1
                            EMER. MECH. RESTRAINTS:    0      0      0      0
                           EMER. PSYCH. RESTRAINTS:    0      0      0      0

                    >
```

	The following sample screen displays a report that includes a list of contracts that had no incidents reported.	This screen is accessed when you type **N** (No) in the SUMMARY ONLY field and **Y** (Yes) in the NOT REPORTED ONLY fields on the header screen.

```
06-17-09            286:CRITICAL INCIDENT DATA INQUIRY            VC026532
                      CONTRACTS NOT REPORTED - HCS ONLY

COMPONENT CODE/NAME: 804 / EDUCARE COMMUNITY LIVING CORPORATION - TEXAS
INCIDENT MONTH/YEAR: 05/2009

            001007102  HCS     EDUCARE COMMUNITY LIVING CORPORATION-TEX
            001007162  HCS     EDUCARE COMMUNITY LIVING CORPORATION-TEX
            001007479  HCS     EDUCARE COMMUNITY LIVING CORPORATION-TEX
            001007518  HCS     EDUCARE COMMUNITY LIVING CORPORATION-TEX

 TOTAL NUMBER OF CONTRACTS NOT REPORTED:   4

                    >
```

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Critical Incident Data (686) - TXHmL

Introduction

The *Critical Incident Data* process allows a provider to add, change, or delete critical incident data.

The entry of critical incident data is required on a monthly basis for *all* of the contracts administered by a provider of MRA General Revenue, HCS, TxHmL, and ICF/MR services. Critical incident data must be entered *no later than* 30 days from the end of the month being reported. For example, the data reported in the month of September will reflect data that was entered in August.

When adding critical incident data, the fields on the **686: Critical Incident Data: Add** screen will clear to allow for multiple entries of the contracts for your component, and the number of contracts entered is displayed.

Reportable Data

The following information provides terms and definitions used on the Critical Incident Data screens.

Term	Definition
Medication Error	A medication error is reported when there is a discrepancy between what a physician prescribes and what an individual actually takes and the individual self-administers medication under supervision of the Program Provider or has medication administered by the Program Provider. A medication error occurs in one of three ways: • **Wrong medication** - an individual takes medication that is not prescribed for that individual. This includes taking medication after it has been discontinued or taking the incorrect medication because it was inappropriately labeled. • **Wrong dose** - an individual takes a dose of medication other than the dose prescribed. • **Omitted dose** - an individual does not take a prescribed dose of medication within one hour before or one hour after the prescribed time, except an omitted dose does not include an individual's refusal to take medication.
Serious Injury	A serious physical injury is reported, regardless of the cause or setting in which it occurred, when an individual sustains: • a fracture; • a dislocation of any joint; • an internal injury; • a contusion larger than 2½ inches in diameter; • a concussion; • a second or third degree burn; • a laceration requiring sutures; or • an injury determined serious by a physician, physician assistant, registered nurse, or a vocational nurse.

continued on next page

Reportable Data, continued

Term	Definition
Behavior Intervention Plan Authorizing Restraint	A behavior intervention plan is reported if it authorizes a personal, mechanical or psychoactive medication, as defined below, for an individual. • **Personal restraint** - the application of pressure, except physical guidance or prompting of brief duration that restricts the free movement of part or all of an individual's body. • **Mechanical restraint** - the use of a device that restricts the free movement of part or all of an individual's body. Such a device includes an anklet, a wristlet, a camisole, a helmet with fasteners, a mitt with fasteners, a posey, a waist strap, a head strap, and a restraining sheet. Such a device does not include one used to provide support for functional body position or proper balance, such as a wheelchair belt, or one used for medical treatment, such as a helmet to prevent injury during a seizure. • **Psychoactive medication** - the use of a chemical, including a pharmaceutical, through topical application, oral administration, injection, or other means, to control an individual's activity and which is not a standard treatment for the individual's medical or psychiatric condition.
Emergency Personal Restraint	An emergency personal restraint is reported when the Program Provider uses a personal restraint, as defined above, and such restraint is not authorized in a written behavior intervention plan approved by the individual's IDT.
Emergency Mechanical Restraint	An emergency mechanical restraint is reported when the Program Provider uses a mechanical restraint, as defined above, and such restraint is not authorized in a written behavior intervention plan approved by the individual's IDT.
Emergency Psychoactive Medication	An emergency psychoactive medication is reported when the Program Provider uses a psychoactive medication, as defined above and such restraint is not authorized in a written behavior intervention plan approved by the individual's IDT.
Individual Requiring Emergency Restraint	An individual is reported as requiring emergency restraint if the individual is restrained (by either personal or mechanical restraint or psychoactive medication) at least once during a calendar month. If an individual is restrained more than once during a calendar month, the individual is reported only once for that month.
Restraint Related Injury	A restraint related injury is a serious injury sustained by an individual that is clearly related to the application of a personal restraint, an emergency mechanical restraint, or an emergency psychoactive medication administered to an individual. Reportable injuries in this category are not due to self-injury that occurred prior to the application of restraint. Serious injuries sustained during the application of a restraint that are investigated by DFPS as an allegation of abuse, neglect or exploitation must be included in CIRS reporting for this category.

Critical Incident Data (686): Add - TXHmL

Procedure — The following table describes the steps a provider will use to enter critical incident data for a specified reporting month.

Step	View	Action
1	_ _	• Type **686** in the ACT: field of any screen. • Press **Enter**. Result: The **686: Critical Incident Data: Add/ Change/Delete** header screen is displayed.
2	A sample **686: Critical Incident Data: Add/Change/ Delete** header screen is shown below. 05-20-09 686:CRITICAL INCIDENT DATA : ADD/CHANGE/DELETE VC026510 PLEASE ENTER THE FOLLOWING: COMPONENT CODE : __ MONTH AND YEAR (MMYYYY) : _____ CONTRACT NUMBER : _____ TYPE OF ENTRY : _ (A/ADD,C/CHANGE,D/DELETE) *** PRESS ENTER *** ACT: ___ (600/COMPONENT DATA ENTRY, M/MENU)	Your component code is displayed based on your logon account number. • Type the month and year being reported in the MONTH AND YEAR (MMYYYY) field. • Type the contract number in the CONTRACT NUMBER field. • Type **A** (Add) in the TYPE OF ENTRY field. • Press **Enter**. Result: The **686: Critical Incident Data: Add** screen is displayed.

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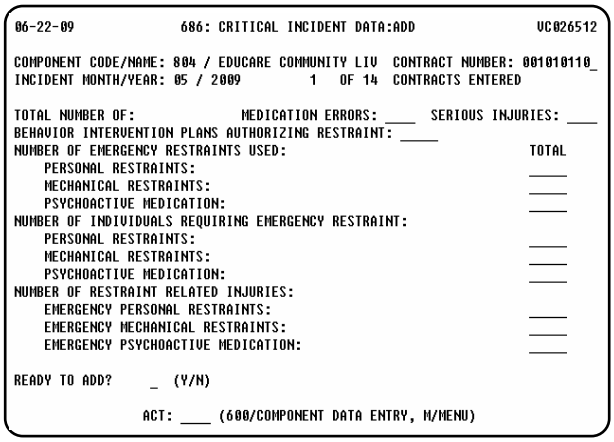
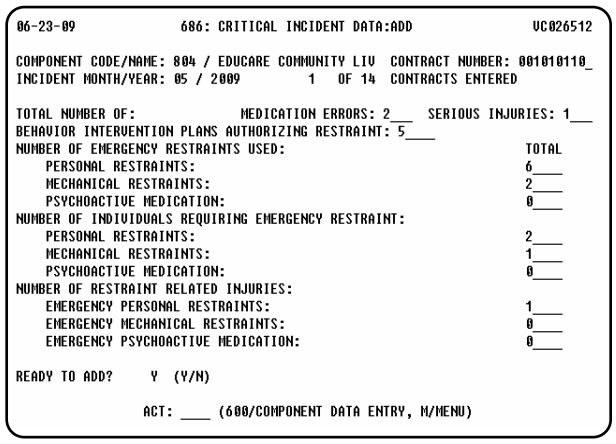
Procedure, continued

Step	View	Action
3	A sample **686: Critical Incident Data: Add** screen is shown below.  06-22-09 686: CRITICAL INCIDENT DATA:ADD VC026512 COMPONENT CODE/NAME: 804 / EDUCARE COMMUNITY LIV CONTRACT NUMBER: 001010110_ INCIDENT MONTH/YEAR: 05 / 2009 1 OF 14 CONTRACTS ENTERED TOTAL NUMBER OF: MEDICATION ERRORS: ___ SERIOUS INJURIES: ___ BEHAVIOR INTERVENTION PLANS AUTHORIZING RESTRAINT: ____ NUMBER OF EMERGENCY RESTRAINTS USED: TOTAL PERSONAL RESTRAINTS: ____ MECHANICAL RESTRAINTS: ____ PSYCHOACTIVE MEDICATION: ____ NUMBER OF INDIVIDUALS REQUIRING EMERGENCY RESTRAINT: PERSONAL RESTRAINTS: ____ MECHANICAL RESTRAINTS: ____ PSYCHOACTIVE MEDICATION: ____ NUMBER OF RESTRAINT RELATED INJURIES: EMERGENCY PERSONAL RESTRAINTS: ____ EMERGENCY MECHANICAL RESTRAINTS: ____ EMERGENCY PSYCHOACTIVE MEDICATION: ____ READY TO ADD? _ (Y/N) ACT: ___ (600/COMPONENT DATA ENTRY, M/MENU) The top of the screen displays the component code and name, the contract number for which you are reporting incidents, and the incident month and year. In this example, *1 of 14 Contracts Entered* is displayed at the top of the screen. As data is entered for each contract, the screen displays the total number of contracts for the component and the number of that total that has been entered. The middle portion of the screen provides fields for you to enter the number of errors, injuries, restraint information, and TOTAL fields. You will enter the following information: **Number Of Emergency Restraints Used:** These fields include the total number of times a restraint was used in each category. **Number Of Individuals Requiring Emergency Restraint:** These fields include the total number of individuals who were injured when a restraint was used in each category. **Number Of Restraint Related Injuries:** These fields include the total number injuries that were a result of restraint in each category. **Note: Zeroes *must* be entered in the fields on this screen even if there are no behavior intervention plans or critical incident data to be reported during the report month. *Data must be entered monthly*.** *See the example on the following page.*	The contract number that was entered on the header screen is displayed but can be changed. • Type the contract number in the CONTRACT NUMBER field, if the contract for which you are entering data is other than the one entered on the header screen. • Type the number of medication errors during the report month for every person served in your contract in the MEDICATION ERRORS field. • Type the number of serious injuries during the report month for every person served in your contract in the SERIOUS INJURIES field. • Type the number of behavior intervention plans authorizing personal, mechanical, or psychoactive medication restraint during the report month in the BEHAVIOR INTERVENTION PLANS AUTHORIZING RESTRAINT field. **Number Of Emergency Restraints Used** • Type the total number of emergency restraints used by category during the report month in the PERSONAL RESTRAINTS, MECHANICAL RESTRAINTS, and PSYCHOACTIVE MEDICATION TOTAL fields. **Number Of Individuals Requiring Emergency Restraint** • Type the total number of individuals requiring emergency restraint during the report month in the PERSONAL RESTRAINTS, MECHANICAL RESTRAINTS, and PSYCHOACTIVE MEDICATION TOTAL fields. **Number Of Restraint Related Injuries** • Type the total number of restraint related injuries during the report month in the EMERGENCY PERSONAL RESTRAINTS, EMERGENCY MECHANICAL RESTRAINTS, and EMERGENCY PSYCHOACTIVE MEDICATION TOTAL fields. • Type **Y** in the READY TO ADD? field. • Press **Enter**. Result: The screen is redisplayed with cleared fields to allow for the entry of data for additional contracts, and the message, *"Previous Information Added"* is displayed. • Repeat this step for all contracts. • When all contracts have been entered, type **N** in the READY TO ADD? field and press **Enter** to return to the header screen.

Procedure, continued

Step	View	Action
3 cont.	Example screen: 	Example: The following describes the data displayed on the sample screen on the left side of the page. **Number of Emergency Restraints** section: • John has had four personal restraints in a month and Sally has had two personal restraints in a month, so you would type **6** in the TOTAL field. • Bob has had two mechanical restraints in a month, so you would type **2** in the TOTAL field. • There were no psychoactive medication restraints, so you would type **0** in the Total field. **Number of Individuals Requiring Emergency Restraint** section: • Even though John has had 4 and Sally has had 2 personal restraints, this field is counting individuals, so you would type **2** in the TOTAL field. Bob has had two mechanical restraints, but you would type **1** in the TOTAL field. There were no psychoactive medication restraints, so you would type **0** in the Total field. **Number of Restraint Related Injuries** section: • One of Bob's restraints resulted in a restraint related injury, so you would type **1** in the TOTAL field. You would type 0 in the EMERGENCY MECHANICAL RESTRAINT and EMERGENCY PSYCHOACTIVE MEDICATION TOTAL fields. ***Important: Remember that you must type zeroes in all fields that have no critical incident data to be reported.***

Critical Incident Data (686): Change - TXHmL

Procedure

The following table describes the steps a provider will use to change critical incident data that has been entered incorrectly.

Step	View	Action
1	_ _	• Type **686** in the ACT: field of any screen. • Press **Enter**. Result: The **686: Critical Incident Data: Add/ Change/Delete** header screen is displayed.
2	A sample **686: Critical Incident Data: Add/Change/ Delete** header screen is shown below. 05-20-09 686:CRITICAL INCIDENT DATA : ADD/CHANGE/DELETE VC026510 PLEASE ENTER THE FOLLOWING: COMPONENT CODE : __ MONTH AND YEAR (MMYYYY) : _____ CONTRACT NUMBER : _____ TYPE OF ENTRY : _ (A/ADD,C/CHANGE,D/DELETE) *** PRESS ENTER *** ACT: ___ (600/COMPONENT DATA ENTRY, M/MENU)	Your component code is displayed based on your logon account number. • Type the month and year being reported in the MONTH AND YEAR (MMYYYY) field. • Type the contract number in the CONTRACT NUMBER field. • Type **C** (Change) in the TYPE OF ENTRY field. • Press **Enter**. Result: The **686: Critical Incident Data: Change** screen is displayed.
3	A sample **686: Critical Incident Data: Change** screen is shown below. 06-22-09 686: CRITICAL INCIDENT DATA:CHANGE VC026512 COMPONENT CODE/NAME: 804 / EDUCARE COMMUNITY LIV CONTRACT NUMBER: 001010110_ INCIDENT MONTH/YEAR: 05 / 2009 2 OF 14 CONTRACTS ENTERED TOTAL NUMBER OF: MEDICATION ERRORS: 2___ SERIOUS INJURIES: 1___ BEHAVIOR INTERVENTION PLANS AUTHORIZING RESTRAINT: 5___ NUMBER OF EMERGENCY RESTRAINTS USED: TOTAL PERSONAL RESTRAINTS: 6___ MECHANICAL RESTRAINTS: 2___ PSYCHOACTIVE MEDICATION: 0___ NUMBER OF INDIVIDUALS REQUIRING EMERGENCY RESTRAINT: PERSONAL RESTRAINTS: 2___ MECHANICAL RESTRAINTS: 1___ PSYCHOACTIVE MEDICATION: 0___ NUMBER OF RESTRAINT RELATED INJURIES: EMERGENCY PERSONAL RESTRAINTS: 1___ EMERGENCY MECHANICAL RESTRAINTS: 0___ EMERGENCY PSYCHOACTIVE MEDICATION: 0___ READY TO CHANGE? _ (Y/N) ACT: ___ (600/COMPONENT DATA ENTRY, M/MENU)	• Type changes to the critical incident data in the appropriate fields. • Type **Y** in the READY TO CHANGE? field to submit the data to the system. • Press **Enter**. Result: The header screen is displayed with the message, *"Previous Information Changed."*

Critical Incident Data (686): Delete - TXHmL

Procedure

The following table describes the steps a provider will use to delete critical incident data that has been entered in error.

Step	View	Action
1	_ _	• Type **686** in the ACT: field of any screen. • Press **Enter**. Result: The **686: Critical Incident Data: Add/ Change/Delete** header screen is displayed.
2	A sample **686: Critical Incident Data: Add/Change/ Delete** header screen is shown below. 05-20-09 686:CRITICAL INCIDENT DATA : ADD/CHANGE/DELETE VC026510 PLEASE ENTER THE FOLLOWING: COMPONENT CODE : __ MONTH AND YEAR (MMYYYY) : _____ CONTRACT NUMBER : _____ TYPE OF ENTRY : _ (A/ADD,C/CHANGE,D/DELETE) *** PRESS ENTER *** ACT: ___ (600/COMPONENT DATA ENTRY, M/MENU)	Your component code is displayed based on your logon account number. • Type the month and year being reported in the MONTH AND YEAR (MMYYYY) field. • Type the contract number in the CONTRACT NUMBER field. • Type **D** (Delete) in the TYPE OF ENTRY field. • Press **Enter**. Result: The **686: Critical Incident Data: Delete** screen is displayed.
3	A sample **686: Critical Incident Data: Delete** screen is shown below. 06-22-09 686: CRITICAL INCIDENT DATA:DELETE VC026512 COMPONENT CODE/NAME: 804 / EDUCARE COMMUNITY LIV CONTRACT NUMBER: 001010110_ INCIDENT MONTH/YEAR: 05 / 2009 2 OF 14 CONTRACTS ENTERED TOTAL NUMBER OF: MEDICATION ERRORS: 2___ SERIOUS INJURIES: 1___ BEHAVIOR INTERVENTION PLANS AUTHORIZING RESTRAINT: 5___ NUMBER OF EMERGENCY RESTRAINTS USED: TOTAL PERSONAL RESTRAINTS: 6___ MECHANICAL RESTRAINTS: 2___ PSYCHOACTIVE MEDICATION: 0___ NUMBER OF INDIVIDUALS REQUIRING EMERGENCY RESTRAINT: PERSONAL RESTRAINTS: 2___ MECHANICAL RESTRAINTS: 1___ PSYCHOACTIVE MEDICATION: 0___ NUMBER OF RESTRAINT RELATED INJURIES: EMERGENCY PERSONAL RESTRAINTS: 1___ EMERGENCY MECHANICAL RESTRAINTS: 0___ EMERGENCY PSYCHOACTIVE MEDICATION: 0___ READY TO DELETE? _ (Y/N) ACT: ___ (600/COMPONENT DATA ENTRY, M/MENU)	• Type **Y** in the READY TO DELETE? field to submit the data to the system. • Press **Enter**. Result: The header screen is displayed with the message, *"Previous Information Deleted."*

Critical Incident Data: Inquiry (286) - TXHmL

Introduction

The **Critical Incident Data: Inquiry** option is used to view critical incident data based on the information reported on the **686: Critical Incident Data** screens.

The report can be displayed in one of three ways. You can:

- Request a complete report that includes both the summary of incidents reported for each contract and a list of contracts for which incidents were not reported.
- Request a report that includes only the summary.
- Request a report that includes a list of contracts for which incidents were not reported.

Requesting Reports

When you request a report and enter only the Component Code and Month and Year on the header screen:

- The first screen(s) will display critical incidents for each contract
- The second screen will display contracts that did not report
- The third screen will display the Total Number of Critical Incidents for all contracts that reported

If you enter the Component Code, Month and Year, and a specific Contract Number on the header screen and:

- If the contract ***reported*** incidents for the Component Code and Month and Year:
  - The first screen will display critical incidents for the contract
  - The second screen will display 0 number of contracts did not report
  - The third screen will display the **total number** of Critical Incidents for that contract
- If the contract ***did not report*** for the Component Code and Month and Year:
  - The first screen will not be displayed
  - The second screen will display that the contract did not report
  - The third screen will display the 0 totals for Critical Incidents for that contract

Procedure

The table below displays the steps taken to access the **286: Critical Incident Data: Inquiry** screen.

Step	View	Action
1	_ _	• Type **286** in the ACT: field of any screen. • Press **Enter**. Result: The **286: Critical Incident Data: Inquiry** header screen is displayed.
2	A sample **286: Critical Incident Data: Inquiry** header screen is shown below. 06-11-09 286:CRITICAL INCIDENT DATA: INQUIRY VC026530 PLEASE ENTER ONE OF THE FOLLOWING: COMPONENT CODE: 804 MONTH AND YEAR: 052009 (MMYYYY) ENTER IF DESIRED: CONTRACT NUMBER: _____ - OR - CONTRACT TYPE: X HCS _ TXHML _ ICF/MR _ GR OR (BLANK=ALL) SUMMARY ONLY?: N (Y/N) NOT REPORTED ONLY?: N (Y/N) PRINTER CODE: _____ (ENTER FOR HARD-COPY) *** PRESS ENTER *** ACT: ___ (C60/PROV INQUIRY MENU, A/MA MAIN MENU, HLP(PF1)/SCRN DOC)	Your component code is displayed based on your logon account number. • Type the month and year in the MONTH AND YEAR field. (MMYYYY format) • Type the contract number in the CONTRACT NUMBER field, or • Type an **X** beside the appropriate contract type. (HCS, TxHmL, ICF/MR, or GR) • Type **Y** in the SUMMARY ONLY field if you want a summary *only*. • Type **Y** in the NOT REPORTED ONLY field if you want a list of contracts for which incidents were not reported *only*. • Press **Enter**. Result: The **286: Critical Incident Data Inquiry** screen is displayed.

continued on next page

Procedure, continued

Step	View	Action
3	A sample **286: Critical Incident Data Inquiry** screen is shown below. The following sample screens display a complete report that includes a summary of total incidents reported, a list of contracts for which no incidents were reported, and a summary for the contract for which data was reported in our example. The system displays data entered for each contract.	The screen displays the data that was entered for each contract on the **686: Critical Incident Data** screens. This screen is accessed when you leave **N** (No) in the SUMMARY ONLY and the NOT REPORTED ONLY fields on the header screen.

```
06-23-09            286:CRITICAL INCIDENT DATA INQUIRY            VC026532

COMPONENT CODE/NAME: 804/EDUCARE COMMUNITY LIVING CORPORATION - TEXAS
INCIDENT MONTH/YEAR: 05/2009   DATE REPORTED: 06/23/2009   STATUS: ON TIME

       CONTRACT NUMBER: TXHML 001010110 EDUCARE COMMUNITY LIVING CORPORATION --
T

         BEHAVIOR INTERVENTION PLANS AUTHORIZING RESTRAINT:               5
                       TOTAL NUMBER OF MEDICATION ERRORS:               2
                          TOTAL NUMBER OF SERIOUS ERRORS:               1
                                                                      TOTAL
NBR. EMER. RESTRAINTS USED:      PERS. RESTRAINTS:                        6
                                 MECH. RESTRAINTS:                        2
                                PSYCH. RESTRAINTS:                        0
NBR. INDIV. REQ. EMERG.RESTRNT:  PERS. RESTRAINTS:                        2
                                 MECH. RESTRAINTS:                        1
                                PSYCH. RESTRAINTS:                        0
NBR. SER. INJ. DUE TO:     EMER. PERS. RESTRAINTS:                        1
                           EMER. MECH. RESTRAINTS:                        0
                          EMER. PSYCH. RESTRAINTS:                        0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06-23-09            286:CRITICAL INCIDENT DATA INQUIRY            VC026532
                       CONTRACTS NOT REPORTED - TXHML ONLY

COMPONENT CODE/NAME: 804 / EDUCARE COMMUNITY LIVING CORPORATION - TEXAS
INCIDENT MONTH/YEAR: 05/2009

            001010462  TXHML   EDUCARE COMMUNITY LIVING CORPORATION - T

 TOTAL NUMBER OF CONTRACTS NOT REPORTED:   1

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06-23-09            286:CRITICAL INCIDENT DATA INQUIRY            VC026532
                              SUMMARY - TXHML ONLY

COMPONENT CODE/NAME: 804/EDUCARE COMMUNITY LIVING CORPORATION - TEXAS
INCIDENT MONTH/YEAR: 05/2009          1 OF 2 CONTRACTS REPORTED

          BEHAVIOR INTERVENTION PLANS AUTHORIZING RESTRAINT:               5
                        TOTAL NUMBER OF MEDICATION ERRORS:               2
                           TOTAL NUMBER OF SERIOUS ERRORS:               1
                                                                      TOTAL
NBR. EMER. RESTRAINTS USED:      PERS. RESTRAINTS:                        6
                                 MECH. RESTRAINTS:                        2
                                PSYCH. RESTRAINTS:                        0
NBR. INDIV. REQ. EMERG.RESTRNT:  PERS. RESTRAINTS:                        2
                                 MECH. RESTRAINTS:                        1
                                PSYCH. RESTRAINTS:                        0
NBR. SER. INJ. DUE TO:     EMER. PERS. RESTRAINTS:                        1
                           EMER. MECH. RESTRAINTS:                        0
                          EMER. PSYCH. RESTRAINTS:                        0


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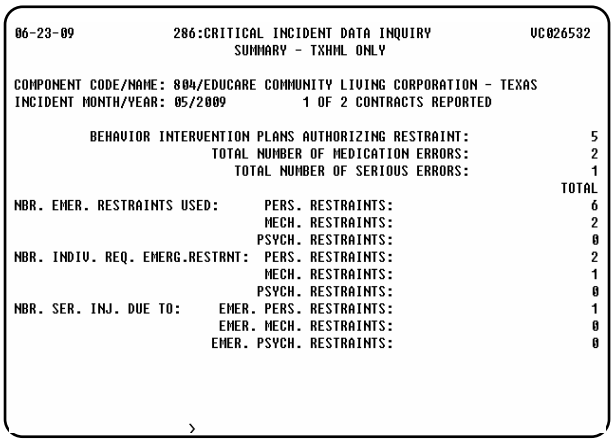
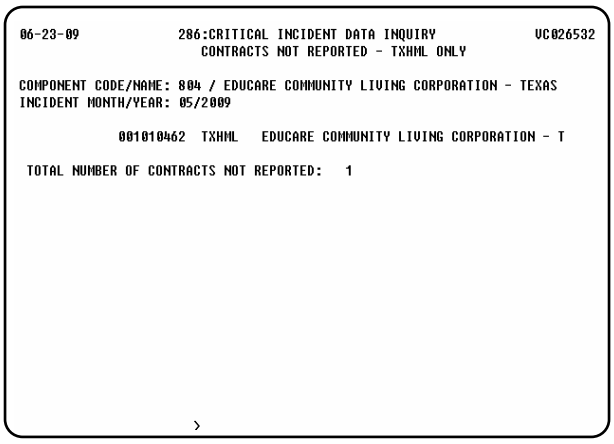
Procedure, continued

Step	View	Action
3, cont.	The following sample screen displays a report that includes only the summary. 	This screen is accessed when you type **Y** (Yes) in the SUMMARY ONLY field and **N** (No) in the NOT REPORTED ONLY fields on the header screen.
	The following sample screen displays a report that includes a list of contracts for which incidents were not reported. 	This screen is accessed when you type **N** (No) in the SUMMARY ONLY field and **Y** (Yes) in the NOT REPORTED ONLY fields on the header screen.

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MRA/MHA Contacts (L28)

Introduction

The *MRA/MHA Contacts* process allows the Mental Retardation Authority (MRA) to add, change or delete MRA contact information. The process is used to specify contact persons with whom the waiver program providers can communicate and designate a sequence and description regarding those contacts for program issues or questions.

A program provider can use **C87: MRA Contacts: Inquiry** to view available contact information.

Sequencing

When adding or changing MRA contact information, the MRA can assign a sequence number to the contact that is being added or changed.

The sequence order is designed in a five-number progression so that a particular contact can be placed between the previously assigned contacts. For example, if the progression is 5, 10, and 15, the contact being added or changed can be assigned a sequence number of **8** so that it will fall between the 5 and 10 positions. The system then reorders the numbers to a new five-number progression.

MRA/MHA Contacts (L28): Add

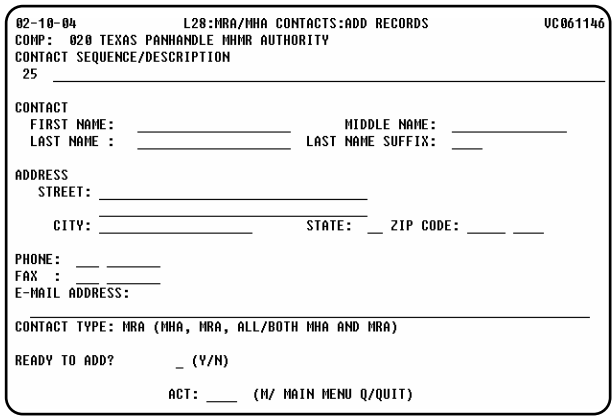
Procedure

The following table describes the steps the MRA will use to add MRA contact information.

Step	View	Action
1	_ _	• Type **L28** in the ACT: field of any screen. • Press **Enter**. Result: The **L28: MRA/MHA Contacts: Add/Change/Delete** header screen is displayed.
2	A sample **L28: MRA/MHA Contacts: Add/Change/ Delete** header screen is shown below. 02-10-04 L28: MRA/MHA CONTACTS:ADD/CHANGE/DELETE VC061140 PLEASE ENTER THE FOLLOWING: COMP: ___ CONTACT TYPE: ___ (MHA/MRA) TYPE OF ENTRY: _ (A/ADD,C/CHANGE,D/DELETE) *** PRESS ENTER *** ACT: ___ (M/ MAIN MENU, Q/QUIT)	• Type the MRA component code in the COMP field. • Type **MRA** in the CONTACT TYPE field. • Type **A** (Add) in the TYPE OF ENTRY field. • Press **Enter**. Result: The **L28: MRA/MHA Contacts: Add Records** screen is displayed.
3	A sample **L28: MRA/MHA Contacts: Add Records** screen is shown below. 02-10-04 L28:MRA/MHA CONTACTS:ADD RECORDS VC061145 COMP: 020 TEXAS PANHANDLE MHMR AUTHORITY SEQUENCE/TYPE/CONTACT DESCRIPTION 5 MRA ICFMR 10 MRA ICFMR 15 MRA ICFMR/HCS 20 MRA MRA/MRLA READY TO CONTINUE? _ (Y/N) ACT: ___ (M/MAIN MENU, Q/QUIT)	• View the sequence/type/contact description information. • Type **Y** (Yes) in the READY TO CONTINUE? field. • Press **Enter**. Result: The **L28: MRA/MHA Contacts: Add Records** (Screen 2) is displayed.

continued on next page

Procedure, continued

Step	View	Action
4	A sample **L28: MRA/MHA Contacts: Add Records** (Screen 2) is shown below.  02-10-04 L28:MRA/MHA CONTACTS:ADD RECORDS VC061146 COMP: 020 TEXAS PANHANDLE MHMR AUTHORITY CONTACT SEQUENCE/DESCRIPTION 25 CONTACT FIRST NAME: MIDDLE NAME: LAST NAME : LAST NAME SUFFIX: ADDRESS STREET: CITY: STATE: ZIP CODE: PHONE: FAX : E-MAIL ADDRESS: CONTACT TYPE: MRA (MHA, MRA, ALL/BOTH MHA AND MRA) READY TO ADD? _ (Y/N) ACT: (M/ MAIN MENU Q/QUIT)	• View the contact sequence number displayed, and, if necessary, type the appropriate contact sequence number for the contact you are adding in the CONTACT SEQUENCE field. • Type the contact description in the DESCRIPTION field. • Type the contact person's name information in the **Contact** fields. • Type the contact person's address information in the **Address** fields. • Type the contact person's area code and telephone number in the PHONE fields. Note: Fax and e-mail address information can also be entered for the contact you are adding. • Type **Y** in the READY TO ADD? field. Note: You can type **N** in the READY TO ADD? field to take no action and return to the header screen. • Press **Enter**. Result: The **L28: MRA/MHA Contacts** header screen is displayed with the message, *"Previous Information Added."*

MRA/MHA Contacts (L28): Change

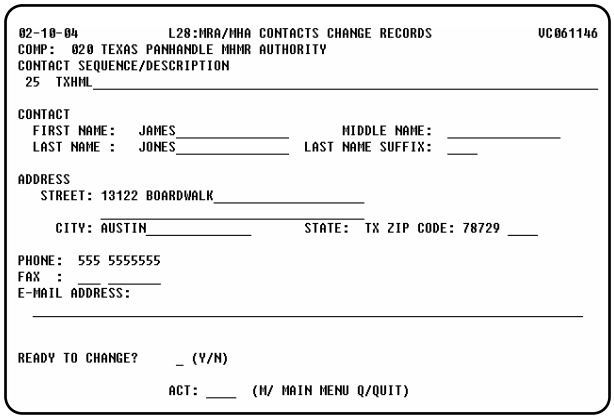
Procedure

The following table describes the steps the MRA will use to change MRA contact information.

Step	View	Action
1	_ _	• Type **L28** in the ACT: field of any screen. • Press **Enter**. Result: The **L28: MRA/MHA Contacts: Add/Change/Delete** header screen is displayed.
2	A sample **L28: MRA/MHA Contacts: Add/Change/ Delete** header screen is shown below. 02-10-04 L28: MRA/MHA CONTACTS:ADD/CHANGE/DELETE VC061140 PLEASE ENTER THE FOLLOWING: COMP: ___ CONTACT TYPE: ___ (MHA/MRA) TYPE OF ENTRY: _ (A/ADD,C/CHANGE,D/DELETE) *** PRESS ENTER *** ACT: ___ (M/ MAIN MENU, Q/QUIT)	• Type the MRA component code in the COMP field. • Type **MRA** in the CONTACT TYPE field. • Type **C** (Change) in the TYPE OF ENTRY field. • Press **Enter**. Result: The **L28: MRA/MHA Contacts Change Records** screen is displayed.
3	A sample **L28: MRA/MHA Contacts Change Records** screen is shown below. 02-10-04 L28:MRA/MHA CONTACTS CHANGE RECORDS VC061145 COMP: 020 TEXAS PANHANDLE MHMR AUTHORITY SELECT/SEQUENCE/TYPE/CONTACT DESCRIPTION _ 5 MRA ICFMR _ 10 MRA ICFMR _ 15 MRA ICFMR/HCS _ 20 MRA MRA/MRLA _ 25 MRA TXHML X-SELECT RECORD TO BE CHANGED READY TO SELECT? _ (Y/N) ACT: ___ (M/MAIN MENU, Q/QUIT)	• View the sequence/type/contact description information. • Type **X** in the SELECT field next to the record to be changed. • Type **Y** in the READY TO SELECT? field. • Press **Enter**. Result: The **L28: MRA/MHA Contacts Change Records** (Screen 2) is displayed.

continued on next page

Procedure, continued

Step	View	Action
4	A sample **L28: MRA/MHA Contacts Change Records** (Screen 2) is shown below.  02-10-04 L28:MRA/MHA CONTACTS CHANGE RECORDS VC061146 COMP: 020 TEXAS PANHANDLE MHMR AUTHORITY CONTACT SEQUENCE/DESCRIPTION 25 TXHML CONTACT FIRST NAME: JAMES MIDDLE NAME: LAST NAME : JONES LAST NAME SUFFIX: ADDRESS STREET: 13122 BOARDWALK CITY: AUSTIN STATE: TX ZIP CODE: 78729 PHONE: 555 5555555 FAX : E-MAIL ADDRESS: READY TO CHANGE? _ (Y/N) ACT: ___ (M/ MAIN MENU Q/QUIT)	• View the current information on the contact record selected. • Type any changes in the appropriate fields. • Type **Y** in the READY TO CHANGE? field. Note: You can type **N** in the READY TO CHANGE? field to take no action and return to the header screen. • Press **Enter**. Result: The **L28: MRA/MHA Contacts** header screen is displayed with the message, *"Previous Information Changed."*

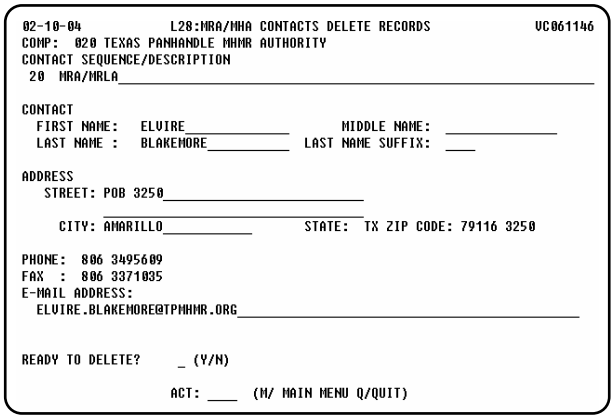
MRA/MHA Contacts (L28): Delete

Procedure — The following table describes the steps the MRA will use to delete MRA contact information.

Step	View	Action
1	_ _	• Type **L28** in the ACT: field of any screen. • Press **Enter**. Result: The **L28: MRA/MHA Contacts: Add/Change/Delete** header screen is displayed.
2	A sample **L28: MRA/MHA Contacts: Add/Change/ Delete** header screen is shown below. 02-10-04 L28: MRA/MHA CONTACTS:ADD/CHANGE/DELETE VC061140 PLEASE ENTER THE FOLLOWING: COMP: ___ CONTACT TYPE: ___ (MHA/MRA) TYPE OF ENTRY: _ (A/ADD,C/CHANGE,D/DELETE) *** PRESS ENTER *** ACT: ___ (M/ MAIN MENU, Q/QUIT)	• Type the MRA component code in the COMP field. • Type **MRA** in the CONTACT TYPE field. • Type **D** (Delete) in the TYPE OF ENTRY field. • Press **Enter**. Result: The **L28: MRA/MHA Contacts Delete Records** screen is displayed.
3	A sample **L28: MRA/MHA Contacts Delete Records** screen is shown below. 02-10-04 L28:MRA/MHA CONTACTS DELETE RECORDS VC061145 COMP: 020 TEXAS PANHANDLE MHMR AUTHORITY SELECT/SEQUENCE/TYPE/CONTACT DESCRIPTION _ 5 MRA ICFMR _ 10 MRA ICFMR _ 15 MRA ICFMR/HCS _ 20 MRA MRA/MRLA X-SELECT RECORD TO BE DELETED READY TO SELECT? _ (Y/N) ACT: ___ (M/MAIN MENU, Q/QUIT)	• View the sequence/type/contact description information. • Type **X** in the SELECT field next to the record to be deleted. • Type **Y** in the READY TO SELECT? field. • Press **Enter**. Result: The **L28: MRA/MHA Contacts Delete Records** (Screen 2) is displayed.

continued on next page

Procedure, continued

Step	View	Action
4	A sample **L28: MRA/MHA Contacts Delete Records** (Screen 2) is shown below.  02-10-04 L28:MRA/MHA CONTACTS DELETE RECORDS VC061146 COMP: 020 TEXAS PANHANDLE MHMR AUTHORITY CONTACT SEQUENCE/DESCRIPTION 20 MRA/MRLA CONTACT FIRST NAME: ELVIRE MIDDLE NAME: LAST NAME : BLAKEMORE LAST NAME SUFFIX: ADDRESS STREET: POB 3250 CITY: AMARILLO STATE: TX ZIP CODE: 79116 3250 PHONE: 806 3495609 FAX : 806 3371035 E-MAIL ADDRESS: ELVIRE.BLAKEMORE@TPMHMR.ORG READY TO DELETE? _ (Y/N) ACT: ___ (M/ MAIN MENU Q/QUIT)	• View the current information on the contact record selected. • Type **Y** in the READY TO DELETE? field. Note: You can type **N** in the READY TO DELETE? field to take no action and return to the header screen. • Press **Enter**. Result: The **L28: MRA/MHA Contacts** header screen is displayed with the message, *"Previous Information Deleted."*

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Permanency Planning Review (309) - HCS

Introduction

The Mental Retardation Authority (MRA) is responsible for completing and data entering permanency plans (initial plan and subsequent plans every six months) for those individuals who are less than 22 years of age and who live in a State School, Community ICF-MR, Nursing Facility or a 3- or 4-person residence, and receive Supervised Living or Residential Support services in the Home and Community based (HCS) Program.

The *Permanency Planning Review* process allows an MRA to add, change, or delete an individual's initial and subsequent permanency plans.

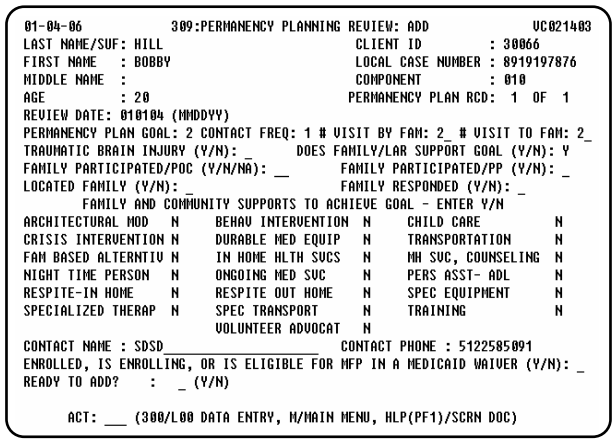
Permanency Planning Review (309): Add

Procedure — The following table describes the steps the MRA will use to add initial and subsequent permanency plans for an individual.

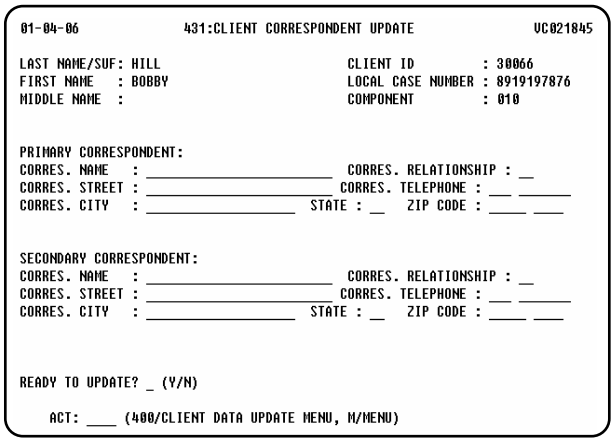
Step	View	Action
1	_ _	• Type **309** in the ACT: field of any screen. • Press **Enter**. Result: The **309: Permanency Planning Review: Add/Change/Delete** header screen is displayed.
2	A sample **309: Permanency Planning Review: Add/ Change/Delete** header screen is shown below. 01-04-06 309:PERMANENCY PLANNING REVIEW: ADD/CHANGE/DELETE VC021402 *** THIS SCREEN USED ONLY FOR PLANS DATED 9/1/05 OR GREATER *** PLEASE ENTER ONE OF THE FOLLOWING: CLIENT ID: _____ COMPONENT CODE/LOCAL CASE NUMBER: __ / _____ PLEASE ENTER THE FOLLOWING: TYPE OF ENTRY: _ (A/ADD,C/CHANGE,D/DELETE) *** PRESS ENTER *** ACT: __ (300/L00 DATA ENTRY, M/MAIN MENU, HLP(PF1)/SCRN DOC)	• Type the MRA component code in the COMPONENT CODE field. • Type the individual's local case number in the LOCAL CASE NUMBER field. • Type **A** (Add) in the TYPE OF ENTRY field. • Press **Enter**. Result: The **309: Permanency Planning Review: Add** screen is displayed.

continued on next page

Procedure, continued

Step	View	Action
3	A sample **309: Permanency Planning Review: Add** screen is shown below.  01-04-06 309:PERMANENCY PLANNING REVIEW: ADD VC021403 LAST NAME/SUF: HILL CLIENT ID : 30066 FIRST NAME : BOBBY LOCAL CASE NUMBER : 8919197876 MIDDLE NAME : COMPONENT : 010 AGE : 20 PERMANENCY PLAN RCD: 1 OF 1 REVIEW DATE: 010104 (MMDDYY) PERMANENCY PLAN GOAL: 2 CONTACT FREQ: 1 # VISIT BY FAM: 2_ # VISIT TO FAM: 2_ TRAUMATIC BRAIN INJURY (Y/N): _ DOES FAMILY/LAR SUPPORT GOAL (Y/N): Y FAMILY PARTICIPATED/POC (Y/N/NA): __ FAMILY PARTICIPATED/PP (Y/N): _ LOCATED FAMILY (Y/N): _ FAMILY RESPONDED (Y/N): _ FAMILY AND COMMUNITY SUPPORTS TO ACHIEVE GOAL - ENTER Y/N ARCHITECTURAL MOD N BEHAV INTERVENTION N CHILD CARE N CRISIS INTERVENTION N DURABLE MED EQUIP N TRANSPORTATION N FAM BASED ALTERNTIV N IN HOME HLTH SVCS N MH SVC, COUNSELING N NIGHT TIME PERSON N ONGOING MED SVC N PERS ASST- ADL N RESPITE-IN HOME N RESPITE OUT HOME N SPEC EQUIPMENT N SPECIALIZED THERAP N SPEC TRANSPORT N TRAINING N VOLUNTEER ADVOCAT N CONTACT NAME : SDSD_____ CONTACT PHONE : 5122585091 ENROLLED, IS ENROLLING, OR IS ELIGIBLE FOR MFP IN A MEDICAID WAIVER (Y/N): _ READY TO ADD? : _ (Y/N) ACT: __ (300/L00 DATA ENTRY, M/MAIN MENU, HLP(PF1)/SCRN DOC)	• Type the date of the individual's permanency planning review in the REVIEW DATE field. • Type the code indicating the permanency plan goal in the PERMANENCY PLAN GOAL field. • Type the code indicating the frequency of parent/guardian contact with the individual during the last six months in the CONTACT FREQ field. • Type the number of visits to the facility by the parent/guardian in the # VISIT BY FAM field. • Type the number of the resident's visits to the home in the # VISIT TO FAM field. • Type **Y** (Yes) or **N** (No) to indicate whether the person has a history of traumatic brain injury in the TRAUMATIC BRAIN INJURY field. • Type **Y** (Yes) or **N** (No) to indicate whether the family/LAR supports the goal in the DOES FAMILY/LAR SUPPORT GOAL field. • Type **Y** (Yes), **N** (No), or **NA** (Not Applicable) to indicate whether the family/LAR participated in the initial or annual meeting to discuss the Plan of Care in the FAMILY PARTICIPATED/POC field. • Type **Y** (Yes) or **N** (No) to indicate whether the family/LAR participated in this initial or review of the permanency plan in the FAMILY PARTICIPATED/PP field. • Type **Y** (Yes) or **N** (No) to indicate whether the family could be located when needed within the last six months in the LOCATED FAMILY field. • Type **Y** (Yes) or **N** (No) to indicate whether the family/LAR responded to requests to participate in permanency planning meetings within the last six months in the FAMILY RESPONDED field. • Type **Y** (Yes) or **N** (No) or **leave blank** for each Family and Community Support. Note: The **Family and Community Supports to Achieve Goal** section of the screen is not required for individuals 18 to 21 years of age with a Permanency Plan Goal of **4**. • Type the name of the permanency planning staff contact in the CONTACT NAME field. • Type the permanency planning staff contact person's telephone number in the CONTACT PHONE field. • Type **Y** (Yes) or **N** (No) to indicate if the individual is enrolled or enrolling in any Medicaid Waiver or is currently living in a nursing home and has access to a Medicaid waiver in the ENROLLED, IS ENROLLING, OR IS ELIGIBLE FOR MFP IN A MEDICAID WAIVER field. • Type **Y** in the READY TO ADD? field. Note: You can type **N** in the READY TO ADD? field to take no action and return to the header screen. • Press **Enter**. Result: The **431: Client Correspondent Update** screen is displayed.

Procedure, continued

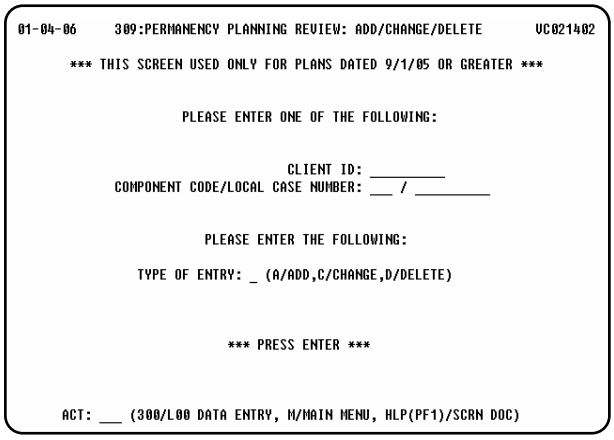
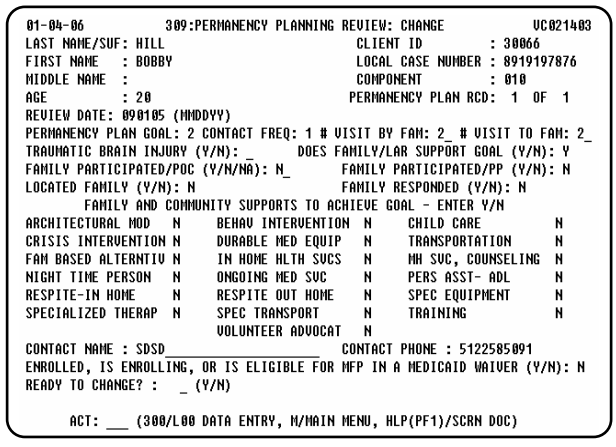
Step	View	Action
4	A sample **431: Client Correspondent Update** screen is shown below.  01-04-06 431:CLIENT CORRESPONDENT UPDATE VC021845 LAST NAME/SUF: HILL CLIENT ID : 30066 FIRST NAME : BOBBY LOCAL CASE NUMBER : 8919197876 MIDDLE NAME : COMPONENT : 010 PRIMARY CORRESPONDENT: CORRES. NAME : _____ 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)	• Type primary and secondary correspondent information as appropriate. • Type **Y** in the READY TO UPDATE? field. Note: You can type **N** in the READY TO UPDATE? field to take no action and return to the header screen. • Press **Enter**. Result: The header screen is displayed with the message, *"Previous Information Changed."*

Permanency Planning Review (309): Change

Procedure

The following table describes the steps the MRA will use to change an individual's initial and subsequent permanency plans.

Note: The MRA can only change plans that *have not been approved or denied*.

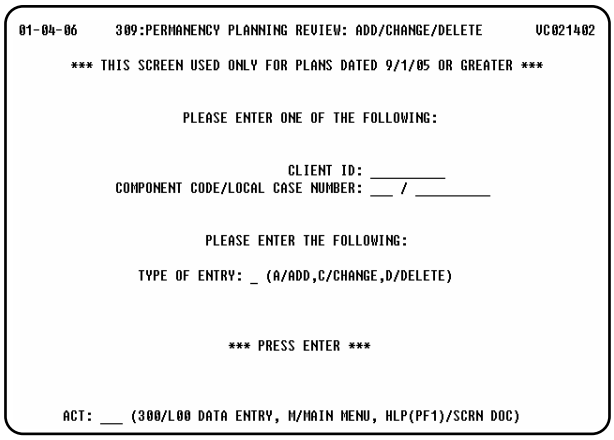
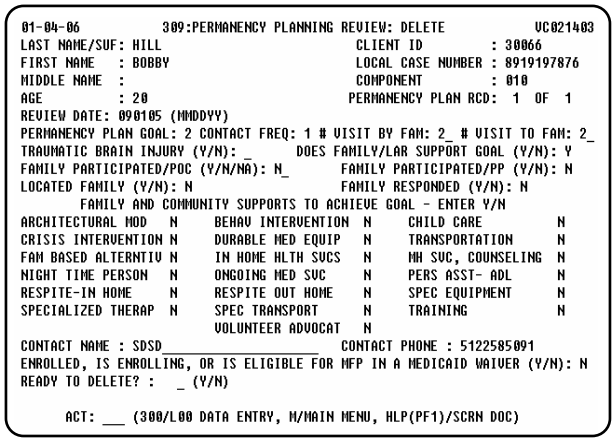
Step	View	Action
1	_ _	• Type **309** in the ACT: field of any screen. • Press **Enter**. Result: The **309: Permanency Planning Review: Add/Change/Delete** header screen is displayed.
2	A sample **309: Permanency Planning Review: Add/ Change/Delete** header screen is shown below.  01-04-06 309:PERMANENCY PLANNING REVIEW: ADD/CHANGE/DELETE VC021402 *** THIS SCREEN USED ONLY FOR PLANS DATED 9/1/05 OR GREATER *** PLEASE ENTER ONE OF THE FOLLOWING: CLIENT ID: _____ COMPONENT CODE/LOCAL CASE NUMBER: __ / _____ PLEASE ENTER THE FOLLOWING: TYPE OF ENTRY: _ (A/ADD,C/CHANGE,D/DELETE) *** PRESS ENTER *** ACT: __ (300/L00 DATA ENTRY, M/MAIN MENU, HLP(PF1)/SCRN DOC)	• Type the MRA component code in the COMPONENT CODE field. • Type the individual's local case number in the LOCAL CASE NUMBER field. • Type **C** (Change) in the TYPE OF ENTRY field. • Press **Enter**. Result: The **309: Permanency Planning Review: Change** screen is displayed.
3	A sample **309: Permanency Planning Review: Change** screen is shown below.  01-04-06 309:PERMANENCY PLANNING REVIEW: CHANGE VC021403 LAST NAME/SUF: HILL CLIENT ID : 30066 FIRST NAME : BOBBY LOCAL CASE NUMBER : 8919197876 MIDDLE NAME : COMPONENT : 010 AGE : 20 PERMANENCY PLAN RCD: 1 OF 1 REVIEW DATE: 090105 (MMDDYY) PERMANENCY PLAN GOAL: 2 CONTACT FREQ: 1 # VISIT BY FAM: 2_ # VISIT TO FAM: 2_ TRAUMATIC BRAIN INJURY (Y/N): _ DOES FAMILY/LAR SUPPORT GOAL (Y/N): Y FAMILY PARTICIPATED/POC (Y/N/NA): N_ FAMILY PARTICIPATED/PP (Y/N): N LOCATED FAMILY (Y/N): N FAMILY RESPONDED (Y/N): N FAMILY AND COMMUNITY SUPPORTS TO ACHIEVE GOAL - ENTER Y/N ARCHITECTURAL MOD N BEHAV INTERVENTION N CHILD CARE N CRISIS INTERVENTION N DURABLE MED EQUIP N TRANSPORTATION N FAM BASED ALTERNTIV N IN HOME HLTH SVCS N MH SVC, COUNSELING N NIGHT TIME PERSON N ONGOING MED SVC N PERS ASST- ADL N RESPITE-IN HOME N RESPITE OUT HOME N SPEC EQUIPMENT N SPECIALIZED THERAP N SPEC TRANSPORT N TRAINING N VOLUNTEER ADVOCAT N CONTACT NAME : SDSD_____ CONTACT PHONE : 5122585091 ENROLLED, IS ENROLLING, OR IS ELIGIBLE FOR MFP IN A MEDICAID WAIVER (Y/N): N READY TO CHANGE? : _ (Y/N) ACT: __ (300/L00 DATA ENTRY, M/MAIN MENU, HLP(PF1)/SCRN DOC)	• Type changes to the permanency plan in the appropriate fields. • Type **Y** in the READY TO CHANGE? field to submit the data to the system. Note: You can type **N** in the READY TO CHANGE? field to take no action and return to the header screen. • Press **Enter**. Result: The header screen is displayed with the message, *"Previous Information Changed."*

Permanency Planning Review (309): Delete

Procedure

The following table describes the steps the MRA will use to delete an individual's initial and subsequent permanency plans.

Note: The MRA can only delete plans that *have not been approved or denied*.

Step	View	Action
1	_ _	• Type **309** in the ACT: field of any screen. • Press **Enter**. Result: The **309: Permanency Planning Review**: **Add/Change/Delete** header screen is displayed.
2	A sample **309: Permanency Planning Review: Add/ Change/Delete** header screen is shown below. 	• Type the MRA component code in the COMPONENT CODE field. • Type the individual's local case number in the LOCAL CASE NUMBER field. • Type **D** (Delete) in the TYPE OF ENTRY field. • Press **Enter**. Result: The **309: Permanency Planning Review: Delete** screen is displayed.
3	A sample **309: Permanency Planning Review: Delete** screen is shown below. 	• Type **Y** in the READY TO DELETE? field to submit the data to the system. Note: You can type **N** in the READY TO DELETE? field to take no action and return to the header screen. • Press **Enter**. Result: The header screen is displayed with the message, *"Previous Information Deleted."*

Consumer Discharge

Introduction

The *Consumer Discharge* process allows the Mental Retardation Authority (MRA) to review and acknowledge the provider's termination of waiver services (permanent discharge) for an individual from the HCS or TxHmL waiver program and enter suspension of waiver services (temporary discharge) for individuals who are self-directing all their services.

Termination of Waiver Services

A termination of waiver services is the termination of enrollment for an individual because the individual is unable or unavailable to receive services.

For termination of waiver services, the provider must complete the **C18: Consumer Discharge** screen and the MRA must complete the **L18: Consumer Discharge** screen *after* **C18** is completed by the provider. ***If there is no program provider***, the MRA must complete both the **C18: Consumer Discharge** and **L18: Consumer Discharge** screens.

The MRA's Service Coordinator *must* fax a copy of the following forms to Program Enrollment after the termination of waiver services staffing occurs and the provider and the MRA have completed the data entry.

For Termination of Waiver Services...	Send the...
due to death	Notification of *Termination of Waiver Services* form. *Indicate* **CLIENT DEATH** *and the specific circumstances of the death in the Comments section.*
for reasons other than death	• Termination of Waiver Services form, • Discharge Staffing Summary, and • Freedom of Choice form.

Suspension of Waiver Services

A suspension of waiver services is the temporary suspension of services to the individual by the provider while the individual is unable or unavailable to receive services.
Data entry is only required by the MRA for suspension of waiver services if the individual is self-directing all their services.

An individual who is on temporary discharge can be transferred directly to the new contract. The temporary discharge *should not be ended* prior to the entry of **L06** by the MRA.

Consumer Discharge (C18)

Procedure

The following table describes the steps the MRA will use to terminate waiver services for an individual from the HCS or TxHmL waiver program if there is **no** program provider.

Step	View	Action
1	_ _	• Type **C18** in the ACT: field of any screen. • Press **Enter**. Result: The **C18: Consumer Discharge** header screen is displayed.
2	A sample **C18: Consumer Discharge** header screen is shown below. 01-22-08 C18:CONSUMER DISCHARGE: ADD/CHANGE/DELETE VC060500 PLEASE ENTER ONE OF THE FOLLOWING: CLIENT ID: _____ COMPONENT CODE/LOCAL CASE NUMBER: __ / _____ MEDICAID NUMBER: _____ PLEASE ENTER THE FOLLOWING: TYPE OF DISCHARGE: _ (P/PERMANENT,T/TEMPORARY) TYPE OF ENTRY: _ (A/ADD,C/CHANGE,D/DELETE) *** PRESS ENTER *** ACT: ___ (C00/HCS DATA ENTRY MENU, A/HCS MAIN MENU, HLP(PF1)/SCRN DOC)	• Type the requested identifying information in the appropriate fields. Rule: You must enter the Client ID, the local case number, *or* the Medicaid number. • Type the provider's component code in the COMPONENT CODE field. • Type **P** (Permanent) in the TYPE OF DISCHARGE field. • Type **A** (Add) in the TYPE OF ENTRY field. • Press **Enter**. Result: The **C18: Consumer Discharge** screen is displayed.
3	A sample **C18: Consumer Discharge: Add** screen is shown below. 01-22-08 C18:CONSUMER DISCHARGE: ADD VC060505 NAME : MOUNTAIN, ROCKY CLIENT ID : 18023509 MEDICAID NUMBER: 546789123 CONTRACT NUMBER: 001010110 LOCAL CASE NUMBER: 0008045555 COMPONENT: 804 CONTRACT NUMBER: 001007044 CDS LOCAL CASE NUMBER: 0003005555 COMPONENT: 300 SERVICE COUNTY : 057 DALLAS DISCHARGE TYPE : PERMANENT PROVIDER REPRESENTATIVE NAME: _____ DATE: 01222008 DISCHARGE DATE : _____ (MMDDYYYY) DID CONSUMER RECEIVE SERVICES ON DISCHARGE DATE?: _ (Y/N) TERMINATION REASON: __ 1. LOSS OF MEDICAID ELIGIBILITY 8. DEATH 2. LOSS OF ICF/MR LOC ELIGIBILITY 9. UNABLE TO MEET HEALTH/WELFARE NEEDS 3. IPC EXCEEDS COST CEILING 10. REFUSAL TO COOPERATE (TXHML ONLY) 4. VOLUNTARY WITHDRAWAL BY CONSUMER 11. QUALIFIES FOR LON 9 (TXHML ONLY) 6. INSTITUTIONALIZATION 12. NO LONGER LIVES IN OHFH (TXHML ONLY) 7. CLIENT CANNOT BE LOCATED (PRESS PF1 TO SEE FULL DESCRIPTION) IF REASON IS DEATH: DATE OF DEATH: _____ TIME OF DEATH: ____ (HHMMA/P) READY TO ADD?: _ (Y/N) ACT: ___ (C00/HCS DATA ENTRY MENU, A/HCS MAIN MENU, HLP(PF1)/SCRN DOC)	• Type the name of the provider representative in the PROVIDER REPRESENTATIVE NAME field. • Type the termination date in the DISCHARGE DATE field. • Type **Y** (Yes) or **N** (No) in the DID CONSUMER RECEIVE SERVICES ON DISCHARGE DATE? field. • Type the number representing the termination reason in the TERMINATION REASON field. ***If the reason of discharge is death***: • Type the date of death in the DATE OF DEATH field. • Type the time of death in the TIME OF DEATH field. (HHMMA/P format) • Type **Y** in the READY TO ADD? field. Note: You can type **N** in the READY TO UPDATE? field to take no action and return to the header screen. • Press **Enter**. Result: The **C18: Consumer Discharge** header screen is displayed with the message, *"Previous Information Added."*

Consumer Discharge (L18)

Procedure

The following table describes the steps the MRA will use to review an individual's termination of waiver services from the HCS or TxHmL waiver programs.

Step	View	Action
1	_ _	• Type **L18** in the ACT: field of any screen. • Press **Enter**. Result: The **L18: Consumer Discharge header screen** is displayed.
2	A sample **L18: Consumer Discharge** header screen is shown below. 01-22-08 L18:CONSUMER DISCHARGE VC060336 PLEASE ENTER ONE OF THE FOLLOWING: CLIENT ID: _____ COMPONENT CODE/LOCAL CASE NUMBER: __ / _____ MEDICAID NUMBER: _____ *** PRESS ENTER *** ACT: ___ (L00/AUTH DATA ENTRY MENU, A/MA MAIN MENU, HLP(PF1)/SCRN DOC)	• Type the requested identifying information in the appropriate fields. Rule: You must enter the Client ID, the local case number, *or* the Medicaid number. • Type the provider's component code in the COMPONENT CODE field. • Press **Enter**. Result: The **L18: Consumer Discharge** screen is displayed.
3	A sample **L18: Consumer Discharge s**creen is shown below. 01-22-08 L18:CONSUMER DISCHARGE VC060337 NAME : MOUNTAIN, ROCKY CLIENT ID : 18023589 MEDICAID NUMBER: 546789123 CONTRACT NUMBER: 001010110 LOCAL CASE NUMBER: 0008045555 COMPONENT: 804 CONTRACT NUMBER: 001007044 CDS LOCAL CASE NUMBER: 0003005555 COMPONENT: 300 PROVIDER REPRESENTATIVE NAME: JANE DOE DATE: 01-22-2008 SERVICE COUNTY : 057 DALLAS REQUESTED DISCHARGE DATE: 01-20-2008 SERVICES PROVIDED THROUGH: 01-19-2008 TERMINATION REASON: DEATH DATE OF DEATH: 01-20-2008 TIME OF DEATH: 0145P TERMINATION REVIEWED?: BY: _____ DATE: _____ (MMDDYYYY) EFFECTIVE DATE OF DISCHARGE: 01-20-2008 READY TO UPDATE? _ (Y/N) ACT: __ (L00/AUTH DATA ENTRY MENU, A/MA MAIN MENU, HLP(PF1)/SCRN DOC)	• Type the name of the MRA Representative in the BY: field. • Type the date the termination was reviewed in the DATE field. • Type **Y** in the READY TO UPDATE? field. Note: You can type **N** in the READY TO UPDATE? field to take no action and return to the header screen. • Press **Enter**. Result: The **L18: Consumer Discharge** header screen is displayed with the message, *"Previous Information Changed."*

Reminder: After the termination of waiver services staffing occurs and the provider and the MRA have completed the data entry, the Service Coordinator must fax to Program Enrollment a copy of the Notification of Termination of Waiver Services form, and the Discharge Meeting Summary.

Consumer Discharge (C18): Add (Suspension of Waiver Services)

Procedure

The following table describes the steps an MRA will use to enter an individual's suspension of waiver services if the individual is self-directing all their services.

Step	View	Action
1	_ _	• Type **C18** in the ACT: field of any screen. • Press **Enter**. Result: The **C18: Consumer Discharge: Add/ Change/Delete** header screen is displayed.
2	A sample **C18: Consumer Discharge: Add/Change/ Delete** header screen is shown below. 01-22-08 C18:CONSUMER DISCHARGE: ADD/CHANGE/DELETE VC060500 PLEASE ENTER ONE OF THE FOLLOWING: CLIENT ID: _____ COMPONENT CODE/LOCAL CASE NUMBER: __ / _____ MEDICAID NUMBER: _____ PLEASE ENTER THE FOLLOWING: TYPE OF DISCHARGE: _ (P/PERMANENT,T/TEMPORARY) TYPE OF ENTRY: _ (A/ADD,C/CHANGE,D/DELETE) *** PRESS ENTER *** ACT: ___ (C00/HCS DATA ENTRY MENU, A/HCS MAIN MENU, HLP(PF1)/SCRN DOC)	• Type the requested identifying information in the appropriate fields. Rule: You must enter the Client ID, the local case number, *or* the Medicaid number. Note: Your component code is displayed based on your logon account number. • Type **T** (Temporary) in the TYPE OF DISCHARGE field. • Type **A** (Add) in the TYPE OF ENTRY field • Press **Enter**. Result: The **C18: Consumer Discharge: Add** screen is displayed.

continued on next page

Procedure, continued

<table>
<tr><th>Step</th><th>View</th><th>Action</th></tr>
<tr>
<td>3</td>
<td>A sample C18: Consumer Discharge: Add screen is shown below.
<pre>
01-29-08   C18:CONSUMER DISCHARGE: ADD   VC060505
NAME   : MOUNTAIN, ROCKY   CLIENT ID   : 18023509
MEDICAID NUMBER: 732402003
CONTRACT NUMBER: 001007199 CDS LOCAL CASE NUMBER: 73248JH004 COMPONENT: 8JH
CONTRACT NUMBER: LOCAL CASE NUMBER: COMPONENT:
SERVICE COUNTY : 006 ARMSTRONG   DISCHARGE TYPE   : TEMPORARY
PROVIDER REPRESENTATIVE NAME: _____________________________ DATE: 01292008
DISCHARGE BEGIN DATE: _______ (MMDDYYYY)   END DATE: _______ (MMDDYYYY)
RETURN TO LOCATION : ___   COUNTY: __ (OWN/FAMILY HOME ONLY)
PROJECTED RETURN DATE   : _______ (MMDDYYYY)
DID CONSUMER RECEIVE SERVICES ON DISCHARGE BEGIN DATE?: _ (Y/N)
TERMINATION REASON: __
 1. LOSS OF FINANCIAL ELIGIBILITY   7. INCARCERATION
 2. HOSPITALIZATION(MEDICAL)   8. STATE SCHOOL
 3. ELOPEMENT(UNABLE TO LOCATE)   9. NURSING FACILITY
 4. CRISIS STABILIZATION
 5. HOSPITALIZATION(PSYCHIATRIC)
 6. VACATION/FURLOUGH

  READY TO ADD?: _ (Y/N)

 ACT: ___ (C00/HCS DATA ENTRY MENU, A/HCS MAIN MENU, HLP(PF1)/SCRN DOC)
</pre>
</td>
<td>
• Type the name of the provider representative in the PROVIDER REPRESENTATIVE NAME field.
• Type the suspension of waiver services begin date in the DISCHARGE BEGIN DATE field.
• Type the projected return date in the PROJECTED RETURN DATE field.
• Type Y (Yes) or N (No) in the DID CONSUMER RECEIVE SERVICES ON DISCHARGE BEGIN DATE? field.
Note: 24-hour services cannot be billed on the suspension date.
• Type the reason for suspension of waiver services in the TERMINATION REASON field. The following table lists the reasons and their descriptions.
<table>
<tr><th>Reason</th><th>Description</th></tr>
<tr><td>1. Loss of Financial Eligibility</td><td>Individual has lost Medicaid eligibility</td></tr>
<tr><td>2. Hospitalization (Medical)</td><td>Individual is in a medical hospital.</td></tr>
<tr><td>3. Elopement (Unable to Locate)</td><td>Individual cannot be found or refuses to cooperate.</td></tr>
<tr><td>4. Crisis Stabilization</td><td>Individual is in a private psychiatric hospital or an acute behavioral treatment center.</td></tr>
<tr><td>5. Hospitalization (Psychiatric)</td><td>Individual is in a State Hospital.</td></tr>
<tr><td>6. Vacation/Furlough</td><td>Individual is on vacation or not receiving waiver services.</td></tr>
<tr><td>7. Incarceration</td><td>Individual is in a city/town, county, state, or federal correction facility.</td></tr>
<tr><td>8. State School</td><td>Individual is in a State Supported Living Center.</td></tr>
<tr><td>9. Nursing Facility</td><td>Individual is in a nursing home or other type of nursing facility.</td></tr>
</table>
• Type Y in the READY TO ADD? field.
Note: You can type N in the READY TO ADD? field to take no action and return to the header screen.
• Press Enter.
Result: The C18: Consumer Discharge header screen is displayed with the message, “Previous Information Added.”
</td>
</tr>
</table>

Consumer Discharge (C18): Change (Suspension of Waiver Services)

Procedure

The following table describes the steps an MRA will use to change an individual's suspension of waiver services if the individual is self-directing all their services.

The MRA will also use the change function to end a suspension of waiver services.

Step	View	Action
1	_ _	• Type **C18** in the ACT: field of any screen. • Press **Enter**. Result: The **C18: Consumer Discharge: Add/ Change/Delete** header screen is displayed.
2	A sample **C18: Consumer Discharge: Add/Change/ Delete** header screen is shown below. 01-22-08 C18:CONSUMER DISCHARGE: ADD/CHANGE/DELETE VC060500 PLEASE ENTER ONE OF THE FOLLOWING: CLIENT ID: _____ COMPONENT CODE/LOCAL CASE NUMBER: __ / _____ MEDICAID NUMBER: _____ PLEASE ENTER THE FOLLOWING: TYPE OF DISCHARGE: _ (P/PERMANENT,T/TEMPORARY) TYPE OF ENTRY: _ (A/ADD,C/CHANGE,D/DELETE) *** PRESS ENTER *** ACT: ___ (C00/HCS DATA ENTRY MENU, A/HCS MAIN MENU, HLP(PF1)/SCRN DOC)	• Type the requested identifying information in the appropriate fields. Rule: You must enter the Client ID, the local case number, *or* the Medicaid number. Note: Your component code is displayed based on your logon account number. • Type **T** (Temporary) in the TYPE OF DISCHARGE field. • Type **C** (Change) in the TYPE OF ENTRY field • Press **Enter**. Result: The **C18: Consumer Discharge: Change** screen is displayed.
3	A sample **C18: Consumer Discharge: Change** screen is shown below. 01-29-08 C18:CONSUMER DISCHARGE: CHANGE VC060505 NAME : MOUNTAIN, ROCKY CLIENT ID : 18023509 MEDICAID NUMBER: 732402003 CONTRACT NUMBER: 001007199 CDS LOCAL CASE NUMBER: 73248JH004 COMPONENT: 8JH CONTRACT NUMBER: LOCAL CASE NUMBER: COMPONENT: SERVICE COUNTY : 006 ARMSTRONG DISCHARGE TYPE : TEMPORARY PROVIDER REPRESENTATIVE NAME: JOHN GLENN_____ DATE: 01292008 DISCHARGE BEGIN DATE: 01282008 (MMDDYYYY) END DATE: _____ (MMDDYYYY) RETURN TO LOCATION : ___ COUNTY: __ (OWN/FAMILY HOME ONLY) PROJECTED RETURN DATE : 03012008 (MMDDYYYY) DID CONSUMER RECEIVE SERVICES ON DISCHARGE BEGIN DATE?: N (Y/N) TERMINATION REASON: 1_ 1. LOSS OF FINANCIAL ELIGIBILITY 7. INCARCERATION 2. HOSPITALIZATION(MEDICAL) 8. STATE SCHOOL 3. ELOPEMENT(UNABLE TO LOCATE) 9. NURSING FACILITY 4. CRISIS STABILIZATION 5. HOSPITALIZATION(PSYCHIATRIC) 6. VACATION/FURLOUGH READY TO CHANGE?: _ (Y/N) ACT: ___ (C00/HCS DATA ENTRY MENU, A/HCS MAIN MENU, HLP(PF1)/SCRN DOC)	• Type changes to the suspension information in the appropriate fields. • If the individual is ending his/her suspension of waiver services, type the end date in the END DATE field. • Type **Y** in the READY TO CHANGE? field. Note: You can type **N** in the READY TO CHANGE? field to take no action and return to the header screen. • Press **Enter**. Result: The **C18: Consumer Discharge** header screen is displayed with the message, *"Previous Information Changed."*

Consumer Discharge (C18): Delete (Suspension of Waiver Services)

Procedure

The following table describes the steps an MRA will use to delete an individual's suspension of waiver services if the individual is self-directing all their services.

Step	View	Action
1	_ _	• Type **C18** in the ACT: field of any screen. • Press **Enter**. Result: The **C18: Consumer Discharge: Add/Change/Delete** header screen is displayed.
2	A sample **C18: Consumer Discharge: Add/Change/Delete** header screen is shown below. 01-22-08 C18:CONSUMER DISCHARGE: ADD/CHANGE/DELETE VC060500 PLEASE ENTER ONE OF THE FOLLOWING: CLIENT ID: _____ COMPONENT CODE/LOCAL CASE NUMBER: __ / _____ MEDICAID NUMBER: _____ PLEASE ENTER THE FOLLOWING: TYPE OF DISCHARGE: _ (P/PERMANENT,T/TEMPORARY) TYPE OF ENTRY: _ (A/ADD,C/CHANGE,D/DELETE) *** PRESS ENTER *** ACT: ___ (C00/HCS DATA ENTRY MENU, A/HCS MAIN MENU, HLP(PF1)/SCRN DOC)	• Type the requested identifying information in the appropriate fields. Rule: You must enter the Client ID, the local case number, *or* the Medicaid number. Note: Your component code is displayed based on your logon account number. • Type **T** (Temporary) in the TYPE OF DISCHARGE field. • Type **D** (Delete) in the TYPE OF ENTRY field • Press **Enter**. Result: The **C18: Consumer Discharge: Delete** screen is displayed.
3	A sample **C18: Consumer Discharge: Delete** screen is shown below. 01-29-08 C18:CONSUMER DISCHARGE: DELETE VC060505 NAME : MOUNTAIN, ROCKY CLIENT ID : 18023509 MEDICAID NUMBER: 732402003 CONTRACT NUMBER: 001007199 CDS LOCAL CASE NUMBER: 73248JH004 COMPONENT: 8JH CONTRACT NUMBER: LOCAL CASE NUMBER: COMPONENT: SERVICE COUNTY : 006 ARMSTRONG DISCHARGE TYPE : TEMPORARY PROVIDER REPRESENTATIVE NAME: JOHN GLENN_____ DATE: 01292008 DISCHARGE BEGIN DATE: 01282008 (MMDDYYYY) END DATE: _____ (MMDDYYYY) RETURN TO LOCATION : ____ COUNTY: __ (OWN/FAMILY HOME ONLY) PROJECTED RETURN DATE : 03012008 (MMDDYYYY) DID CONSUMER RECEIVE SERVICES ON DISCHARGE BEGIN DATE?: N (Y/N) TERMINATION REASON: 1_ 1. LOSS OF FINANCIAL ELIGIBILITY 7. INCARCERATION 2. HOSPITALIZATION(MEDICAL) 8. STATE SCHOOL 3. ELOPEMENT(UNABLE TO LOCATE) 9. NURSING FACILITY 4. CRISIS STABILIZATION 5. HOSPITALIZATION(PSYCHIATRIC) 6. VACATION/FURLOUGH READY TO DELETE?: _ (Y/N) ACT: ___ (C00/HCS DATA ENTRY MENU, A/HCS MAIN MENU, HLP(PF1)/SCRN DOC)	• Type **Y** in the READY TO DELETE? field. Note: You can type **N** in the READY TO DELETE? field to take no action and return to the header screen. • Press **Enter**. Result: The **C18: Consumer Discharge** header screen is displayed with the message, *"Previous Information Deleted."*

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Inquiry

Introduction

The inquiry screens offer a variety of online reports that provide quick response and are useful for data entry reference and for listing readily available information.

The *Inquiry* section provides general instructions on how to access and display information for the options on the **L60: Authority Inquiry Menu**. It does not include an example of how to access *each* inquiry option.

Inquiry Screens

The inquiry screens allow you to access and view individual, service, and billing information. The following table provides a listing of the inquiry screens and descriptions of inquiry results.

Inquiry Screen	Description
A63: Consumer Transfer	Provides transfer record information by individual, including transfer from and to component and contract number, services paid and to be provided to transfer date, and transfer accepted and authorized status.
C61: Consumer Demographics	An individual's demographic information, including name, client ID, local case number, address, birthdate, SSN, contract number, service county, location, and dates for IPC, Level of Care/Need, and Medicaid program.
C62: Individual Plan of Care (IPC)	An individual's IPCs including revisions are displayed. Data displayed includes IPC dates, service units, annual cost, authorized amount, and signature information.
C63: DHS Medicaid Eligibility Search	Medicaid recipient information, including certification date, eligibility date, and other Medicaid eligibility information.
C66: Consumer Discharges	Lists individuals at your MRA who have been discharged with discharge begin/end dates. May be limited to display temporary, permanent, or all discharges and by specific date ranges.
C68: MR/RC Assessments - Summary	An individual's MR/RC Assessment information, including dates, level of care (LOC), level of need (LON), effective dates, and purpose code.
C69: Provider Information	Information on providers, including legal name, CEO contact name, address/telephone information, and corresponding contract number, name, and status information.
C70: Contract Information	Information on contracts at your MRA, including dates, authorized designee, program contact, address/telephone information, and contract service areas.
C71: Provider/Contract List	Current contract list with contract name/number in component code or component name order.
C72: Service Delivery by IPC	Includes billing information by IPC (paid, not paid, amount remaining on IPC) in program units or dollars by selected individual. Shows category totals for TxHmL plans.
C73: Service Delivery by Provider	Service delivery for the specified component using service begin/end dates and services paid, approved to pay, and not paid for each individual served.
C74: Checklist	Enrollment checklist by individual, including IPC and service begin date and dates of pertinent documentation.
C75: Prior Approval	Listing of individuals at the specified component for whom you have requested prior approval for adaptive aides/minor home modifications/dental services. Screen displays approval status and tracking number.

continued on next page

Inquiry Screens, continued

Inquiry Screen	Description
C77: Reimbursement Authorization	Listing of individuals at the specified component for whom you have requested a reimbursement authorization for adaptive aids/minor home modifications/dental services. Screen displays approval status and tracking/authorization number.
C80: Provider/Contract Roster	Listing of providers and contract information, including CEO contact name and telephone number, provider physical/mailing address, billing contact person, and contract information.
C83: MR/RC Assessments	Displays the completed MR/RC Assessment by selected individual.
C84: Provider Location	Lists detailed information about a provider's residential locations, including address, dates, and contact information. Option to view clients assigned to residential location.
C85: Client Assignments	Displays assignment information for a selected individual, including assignment effective date, end date (if applicable), service county, and location.
C86: Provider Location List	Listing of provider residential locations at the specified component with location codes, names, status, and location type.
C87: MRA Contacts	Listing of Mental Retardation Authority (MRA) contacts, including contact name, address, telephone number, and email address.
L61: Waiver Slot Counts	Lists the count of waiver slots at your MRA for a specific waiver or for all waivers, including the count of slots allocated and available.
L62: Waiver Slot Detail	Provides a detail listing of waiver slots with individual name, Client ID, component code, local case number, and slot tracking numbers for each slot.
L64: IPC Expiration	Lists individuals at your MRA with IPCs due to expire by a specified date.
L65: MR/RC Assessment Expiration	Lists individuals at your MRA with MR/RC Assessments due to expire by a specified date.
L67: Consumer Roster	Complete consumer roster for your MRA, including name, Client ID, local case number, Medicaid number, enrollment status, and contract number and name.
L68: WS/C TXHML MRA Notations/ Provider Reviews Inquiry	The Authority may review the L68 screen after a TxHmL provider review to see if there were any concerns noted about the Authority's performance during the provider review.
L82: Pending MR/RC Assessments	Listing of individuals at your MRA with MR/RC Assessments for whom a final decision has not been made. The pending status of the assessment is displayed.
L83: IPC MRA Review Pending (HCS)	Displays IPCs that have been sent to the MRA for completion of their review, or returned to the provider to obtain more information.
C103: Pending IPC MRA Review – Provider Inquiry	Displays MR/RC Assessments that have been sent to the MRA for completion of their review, or returned to the provider to obtain more information.
249: PPR Approval Status	Displays the DADS approval status and date of the Permanency Planning Review.

Accessing an Inquiry Screen

Introduction

Accessing an Inquiry Screen provides general instructions on the steps involved in accessing an Inquiry screen. The procedure is the same for accessing all Inquiry screens, although the criteria you enter on the header screen may be different for each option.

Basic Steps

The basic steps for accessing and viewing all Inquiry options are:

- Type the Inquiry option action code in the ACT: field of any screen.
- Enter the type fields used to access the information.
- View the online Inquiry information.

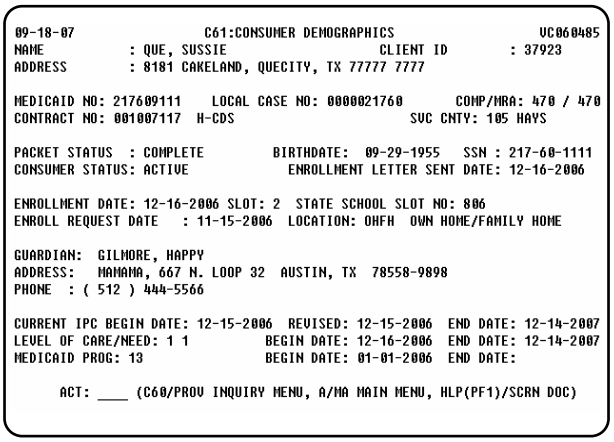
Procedure

The following table displays the steps taken to access an Inquiry screen. For this example, the **C61: Consumer Demographics** option is used.

Step	View	Action
1	_ _	• Type **C61** in the ACT: field of any screen. • Press **Enter**. Result: The **C61: Consumer Demographics: Inquiry** header screen is displayed.
2	A sample **C61: Consumer Demographics: Inquiry** header screen is shown below. 01-07-08 C61:CONSUMER DEMOGRAPHICS: INQUIRY VC060480 PLEASE ENTER ONE OF THE FOLLOWING: CLIENT ID: _____ COMPONENT CODE/LOCAL CASE NUMBER: __ / _____ MEDICAID NUMBER: _____ *** PRESS ENTER *** ACT: ___ (C60/PROV INQUIRY MENU, A/MA MAIN MENU, HLP(PF1)/SCRN DOC)	• Type the requested identifying information in the appropriate fields. Rule: You must enter the Client ID, the local case number, *or* the Medicaid number. Note: Your component code is displayed based on your logon account number. • Press **Enter**. Result: The **C61: Consumer Demographics** screen is displayed.

continued on next page

Procedure, continued

Step	View	Action
3	A sample **C61: Consumer Demographics** screen is shown below.  09-18-07 C61:CONSUMER DEMOGRAPHICS VC060485 NAME : QUE, SUSSIE CLIENT ID : 37923 ADDRESS : 8181 CAKELAND, QUECITY, TX 77777 7777 MEDICAID NO: 217609111 LOCAL CASE NO: 0000021760 COMP/MRA: 470 / 470 CONTRACT NO: 001007117 H-CDS SVC CNTY: 105 HAYS PACKET STATUS : COMPLETE BIRTHDATE: 09-29-1955 SSN : 217-60-1111 CONSUMER STATUS: ACTIVE ENROLLMENT LETTER SENT DATE: 12-16-2006 ENROLLMENT DATE: 12-16-2006 SLOT: 2 STATE SCHOOL SLOT NO: 806 ENROLL REQUEST DATE : 11-15-2006 LOCATION: OHFH OWN HOME/FAMILY HOME GUARDIAN: GILMORE, HAPPY ADDRESS: MAMAMA, 667 N. LOOP 32 AUSTIN, TX 78558-9898 PHONE : (512) 444-5566 CURRENT IPC BEGIN DATE: 12-15-2006 REVISED: 12-15-2006 END DATE: 12-14-2007 LEVEL OF CARE/NEED: 1 1 BEGIN DATE: 12-16-2006 END DATE: 12-14-2007 MEDICAID PROG: 13 BEGIN DATE: 01-01-2006 END DATE: ACT: ___ (C60/PROV INQUIRY MENU, A/MA MAIN MENU, HLP(PF1)/SCRN DOC)	View the data. The sample screen displays the following information about the individual: • name • Client ID • address • Medicaid number • local case number • component/MRA • contract number • service county • packet status • birthdate • SSN • consumer status • enrollment letter sent date • enrollment date • slot and slot number • enroll request date • location • guardian information (if applicable) • current IPC begin date, revised date, end date • Level of Care/Need, begin date, end date • Medicaid program, begin date, end date

Accessing Reports

Overview

Introduction

Reports have been developed to give MRAs and program providers cost, claim, billing, and information about individuals. A provider will receive, via the internet, Waiver reports, such as the consumer billing report, client profile report, etc., which will assist the provider in managing the program.

Providers will continue to be able to view reports using XPTR. However, since most providers have been unable to print reports from XPTR, the EDTS server has been established. Providers will be able to access this server to obtain certain reports.

EDTS Server

The DADS HCS/TXHML EDTS server was purchased solely for DADS HCS/TXHML to send reports to the provider and to send/receive X12 transaction files from/to the provider. No extraneous space was purchased, nor is any space available for providers to store copies of reports or uploads of any other miscellaneous data. Monthly scans are performed to clean out report files older than 16 days. In addition, random scans are performed and unauthorized data (i.e., files and folders) will be removed without notification to the provider.

Obtain Access

For a Waiver provider to establish a connection with DADS HCS/TXHML to retrieve Waiver reports, the following steps must be completed.

To obtain access to the EDTS server:

1. A provider must submit an Electronic Transmission Agreement (ETA) form fax to HHS Enterprise Security Management (ESM), using the fax number provided in the **Forward Completed Form To:** section of the form. The ETA form is, in part, a request for a user ID and password to have access to retrieve the Waiver reports. The user ID and password created by the ETA form are **separate** from the CARE user ID and password and the retrieval of the Waiver reports uses a process that is also completely separate from CARE. ***DO NOT*** confuse the ETA and CARE user IDs and passwords.
2. While ESM is processing the ETA form, the provider must determine which software to use and download it. Because of HIPAA Privacy rules, providers must use encryption software to retrieve Waiver reports. See the options in the *Recommended Client Software* section (most options can be downloaded from the Internet).

Obtain Access, continued	3. After the ETA form is processed, HHS Enterprise Security Management (ESM) will telephone the provider with a user ID and password. This process should take about two weeks.
Retrieve Reports in a Timely Manner	It is the provider's responsibility to retrieve the reports from their respective EDTS server folder. Providers should be aware that their reports are overwritten each time new reports are loaded. Several of these reports are loaded weekly. Therefore, providers must access the EDTS server on a weekly basis to avoid missing reports.
Backup Files	Backup files are kept in the event that previous reports must be recovered. These files, however, are not kept indefinitely, and reports can only be recovered for a limited period of time. Reports will be limited only to recovery for the most recent three months including the current month. Reports requested for recovery will be loaded to the provider's EDTS server folder. They will not be mailed.

Recommended Client Software

Introduction

The following table lists the recommended client software and their Internet addresses.

Note: Questions regarding specific software should be directed to the respective product vendor.

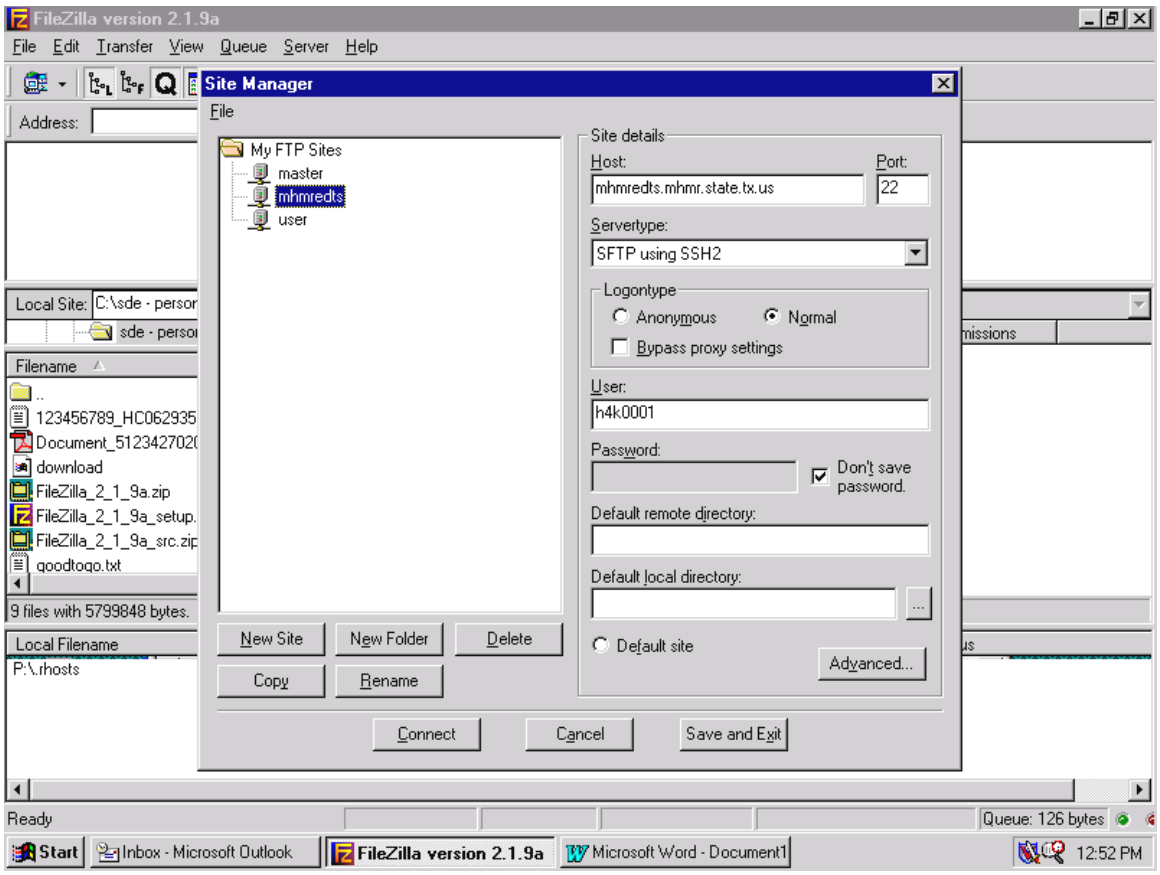
Type	Windows	Unix (and Variants)
Free	PuTTY (PSFTP command line client. Binary only transfers.) http://www.chiark.greenend.org.uk/~sgtatham/putty/download.html Note: It is suggested that you download the user manual and review the manual before downloading PSFTP.Exe. This is a DOS-based command requiring the EDTS server name (domain name) and your ETA Logon/password issued by IASS.	OpenSSH http://www.openssh.org/ Note: Only SFTP is supported for connections from OpenSSH clients.
	FileZilla (GUI client, based on PuTTY PSFTP code for SFTP connections) http://sourceforge.net/projects/filezilla Note 1: Select the latest version and download the highlighted items. This is a Windows-based command requiring the EDTS server name (domain name) and your ETA Logon/password issued by IASS. Note 2: Because DADS HCS/TXHML requires providers to have Windows-based systems for QWS3270 software for use with DADS HCS/TXHML's Automated System, it is thought that most Waiver providers will use the FileZilla software.	
Commercial	SSH Secure Shell for Workstations http://www.ssh.com/products/security/secureshellwks/	SSH Secure Shell for Servers http://www.ssh.com/products/security/secureshellserver/

FileZilla

FileZilla

The majority of providers are selecting the Windows-based free encryption software FileZilla.

The site manager function of FileZilla should be set up as shown below.



FileZilla allows you to highlight (click) the file inside the **Rpt/Waivers** folder, then drag the folder to your "C" drive displayed on the left center side of the FileZilla screen.

Zip/Unzip Software

Introduction	Starting July 1, 2004, DADS HCS/TXHML began compressing or 'Zipping' all reports loaded to the EDTS server. Therefore, providers will be required to use zip software to open their report files. This was done to conserve space on the server in anticipation of an increased number of providers needing access to the EDTS server, as well as additional reports becoming available.
Zip Software	DADS HCS/TXHML plans to use the WINZIP software, which does have a minor cost associated with it. Providers may use any ZIP software to Unzip a file, regardless of the software that DADS HCS/TXHML uses to Zip the file. A comprehensive list of ZIP software products can be found at http://www.tucows.com/. A search on this site will identify software that can be downloaded.
Freeware	Some of the ZIP software products available at the above link are available at no cost to the user. They are listed as 'Freeware.' It is at the provider's discretion which ZIP Software is downloaded and used to UnZIP files.
Support	DADS HCS/TXHML will not provide support for any non-DADS HCS/TXHML software downloaded by the provider. It will be the provider's responsibility to contact the software company or vendor if problems are encountered during downloading or usage of ZIP software.

Access Server Connection/Load Reports/Retrieve Waiver Reports

Access the EDTS Server Connection

After the software has been downloaded, the provider must access the EDTS server to retrieve the Waiver reports. This server is accessible from any internet provider. Connections to the server must use the Secure Shell (SSH) version 2 protocol via an SFTP server. The EDTS server name (domain name) that must be used with the software is **mhmredts.mhmr.state.tx.us**

The contact name from ETA form will be considered the primary user and will have access to a folder named **Rpt** Folders named **X12in** and **X12out** will be visible on the screen, but will not be able to be accessed unless the provider is billing via X12 transactions (batch billing).

Additional provider staff who have access will be considered secondary users and will only see and have access to the **Rpt** folder (the **X12in** and **X12out** folders will not be visible to secondary users). Request for additional access may be obtained by completing the IS090 form and faxing it to the appropriate party.

Reports Loaded

By obtaining access, a folder unique to the provider will be created. As reports are prepared, they will be loaded to the folder according to the report time schedule.

The following reports will be loaded to the **Rpt** folder:

- **HC062460 – MRA Service Utilization Report *** (Portrait) Tuesday after the last Friday of the month/Monthly
  The Texas Home Living Utilization Report.
- **HC062942 – Remittance & Status Report** (Landscape) Friday/Weekly
  The Remittance & Status Report reconciles the warrant (actual paid claims from the Comptroller) to claims submitted, minus any additional credits from the Comptroller.
- **HC062962 – HCS Accumulated Approved to Pay Report** (Landscape) Friday/Weekly
  The Accumulated Approved to Pay report contains information on all claims submitted and sent to the comptroller for payment, but it does not indicate payment from the comptroller.
- **HC062017 – Approved to Pay Report *** (Landscape) Tuesday/Weekly
  Formerly known as the Billing Report. The information on this report now includes ICN & Line numbers. This report has the same information as the Paid Claim File (GC062040), except that it is in a report format.
- **HC062310 – Service Utilization Report *** (Portrait) Tuesday after the last Friday of the month/Monthly
  The Utilization Report has not changed.

continued on next page

Reports Loaded, continued

- **HC062015 – Denied Claims Report *** (Landscape) Tuesday/Weekly
  Formerly known as the Exceptions Report. The information on this report now includes ICN & Line numbers.
- **GC062040 – Paid Claim File** * (File, semi-colon delimited) Tuesday/Weekly

  (For formatting instructions see ***Paid Claims Files*** section)

  The Paid Claims File is new and contains data on claims DADS HCS & TXHML Waiver Programs have sent to the Comptroller to be paid. The data in this file is in semi-colon delimited format, which can be downloaded directly into the provider's local billing program.
- **HC062020 – Client Profile Report** * (Landscape) Tuesday after the last Friday of the month/Monthly
- **HC062746 – Waiver Local Authority Refinance by MRA Report** * (Landscape) Monday/Weekly

  This report is only distributed to MRAs. Waiver Refinance Status by MRA.
- **HC062835 – HHSC Cost Report** (Portrait) Annually after 1st billing run in September.

  Contains information that will assist with Annual Cost Reports.
- **GC027877 - HCS Waiting List Report of Contacts by Wait Date*** (File, semi-colon delimited) Monday/Weekly

  (For formatting instructions see ***Paid Claims Files*** section)

  This semi-colon delimited file is only distributed to MRAs.

*All billing reports will be available once Medicaid Administration approves billing.
Note: See *Format Report* for assistance on formatting the reports.

continued on next page

Retrieve Reports

The reports that are in the **Rpt** subfolder use the following naming convention: nnnnnnnnn_rrrrrrrr.txt. The nnnnnnnnn represents the provider's Electronic Transmission Interface Number (ETIN) and rrrrrrrr is the report number. Example: 123456789_HC062020

Note: The ETIN is a unique number assigned to each provider to ensure the provider receives the correct reports and is the same as the provider's Federal Tax Identification Number or Social Security Number.

Report files will be available for download into the provider's system from the **Rpt** sub-folder. See the *Formatting Report* section for formatting assistance.

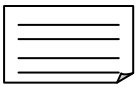
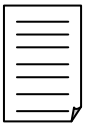
The reports in the **Rpt** folder will be overwritten each week, so the provider must save them to the **C:** drive if the reports are to be saved. To copy a report from the EDTS Server to your **C** drive:

- Click **Rpt**.
- Click **Waiver**.
- Locate the report you want to copy.
- Click and hold down the button to select the report.
- Drag and drop the document in the **Rpt/Waiver** section on the left side of the screen.
- Replace each saved file name with a unique name so the report will not be overwritten the next time the report is retrieved.

Format Report

Format Report

Any word-processing software can be used to view reports and report files opened as text. The following page setup instructions are based on the use of **Microsoft Word**.

Page Orientation	Format
Landscape 	Use these instructions to format the following reports. HC062015 – Denied Claims Report HC062017 – Approved To Pay Report HC062020 – Client Profile Report HC062942 – Remittance & Status HC062962 – HCS Accumulated Approved to Pay Report To format the font: • Click **Format**. • Click **Font**. • Select **Courier New** in the **Font** section. • Select **Regular** in the **Font style** section. • Type **8.5** in the **Size** section. • Click **OK**. To format the page: • Click **File**. • Click **Page Setup**. • Click **Landscape** in the **Orientation** section. • Type the following settings in the **Margins** section. - Top: 0.2" - Bottom: 0.2" - Right: 0.17" - Left: 0.5"
Portrait 	Use these instructions to format the following reports. HC062460 – MRA Service Utilization Report HC062310 – Service Utilization Report HC062835 – HHSC Cost Report To format the font: • Click **Format**. • Click **Font**. • Select **Courier New** in the **Font** section. • Select **Regular** in the **Font style** section. • Select **10** in the **Size** section. • Click **OK**. To format the page: • Click **File**. • Click **Page Setup**. • Click **Portrait** in the **Orientation** section. • Type the following settings in the **Margins** section. - Top: 0.8" - Bottom: 0.7" - Right: 1.0" - Left: 1.0"

Paid Claims Files

Format Paid Claim File

Paid Claims files will be available on request for those providers who want to receive a semi-colon delimited file (information that is not in any particular format.)

- **Spreadsheet Software -** Any spreadsheet software capable of importing delimited files can be used.
- **Semi-Colon Delimited Files -** Open the file in Excel, then follow the **Text Import Wizard** pop-up screens.
  - For **Original Data Type** select **Delimited** (instead of **Fixed-width**).
  - Click on **Next** to go to the next window.
  - In **Delimiters** check **Semicolon** and uncheck all others.
  - Click on **Next**.

  Note: Providers will need to adjust column formats in this third window.
  - Click on the columns that contain numbers (especially those with large numbers) in **Data Preview**
  - Select **Text** (instead of **General**) in **Column Data Format**.
  - Click **Finish**.

Passwords/Contacts

Passwords

DADS HCS/TXHML guidelines require passwords to be changed every 90 days. This includes those logon passwords issued for the mhmredts.mhmr.state.tx.us secure server. Users will be notified, via an email, that a message containing the user's new password has been placed in their EDTS server primary folder. This message will be placed in the primary folder seven (7) days prior to the old password expiration date. It will be the user's responsibility to read this message and note the new password. Should the message not be read in time, the user will be able to have a new password set by calling the Help Desk. The Help Desk will route the call to the appropriate office, which in turn will call the user with the new password.

Contacts

Use the following guidelines when you encounter problems or have questions:

For **Rpt** folder questions:

- HHSC Help Desk, 512-438-4720 or 1-888-952-4357 Monday through Friday between the hours of 7:00 a.m. – 6:00 p.m.

For HIPAA inquiries:

- DADS HCS/TXHML website: www.Dads.state.tx.us
- CMS (Centers for Medicare & Medicaid Services) ask for HIPAA.com (www.cms.hhs.gov/hipaa/hipaa2)

For questions regarding DADS HCS/TXHML forms, contact:

- HHSC Help Desk, Field Support, 1-512-438-4720 or 1-888-952-4357

For questions regarding software, contact:

- the software vendor.

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Screen Fields

Screen Field Table

The following table describes fields displayed on various data entry and inquiry screens used for the waiver programs.

Field	Description
AA	Local code for Adaptive Aids. AA is one of the services provided by the HCS and/or TxHmL programs.
ABL	Code indicating the individual's adaptive behavior level. 1 = Mild ABL deficit 2 = Moderate ABL deficit 3 = Severe ABL deficit 4 = Profound ABL deficit
ADAPTIVE AIDS	The amount to be spent on adaptive aids. (Do not use commas - $$$$$ format.)
ADAPTIVE AIDS ASSESSMENT/BID	An assessment allowing the provider (HCS) or MRA (TxHmL) to seek a bid for the Adaptive Aids.
ADD TO HCS LIST?	Indicate whether individual is to be added to the Interest List.
ADDING A PROGRAM PROVIDER OR CDS AGENCY?	When transferring an individual, indicates whether a Program Provider or CDSA will be added when an SDO will be added where it does not exist.
ADDRESS DATE	Date the individual's address record is being updated.
ADDRESS TYPE	Type of address being updated on the Provider/Contract Update screen. 1 = Provider Physical 2 = Provider Mailing 3 = Provider Billing 4 = Contract Physical 5 = Contract Mailing
ADMIT FROM	The living arrangement in which the individual is currently residing. 1=Community 2=ICF-MR 3=State School 4=Refinance 5=State Hospital
AGE OF MAIN CAREGIVER	The age of the person who is the main caregiver of the individual.
AGGRESSIVE BEHAVIOR	Behavior intended to cause harm or injury to others.
AMBULATION	An individual's ability to walk or move about reflecting the amount of assistance required
ANNUAL COST	Total annual cost of the IPC.

Field	Description
ARE ANY SERVICES STAFFED BY A RELATIVE/GUARDIAN?	On the IPC, indicates whether any services are provided by a relative or guardian.
ASSIGNMENT BEGIN DATE	The date the IPC begins.
ASSIGNMENT END DATE	The date the individual is permanently discharged or transferred to a different MRA.
AUTHORIZATION NUMBER	For **C22: Service Delivery**, the Reimbursement Authorization Tracking Number obtained from the **C77: Reimbursement Authorization Inquiry** screen for Adaptive Aids/Minor Home Modifications/Dental services. Only Reimbursement Authorization Tracking Numbers with approved status can be used in this field.
AUTHORIZED DESIGNEE	Full name of the person authorized to respond to contract related issues.
BEG DT	Begin date of the IPC. Note: If this date is incorrect, contact Medicaid Administration.
BEHAVIOR PROGRAM	**Y** (Yes) or **N** (No) to indicate whether or not a behavior program is in place for the person.
BILLABLE UNITS	Term used by DADS to describe one (1) unit of a HIPAA Standard Procedure Code (e.g., HCPCS, Dental, or CPT code). Depending on the procedure code, one (1) unit may be equal to either 15 minutes or 1 day of service.
BILLED AMOUNT	For **C22: Service Delivery**, this field allows the provider to indicate the cost of providing the specific service. If left blank, the standard rate is applied.
BILLING ADDRESS	The billing contact's billing address.
BILLING CONTACT LAST NAME	The last name of the billing contact's name.
BROAD INDEPENDENCE	A number from the 3rd page of the ICAP Computer Report that reflects an individual's ability to independently perform activities of daily living
C.O. AUTHORIZE TRANSFER?	Field for DADS Access & Intake, Program Enrollment to authorize the transfer after the transfer has been accepted by the receiving provider.
C/O	Field that can be used as an extra address line.
CALCULATE?	Calculate the total annual cost of the IPC.
CARE ID	*Same as Client ID*. Individual's unique statewide identification number generated by the CARE system when each person is registered.
CASE COORDINATOR	Case coordinator's name. The signature must be on the IPC in the individual's chart.
CASE MANAGER POSITION	A code assigned to an MRA employee, usually an MRA service coordinator.

Field	Description
CASE MANAGEMENT UNIT	A code assigned to an MRA service coordination unit.
CASE NUMBER	Individual's local case number issued by your component.
CEO CONTACT LAST NAME	Last name of the Chief Executive Officer (CEO) contact.
CHANGING A PROGRAM PROVIDER OR CDS AGENCY?	When transferring an individual, indicates whether a Program Provider or CDSA is being changed when the SDO currently exists.
CHANGING SERVICE DELIVERY OPTIONS?	When transferring an individual, indicates whether an SDO is being changed when an existing service(s) is moved from one SDO to another SDO (contract numbers do not change).
CITY	Depending on the screen, indicates the city of residence of the individual/CEO contact/provider/billing contact/guardian, or the city of the contract
CLAIM STATUS	For **C89: Claims Inquiry** indicates a particular status for a specified claim. Possible values are: U = Pending P = Paid A = Approved to Pay D = Denied (Batch) Blank = All claims
CLIENT BIRTHDATE	Individual's date of birth.
CLIENT FIRST NAME	Individual's first name.
CLIENT ID	Individual's unique statewide identification number generated by the CARE system when each person is registered.
CLIENT LAST NAME	Individual's last name.
CLIENT LAST NAME/SUF	Individual's last name and suffix, if any.
CLIENT MIDDLE NAME	Individual's middle name.
CLOSE DATE	Date the location closed.
COMPLETED DATE (MR/RC ASSESSMENT)	Date the MR/RC assessment was completed.
COMPONENT	Three-digit unique code that identifies a state hospital, state school, state center, community center, or private provider.
COMPONENT CODE	Three-digit unique code that identifies a state hospital, state school, state center, community center, or private provider.
COMPTROLLER VENDOR NUMBER	Fourteen-digit number by which the State of Texas Comptroller's Office identifies the provider.
CONSUMER CONSENT DATE	Date the individual consented to the transfer.

Field	Description
CONSUMER/LEGAL REPRESENTATIVE	Name of the individual or legal representative. The signature must be on the IPC in the individual's chart.
CONSUMER STATUS	Individual's enrollment status. (Pre-enroll, Active, Enrollment Denied, Enrollment Terminated, Hold, Transferred)
CONTACT FREQ (Permanency Planning)	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
CONTACT INFO	**Y** (Yes) or **Blank** (No) to indicate whether you want to view contact information for Central Office staff who reviewed your Prior Approval packet/4116A.
CONTACT NAME (Permanency Planning)	The name of the permanency planning staff contact.
CONTACT PHONE (Permanency Planning)	The telephone number of the permanency planning staff contact.
CONTACT TYPE	Indicates **MHA** (Mental Health Authority) or **MRA** (Mental Retardation Authority) for adding contact information.
CONTRACT NAME	Name of the contract.
CONTRACT NUMBER	Nine-digit number that identifies the contract under which an individual is receiving services.
CONTRACTED PROVIDER NAME	Name of the provider representative. The signature must be on the IPC in the individual's chart and should be the name of the individual who signed the IPC.
CORRES. CITY	The primary/secondary correspondent's city of residence.
CORRES. NAME	The primary/secondary correspondent's name. The primary correspondent is the first person to contact on behalf of an individual in case of an emergency. The secondary correspondent is the person to contact on behalf of an individual if the primary correspondent cannot be reached.

Field	Description
CORRES. RELATIONSHIP	Code that represents the primary correspondent's relationship to the individual. 01 = Parent 02 = Child 03 = Spouse/Posslq 04 = Sibling 05 = Grandparent 06 = Step-child 07 = Step-parent 08 = Step-sibling 09 = Child-in-law 10 = Sibling-in-law 11 = Foster Parent 12 = Aunt/uncle 13 = Niece/nephew 14 = Cousin 15 = Guardian 16 = Trustee 17 = Executor 18 = Attorney 19 = Legal representative 20 = Sponsor 21 = Friend 22 = Parent-in-law 23 = Other relation 24 = This component 25 = Case manager 26 = Unknown 27 = Self
CORRES. STREET	The primary/secondary correspondent's street address.
CORRES. TELEPHONE	The primary/secondary correspondent's area code and telephone number.
COST CEILING	Total $ amounts currently allowed on an individual's IPC. Exceeding this amount requires a review by Utilization Review/Utilization Control section of Medicaid Administration.
COUNTY OF SERVICE	The county where the individual lives.
CURRENT LIVING ARRANGEMENT	Where the individual is currently living.
CURRENT MED. DIAG	Any other current medical diagnoses that the individual may have as determined by a physician.
DATE BEGIN	The date the individual requested the service type.
DENTAL	The amount to be spent on dental services. (Do not use commas - $$$$$ format.)
DE	Local code for Dental Services. DE is one of the services provided by the HCS program.
DID CONSUMER RECEIVE SERVICES ON DISCHARGE BEGIN DATE? (Y/N)	**Y** (Yes) or **N** (No) to indicate whether the individual received services on the discharge date. Note: Payment for residential support and foster care services cannot be billed on the date of discharge.
DISCHARGE DATE	Date of the person's discharge.
DISCHARGE TYPE	Type of discharge (Permanent, Temporary). Permanent discharge is the termination of services to the individual by DADS because the individual has voluntarily left the program or is found to be ineligible for the program. Temporary discharge is the suspension of services to the individual by the provider while the individual is unable or unwilling to receive services.

Field	Description
DOES FAMILY/LAR SUPPORT GOAL?	Does the family/LAR support the goal?
EFFECTIVE DATE	Effective date of the particular status or determination, including Level of Care, Medicaid eligibility.
END DATE	Last day of a particular status or determination, including the current IPC, Level of Care, Medicaid eligibility, the last day the staff member provided services, date the temporary discharge ends, end date of the IPC.
ENROLLED, IS ENROLLING, OR IS ELIGIBLE FOR MFP IN A MEDICAID WAIVER	Indicate whether the individual is enrolled or enrolling in any Medicaid Waiver or is currently living in a nursing home and has access to a Medicaid waiver via the Money Follows the Person Program.
ENROLLMENT DATE	Date the individual was enrolled in the HCS and/or TxHmL program.
ENROLLMENT REQUEST DATE	The date the individual begins to receive services. Note: If the Enrollment Request date needs to be changed, the L01 screen must be completed and the date can be changed by re-entering the screen as a Change.
ENROLLMENT STATUS (or Consumer Status)	Individual's enrollment status in the HCS and/or TxHmL program. (Pre-enroll, Active, Enrollment Denied, Enrollment Terminated, Hold, Transferred)
ENTER BEGIN DATE FOR INITIAL ONLY (MMDDYYYY)	IPC begin date when entering an Initial IPC *only*. This date cannot be prior to the enrollment request date.
ENTERED BUT NOT PAID	Dollars entered but not paid for all services by service category.
ESTIMATED ANNUAL GROSS FAMILY INCOME	Total annual gross income of all family members living with the person, rounded to the nearest thousand. Note: Do not enter commas or decimal points.
ETHNICITY	The individual's ethnicity. B = Black H = Hispanic W = White A = Asian I = American Indian O = Other
ETHNIC/NEW FED RACE	**H** for Hispanic or Latino or **N** for not Hispanic or Latino.
FAMILY AND COMMUNITY SUPPORTS TO ACHIEVE GOAL	Indicate Y (Yes), N (No), or leave blank for each Family and Community Support option. Note: These are not required entry fields for individuals 18 to 21 years of age with a Permanency Plan Goal of 4.
FAMILY PARTICIPATED/POC	Indicate whether the family/LAR participated in the initial or annual meeting to discuss the Plan of Care.
FAMILY PARTICIPATED/PP	Indicate whether the family/LAR participated in the initial or review of the permanency plan.

Field	Description
FAMILY RESPONDED	Indicate whether the family/LAR responded to requests to participate in permanency planning meetings within the last six months.
FAMILY SIZE	Number of persons supported on the person's estimated annual gross family income including: • the number of parents living in the household, • the number of dependent children, • the person, and • any other persons dependent on the family for support.
FAX	The CEO/program contact's Fax number.
FIRST NAME	Depending on the screen, the first name of the individual, service provider, CEO contact, billing contact, program contact, or guardian.
FOR ADDRESS TYPE 4 OR 5 ENTER CONTRACT NUMBER	You *must* type the contract number if you typed **4** or **5** in the ADDRESS TYPE field to update a contract's physical or mailing address.
FOSTER COMPANION CARE	A person with whom the individual lives and that person provides assistance with a wide variety of daily living activities.
FREEDOM OF CHOICE FORM	The form the individual/LAR must sign indicating that he/she wants to participate in the HCS or TxHmL waiver.
FREQUENCY CODE (Waiver MR/RC Assessment)	(Nursing, Non-Vocational, and Vocational Settings) The code reflecting the amount of time a service is provided
FUNDING CODE	The code reflecting the source of funding for the service
GEN. MALADAPTIVE	A number from the 3rd page of the ICAP Computer Report that reflects the degree of behavioral problems the individual exhibits Note: If the number is negative, you *must* use the - (minus) sign just above the alpha section of the keyboard, **not** the **–** sign on the 10-key pad.
GUARDIAN	A person appointed by the Court to act on behalf of an individual who has been deemed incompetent to manage his/her affairs.
GUARDIAN'S CURRENT ADDRESS	Guardian's current address. A guardian is a person appointed by law to represent and make appropriate decisions for an individual.
HCS GROUP HOME (Y/N)	A home where three or four individuals reside in which supervised living service and/or residential support services is provided.
ICAP SERVICE LEVEL	Identifies the level of assistance required by an individual as determined by the Inventory for Client and Agency Planning (ICAP) assessment instrument.
IF REASON IS DEATH: DATE OF DEATH	If the Termination Reason is **8** (Death), the date of the death.

Field	Description
INTERNAL CONTROL NUMBER or ICN	Number used to uniquely identify a single claim. An ICN will be assigned to a claim when at least 1 line item for that claim has passed the Phase 1 edits (i.e., has been accepted into the system).
INTEREST COUNTY	The county of residence of the individual or LAR.
IPC BEGIN DATE	Date the Individual Plan of Care (IPC) began.
IPC END DATE	Date the Individual Plan of Care (IPC) ends.
IPC NON WAIVER SERVICES	Services that will be provided to the individual that are not HCS or TxHmL waiver services.
IPC REMAINING - AMTS TO BE PROVIDED	Total dollars for all services minus the amounts the transferring provider will be paid for services provided prior to the transfer effective date.
IQ	Actual IQ score, if obtainable. IF IQ cannot be ascertained for a person because of the severity of the disability (such as profound mental retardation), 19 should be entered as the score.
LAST NAME	Last name of the service provider.
LAST NAME/SUF	Individual's last name and suffix, if any.
LAST REVISION DATE	Date of the last revision.
LEGAL GUARDIANSHIP	Code that represents the individual's legal guardianship status. 1 = Minor 2 = Minor w/Conservator 3 = Adult w/Guardian of Estate and Person 4 = Adult w/ Guardian of Estate 5 = Adult w/Guardian of Person 6 = Adult w/Limited Guardian 7 = Adult w/Temporary Guardian 8 = Adult, No Guardian
LEGAL STATUS	Code to indicate the person's legal status. 0 = Minor – less than 18 years of age (with parent/guardian) 1 = Minor (ward of the state) 2 = Minor w/conservator 3 = Adult w/guardian of estate and person 4 = Adult w/guardian of estate 5 = Adult w/guardian of person 6 = Adult w/limited guardianship 7 = Adult w/temporary guardian 8 = Adult, no guardian
LEVEL OF CARE (LOC)	A determination of eligibility of an individual for the HCS and/or TxHmL programs. Assignment of the LOC is based on medical and intellectual diagnosis and professional evaluation of the person's needs.

Field	Description
LEVEL OF NEED (LON)	An assignment given to an individual enrolled in the HCS and/or TxHmL programs upon which reimbursement for services is based. The Level of Need determines the payment rate for Day Habilitation, Supervised Living, Residential Support Service, and Foster Care.
LINE ITEM	A single service or item submitted by the provider for payment. The line item contains information such as the billing procedure code, Staff ID, and date of service, or date range (for per diem services only). Claims are made up of one or more line items.
LINE NUMBER	Number used to uniquely identify a single line item within a claim. It is always used in conjunction with the ICN. Both the ICN and Line Number will be assigned to a line item when at least 1 line item on a claim has passed the Phase 1 edits (i.e., has been accepted into the system).
LOCAL CASE NUMBER	Number assigned to the individual by the provider. The number can be 1-10 characters with any combination of letters and numbers.
LOCATED FAMILY	Indicate whether the family could be located when needed within the last six months.
MAILING ADDRESS	The mailing address of the contract/provider.
MARITAL STATUS	Code that represents the individual's marital status. 1 = Married 2 = Widowed 3 = Divorced 4 = Separated 5 = Never Married 6 = Unknown/NA
MEDICAID NUMBER	The number assigned by HHSC to an individual who receives Medicaid. Note: The provider *cannot* change the Medicaid number of a currently enrolled HCS individual. Call DADS Access & Intake, Program Enrollment if you feel the number is incorrect and needs to be changed.
MEDICAID RECIPIENT NUMBER	Number that uniquely identifies an individual in the Medicaid Eligibility file.
MEDICARE NUMBER	The number assigned by the SSA to an individual who receives Medicare. Note: The provider *cannot* change the Medicare number of a currently enrolled HCS individual. Call DADS Access & Intake, Program Enrollment if you feel the number is incorrect and needs to be changed.
MFP DEMO	Indicate whether the person is participating in the Money Follows the Person Demonstration Grant.
MHM	Local code for Minor Home Modifications. MHM is one of the services provided by the HCS and/or TxHmL programs.

Field	Description
MID INIT	Depending on the screen, the middle initial of the individual/ CEO contact/program contact/guardian.
MIDDLE INITIAL	Middle initial of the service provider.
MIDDLE NAME	Individual's middle name.
MINOR HOME MOD	The amount to be spent on minor home modifications. (Do not use commas - $$$$$ format.)
MINOR HOME MODS ASSESSMENT/BID	An assessment allowing the provider (HCS) or MRA (TxHmL) to seek a bid for the Minor Home Modifications.
MODIFIER	*See Procedure Code Modifier*.
MOVE DATE (MRA Assignment Notification)	The date the individual moves to the new location (address).
MRA	Mental Retardation Authority.
NAME	The individual's name.
NEW FED ETHNICITY	**H** for Hispanic or Latino or **N** for not Hispanic or Latino.
NEW SDO	The Service Delivery Option for the existing services the receiving or current program provider enters.
NURSE	Name of the nurse on the interdisciplinary team. The signature must be on the IPC in the individual's chart.
ONSET	The month and year that the individual's condition was diagnosed.
OPEN DATE	Date the location type opened.
PACKET STATUS	The latest enrollment/renewal packet status. Enrollment packet = Pre-enroll, In-progress, Complete, Hold Renewal packet = Pre-renew, Complete, Hold
PERMANENCY PLAN GOAL	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).
PERSON DIRECTED PLANS/SMRF COMMUNITY LIVING PLAN	A Person Directed Plan is completed by the MRA and a SMRF Community Living Plan is completed by the State School.
PHONE	Depending on the screen, the phone number of the CEO/ billing/program contact.

Field	Description
PHYS EXAM DATE	Date of the individual's physical examination.
PHYSICAL ADDRESS	CEO contact's physical address.
PHYSICIANS EVALUATION AND RECOMMENDATIOIN	Physician's assessment of the individual. Note: Fields in this section are **not** required for waiver programs. Note: If this screen is used, **all** entries must be completed.
PLACE OF SERVICE or POS	One of five code sets providers use in **C22: Service Delivery** to bill for services. POS codes are used to identify the physical location where services were provided.
PRESENTING PROBLEM	Code representing the individual's presenting problem. 1 = MH (Mental Health) 2 = MR (Mental Retardation) 3 = ECI/DD (Early Childhood Intervention/Developmentally Delayed 4 = SA (Substance Abuse) 5 = Related Condition - MR
PREV. RES.	Code to indicate the individual's previous residence location (program) immediately before the current enrollment. 1 = Home (not enrolled in any program) 2 = Hospital 3 = Another ICF/MR community-based facility 4 = HCS provider services 5 = State hospital or state school 6 = Nursing facility 7 = Other 8 = Cannot determine
PRIMARY CORRESPONDENT	Name of the individual's primary correspondent.
PRIMARY DIAG	Individual's current primary diagnosis (not symptoms) as determined by a physician.
PROCEDURE CODE MODIFIER	One of five code sets providers use in **C22: Service Delivery** to bill for services. A Procedure Code Modifier is a two-digit code that further defines the services described by a HCPCS, CPT® or Dental procedure code. DADS uses modifiers to distinguish between services that are billed using the same HCPCS or CPT® code (e.g., SL and RSS, OT and PT).
PROCEDURE CODE QUALIFIER	One of five code sets providers use in **C22: Service Delivery** to bill for services. Procedure Code Qualifier **HC** indicates that HCPCS or CPT® procedure codes are being used to bill for services. Procedure Code Qualifier **AD** indicates that Dental procedure codes are being used to bill for services.
PROGRAM CONTACT LAST NAME	The program contact's last name.
PROJECTED RETURN DATE	Individual's projected return date.

Field	Description
PROVIDER COMMENTS	The MRA may enter comments for DADS review.
PROVIDER COMPONENT	Component code of the program provider chosen by the individual for **L05: Provider Choice**.
PROVIDER CONTRACT NUMBER	Contract number of the program provider chosen by the individual for **L05: Provider Choice**.
PROVIDER LOCAL CASE NUMBER	Local case number that the program provider assigned the individual for **L05: Provider Choice**.
PROVIDER REPRESENTATIVE NAME	Name of the provider representative.
PSYCHIATRIC DIAG	Diagnosis of an individual's current mental disorder(s), if applicable, as defined in the DSM.
PURPOSE CODE	Code to indicate the purpose of the MR/RC Assessment. 2 = No Current Assessment 3 = Continued Stay Assessment 4 = Change LON on Existing Assessment E = Gaps in Assessment
QUALIFIER	*See Procedure Code Qualifier.*
READY TO ADD?	Determine the action you want to take to submit the data to the system or cancel your request to add data.
READY TO CHANGE?	Determine the action you want to take to submit the data to the system or cancel your request to change data.
READY TO CORRECT?	Determine the action you want to take to submit the data to the system or cancel your request to correct data.
READY TO REACTIVATE?	Determine the action you want to take to submit the data to the system or cancel your request to reactivate.
READY TO RENEW?	Determine the action you want to take to submit the data to the system or cancel your request to renew the IPC.
READY TO REVISE?	Determine the action you want to take to submit the data to the system or cancel your request to revise data.
READY TO SEND FOR AUTHORIZATION?	Determine whether you want to submit the MR/RC Assessment to Utilization Review (UR).
READY TO TRANSFER?	Determine the action you want to take to submit the data to the system or cancel your request to transfer.
REC. LOC	Code identifying the recommended level of care for the individual. 0 = Denial of LOC (only entered by DADS) 1 = Mild to Profoundly Mentally Retarded or Related Conditions with an IQ of 75 or below 8 = Primary Diagnosis is a Related Condition with an IQ of 76 and above
REC. LON	Code identifying the recommended level of need for the individual.

Field	Description
RECEIVING AUTHORITY ACCEPTED BY (MRA Assignment Notification)	The name of the receiving MRA contact person.
RECEIVING AUTHORITY DATE (MRA Assignment Notification)	The date the MRA entered the data.
REGISTRATION EFFECTIVE DATE (MMDDYY)	Effective date of the individual's registration, the formal enrollment into the CARE system which establishes that an individual is registered to receive services from the system. Registration is done by the MRA only.
REGISTRATION EFFECTIVE TIME (HHMM A/P)	Effective time of the individual's registration.
RESIDENTIAL TYPE (ENTERED ON IPC)	Individual's residence type. 2 = Foster/companion care 3 = Own home/family home (OHFH) 4 = Supervised Living 5 = Residential Support
REV DT	Effective date of revisions made to the IPC. This field is required if the TYPE OF ENTRY is **R** (Revision).
REVENUE CODE	One of five code sets providers use in **C22: Service Delivery** to bill for services. A Revenue Code groups services into distinct cost centers. Revenue codes are required on the **C22: Service Delivery** screen when billing for services other than adaptive aids, minor home modifications, and dental.
REVIEW DATE	Date of the permanency planning review.
REVISION DATE	Effective date of revisions made to the IPC. This field is required if the TYPE OF ENTRY is **R** (Revision).
SELF-INJURY BEHAVIOR	Behavior which may result in physical injury to one's self.
SECONDARY CORRESPONDENT	Name of the individual's secondary correspondent.
SENDING AUTHORITY DATE (MRA Assignment Notification)	The date the Sending Authority entered the data.
SENDING AUTHORITY CONTACT NAME (MRA Assignment Notification)	The name of the Sending Authority MRA contact person.
SENDING AUTHORITY PHONE (MRA Assignment Notification)	The area code and telephone number of the Sending Authority MRA contact person.
SERIOUS DISRUP BEH	Behavior that seriously disrupts social activities or results in property damage.

Field	Description
SERVICE (Waiver MR/RC Assessment)	(Non -Vocational or Vocational) Whether and what kind of day services in which the individual participates.
SERVICE CATEGORY *or* SVC CATEGORY *or* SVC CAT	For **C89: Claims Inquiry**, this field indicates the formerly used bill code. You may enter this service category code *or* the HCPCS procedure code and modifier.
SERVICE CODE	One of five code sets providers use in **C22: Service Delivery** to bill for services. HCPCS and CPT® procedure codes are used in this field.
SERVICE COUNTY *or* SVC CNTY	Code for the county in which an individual is receiving services.
SERVICE DATE	Date services were provided.
SERVICE DATE FOR MM-YYYY	The month and year of the requested service date. If you requested a date in the current month, the days of the month are displayed with the cursor in the field for the date specified. You can enter data for days prior to and including the current date. You ***cannot*** enter data for future dates. If you requested a date in the previous month, the days for the month are displayed with the cursor in the date you specified. You can enter data for any day of the month.
SERVICE PROVIDER	Code to indicate if nursing services are provided by an LVN or RN.
SERVICE TYPE	Type of service based on the code entered on the request screen.
SERVICES BEGIN DATE	The date the waiver services will begin.
SERVICES PAID	Dollars for all services by service category.
SEX	Code indicating the individual's sex. (M = Male, F = Female)
SEXUAL AGGRESSIVE BEHAVIOR	Trying to impose one's sexual desires on another individual who is unwilling or unable to consent to such activities
SLOT TRACKING NUMBER	The number assigned to a specific type of slot. Note: the MRA can only enter the Slot Tracking Number **or** the Slot Type field.
SLOT TYPE	Refers to HCS waiver category offered to the individual.
SOCIAL SECURITY NUMBER	Individual's social security number. (N=None, U=Unknown)
STAFF BEGIN DATE	Date the staff member began providing services at your program.
STAFF ID	Staff member's identification number. Note: Providers define their own staff ID numbers. The numbers can be alpha or numeric or alphanumeric and up to five characters in length.

Field	Description
STATE	Depending on the screen, the state of residence of the primary/secondary correspondent, individual, CEO contact, provider, billing contact, guardian, or the contract.
STAT	The individual's current status relative to the service type.
STATUS	• For **C89: Claims Inquiry**, displays the status for a specified claim. Possible values are: U =Pending P =Paid A =Approved to Pay D =Denied (Batch) Blank = All Claims • For **C77: Reimbursement Authorization Inquiry**, indicate the status of the AA/MHM/DE claim. Possible values are: A =Authorized D =Denied Blank = All Claims • For **C75: Prior Approval Inquiry**, indicate the status of the AA/MHM claim. Possible values are: P =Pending A =Authorized D =Denied Blank = All Claims
STATUS DATE	The date the current status was changed. Note: The Status Date cannot be changed without changing the Status Field.
STREET	Depending on the screen, the street address of the contract, individual, CEO contact, provider, billing contact, or guardian.
SUF	Depending on the screen, the suffix (if any) of the service provider, CEO contact, billing contact, or program contact.
TERMINATION REASON (PERMANENT DISCHARGE)	Code that indicates the reason the individual is being *permanently* discharged. 1 = Loss of Medicaid Eligibility 2 = Loss of ICF/MR LOC Eligibility 3 = IPC Exceeds Cost Ceiling 4 = Voluntary Withdrawal by Consumer 6 = Institutionalization (Hospital, NF, ICFMR) 7 = Client Cannot Be Located 8 = Death 9 = Unable to Meet Health and Welfare Needs
TERMINATION REASON (TEMPORARY DISCHARGE)	Code that indicates the reason the individual is being *temporarily* discharged. 1 = Loss of Financial Eligibility 2 = Hospitalization 3 = Elopement 4 = Crisis Stabilization

Field	Description
TERMINATION REVIEWED BY: DATE:	The name of the MRA Representative who reviewed the termination request and the date the request was reviewed. Note: the date entered should be the same as the **Effective Date of Discharge** located under the signature line.
TIME (HHMM A/P)	The registration effective time.
TIME OF DEATH	If the TERMINATION REASON is **Death**, indicates the time of the death.
TO BE PROVIDED NOW TO TRANSFER DT	Dollars to be provided between today and the transfer effective date for all services that have not been entered. Note: If no amount is entered, the transferring provider will not be able to enter any additional services for that individual.
TO USE	The number of units to be used from now to transfer effective date (units that have not been claimed) for the transferring program and/or the transferring CDSA. The entry must be a valid number or "NA." The field will allow decimal fraction of units up to two decimal places (dollars for CDS services).
TOTAL ANNUAL COST	Total annual cost of the IPC.
TRANSFER ACCEPTED?	Indicates whether the provider receiving the individual accepts the transfer. The receiving provider completes this field ***after*** the transfer IPC has been entered.
TRANSFER EFFECTIVE DATE	Effective date of the individual's transfer.
TRANSFER TO COMPONENT	Three-digit code of the component to which the individual is transferring. Note: The provider transferring the individual completes this field. When the receiving provider accesses this screen, this field is displayed.
TRANSFER TO CONTRACT NUMBER	Contract number to which the individual is transferring.
TRANSFER TO SERVICE COUNTY	Service county to which the individual is transferring. See the *County Codes* section for a list of county codes and names.
TRAUMATIC BRAIN INJURY	Indicate whether the person has a history of traumatic brain injury.
TXHML STATUS	The status of the individual's TxHmL offer.
TYPE OF DISCHARGE	Type of discharge (P=Permanent, T=Temporary).
TYPE OF ENTRY	Determine the action you want to take. (A=Add, C=Change/Correct, D=Delete).

Field	Description
TYPE OF ENTRY (Individual Plan of Care)	Type of IPC (Individual Plan of Care) being entered. I = Initial E = Error Correction R = Revision N = Renewal T = Transfer D = Delete
TYPE OF LOCATION (entered on **C:24 Location** and **C25: Location Type Modification** screens)	Code to indicate the type of location. 2 = Foster/Companion Care 3 = 3-bed facility 4 = 4-bed facility
UNITS	Units (hours, days, or months) the service was provided.
UNITS REMAIN IN IPC	The remaining units in the IPC for the type of service requested. Indicates whether the units are by hours, days, or months.
VIEW COMMENTS	**Y** (Yes) or **Blank** (No) to indicate whether you want to view comments made by your reviewer concerning your Prior Approval packet/4116A.
ZIP CODE	Depending on the screen, the zip code of the individual/primary correspondent/secondary correspondent/CEO contact/provider/ billing contact/contract.
ZIP CODE/SUFFIX	Individual's zip code and suffix.
# VISITS BY FAM	Number of visits to the facility by the parent/guardian.
# VISITS TO FAM	Number of the resident's visits to the home.
WAIVER TYPE	The waiver type in which the individual is to be enrolled. (1=HCS, 4=TxHmL)

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County Codes

County Codes

The following table provides a list of Texas county names and codes.

County	Code
Anderson	001
Andrews	002
Angelina	003
Aransas	004
Archer	005
Armstrong	006
Atascosa	007
Austin	008
Bailey	009
Bandera	010
Bastrop	011
Baylor	012
Bee	013
Bell	014
Bexar	015
Blanco	016
Borden	017
Bosque	018
Bowie	019
Brazoria	020
Brazos	021
Brewster	022
Briscoe	023
Brooks	024
Brown	025
Burleson	026
Burnet	027
Caldwell	028

County	Code
Calhoun	029
Callahan	030
Cameron	031
Camp	032
Carson	033
Cass	034
Castro	035
Chambers	036
Cherokee	037
Childress	038
Clay	039
Cochran	040
Coke	041
Coleman	042
Collin	043
Collingsworth	044
Colorado	045
Comal	046
Comanche	047
Concho	048
Cooke	049
Coryell	050
Cottle	051
Crane	052
Crockett	053
Crosby	054
Culberson	055
Dallam	056
Dallas	057
Dawson	058
Deaf Smith	059

County	Code
Delta	060
Denton	061
Dewitt	062
Dickens	063
Dimmit	064
Donley	065
Duval	066
Eastland	067
Ector	068
Edwards	069
Ellis	070
El Paso	071
Erath	072
Falls	073
Fannin	074
Fayette	075
Fisher	076
Floyd	077
Foard	078
Fort Bend	079
Franklin	080
Freestone	081
Frio	082
Gaines	083
Galveston	084
Garza	085
Gillespie	086
Glasscock	087
Goliad	088
Gonzales	089
Gray	090

County	Code
Grayson	091
Gregg	092
Grimes	093
Guadalupe	094
Hale	095
Hall	096
Hamilton	097
Hansford	098
Hardeman	099
Hardin	100
Harris	101
Harrison	102
Hartley	103
Haskell	104
Hays	105
Hemphill	106
Henderson	107
Hidalgo	108
Hill	109
Hockley	110
Hood	111
Hopkins	112
Houston	113
Howard	114
Hudspeth	115
Hunt	116
Hutchinson	117
Irion	118
Jack	119
Jackson	120
Jasper	121

County	Code
Jeff Davis	122
Jefferson	123
Jim Hogg	124
Jim Wells	125
Johnson	126
Jones	127
Karnes	128
Kaufman	129
Kendall	130
Kenedy	131
Kent	132
Kerr	133
Kimble	134
King	135
Kinney	136
Kleberg	137
Knox	138
Lamar	139
Lamb	140
Lampasas	141
La Salle	142
Lavaca	143
Lee	144
Leon	145
Liberty	146
Limestone	147
Lipscomb	148
Live Oak	149
Llano	150
Loving	151
Lubbock	152

County	Code
Lynn	153
McCullough	154
McLennan	155
McMullen	156
Madison	157
Marion	158
Martin	159
Mason	160
Matagorda	161
Maverick	162
Medina	163
Menard	164
Midland	165
Milam	166
Mills	167
Mitchell	168
Montague	169
Montgomery	170
Moore	171
Morris	172
Motley	173
Nacogdoches	174
Navarro	175
Newton	176
Nolan	177
Nueces	178
Ochiltree	179
Oldham	180
Orange	181
Palo Pinto	182
Panola	183

County	Code
Parker	184
Parmer	185
Pecos	186
Polk	187
Potter	188
Presidio	189
Rains	190
Randall	191
Reagan	192
Real	193
Red River	194
Reeves	195
Refugio	196
Roberts	197
Robertson	198
Rockwall	199
Runnels	200
Rusk	201
Sabine	202
San Augustine	203
San Jacinto	204
San Patricio	205
San Saba	206
Schleicher	207
Scurry	208
Shackelford	209
Shelby	210
Sherman	211
Smith	212
Somervell	213
Starr	214

County	Code
Stephens	215
Sterling	216
Stonewall	217
Sutton	218
Swisher	219
Tarrant	220
Taylor	221
Terrell	222
Terry	223
Throckmorton	224
Titus	225
Tom Green	226
Travis	227
Trinity	228
Tyler	229
Upshur	230
Upton	231
Uvalde	232
Val Verde	233
Van Zandt	234
Victoria	235
Walker	236
Waller	237
Ward	238
Washington	239
Webb	240
Wharton	241
Wheeler	242
Wichita	243
Wilbarger	244
Willacy	245

County	Code
Williamson	246
Wilson	247
Winkler	248
Wise	249
Wood	250
Yoakum	251
Young	252
Zapata	253
Zavala	254

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Glossary

Introduction

The following terms and definitions are used in the automated systems for the Home and Community-Based Services (HCS) and Texas Home Living (TxHmL) programs.

Forms identified in the *Glossary* are located on the Department of Aging and Disability Services (DADS) website. For a listing of web sites and their corresponding web addresses, refer to the *Web Addresses* section of the *Introduction.*

Adult

A person who is 18 years of age or older.

Actively involved

Involvement with an individual that the individual's service planning team deems to be of a quality nature based on the following:

- observed interactions of the person with the individual;
- a history of advocating for the best interests of the individual;
- knowledge and sensitivity to the individual's preferences, values, and beliefs;
- ability to communicate with the individual; and
- availability to the individual for assistance or support when needed.

Allowable Cost

A billable service or item that is within the rate and spending limits of the rate established by the Health and Human Services Commission and that meets the requirements of an individual's program.

Applicant

Depending on the context, an applicant is:

- a person applying for employment with an employer;
- a person or legal entity applying for a contract with an employer to deliver services to an individual; or
- a person applying for services through a DADS program.

Assignment (to Location Code)

Identifies the location and residential type of an individual's residence.

Authorized Amount

Total dollar amounts currently allowed on an individual's IPC (Individual Plan of Care). Exceeding this amount requires a review by the Program Enrollment/Utilization Review (PE/UR) unit of Mental Retardation Authorities.

Billable Unit

A term used by DADS to describe one (1) unit of a HIPAA standard procedure code. Depending on the procedure code, one (1) Billable Unit may be equal to 15 minutes, 1 day of service, or 1 month of service.

Budget	A written projection of expenditures for each program service delivered through the CDS option.
Budgeted Unit Rate	The unit rate calculated for employee compensation (wages and benefits) in the budgeting process for services delivered through the CDS option. The rate is calculated after employer support services have been budgeted.
CARE (Client Assignment and REgistration) System	Centralized, confidential client database, in which service recipients are registered and tracked.
CARE CDS Service Codes	In the CARE system, all services being self-directed have acronyms that end in "V." For example, in HCS with Supported Home Living (SHL), this service will appear as "SHLV."
Case Manager	A person who provides case management services to an individual. The case manager assists an individual who receives program services in gaining access to needed services, regardless of the funding source for the services, and assists with other duties as required by the individual's program. In the HCS Program, an individual is assigned a case manager.
CDS Option (Consumer Directed Services)	A service delivery option that allows individuals or their legally authorized representatives to be the employer of their direct service providers by recruiting, hiring, training, supervising, and terminating their service providers. Services that can be self-directed vary depending on the DADS program.
Certified HCS Provider	A contracted HCS program provider, serving enrolled individuals, that has received an on-sight survey by DADS and has demonstrated compliance with the HCS Principles.
Certified TxHmL Provider	A contracted TxHmL program provider, serving enrolled individuals, that has received an on-sight survey by DADS and has demonstrated compliance with TxHmL standards.
Claim	A service that is submitted by the provider for payment. Each claim must be for one individual, one contract, one service type, one month, one place of service, and one level of need. A single claim may include multiple dates of service within the month.
Client Identification Number (Client ID)	Unique statewide identifier generated by the CARE system when each person is registered by the Mental Retardation Authority. Also referred to as the CARE ID.

Client/Consumer	A person enrolled in the HCS and/or TxHmL program.
Community-Based Services	Services provided within the community by community centers or private providers. Includes the array of services reflected on the IPC.
Component Code	Three-digit unique code that identifies a state hospital, state school, state center, community center, or private provider. You must provide this three-digit code each time you contact DADS.
Comptroller Vendor Number	Fourteen-digit number by which the State of Texas Comptroller's office identifies the provider.
Consumer Directed Services Agency (CDSA)	An agency that contracts with DADS to provide financial management services (FMS) to individuals who choose to use the consumer directed services option.
Consumer Enrollment	Process of enrolling an individual into HCS and/or TxHmL in which the local Mental Retardation Authority has the responsibility of completing all steps in the enrollment process, including developing the PDP, MRRC, and IPC, monitoring the financial eligibility determination process, and electronically submitting information to the DADS, Program Enrollment/Utilization Review unit for review. The Program Enrollment unit approves all enrollments into the HCS or TxHmL program.
Consumer Hold	Consumer hold may be temporary hold or permanent hold and results in withholding of payment after claims have been submitted. Reasons for consumer hold are listed on the Consumer Hold Report (HC062270).
Contract Number	Nine-digit number that identifies the contract under which an individual is receiving services.
Contractor	A person, such as a licensed or certified therapist, a licensed or registered nurse, or other professional, who has a service agreement with an employer to perform one or more program services as an independent contractor, rather than an employee of the employer or of an entity. A contractor may be a sole proprietor.
Correspondent	In case of an emergency, the primary correspondent is the first person to contact on behalf of an individual. This person is not necessarily a relative or financially responsible for the care of the individual being served. The secondary correspondent is the person to contact on behalf of an individual if the primary correspondent cannot be reached.

Cost Ceiling	See *Authorized Amount*.
CPT®Code	Current Procedural Terminology (CPT®) is a set of procedure codes providers use to bill for services in **C22: Service Delivery**. CPT® Codes are used in the SERVICE CODE field.
DADS	The Department of Aging and Disability Services.
Designated Representative (DR)	An adult who is chosen by the employer (individual or LAR) to assist or to perform employer responsibilities in the CDS option. This individual must be willing to perform these duties on a volunteer basis, must be age 18 years or older, must pass a criminal background check and must not be listed on either the Employee Misconduct Registry or the Nurse Aid Registry.
Discharge	**Permanent Discharge (PD)**: the termination of services to the individual by DADS because the individual has voluntarily left the program or is found to be ineligible for the program. **Temporary Discharge (TD)**: the suspension of services to the individual by the provider while the individual is unable, ineligible, or unwilling to receive services.
Electronic Transmission Agreement (ETA)	A DADS form that providers use to request access to a secure server. Access may be for the provider, a clearinghouse that the provider has designated to transmit X12 transactions on its behalf, *or* any provider to retrieve reports from the EDTS server.
Employee	A person employed by an employer through a service agreement to deliver program services and is paid an hourly wage for those services.
Employer	An individual or LAR who chooses to participate in the CDS option, and, therefore, is responsible for hiring and retaining service providers to deliver program services. In the CDS option the employer must be either the individual receiving services (who is at least 18 years of age and does not have a legal guardian), a parent, or legal representative of a minor-aged individual, or the legal guardian, regardless of the age of the individual receiving services.
Employer-Agent	The Internal Revenue Service (IRS) designation of a CDSA as the entity responsible for specific activities and responsibilities required by the IRS on behalf of an employer in the CDS option.

Employer Support Services	Services and items the employer needs to perform employer and employment responsibilities, such as office equipment and supplies, recruitment, and payment of Hepatitis B vaccinations for employees and support consultation.
Entity	An organization that has a legal identity such as a corporation, limited partnership, limited liability company, professional association, or cooperative.
Financial Eligibility	To be served in the HCS or TxHmL program, an individual must receive Medicaid benefits. An individual is financially eligible if he/she is receiving Supplemental Security Income (SSI) benefits through the Social Security Administration *or* is receiving Medicaid Assistance Only (MAO) through the Texas Health and Human Services Commission.
Financial Management Services (FMS)	A service provided to the employer (individual or LAR) by a CDSA. This service consists of registration as the individual's employer-agent, assistance as necessary with the individual's service budget, approval of the service budget, performance of criminal background and registry checks upon request, verification of direct service provider credentials, processing direct service provider timesheets, computing and paying all federal and state taxes, distributing payroll, processing invoices and receipts for payment, maintenance of records for all expenses and reimbursements, monitoring of budgets, preparation of at least quarterly reports regarding the CDS budget for the employer and CM or SC.
Guardian	A person appointed by law to represent and make appropriate decisions for an individual because of a physical, mental, psychological, or intellectual condition that prevents the individual from making reasonable decisions or doing what is necessary for his or her health or welfare.
HCPCS	Healthcare Common Procedure Coding System. HCPCS (pronounced **hick′ • picks**) is a set of procedure codes providers use to bill for services in **C22: Service Delivery**. HCPCS Codes are used in the SERVICE CODE field.
Home and Community-Based Services (HCS) Waiver Program	A waiver of the Medicaid state plan granted under Section 1915 (c) of the Social Security Act which provides community-based services to certain people with mental retardation as an alternative to institutional care.
ICAP Service Level	The ICAP service level identifies the level of service as determined by the Inventory for Client and Agency Planning (ICAP) assessment instrument.
ICF/MR	An intermediate care facility for persons with mental retardation or a related condition.

Individual	A person enrolled in a program.
Individual Plan of Care (IPC)	A format for documentation of services needed by a person receiving services in the HCS or TxHmL program. The IPC is based on an assessment of the individual's needs and personal goals and is developed by qualified individuals. The IPC contains the specific types of services required to support an individual in the community, the units of services, and the estimated annual cost.
Individual Service Plan (ISP)	A written plan developed by the Interdisciplinary Team that describes the individual's characteristics, desires, needs, and personal outcomes, the waiver and non-waiver services necessary to achieve the individual's outcomes, the objectives and methodologies related to each service, and the justification for each service. The ISP must be reviewed and updated at least annually and as the individual's circumstances change. The ISP describes the services to be included in the IPC.
Interdisciplinary Team (IDT)	A planning team constituted by the provider consisting of the individual and Legally Authorized Representative (LAR), a case manager, a nurse, other persons chosen by the individual/LAR, and professional or direct care staff necessary to address the needs and desires of the individual.
Internal Control Number *or* **ICN**	An ICN is used to uniquely identify a single claim. An ICN will be assigned to a claim when at least 1 line item for that claim has passed the Phase 1 edits (i.e., has been accepted into the system).
Inventory for Client and Agency Planning (ICAP)	A validated, standardized assessment that measures the level of assistance and supervision an individual requires and, thus, the amount and intensity of services and supports an individual needs.
Legally Authorized Representative (LAR)	A person authorized or required by law to act on behalf of an individual with regard to a matter described in this chapter, including a parent, guardian, managing conservator of a minor, or the guardian of an adult.
Level of Care (LOC)	A determination of eligibility of an individual for the ICF/MR, HCS, or TxHmL programs. Assignment of the LOC is based on medical and intellectual diagnosis and professional evaluation of the person's needs.
Level of Need (LON)	An assignment given to an individual enrolled in the ICF/MR, HCS, or TxHmL programs upon which reimbursement for services is based. The Level of Need determines the payment rate for Day Habilitation, Supervised Living, Residential Support Service, and Foster Care in HCS and the daily rate in community ICF/MRs.

Line Item	The part of the claim that specifies the date of service. Multiple line items can be included as part of one claim.
Line Number	Number used to uniquely identify a single line item within a claim. It is always used in conjunction with the ICN. Both the ICN and Line Number will be assigned to a line item when at least 1 line item on a claim has passed the Phase 1 edits (i.e., has been accepted into the system).
Local Case Number	Number assigned to the individual by the provider. The local case number can be 1-10 characters with any combination of letters and numbers. When an individual moves from one provider to another, the new provider must assign a local case number.
Location Code	Code used to identify a home in which residential services are provided. The Location Code can be 1-4 characters with any combination of letters and numbers.
Logon Account Number (User ID Number)	Number assigned to each user by DADS that identifies the user and allows that user to access the network.
Mental Retardation Authority (MRA)	An entity to which the Texas Health and Human Services Commission's authority and responsibility described in THSC, §531.002(11) has been delegated.
Minor	A person who is 17 years of age or younger.
Minor Home Modification/ Adaptive Aids/ Dental Summary Sheet (4116A)	A form that is used to request Reimbursement Authorization for adaptive aids, minor home modifications, or dental services.
Modifier	See *Procedure Code Modifier*.
MR/RC Assessment	A form utilized by DADS for eligibility determination, LOC determination, and LON assignment. Refer to the MR/RC Assessment instructions at http://www.dads.state.tx.us/handbooks/instr/8000/F8578-HCS/ for definitions of the terms used on the MR/RC.
Non-Program Resource	A resource other than an individual's program that provides one or more support services or items.
Parent	A natural, legal, foster, or adoptive parent of a minor.

Permanency Planning	A philosophy and planning process that focuses on the outcome of family support for an individual under 22 years of age by facilitating a permanent living arrangement in which the primary feature is an enduring and nurturing parental relationship.
Person-Directed Plan (PDP)	The service plan for individuals in the TxHmL program that describes the supports and services necessary to achieve the desired outcomes identified by the individual, or the LAR on behalf of the individual. This document identifies the program services to be provided to the individual, the number of units of each service to be provided, and the projected cost of each service.
Place of Service *or* POS	One of five code sets providers use in **C22: Service Delivery** to bill for services. POS codes are used to identify the physical location where services were provided.
Prior Approval	Approval for those adaptive aids (AA) and minor home modifications (MHM) that have not been purchased. Providers may obtain prior approval to determine how much DADS will pay for a particular AA or MHM. Providers submit the *AA/MHM Request for Prior Approval* form to DADS, Provider Services, Billing and Payment unit to request approval of an AA or MHM prior to its purchase. Submitted requests will be assigned a Prior Approval (PA) Tracking Number. Providers are responsible for accessing **C75: Prior Approval Inquiry** to look up the PA Tracking Number and status for a submitted request.
Prior Authorization	A general term used in the healthcare industry to describe a process in which providers are responsible for getting services authorized, usually before the services have been provided, but in some cases afterward. Both Prior Approval and Reimbursement Authorization are types of prior authorization.
Procedure Code Modifier	One of five code sets providers use in **C22: Service Delivery** to bill for services. A Procedure Code Modifier is a two-digit code that further defines the services described by a HCPCS, CPT®, or Dental procedure code. DADS uses modifiers to distinguish between services that are billed using the same HCPCS or CPT® code (e.g., SL and RSS, OT and PT).
Procedure Code Qualifier	One of five code sets providers use in **C22: Service Delivery** to bill for services. Procedure Code Qualifier **HC** indicates that HCPCS or CPT® procedure codes are being used to bill for services. Procedure Code Qualifier **AD** indicates that Dental procedure codes are being used to bill for services.

Program	A community services program administered by DADS.
Program Unit	A term used by DADS to describe one (1) unit of service as it appears on the IPC. Depending on the service type, one (1) unit may be equal to 1 hour, 1 day, or 1 month of service.
Provider	A service provider with whom the department contracts for the delivery of community-based mental retardation services in a specified local service area (*contract area*) of the state.
Program Provider (PRGP)	In the CDS option, this term refers to the individual's comprehensive program provider agency.
Provisionally Certified HCS Provider	A legal entity that has completed the application process to become an HCS program provider, including submission of required contract information and an HCS Self-Assessment, attendance at the Pre-Application Orientation and New Provider Orientation, and demonstration of an HCS Self-Assessment that is in 100% compliance with the HCS Principles. Provisional certification must be obtained prior to the legal entity contracting with DADS as an HCS program provider.
Provisionally Certified TxHmL Provider	A legal entity that has completed the application process to become a TxHmL program provider. Provisional certification must be obtained prior to the legal entity contracting with DADS as a TxHmL program provider.
Qualifier	See *Procedure Code Qualifier*.
Registration	Formal enrollment into the CARE system which establishes that an individual is registered to receive services. Registration is done by the MRA only.
Reimbursement Authorization	Authorization that providers request from DADS to bill for adaptive aids (AA), minor home modifications (MHM), or dental (DE) services that have already been purchased and which may or may not have gone through the Prior Approval process. When providers submit a *Minor Home Modification/Adaptive Aids/Dental Summary Sheet* (4116A) with receipts and any other needed information, they are requesting Reimbursement Authorization (i.e., authorization for payment). Once Reimbursement Authorization has been given an "approved" status in **C77: Reimbursement Authorization Inquiry**, providers may bill for the AA, MHM, or DE service using **C22: Service Delivery**. The Reimbursement Authorization (RA) Tracking Number obtained from **C77** should be used as the authorization number in **C22**. Providers are responsible for reviewing **C77** to obtain the RA Tracking Number and status for a submitted request.

Related Condition

A severe, chronic disability that meets all of the following conditions:

(A) a condition attributable to:
  (i) cerebral palsy or epilepsy; or
  (ii) any other condition including autism, but excluding mental illness, found to be closely related to mental retardation because this condition results in impairment of general intellectual functioning or adaptive behavior similar to that of persons with mental retardation and requires treatment or services similar to those required for these persons;

(B) a condition manifested before the person reaches age 22 years;

(C) a condition likely to continue indefinitely; and

(D) a condition that results in substantial functional limitations in three or more of the following areas of major life activity:
  (i) self-care;
  (ii) understanding and use of language;
  (iii) learning;
  (iv) mobility;
  (v) self-direction; and
  (vi) capacity for independent living.

Residential Type *(for IPC entry)*

Code for the type of residential services the individual is receiving.

See the *Screen Fields* section of this User Guide for the complete list of Residential Type codes.

Revenue Code

One of five code sets providers use in **C22: Service Delivery** to bill for services. Revenue codes group services into distinct cost centers. Revenue codes are required on the **C22: Service Delivery** screen when billing for services other than adaptive aids, minor home modifications, and dental.

SDO

See *Service Delivery Option*

Service Agreement

A written agreement or acknowledgment between two parties that defines the relationship and lists respective roles and responsibilities.

Service Area

A geographic area served by a program or specified in a contract with DADS.

Service Back-Up Plan

A documented plan to ensure that critical program services delivered through the CDS option are provided to an individual when normal service delivery is interrupted or there is an emergency.

Service Code	One of five code sets providers use in C22: Service Delivery to bill for services. HCPCS and CPT® procedure codes are used in the Service Code field.
Service Coordinator	An employee of a mental retardation authority who is responsible for assisting an applicant, individual, or LAR to access needed medical, social, educational, and other appropriate services, including DADS program services. A service coordinator provides case management services to an individual in the TxHmL program.
Service County	County in which an individual is receiving services.
Service Delivery Option (SDO)	The manner in which individuals choose to receive their program services. In HCS, an individual can choose to self-direct supported home living and respite while having the remainder of their services provided by their program provider. An individual may also choose to have all of their services delivered by their program provider with the agency option. In TxHmL, and individual may choose to use CDS with ALL of their services. An individual may also choose to have a program provider agency provide all of their services, or may choose to self-direct some services while having a program provider deliver others.
Service Plan	A document developed in accordance with rules governing an individual's program that identifies the program services to be provided to the individual, the number of units of each service to be provided, and the projected cost of each service.
Service Planning Team	A group of people convened to plan services and supports with an individual receiving services, determined based on the requirements of an individual's program. Some DADS programs refer to the service planning team as an interdisciplinary team.
Service Provider	An employee, contractor, or vendor.
Service Type (for Waiting List entry)	Code for the type of service the individual is waiting to receive.

Slot Tracking Number	When an individual is enrolled in the waiver program, a Slot Tracking Number is assigned to the individual if the slot is classified as new allocation. When an individual is permanently discharged from the waiver program, the status of the Slot Tracking Number is automatically changed to unavailable. When a slot is released for use, the slot is assigned to a particular slot type and the status is changed to available. When an MRA enters the L01 screen and the individual has an assigned Slot Tracking Number, the slot type is omitted and the Slot Tracking Number is entered.
Slot Type	The slot type is determined by the specific funding allocation from the Texas Legislature.
Support Advisor	A person who provides support consultation to an employer, or a DR, or an individual receiving services through the CDS option. This person must have been certified through DADS to provide the service.
Support Consultation	An optional service that is provided by a support advisor and provides a level of assistance and training beyond that provided by the CDSA through FMS. Support consultation helps an employer to meet the required employer responsibilities of the CDS option and to successfully deliver program services.
Texas Home Living (TxHmL) Waiver Program	A Medicaid waiver program which provides community-based services and supports to eligible individuals who live in their own homes or in their family homes.
Transfer	The movement of an individual from one provider to a different provider or from one contract to another contract. All transfers *must be approved* by Program Enrollment staff of DADS, Access and Intake, Mental Retardation Authorities.
Vendor	A person selected by an employer or DR to deliver services, goods, or items, other than a direct service to an individual. Examples of vendors include a building contractor, electrician, durable medical equipment provider, pharmacy, or a medical supply company.
Vendor Hold	Temporary suspension of payment from department to a program provider.
Working Day	Any day except Saturday, Sunday, a state holiday, or a federal holiday.
4116A Form	See *Minor Home Modification/Adaptive Aids/Dental Summary Sheet*.

Quick Reference

Introduction

The *Quick Reference* section of the manual provides quick references for the following procedures.

Introduction, continued

Add Case to ID/Demographic Update (410)

Step 1 – Access the Add Case to ID/Demographic Update option.

- Type **410** in the ACT: field of any screen.
- Press **Enter**.

Step 2 – Identify the individual and indicate the type of entry.

On the **410: Add Case to ID/Demographic Update** header screen:

- Type the Client ID in the CLIENT ID field.
- Type the MRA component code in the COMPONENT CODE field.
- Type **A** (Add Case) in the TYPE OF ENTRY field.
- Press **Enter**.

Step 3 – Add a local case number for the MRA component.

On the **410: Add Case to ID/Demographic Update** screen:

- Type the local case number for the MRA in the LOCAL CASE NUMBER field.
- Type **Y** in the READY TO UPDATE? field to submit the data to the system.
- Press **Enter**.

Client Address Update (L12)

Step 1 – Access the Client Address Update option.

- Type **L12** in the ACT: field of any screen.
- Press **Enter**.

Step 2 – Identify the individual.

On the **L12: Client Address Update** header screen:

- Type the requested identifying information in the appropriate fields.

Rule: You must enter the Client ID *or* the local case number.

- Type the component code of the individual's current component in the COMPONENT CODE field.
- Press **Enter**.

Step 3 – Update an individual's address information.

On the **L12: Client Address Update** screen:

- Type update information (street address, city, state, zip code) in the appropriate CLIENT'S CURRENT ADDRESS fields.
- Type the date the individual's address record is being updated in the ADDRESS DATE field.
- Type **Y** in the READY TO UPDATE? field to submit the data to the system.
- Press **Enter**.

Client Assignments (L26): Add

Step 1 – Access the Client Assignments option.

- Type **L26** in the ACT: field of any screen.
- Press **Enter**.

Step 2 – Identify the individual and indicate the type of entry.

On the **L26: Client Assignments: Add/ Correct/Delete** header screen:

- Type the requested identifying information in the appropriate fields.

Rule: You must enter the Client ID, the local case number, *or* the Medicaid Number.

- Type the provider's component code in the COMPONENT CODE field.
- Type **A** (Add) in the TYPE OF ENTRY field.
- Press **Enter**.

Step 3 – Add a new client assignment record for a TxHmL individual if the individual moves to a different county.

On the **L26: Client Assignments: Add** screen:

- Type the effective date of the new assignment in the EFFECTIVE DATE field.
- Type **OHFH** (Own Home/Family Home) in the LOCATION CODE field.
- Type the county code of the new assignment in the COUNTY field.
- Type **Y** in the READY TO ADD? field.
- Press **Enter**.

Client Assignments (L26): Correct

Step 1 – Access the Client Assignments option.

- Type **L26** in the ACT: field of any screen.
- Press **Enter**.

Step 2 – Identify the individual and indicate the type of entry.

On the **L26: Client Assignments: Add/ Correct/Delete** header screen:

- Type the requested identifying information in the appropriate fields.

Rule: You must enter the Client ID, the local case number, *or* the Medicaid Number.

- Type the provider's component code in the COMPONENT CODE field.
- Type **C** (Correct) in the TYPE OF ENTRY field.
- Press **Enter**.

Step 3 – Correct errors on existing TxHmL assignments (incorrect assignment date, location code, or county).

On the **L26: Client Assignments: Correct** screen:

- Type corrections to errors in the *current assignment* in the appropriate fields.
- Type **Y** in the READY TO CHANGE? field.
- Press **Enter**.

Client Assignments (L26): Delete

Step 1 – Access the Client Assignments option.

- Type **L26** in the ACT: field of any screen.
- Press **Enter**.

Step 2 – Identify the individual and indicate the type of entry.

On the **L26: Client Assignments: Add/ Correct/Delete** header screen:

- Type the requested identifying information in the appropriate fields.

Rule: You must enter the Client ID, the local case number, *or* the Medicaid Number.

- Type the provider's component code in the COMPONENT CODE field.
- Type **D** (Delete) in the TYPE OF ENTRY field.
- Press **Enter**.

Step 3 – Add a new client assignment record for a TxHmL individual if the individual moves to a different county.

On the **L26: Client Assignments: Delete** screen:

- Type **Y** in the READY TO DELETE? field.
- Press **Enter**.

Client Correspondent Update (L10)

Step 1 – Access the Client Correspondent Update option.

- Type **L10** in the ACT: field of any screen.
- Press **Enter**.

Step 2 – Identify the individual.

On the **L10: Client Correspondent Update** header screen:

- Type the requested identifying information in the appropriate fields.

Rule: You must enter the Client ID *or* the local case number.

- Type the component code of the individual's current component in the COMPONENT CODE field.
- Press **Enter**.

Step 3 – Update an individual's correspondent information.

On the **L10: Client Correspondent Update** screen:

- Type Primary Correspondent and/or Secondary Correspondent information (name, relationship, street, telephone, city, state, zip code) in the appropriate **Primary Correspondent** and/or **Secondary Correspondent** fields.

Note: If you type a name in the CORRES. NAME field, you must type a code for the correspondent's relationship in the CORRES. RELATIONSHIP field.

- Type **Y** in the READY TO UPDATE? field to submit the data to the system.
- Press **Enter**.

Client Name Update (L11): Add

Step 1 – Access the Client Name Update option.

- Type **L11** in the ACT: field of any screen.
- Press **Enter**.

Step 2 – Identify the individual and indicate the type of entry.

On the **L11: Client Name Update** header screen:

- Type the requested identifying information in the appropriate fields.

Rule: You must enter the Client ID *or* the local case number.

- Type the component code of the individual's current component in the COMPONENT CODE field.
- Type **A** (Add) in the TYPE OF ENTRY field.
- Press **Enter**.

Step 3 – Add information to an individual's name record.

On the **L11: Client Name Update** screen:

- Type update information (last name/suffix, first name, middle name) in the appropriate **Add Client Name** fields.
- Type **Y** in the READY TO ADD? field to submit the data to the system.
- Press **Enter**.

Client Name Update (L11): Change

Step 1 – Access the Client Name Update option.

- Type **L11** in the ACT: field of any screen.
- Press **Enter**.

Step 2 – Identify the individual and indicate the type of entry.

On the **L11: Client Name Update** header screen:

- Type the requested identifying information in the appropriate fields.

Rule: You must enter the Client ID *or* the local case number.

- Type the component code of the individual's current component in the COMPONENT CODE field.
- Type **C** (Change) in the TYPE OF ENTRY field.
- Press **Enter**.

Step 3 – Change name information that was entered incorrectly by your MRA.

On the **L11: Client Name Update** screen:

- Type update information (last name/suffix, first name, middle name) in the appropriate **Change Client Name** fields.
- Type **Y** in the READY TO CHANGE? field to submit the data to the system.
- Press **Enter**.

Client Name Update (L11): Delete

Step 1 – Access the Client Name Update option.

- Type **L11** in the ACT: field of any screen.
- Press **Enter**.

Step 2 – Identify the individual and indicate the type of entry.

On the **L11: Client Name Update** header screen:

- Type the requested identifying information in the appropriate fields.

Rule: You must enter the Client ID *or* the local case number.

- Type the component code of the individual's current component in the COMPONENT CODE field.
- Type **D** (Delete) in the TYPE OF ENTRY field.
- Press **Enter**.

Step 3 – Delete a name update that was entered in error by your MRA.

Note: If there is more than one name update record, the system displays the most recent name update record.

On the **L11: Client Name Update** screen:

- Type **Y** in the READY TO DELETE? field to submit the data to the system.
- Press **Enter**.

Result: If there is more than one record, the next record is displayed with the message, *"Previous Information Deleted."*

- Repeat the action to delete the record displayed

or

- Type **N** in the READY TO DELETE? field to take no action and return to the header screen.
- Press **Enter**.

Consumer Discharge (L18)

The Consumer Discharge process allows the MRA to review the provider's *permanent* discharge of an individual from the HCS or TxHmL waiver program.

For termination of waiver services, the provider must complete the **C18: Consumer Discharge** screen and the MRA must complete the **L18: Consumer Discharge** screen *after* **C18** is completed by the provider. ***If there is no program provider***, the MRA must complete both the **C18: Consumer Discharge** and **L18: Consumer Discharge** screens.

Step 1 – Access the Consumer Discharge option.

- Type **L18** in the ACT: field of any screen.
- Press **Enter**.

Step 2 – Identify the individual.

On the **L18: Consumer Discharge** header screen:

- Type the requested identifying information in the appropriate fields.

Rule: You must enter the Client ID, the local case number, *or* the Medicaid number.

- Type the provider's component code in the COMPONENT CODE field.
- Press **Enter**.

Step 3 – Review an individual's permanent discharge from the TxHmL waiver program.

On the **L18: Consumer Discharge** screen:

- Type the name of the MRA Representative in the BY: field.
- Type the date the termination was reviewed in the DATE field.
- Type **Y** in the READY TO UPDATE? field.
- Press **Enter**.

Consumer Discharge – Permanent (C18/L18) (No Program Provider)

For termination of waiver services, the provider must complete the **C18: Consumer Discharge** screen and the MRA must complete the **L18: Consumer Discharge** screen *after* **C18** is completed by the provider. ***If there is no program provider***, the MRA must complete both the **C18: Consumer Discharge** and **L18: Consumer Discharge** screens.

The MRA will use the following steps to terminate waiver services for an individual from the HCS or TxHmL waiver program if there is no program provider.

Step 1 – Access the Consumer Discharge option.

- Type **C18** in the ACT: field of any screen.
- Press **Enter**.

Step 2 – Identify the individual.

On the **C18: Consumer Discharge** header screen:

- Type the requested identifying information in the appropriate fields.

Rule: You must enter the Client ID, the local case number, *or* the Medicaid number.

- Type the provider's component code in the COMPONENT CODE field.
- Type **P** in the TYPE OF DISCHARGE field.
- Type **A** in the TYPE OF ENTRY field.
- Press **Enter**.

Step 3 – Discharge the individual

On the **C18: Consumer Discharge** screen:

- Type the name of the provider representative in the PROVIDER REPRESENTATIVE NAME field.
- Type the discharge date in the DISCHARGE DATE field.
- Type **Y** (Yes) or **N** (No) in the DID CONSUMER RECEIVE SERVICES ON DISCHARGE DATE? field.
- Type the number representing the termination reason in the TERMINATION REASON field.

If the reason of discharge is death:

- Type the date of death in the DATE OF DEATH field.
- Type the time of death in the TIME OF DEATH field. (HHMMA/P format)
- Type **Y** in the **READY TO ADD?** field.
- Press **Enter**.

Step 4 – Access the Consumer Discharge option.

- Type **L18** in the ACT: field of any screen.
- Press **Enter**.

Step 5 – Identify the individual.

On the **L18: Consumer Discharge** header screen:

- Type the requested identifying information in the appropriate fields.

Rule: You must enter the Client ID, the local case number, *or* the Medicaid number.

- Type the provider's component code in the COMPONENT CODE field.
- Press **Enter**.

Step 6 – Review an individual's permanent discharge from the TxHmL waiver program.

On the **L18: Consumer Discharge** screen:

- Type the name of the MRA Representative in the BY: field.
- Type the date the termination was reviewed in the DATE field.
- Type **Y** in the READY TO UPDATE? field.
- Press **Enter**.

Consumer Discharge – Temporary (C18) (Consumer is Self-Directing Services)

Step 1 – Access the Consumer Discharge option.

- Type **C18** in the ACT: field of any screen.
- Press **Enter**.

Step 2 – Identify the individual.

On the **C18: Consumer Discharge** header screen:

- Type the requested identifying information in the appropriate fields.

Rule: You must enter the Client ID, the local case number, *or* the Medicaid number.

- Type **T** in the TYPE OF DISCHARGE field.
- Type **A** in the TYPE OF ENTRY field.
- Press **Enter**.

Step 3 – Suspend the individual's waiver services

On the **C18: Consumer Discharge** screen:

- Type the name of the provider representative in the PROVIDER REPRESENTATIVE NAME field.
- Type the discharge date in the DISCHARGE DATE field.
- Type **Y** (Yes) or **N** (No) in the DID CONSUMER RECEIVE SERVICES ON DISCHARGE DATE? field.
- Type the number representing the termination reason in the TERMINATION REASON field.
- Type **Y** in the **READY TO ADD?** field.
- Press **Enter**.

Consumer Discharge (C18): Change (Temporary) (Consumer is Self-Directing Services)

Step 1 – Access the Consumer Discharge option.

- Type **C18** in the ACT: field of any screen.
- Press **Enter**.

Step 2 – Identify the individual.

On the **C18: Consumer Discharge** header screen:

- Type the requested identifying information in the appropriate fields.

Rule: You must enter the Client ID, the local case number, *or* the Medicaid number.

- Type **T** in the TYPE OF DISCHARGE field.
- Type **C** in the TYPE OF ENTRY field.
- Press **Enter**.

Step 3 – Change the suspension of waiver services.

On the **C18: Consumer Discharge** screen:

- Type the changes to the discharge information in the appropriate fields.
- If the individual is ending his/her temporary discharge, type the end date in the END DATE field.
- Type **Y** in the **READY TO CHANGE?** field.
- Press **Enter**.

Consumer Discharge (C18): Delete (Temporary) (Consumer is Self-Directing Services)

Step 1 – Access the Consumer Discharge option.

- Type **C18** in the ACT: field of any screen.
- Press **Enter**.

Step 2 – Identify the individual.

On the **C18: Consumer Discharge** header screen:

- Type the requested identifying information in the appropriate fields.

Rule: You must enter the Client ID, the local case number, *or* the Medicaid number.

- Type **T** in the TYPE OF DISCHARGE field.
- Type **D** in the TYPE OF ENTRY field.
- Press **Enter**.

Step 3 – Delete the suspension of waiver services.

On the **C18: Consumer Discharge** screen:

- Type **Y** in the **READY TO DELETE?** field.
- Press **Enter**.

Consumer Enrollment (L01)

Step 1 – Access the Consumer Enrollment option.

- Type **L01** in the ACT: field of any screen.
- Press **Enter**.

Step 2 – Identify the individual and indicate the type of entry.

On the **L01: Consumer Enrollment: Add/ Change/Delete** header screen:

- Type the requested identifying information in the appropriate fields.

Rule: You must enter the Client ID *or* the local case number.

- Type the MRA component code in the COMPONENT CODE field.
- Type **A** (Add) in the TYPE OF ENTRY field.
- Press **Enter**.

Step 3 – Establish a waiver program enrollment for an individual.

On the **L01: Consumer Enrollment: Add** screen:

- Type the code for the waiver type in which the applicant is to be enrolled in the WAIVER TYPE field.
- Type **Y** (Yes) or **N** (No) in the PRIOR DISCHARGE FROM A MEDICAID CERTIFIED NF OR ICF-MR? field.
- Type the code for where the person was living prior to entering the waiver program in the ADMIT FROM field.
- Type *either* the Slot Type (for new allocation slots) in the SLOT TYPE field *or* the Slot Tracking Number (for recycled slots) in the SLOT TRACKING NUMBER field.
- Type **Y** (Yes) or **N** (No) to indicate whether the person is participating in the Money Follows the Person Demonstration Project in the MFP DEMO? field.
- Type the county code of the county in which the individual will receive services in the COUNTY OF SERVICE field.
- Type **Y** in the READY TO ADD? field.
- Press **Enter**.

Consumer Transfer – Transfers Involving a Program Provider Only (L06)

No services are or will be self-directed. If more than one MRA is involved in the transfer, the ***transferring*** MRA is responsible for completing ***all*** of the data entry screens.

Step 1 – Access the Consumer Hold Inquiry screen.

- Type **C88** in the ACT: field of any screen.
- Press **Enter**.

Step 2 – Identify the individual.

On the **C88: Consumer Hold Inquiry** header screen:

- Type the requested identifying information in the appropriate fields.
- Type the transferring provider's component code in the COMPONENT CODE field.
- Type **T** in the HOLD TYPE field.
- Type **O** in the HOLD STATUS field.
- Leave the OVERRIDES field blank.
- Press **Enter**.

Step 3 – View the Hold information.

- If no hold records are found, proceed with the transfer.
- If the individual has been placed on Hold, correct the error and repeat **Steps 1 and 2** before you proceed with the transfer.

Step 4 – Assign a Local Case Number.

- Type **L09** in the ACT: field of any screen.
- Press **Enter**.

Step 5 – Identify the individual.

On the **L09: Register Client Update** screen:

- Type the Client ID in the **CLIENT ID** field.
- Type the ***Component Code of the receiving*** provider in the COMPONENT CODE field.
- Press **Enter**.

Step 6 – Assign the Local Case Number.

On the **L09: Register Client Update** screen:

- Type the individual's local case number ***obtained from the receiving Program Provider*** in the LOCAL CASE NUMBER field.

Note: The LOCAL CASE NUMBER field *cannot* be blank.

- Type updated information in the appropriate fields, if necessary.
- Type **Y** in the READY TO UPDATE? field to submit the data to the system.
- Press **Enter**.

Step 7 – Access the Transfer Option.

On the **L09: Register Client Update** header screen:

- Type **L06** in the ACT: field.
- Press **Enter**.

Step 8 – Identify the Transferring Component and the Individual.

On the **L06: Consumer Transfer: Contract Services: A/C/D** header screen.

- Type the requested identifying information in the appropriate fields.

Step 8, continued

Rule: You must enter the Client ID, the local case number, *or* the Medicaid Number.

- Type the Component Code of the ***transferring*** (current) Program Provider in the COMPONENT CODE field.
- Type the contract number in the CONTRACT field.
- Type the transfer effective date in the TRANSFER EFFECTIVE DATE field.
- Type **A** (Add) in the TYPE OF ENTRY field.
- Type **Y** (Yes) as the answer to question 1. CHANGING A PROGRAM PROVIDER OR CDS AGENCY?
- Type **N** (No) as the answer to question 2. ADDING A PROGRAM PROVIDER OR CDS AGENCY?
- Type **N** (No) as the answer to question 3. CHANGING SERVICE DELIVERY OPTIONS?
- Press **Enter**.

Step 9 – Indicate Units/Dollars to be Reserved for Services to be Provided Prior to the Transfer Effective Date.

On the **L06: Consumer Transfer: Contract/Services: Add** screen:

- Type the units/dollars to be reserved in the appropriate field for each service under the TO USE column.
- Type **Y** in the **READY TO ADD?** field.
- Press **Enter**.

Step 10 – Add the Transfer.

On the **L06: Consumer Transfer: Add** screen:

- Type the new service county code in the SERVICE COUNTY field.
- Type the location code in the LOCATION CODE field.
- Type the residential type in the RESIDENTIAL TYPE field, if necessary.

Complete the following fields as they apply to the receiving provider.

- Type the component code of the new Program Provider in the COMP field.
- Type the local case number in the LCN field.
- Type the contract number of the new Program Provider in the CONTRACT NUMBER field,
- Type **Y** in the READY TO ADD? field.
- Press **Enter**.

Result: A screen containing the transfer effective date is displayed. If the date is incorrect, do not proceed. You must delete the transfer record and begin again.

- Press **Enter** to continue.

Step 11 – Access the IPC.

On the **L06: Consumer Transfer** header screen:

- Type **L02** in the ACT: field.
- Press **Enter**.

Consumer Transfer - Transfers Involving a Program Provider Only (L06), Continued

Step 12 – Identify the Receiving Provider and the Individual.

On the **L06: Consumer Transfer** header screen:

- Type the requested identifying information in the appropriate fields.

Rule: You *must* enter the Client ID, the local case number, or the Medicaid Number.

- Type the Component Code of the ***receiving*** provider in the COMPONENT CODE field.
- Type **T** (Transfer) in the TYPE OF ENTRY field.
- Press **Enter**.

Step 13 – Make Adjustments to the IPC.

On the **L02: Individual Plan of Care Entry: Transfer** screen:

- Use this screen to make the adjustments to the IPC that were agreed upon in the Transfer IPC meeting.

Note: You cannot reduce services below what has already been claimed.

- Type **Y** in the READY TO CONTINUE? field.
- Press **Enter**.

On the **L02: Individual Plan of Care Entry: Transfer** screen (screen 2):

- Type **Y** in the READY TO CONTINUE? field.
- Press **Enter**.

On the **L02: Individual Plan of Care Entry: Transfer** screen (screen 3):

- Type **Y** (Yes) or **N** (No) to indicate whether any services are staffed by a relative or guardian.
- You must change the date in the DATE fields. The dates must be after the previous REVISE DATE and on or before the current TRANSFER date.
- Change the names if necessary.
- Type **Y** in the READY TO TRANSFER? field to submit the data to the system.
- Press **Enter**.

Result: You are informed that the transfer IPC has been entered and that you must return to the **L06** screen to complete the transfer.

- Press **Enter**.

Step 14 – Access the L06 Transfer Screen.

On the **L02: Individual Plan of Care** header screen:

- Type **L06** in the ACT: field.
- Press **Enter**.

Step 15 – Identify the Component and Individual.

On the **L06: Consumer Transfer** header screen:

- Type the requested identifying information in the appropriate fields.

Rule: You must enter the Client ID, the local case number, *or* the Medicaid Number.

- Type the Component Code of the ***receiving*** provider in the COMPONENT CODE field.
- Type the contract number in the CONTRACT field.
- Type the transfer effective date in the TRANSFER EFFECTIVE DATE field.
- Type **C** (Change) in the **TYPE OF ENTRY** field.

Note: ***DO NOT*** attempt to answer the three questions on the header screen for this action. *Leave the fields blank.*

- Press **Enter**.

Step 16 – Accept the Transfer Data Entry.

On the **L06: Consumer Transfer: Change** screen:

- Type **Y** in the TRANSFER ACCEPTED field.
- Type the name of the person accepting the transfer data entry in the BY field.
- If the:
  - Transfer will occur in the *future*, type the date of data entry in the DATE field.
  - Transfer occurred in the *past*, type the date of the transfer in the Date field.
- Type **Y** in the READY TO CHANGE? field.
- Press **Enter**.

Result: A screen containing the transfer effective date is displayed. If the date is incorrect, the entire transfer record must be deleted and the transfer must be re-entered.

- Press **Enter**.

Reminder: A transfer is not complete until authorized by Program Enrollment.
After all of the data entry is complete, the MRA must send the signed Form 3617 Request for Transfer of Waiver Program Services and the ***receiving provider's*** transfer IPC to Program Enrollment for authorization. Do not send any documentation until **all** of the data entry is complete.

Service claims cannot be entered by the receiving program provider until the transfer has been authorized and the individual is listed as active on the receiving program provider's Consumer Roster (**C67/L67**).

Use the **A63** screen to view the status of the transfer.

Consumer Transfer – Transfers Involving a CDSA (L06)

At least one service is or will be self-directed. If more than one MRA is involved in the transfer, the ***transferring*** MRA is responsible for completing ***all*** of the data entry screens.

Step 1 – Access the Consumer Hold Inquiry screen.

- Type **C88** in the ACT: field of any screen.
- Press **Enter**.

Step 2 – Identify the individual.

On the **C88: Consumer Hold Inquiry** header screen:

- Type the requested identifying information in the appropriate fields.
- Type the transferring provider's component code in the COMPONENT CODE field.
- Type **T** in the HOLD TYPE field.
- Type **O** in the HOLD STATUS field.
- Leave the OVERRIDES field blank.
- Press **Enter**.

Step 3 – View the Hold information.

- If no hold records are found, proceed with the transfer.
- If the individual has been placed on Hold, correct the error and repeat **Steps 1 and 2** before you proceed with the transfer.

Step 4 – Assign a Local Case Number.

- Type **L09** in the ACT: field of any screen.
- Press **Enter**.

Step 5 – Identify the individual.

On the **L09: Register Client Update** screen:

- Type the Client ID in the **CLIENT ID** field.
- Type the ***Component Code of the receiving*** provider in the COMPONENT CODE field.
- Press **Enter**.

Step 6 – Assign the Local Case Number.

On the **L09: Register Client Update** screen:

- Type the individual's local case number ***obtained from the receiving provider and/or CDSA*** in the LOCAL CASE NUMBER field.

Note: The LOCAL CASE NUMBER field *cannot* be blank.

- Type updated information in the appropriate fields, if necessary.
- Type **Y** in the READY TO UPDATE? field to submit the data to the system.
- Press **Enter**.

Step 7 – Access the Transfer Option.

On the **L09: Register Client Update** header screen:

- Type **L06** in the ACT: field.
- Press **Enter**.

Step 8 – Identify the Transferring Component and the Individual.

On the **L06: Consumer Transfer: Contract Services: A/C/D** header screen.

- Type the requested identifying information in the appropriate fields.

Step 8, continued

Rule: You must enter the Client ID, the local case number, *or* the Medicaid Number.

- Type the Component Code of the ***transferring*** (current) Program Provider or CDSA in the COMPONENT CODE field.
- Type the contract number in the CONTRACT field.
- Type the transfer effective date in the TRANSFER EFFECTIVE DATE field.
- Type **A** (Add) in the TYPE OF ENTRY field.
- Type **Y** (Yes) or **N** (No) to answer each of the following three questions, as appropriate:
  1. CHANGING PROGRAM PROVIDER OR CDS AGENCY?
  2. ADDING A PROGRAM PROVIDER OR CDS AGENCY?
  3. CHANGING SERVICE DELIVERY OPTIONS?

Refer to the charts provided in the Transfer section of the User Guide for help in answering the questions correctly.

- Press **Enter**.

Step 9 – Answer follow up questions.

On the screen containing the follow up questions:

- Answer **Y** or **N** to each question and press **Enter** after each question.

Refer to the charts in provided in the Transfer section of the User Guide for help in answering the questions correctly.

- Verify that the last statement is correct.

If the statement is…	Then…
Correct	• Type **Y**. • Press **Enter**. Result: The **L06: Consumer Transfer: Contract/Services: Add** screen is displayed. Continue with *Step 10*.
Incorrect	• Type **N**. • Press **Enter**. Result: The header screen is displayed with the information you just entered. • Check the information and make any necessary changes. • Press **Enter**. • Repeat this step.

Step 10 – Indicate Units/Dollars to be Reserved for Services to be Provided Prior to the Transfer Effective Date.

On the **L06: Consumer Transfer: Contract/Services: Add** screen:

Note: The transferring program provider and/or CDSA calculates the amount of units/dollars to be reserved for services that will be provided by them prior to the transfer effective date and/or have been provided by them but not yet claimed and indicates those units/dollars on Form 3617.

Step 10, continued

- Type the units/dollars to be reserved in the appropriate field for each service under the TO USE column. Enter **NA** if the service is not impacted by the transfer.

Note 1: If no units/dollars are entered in the fields of the **TO USE** column, the transferring Program Provider and/or CDSA will be prevented from entering any additional service claims for the individual.

Note 2: If no unit/dollars need to be reserved, enter zeroes in the fields of the **TO USE** column.

Typing:

- **0** indicates that this service is being transferred to a new contract or changing to a new SDO and no units/dollars are being reserved.
- ***A number greater than 0*** represents the amount of units/dollars reserved for the transferring program provider and/or CDSA to claim.
- **NA** indicates that the service is not included in the transfer.

- Type the ***receiving*** Program Provider and/or CDSA's service delivery option (**P** - Program Provider or **C** - CDSA) for the service after the transfer in the NEW SDO field.

Note: You may require two screens to list all services. CDS services will list units and dollars.

- Type **Y** in the READY TO ADD? field.
- Press **Enter**.

Step 11 – Add the Transfer.

On the **L06: Consumer Transfer: Add** screen:

- Type the new service county code in the SERVICE COUNTY field.
- Type the location code in the LOCATION CODE field.
- Type the residential type in the RESIDENTIAL TYPE field, if necessary.

Complete the following fields as they apply to the receiving provider.

- Type the component code of the new Program Provider in the COMP field.
- Type the local case number in the LCN field.
- Type the contract number of the new Program Provider in the CONTRACT NUMBER field.

If the individual is transferring to a different CDSA or adding a CDSA:

- Type the component code of the new CDSA in the COMP field.
- Type the local case number in the LCN field.
- Type the contract number of the new CDSA in the CONTRACT NUMBER field.
- Type **Y** in the READY TO ADD? field.
- Press **Enter**.

Step 11, continued

Result: A screen containing the transfer effective date is displayed. If the date is incorrect, do not proceed. You must delete the transfer record and begin again.

- Press **Enter**.

Step 12 – Access the IPC screen.

On the **L06: Consumer Transfer** header screen:

- Type **L02** in the ACT: field.
- Press **Enter**.

Step 13 – Identify the individual.

On the **L02: Individual Plan of Care** header screen:

- Type the requested identifying information in the appropriate fields.
- Type the Component Code of the receiving provider in the COMPONENT CODE field.
- Type **T** (Transfer) in the TYPE OF ENTRY field.
- Press **Enter**.

Step 14 – Make adjustments to the IPC.

Use this screen to make the adjustments to the IPC that were agreed upon in the Transfer IPC meeting.

Note: You cannot reduce services below what has already been claimed.

- Type **Y** in the READY TO CONTINUE? field.
- Press **Enter**.

On the **L02: Individual Plan of Care Entry: Transfer** screen (screen 2):

Services currently being self-directed and new services added to the plan which are eligible to be self-directed are displayed on this screen.

- Type **N** in the CALCULATE? field.
- Type **Y** in the READY TO CONTINUE? field.
- Press **Enter**.

On the **L02: Individual Plan of Care Entry: Transfer** screen (screen 3):

Note: Services not being self-directed are ***displayed and cannot be changed***.

- Type **Y** in the READY TO CONTINUE? field.
- Press **Enter**.

On the **L02: Individual Plan of Care Entry: Transfer** screen (screen 4):

- Type **Y** (Yes) or **N** (No) to indicate whether any services are staffed by a relative or guardian.
- You must change the date in the DATE fields. The dates must be after the previous Revise Date and on or before the current Transfer date.
- Change the names if necessary.
- Type **Y** in the READY TO TRANSFER? field to submit the data to the system.
- Press **Enter**.

Result: You are informed that the transfer IPC has been entered and that you must return to the L06 screen to complete the transfer.

- Press **Enter**.

Step 15 – Complete the Transfer.

On the **L02: Individual Plan of Care** header screen:

- Type **L06** in the Act: field.
- Press **Enter**.

Step 16 – Identify the Individual.

On the **L06: Consumer Transfer** header screen:

- Type the requested identifying information in the appropriate fields.
- Type the Component Code of the ***receiving*** provider in the COMPONENT CODE field.
- Type the contract number in the CONTRACT field.
- Type the transfer effective date in the TRANSFER EFFECTIVE DATE field.
- Type **C** (Change) in the **TYPE OF ENTRY** field.

Note: ***DO NOT*** attempt to answer the three questions on the header screen for this action. *Leave the fields blank.*

- Press **Enter**.

On the **L06: Consumer Transfer: Change** screen:

- Type **Y** in the TRANSFER ACCEPTED field.
- Type the name of the person accepting the transfer data entry in the BY field.
- If the:
  - Transfer will occur in the future, type the date of data entry in the DATE field.
  - Transfer occurred in the past, type the date of the transfer in the Date field.
- Type **Y** in the READY TO CHANGE? field.
- Press **Enter**.

Result: A screen containing the transfer effective date is displayed. If the date is incorrect, the entire transfer record must be deleted and the transfer must be re-entered.

- Press **Enter**.

Reminder: A transfer is not complete until authorized by Program Enrollment. After all of the data entry is complete, the MRA must send the signed Form 3617 Request for Transfer of Waiver Services and the ***receiving provider's*** Transfer IPC to Program Enrollment for authorization. Do not send any documentation until **all** of the data entry is complete.

Service claims cannot be entered by the receiving program provider and/or CDSA until the transfer has been authorized and the individual is listed as active on the receiving provider's and/or CDSA's Consumer Roster (**C67**/**L67**).

Use the **A63** screen to view the status of the transfer.

Critical Incident Data (686): Add - HCS

Step 1 – Access the Critical Incident Data option.

- Type **686** in the ACT: field of any screen.
- Press **Enter**.

Step 2 – Identify the report month, contract number, and type of entry.

On the **686: Critical Incident Data: Add/ Change/ Delete** header screen:

- Type the month and year being reported in the MONTH AND YEAR (MMYYYY) field.
- Type the contract number in the CONTRACT NUMBER field.
- Type **A** (Add) in the TYPE OF ENTRY field.
- Press **Enter**.

Step 3 – Enter critical incident data for a specified reporting month.

On the **686: Critical Incident Data: Add** screen:

- Type the contract number in the CONTRACT NUMBER field, if the contract for which you are entering data is other than the one entered on the header screen.
- Type the number of medication errors during the report month for every person served in your contract in the MEDICATION ERRORS field.
- Type the number of serious injuries during the report month for every person served in your contract in the SERIOUS INJURIES field.
- Type the number of behavior intervention plans authorizing personal, mechanical, or psychoactive medication restraint during the report month in the BEHAVIOR INTERVENTION PLANS AUTHORIZING RESTRAINT field.

Number Of Emergency Restraints Used

- Type the number of emergency restraints used by category during the report month in the PERSONAL RESTRAINTS, MECHANICAL RESTRAINTS, and PSYCHOACTIVE MEDICATION fields.
- Type the total number of emergency restraints used in the TOTAL field.

Number Of Individuals Requiring Emergency Restraint

- Type the number of individuals requiring emergency restraint during the report month in the PERSONAL RESTRAINTS, MECHANICAL RESTRAINTS, and PSYCHOACTIVE MEDICATION fields.
- Type the total number of individuals requiring emergency restraints in the TOTAL field.

Number Of Restraint Related Injuries

- Type the number of restraint related injuries during the report month in the EMERGENCY PERSONAL RESTRAINTS, EMERGENCY MECHANICAL RESTRAINTS, and EMERGENCY PSYCHOACTIVE MEDICATION fields.
- Type the total number of restraint related injuries in the TOTAL field.
- Type **Y** in the READY TO ADD? field.
- Press **Enter**.

Result: The screen is redisplayed with cleared fields to allow for the entry of data for additional contracts, and the message, *"Previous Information Added"* is displayed.

- Repeat this step for all contracts.

When all contracts have been entered, type **N** in the READY TO ADD? field and press **Enter** to return to the header screen.

Critical Incident Data (686): Change - HCS

Step 1 – Access the Critical Incident Data option.

- Type **686** in the ACT: field of any screen.
- Press **Enter**.

Step 2 – Identify the report month and type of entry.

On the **686: Critical Incident Data: Add/ Change/ Delete** header screen:

- Type the month and year being reported in the MONTH AND YEAR (MMYYYY) field.
- Type the contract number in the CONTRACT NUMBER field.
- Type **C** (Change) in the TYPE OF ENTRY field.
- Press **Enter**.

Step 3 – Change critical incident data that has been entered incorrectly.

On the **686: Critical Incident Data: Change** screen:

- Type changes to the critical incident data in the appropriate fields.
- Type **Y** in the READY TO CHANGE? field.
- Press **Enter**.

Critical Incident Data (686): Delete - HCS

Step 1 – Access the Critical Incident Data option.

- Type **686** in the ACT: field of any screen.
- Press **Enter**.

Step 2 – Identify the report month and type of entry.

On the **686: Critical Incident Data: Add/ Change/ Delete** header screen:

- Type the month and year being reported in the MONTH AND YEAR (MMYYYY) field.
- Type the contract number in the CONTRACT NUMBER field.
- Type **D** (Delete) in the TYPE OF ENTRY field.
- Press **Enter**.

Step 3 – Delete critical incident data that has been entered in error.

On the **686: Critical Incident Data: Delete** screen:

- Type **Y** in the READY TO DELETE? field.
- Press **Enter**.

Critical Incident Data (686): Add - TxHmL

Step 1 – Access the Critical Incident Data option.

- Type **686** in the ACT: field of any screen.
- Press **Enter**.

Step 2 – Identify the report month and type of entry.

On the **686: Critical Incident Data: Add/ Change/ Delete** header screen:

- Type the month and year being reported in the MONTH AND YEAR (MMYYYY) field.
- Type the contract number in the CONTRACT NUMBER field.
- Type **A** (Add) in the TYPE OF ENTRY field.
- Press **Enter**.

Step 3 – Enter critical incident data for a specified reporting month.

On the **686: Critical Incident Data: Add** screen:

- Type the contract number in the CONTRACT NUMBER field, if the contract for which you are entering data is other than the one entered on the header screen.
- Type the number of medication errors during the report month for every person served in your contract in the MEDICATION ERRORS field.
- Type the number of serious injuries during the report month for every person served in your contract in the SERIOUS INJURIES field.
- Type the number of behavior intervention plans authorizing personal, mechanical, or psychoactive medication restraint during the report month in the BEHAVIOR INTERVENTION PLANS AUTHORIZING RESTRAINT field.

Number Of Emergency Restraints Used

- Type the total number of emergency restraints used by category during the report month in the PERSONAL RESTRAINTS, MECHANICAL RESTRAINTS, and PSYCHOACTIVE MEDICATION TOTAL fields.

Number Of Individuals Requiring Emergency Restraint

- Type the total number of individuals requiring emergency restraint during the report month in the PERSONAL RESTRAINTS, MECHANICAL RESTRAINTS, and PSYCHOACTIVE MEDICATION TOTAL fields.

Number Of Restraint Related Injuries

- Type the total number of restraint related injuries during the report month in the EMERGENCY PERSONAL RESTRAINTS, EMERGENCY MECHANICAL RESTRAINTS, and EMERGENCY PSYCHOACTIVE MEDICATION TOTAL fields.
- Type **Y** in the READY TO ADD? field.
- Press **Enter**.

Result: The screen is redisplayed with cleared fields to allow for the entry of data for additional contracts, and the message, *"Previous Information Added"* is displayed.

- Repeat this step for all contracts.
  - When all contracts have been entered, type **N** in the READY TO ADD? field and press **Enter** to return to the header screen.

Critical Incident Data (686): Change - TxHmL

Step 1 – Access the Critical Incident Data option.

- Type **686** in the ACT: field of any screen.
- Press **Enter**.

Step 2 – Identify the report month and type of entry.

On the **686: Critical Incident Data: Add/ Change/ Delete** header screen:

- Type the month and year being reported in the MONTH AND YEAR (MMYYYY) field.
- Type the contract number in the CONTRACT NUMBER field.
- Type **C** (Change) in the TYPE OF ENTRY field.
- Press **Enter**.

Step 3 – Change critical incident data that has been entered incorrectly.

On the **686: Critical Incident Data: Change** screen:

- Type changes to the critical incident data in the appropriate fields.
- Type **Y** in the READY TO CHANGE? field.
- Press **Enter**.

Critical Incident Data (686): Delete - TxHmL

Step 1 – Access the Critical Incident Data option.

- Type **686** in the ACT: field of any screen.
- Press **Enter**.

Step 2 – Identify the report month and type of entry.

On the **686: Critical Incident Data: Add/ Change/ Delete** header screen:

- Type the month and year being reported in the MONTH AND YEAR (MMYYYY) field.
- Type the contract number in the CONTRACT NUMBER field.
- Type **D** (Delete) in the TYPE OF ENTRY field.
- Press **Enter**.

Step 3 – Delete critical incident data that has been entered in error.

On the **686: Critical Incident Data: Delete** screen:

- Type **Y** in the READY TO DELETE? field.
- Press **Enter**.

DHS Medicaid Eligibility Search (C63)

Step 1 – Access the DHS Medicaid Eligibility Search option.

- Type **C63** in the ACT: field of any screen.
- Press **Enter**.

Step 2 – Identify the individual and indicate the type of entry.

On the **C63: DHS Medicaid Eligibility Search** header screen:

- Type the Client ID in the CLIENT ID field to scan the Medicaid eligibility file for matches to the demographic fields entered in CARE, ***or***
- Type the Medicaid Number in the MEDICAID RECIP NO field to search the Medicaid file directly, ***or***
- Type *at least two* of Name, SSN, and Birthdate.
- Press **Enter**.

Step 3 – View the Medicaid file information.

On the **C63: Medicaid Recipient Information** screen:

- View the information from the Medicaid file.
- For further information, type a line number in the ENTER A LINE NUMBER field.
- Press **Enter**.

Note: If multiple names are displayed on this screen, contact the Program Enrollment section of DADS.

Step 4 – View the DHS Demographics.

On the **Medicaid Eligibility Information** screen:

- View the DHS demographics, including the Medicaid Certification date.
- Press **Enter**.

Step 5 – View the Medicaid eligibility information.

On the **Medicaid Eligibility Information** (screen 2):

- View the Medicaid eligibility information for the selected DHS recipient number, including the program type and begin date.
- Press **Enter** to display the **C63: Medicaid Recipient Information** screen.
- Press **Enter**.

Enrollment Packet Checklist (L03)

Step 1 – Access the Enrollment Packet Checklist option.

- Type **L03** in the ACT: field of any screen.
- Press **Enter**.

Step 2 – Identify the individual and indicate the type of entry.

On the **L03: Enrollment Packet Checklist: Add/Change/Delete** header screen:

- Type the Client ID in the CLIENT ID field.
- Type the MRA component code in the COMPONENT CODE field.
- Type **A** (Add) in the TYPE OF ENTRY field.
- Press **Enter**.

Step 3 – Enter the enrollment packet checklist.

On the **L03: Enrollment Packet Checklist: Add** screen:

- Type the date waiver services will begin in the SERVICES BEGIN DATE field.
- Type the date the Freedom of Choice form was signed by the individual/legal representative in the FREEDOM OF CHOICE FORM field.
- Type the date of the adaptive aids bid or, if unavailable, the date of the assessment in the ADAPTIVE AIDS ASSESSMENT/BID field.

Note: This date is necessary *only* if the amount of adaptive aids on the IPC exceeds what is approved in the billing guidelines.

- Type the date of the minor home modification bid or, if unavailable, the date of the assessment in the MINOR HOME MODS ASSESSMENT/BID fields.

Note: This date is necessary *only* if the amount of minor home modifications on the IPC exceeds what is approved in the billing guidelines.

- Type the date the Person Directed Plan/SMRF Community Living Plan was completed in the PERSON DIRECTED PLAN/SMRF COMMUNITY LIVING PLAN field.
- Type **Y** in the READY TO ADD? field.
- Press **Enter**.

Guardian Information Update (L20)

Step 1 – Access the Guardian Information Update option.

- Type **L20** in the ACT: field of any screen.
- Press **Enter**.

Step 2 – Identify the individual.

On the **L20: Guardian Information Update** header screen:

- Type the requested identifying information in the appropriate fields.

Rule: You must enter the Client ID, the local case number, *or* the Medicaid number.

- Type the component code of the individual's current component in the COMPONENT CODE field.
- Press **Enter**.

Step 3 – Update information about an individual's guardian.

On the **L20: Guardian Information Update** screen:

In the **Guardian's Name** section:

- The system displays the guardian's name if the individual has a guardian. Update the guardian's name in the name fields, if appropriate.
- The system displays ***SELF*** in the LAST NAME field if the individual does *not* have a guardian.

Rule: If ***SELF*** is displayed, the individual *must* have an address on file in the system. Use **L12: Client Address Update** to verify the individual's address.

- Type the guardian code in the TYPE field.

If the guardian is someone other than the individual:

- Type the guardian's name in the LAST NAME, LAST NAME SUFFIX, FIRST NAME, and MIDDLE INITIAL fields.
- Type the guardian's current address in the STREET ADDRESS, CITY, STATE, and ZIP CODE fields.
- Type the guardian's telephone number in the PHONE field.
- Type **Y** in the READY TO UPDATE? field to submit the data to the system.
- Press **Enter**.

Individual Plan of Care (L02): Initial – HCS

Step 1 – Access the Individual Plan of Care option.

- Type **L02** in the ACT: field of any screen.
- Press **Enter**.

Step 2 – Identify the individual and indicate the type of entry.

On the **L02: Individual Plan of Care** header screen:

- Type the requested identifying information in the appropriate fields.

Rule: You must enter the Client ID, the local case number, *or* the Medicaid Number.

- Type the MRA component code in the COMPONENT CODE field.
- Type **I** (Initial) in the TYPE OF ENTRY field.
- Type the date the provider began or will begin providing services in the BEGIN DATE field.

Note: The IPC Begin Date *cannot* be prior to the enrollment request date reflected on screen **L01**.

- Press **Enter**.

Step 3 – Begin the entry of the initial IPC.

On the **L02: Individual Plan of Care Entry: Initial** entry screen (screen 1):

- Type the number of units of each service category in the appropriate fields and the dollar amounts in the ADAPTIVE AIDS, MINOR HOME MOD, and DENTAL fields (from pages 1 and 2 of the IPC).
- Type **Y** (Yes) or **N** (No) in the ANY SERVICES SELF DIRECTED? field to indicate whether any of the services will be self-directed.

Note 1: If **Y** (Yes) is entered and services are to be self-directed, the FMS MONTHLY FEE is required. You ***must*** enter one unit per month of the IPC in the FMS MONTHLY FEE field.

Note 2: If you enter any units in the SUPPORT CONSULTATION field, you ***must*** answer **Y** (Yes).

Note 3: Only Supported Home Living and Respite can be self-directed in HCS.

- Type the individual's residence type in the RESIDENTIAL TYPE field. (2=Foster/Companion Care, 3=Own Home/Family Home, 4=Supervised Living, 5=Residential Support)

Note: For CDS you ***must*** select **3** (Own Home/Family Home).

- Type **Y** in the READY TO CONTINUE? field.
- Press **Enter**.

If you answered…	The…
Y to the question, ANY SERVICES BE SELF DIRECTED?	**L02: Individual Plan of Care Entry: Initial** CDS screen is displayed.
N to the question, ANY SERVICES BE SELF DIRECTED?	**L02: Individual Plan of Care Entry: Initial** program provider screen is displayed. *Skip to Step 5.*

Step 4 – Continue with the IPC – Consumer Directed Services

On the **L02: Individual Plan of Care Entry: Initial** screen (screen 2):

Note: This screen displays the CDS portion of the IPC. The units for services eligible to be self-directed are displayed ***and cannot be changed***.

Note: All services that are self-directed contain a **V** at the end of the service abbreviation on this screen. For example, the service abbreviation for Respite is **REH**. If that service is self-directed, the abbreviation becomes **REHV**.

- Type **N** in the CALCULATE? field.
- Type **Y** in the READY TO CONTINUE? field.
- Press **Enter**.

Step 5 – Continue with the private provider portion of the IPC on the third screen.

The **L02: Individual Plan of Care Entry: Initial** screen (screen 3):

This screen displays the program provider portion of the IPC. Services not being self-directed are displayed and cannot be changed.

- Type **Y** in the READY TO CONTINUE? field.
- Press **Enter**.

Step 6 – Complete the initial IPC entry.

On the **L02: Individual Plan of Care Entry: Initial** screen (screen 4):

- Type **Y** (Yes) or **N** (No) to indicate whether any services are staffed by a relative or guardian.
- Type the name of the provider representative (individual's name) in the PROVIDER REPRESENTATIVE field and the date the provider representative signed the IPC in the DATE field.
- Type the Service Coordinator's name in the SERVICE COORDINATOR field and the date the Service Coordinator signed the IPC in the DATE field.
- The name of the individual or legal representative is pre-filled based on whether or not a guardian has been identified (screen **L20**) in the CONSUMER/LEGAL REPRESENTATIVE field. Type the date the individual or legal representative signed the IPC in the DATE field.

Note: Before you enter names in the fields on this screen, signatures *must* be on the IPC in the individual's chart. **All data entered into the CARE system should be entered from a paper copy (a hard copy) and match exactly**.

- Type **Y** in the READY TO ADD? field to submit the data to the system.
- Press **Enter**.

Individual Plan of Care (L02): Initial – TxHmL

Step 1 – Access the Individual Plan of Care option.

- Type **L02** in the ACT: field of any screen.
- Press **Enter**.

Step 2 – Identify the individual and indicate the type of entry.

On the **L02: Individual Plan of Care** header screen:

- Type the requested identifying information in the appropriate fields.

Rule: You must enter the Client ID, the local case number, *or* the Medicaid Number.

- Type the MRA component code in the COMPONENT CODE field.
- Type **I** (Initial) in the TYPE OF ENTRY field.
- Type the date the provider began or will begin providing services in the BEGIN DATE field.

Note: The IPC Begin Date *cannot* be prior to the enrollment request date reflected on screen **L01**.

- Press **Enter**.

Step 3 – Begin the entry of the initial IPC.

On the **L02: Individual Plan of Care Entry: Initial** entry screen (screen 1):

- Type the number of units of each service category in the appropriate fields and the dollar amounts in the ADAPTIVE AIDS, MINOR HOME MOD, and DENTAL fields (from the IPC).
- Type **Y** (Yes) or **N** (No) in the ANY SERVICES SELF DIRECTED? field to indicate whether any of the services will be self-directed.

Note 1: If you enter any units in the SUPPORT CONSULTATION or FINANCIAL MANAGEMENT fields, you ***must*** answer **Y** (Yes).

Note 2: If **Y** (Yes) is entered and services are to be self-directed, the FMS MONTHLY FEE is required. You ***must*** enter one unit per month of the IPC in the FMS MONTHLY FEE field.

Note 3: If units have been entered for Adaptive Aids or Minor Home Modifications, no requisition fee is allowed when self-directing.

- Type **3** (Own Home/Family Home) in the RESIDENTIAL TYPE field.
- Type **Y** in the READY TO CONTINUE? field.
- Press **Enter**.

Step 4 – Continue with the IPC – Consumer Directed Services

On the **L02: Individual Plan of Care Entry: Initial** screen (screen 2):

Note 1: Support Consultation and Financial Management Service fee units ***cannot*** be changed on this screen.

Step 4, continued

Note 2: All services that are self-directed contain a **V** at the end of the service abbreviation on this screen. For example, the service abbreviation for Respite is **REH**. If that service is self-directed, the abbreviation becomes **REHV**.

If you …	Then…
want to continue to the Program Provider screen (screen 3) after calculating	• Type **N** in the CALCULATE? field. • Type **Y** in the READY TO CONTINUE? field. • Press **Enter**. • *Continue with Step 5.*
want to indicate that some of the services are not to be self-directed, but will be provided by the Program Provider	• Replace the displayed units of service with **0** (zero) for each service that is to be provided by the Program Provider. • Press **Enter** to calculate. • Type **N** in the CALCULATE? field. • Type **Y** in the READY TO CONTINUE? field. • Press **Enter**. • *Continue with Step 5.*

Step 5 – Continue with the IPC - Program Provider

The **L02: Individual Plan of Care Entry: Initial** screen (screen 3)

This screen displays the Program Provider portion of the IPC. Services not being self-directed are displayed and cannot be changed.

- Type **Y** in the READY TO CONTINUE? field.
- Press **Enter**.

Step 6 – Complete the initial IPC entry.

On the **L02: Individual Plan of Care Entry: Initial** screen (screen 4):

- Type **Y** (Yes) or **N** (No) to indicate whether any services are staffed by a relative or guardian.
- Type the name of the provider representative (individual's name) in the PROVIDER REPRESENTATIVE field and the date the provider representative signed the IPC in the DATE field.
- Type the Service Coordinator's name in the SERVICE COORDINATOR field and the date the Service Coordinator signed the IPC in the DATE field.
- The name of the individual or legal representative is pre-filled based on whether or not a guardian has been identified (screen **L20**) in the CONSUMER/LEGAL REPRESENTATIVE field. Type the date the individual or legal representative signed the IPC in the DATE field.

Note: Before you enter names in the fields on this screen, signatures *must* be on the IPC in the individual's chart. **All data entered into the CARE system should be entered from a paper copy (a hard copy) and match exactly**.

- Type **Y** in the READY TO ADD? field to submit the data to the system.
- Press **Enter**.

Individual Plan of Care (L02): Revision

Step 1 – Access the Individual Plan of Care option.

- Type **L02** in the ACT: field of any screen.
- Press **Enter**.

Step 2 – Identify the individual and indicate the type of entry.

On the **L02: Individual Plan of Care** header screen:

- Type the requested identifying information in the appropriate fields.

Rule: You must enter the Client ID, the local case number, *or* the Medicaid Number.

- Type the component code of the individual's current component in the COMPONENT CODE field.
- Type **R** (Revision) in the TYPE OF ENTRY field.
- Type the revision date in the REVISE field.
- Press **Enter**.

Step 3 – Enter a revision to a TxHmL individual's existing IPC.

On the **L02: Individual Plan of Care Entry: Revise** screen:

Note: The provider will modify the total plan with the required revisions to service units. You cannot reduce the units where it would leave a current provider without any service authorizations for their service delivery option.

- Type the number of units of each service type in the appropriate fields and the dollar amounts in the ADAPTIVE AIDS, MINOR HOME MOD, and DENTAL fields.
- Type or verify **Y** in the ANY SERVICES SELF DIRECTED? field.
- Type **3** (OHFH) in the RESIDENTIAL TYPE field.
- Type **Y** in the READY TO CONTINUE? field.
- Press **Enter**.

Step 4 – Continue the IPC revision – Consumer Directed Services

On the **L02: Individual Plan of Care Entry: Revise** screen (screen 2):

Services currently being self-directed and new services added to the plan which are eligible to be self-directed are displayed on this screen. The units of new services added to the plan must be changed to zero if they are not being self-directed.

Note 1: The units for services currently being self-directed are displayed **and cannot be changed**.

Note 2: All services that are self-directed contain a V at the end of the service abbreviation on this screen. For example, the service abbreviation for Respite is REH. If that service is self-directed, the abbreviation becomes REHV.

Step 4, continued

- Make any necessary changes.
- Press **Enter** to calculate.

Result: The system calculates and displays the total annual cost for the IPC, and the message, *"Please verify the new plan cost"* is displayed.

Once the system has calculated the IPC

- Type **N** in the CALCULATE? field.
- Type **Y** in the READY TO CONTINUE? field.
- Press **Enter**.

Step 5 – Continue the IPC revision – Program Provider

On the **L02: Individual Plan of Care Entry: Revise** screen (screen 3):

Services not being self-directed are displayed on this screen and cannot be changed.

- Type **Y** in the READY TO CONTINUE? field.
- Press **Enter**.

Step 6 – Complete the IPC revision

On the **L02: Individual Plan of Care Entry: Revise** screen (screen 4):

- Type **Y** (Yes) or **N** (No) to indicate whether any services are staffed by a relative or guardian.
- Type or verify the name of the provider representative (individual's name) in the PROVIDER REPRESENTATIVE field and the date the provider representative signed the IPC in the DATE field.
- Type or verify the Service Coordinator's name in the SERVICE COORDINATOR field and the date the Service Coordinator signed the IPC in the DATE field.
- The name of the individual or legal representative is pre-filled based on whether or not a guardian has been identified (screen **L20**) in the CONSUMER/LEGAL REPRESENTATIVE field. Type the date the individual or legal representative signed the IPC in the DATE field.

Note: Before you enter names in the fields on this screen, signatures *must* be on the IPC in the individual's chart. **All data entered into the CARE system should be entered from a paper copy (a hard copy) and match exactly**.

- Type **Y** in the READY TO REVISE? field to submit the data to the system.
- Press **Enter**.

Individual Plan of Care (L02): Renewal

Step 1 – Access the Individual Plan of Care option.

- Type **L02** in the ACT: field of any screen.
- Press **Enter**.

Step 2 – Identify the individual and indicate the type of entry.

On the **L02: Individual Plan of Care** header screen:

- Type the requested identifying information in the appropriate fields.

Rule: You must enter the Client ID, the local case number, *or* the Medicaid Number.

- Type the component code of the individual's current component in the COMPONENT CODE field.
- Type **N** (Renewal) in the TYPE OF ENTRY field.
- Press **Enter**.

Step 3 – Renew an IPC for a TxHmL individual.

On the **L02: Individual Plan of Care Entry: Renewal** screen:

- Type the number of units of each service category in the appropriate fields and the dollar amounts in the ADAPTIVE AIDS, MINOR HOME MOD, and DENTAL fields.
- Type or verify **Y** in the ANY SERVICES SELF DIRECTED? field.

Note 1: If you enter units in the SUPPORT CONSULTATION or FINANCIAL MANAGEMENT fields, you ***must*** answer **Y** (Yes).

Note 2: If **Y** (Yes) is entered and services are to be self-directed, the FMS MONTHLY FEE is required. You must then enter one unit per month of the IPC in the FMS MONTHLY FEE field.

- Type **3** (Own Home/Family Home) in the RESIDENTIAL TYPE field.
- Type **Y** in the READY TO CONTINUE? field.
- Press **Enter**.

Step 4 – Continue the IPC renewal – Consumer Directed Services

On the **L02: Individual Plan of Care Entry: Renewal** screen (screen 2):

Services currently being self-directed and new services added to the plan which are eligible to be self-directed are displayed on this screen. The units of new services added to the plan must be changed to zero if they are not being self-directed.

Note 1: Support Consultation and Financial Management Service fee units ***cannot*** be changed on this screen.

Note 2: All services that are self-directed contain a V at the end of the service abbreviation on this screen. For example, the service abbreviation for Respite is REH. If that service is self-directed, the abbreviation becomes REHV.

Step 4 , continued

If you …	Then…
want to continue to the Program Provider screen (screen 3)	• Type **N** in the CALCULATE? field. • Type **Y** in the READY TO CONTINUE? field. • Press **Enter**. • *Continue with Step 5.*
want to indicate that some of the new services are not to be self-directed, but will be provided by the Program Provider	• Type a zero (**0**) in the UNITS column for each service that is to be provided by the Program Provider. • Press **Enter**. • Type **N** in the CALCULATE? field. • Type **Y** in the READY TO CONTINUE? field. • Press **Enter**. • *Continue with Step 5.*

Step 5 – Continue the IPC renewal – Program Provider

On the **L02: Individual Plan of Care Entry: Renewal** screen (screen 3):

This screen displays the Program Provider portion of the IPC. Services not being self-directed are displayed and cannot be changed.

- Type **Y** in the READY TO CONTINUE? field.
- Press **Enter**.

Step 6 – Complete the IPC renewal

On the **L02: Individual Plan of Care Entry: Renewal** screen (screen 3):

- Type **Y** (Yes) or **N** (No) to indicate whether any services are staffed by a relative or guardian.
- Type the name of the provider representative (individual's name) in the PROVIDER REPRESENTATIVE field and the date the provider representative signed the IPC in the DATE field.
- Type or verify the Service Coordinator's name in the SERVICE COORDINATOR field and the date the Service Coordinator signed the IPC in the DATE field.
- The name of the individual or legal representative is pre-filled based on whether or not a guardian has been identified (screen **L20**) in the CONSUMER/LEGAL REPRESENTATIVE field. Type the date the individual or legal representative signed the IPC in the DATE field.

Note: Before you enter names in the fields on this screen, signatures *must* be on the IPC in the individual's chart. **All data entered into the CARE system should be entered from a paper copy (a hard copy) and match exactly**.

- Type **Y** in the READY TO RENEW? field to submit the data to the system.
- Press **Enter**.

Individual Plan of Care (L02): Error Correction

Step 1 – Access the Individual Plan of Care option.

- Type **L02** in the ACT: field of any screen.
- Press **Enter**.

Step 2 – Identify the individual and indicate the type of entry.

On the **L02: Individual Plan of Care** header screen:

- Type the requested identifying information in the appropriate fields.

Rule: You must enter the Client ID, the local case number, *or* the Medicaid Number.

- Type the component code of the individual's current component in the COMPONENT CODE field.
- Type **E** (Error Correction) in the TYPE OF ENTRY field.
- Type the effective date if error correcting a revision to the IPC in the REVISE DATE field.
- Press **Enter**.

Step 3 – Correct data entry errors on a previously entered IPC for a TxHmL individual.

On the **L02: Individual Plan of Care Entry: Correct** screen:

- Enter the number of units of each service type in the appropriate fields and the dollar amounts in the ADAPTIVE AIDS, MINOR HOME MOD, and DENTAL fields.
- Type or verify **Y** in the ANY SERVICES SELF DIRECTED? field, if services are to be self-directed.

Note 1: If you enter units in the SUPPORT CONSULTATION or FINANCIAL MANAGEMENT fields, you ***must*** answer **Y** (Yes).

Note 2: If **Y** (Yes) is entered and services are to be self-directed, the FMS MONTHLY FEE is required. You must then enter one unit per month of the IPC in the FMS MONTHLY FEE field.

- Type or verify **3** (Own Home/Family Home) in the RESIDENTIAL TYPE field.
- Type **Y** in the READY TO CONTINUE? field.
- Press **Enter**.

Step 4 – Continue with the IPC corrections – Consumer Directed Services

On the **L02: Individual Plan of Care Entry: Correct** screen (screen 2):

Services currently being self-directed and new services added to the plan which are eligible to be self-directed are displayed on this screen. The units of new services added to the plan must be changed to zero if they are not being self-directed.

Note 1: Support Consultation and Financial Management Service fee units ***cannot*** be changed on this screen.

Note 2: All services that are self-directed contain a V at the end of the service abbreviation on this screen. For example, the service abbreviation for Respite is REH. If that service is self-directed, the abbreviation becomes REHV.

Step 4, continued

- Type **Y** in the CALCULATE? field.
- Press **Enter**.

If you …	Then…
want to continue to the Program Provider screen (screen 3)	• Type **N** in the CALCULATE? field. • Type **Y** in the READY TO CONTINUE? field. • Press **Enter**. • Continue with Step 5.
want to indicate that some of the services are not to be self-directed, but will be provided by the Program Provider	• Type a zero (**0**) in the UNITS column for each service that is to be provided by the Program Provider. • Press **Enter**. • Type **N** in the CALCULATE? field. • Type **Y** in the READY TO CONTINUE? field. • Press **Enter**. • Continue with Step 5.

Step 5 – Continue with the IPC corrections – Program Provider

On the **L02: Individual Plan of Care Entry: Correct** screen (screen 3):

This screen displays the program provider portion of the IPC. Services not being self-directed are displayed and cannot be changed.

- Type **Y** in the READY TO CONTINUE? field.
- Press **Enter**.

Step 6 – Complete the IPC corrections

On the **L02: Individual Plan of Care Entry: Correct** screen (screen 4):

- Type **Y** (Yes) or **N** (No) to indicate whether any services are staffed by a relative or guardian.
- Type the name of the provider representative (individual's name) in the PROVIDER REPRESENTATIVE field and the date the provider representative signed the IPC in the DATE field.
- Type or verify the Service Coordinator's name in the SERVICE COORDINATOR field and the date the Service Coordinator signed the IPC in the DATE field.
- The name of the individual or legal representative is pre-filled based on whether or not a guardian has been identified (screen **L20**) in the CONSUMER/LEGAL REPRESENTATIVE field. Type the date the individual or legal representative signed the IPC in the DATE field.

Note: Before you enter names in the fields on this screen, signatures *must* be on the IPC in the individual's chart. **All data entered into the CARE system should be entered from a paper copy (a hard copy) and match exactly**.

- Type **Y** in the READY TO CORRECT? field to submit the data to the system.
- Press **Enter**.

Individual Plan of Care (L02): Delete

Note: An IPC can be deleted *only if no billing has been entered*.

Step 1 – Access the Individual Plan of Care option.

- Type **L02** in the ACT: field of any screen.
- Press **Enter**.

Step 2 – Identify the individual and indicate the type of entry.

On the **L02: Individual Plan of Care** header screen:

- Type the requested identifying information in the appropriate fields.

Rule: You must enter the Client ID, the local case number, *or* the Medicaid Number.

- Type the component code of the individual's current component in the COMPONENT CODE field.
- Type **D** (Delete) in the TYPE OF ENTRY field.
- Press **Enter**.

Step 3 – Delete an IPC.

On the **L02: Individual Plan of Care Entry: Delete** screen:

- Type **Y** in the READY TO DELETE? field.
- Press **Enter**.

Interest List - Services (W21)

If the person has accepted the waiver slot they were offered, no action is taken on the W21 screens.

HCS Enrollment:
The MRA no longer changes the status to **2** (Pending). This is done by the MRA section at DADS and requires no action by the MRA. You will ***only*** use **W21: Interest List - Services** to change the Status field to **6** (Can't Contact), or to **8** (Refused Offer) if the individual has signed the *Verification of Freedom of Choice* form.

TxHmL Enrollment:
The MRA will use **W21: Interest List - Services** to change the TxHmL Status field to **2** (Declined) *only if the individual declines enrollment in TxHmL.* No other action on Interest List is required for TxHmL individuals. The following steps will be taken when changing the interest list status to **2** (Declined).

Step 1 – Access W26: Interest List – Services Inquiry by Person to determine whether the person is currently on the Waiting List.

Step 2 – Access the Waiting List - Services option.

- Type **W21** in the ACT: field of any screen.
- Press **Enter**.

Step 2 – Identify the individual and indicate the type of entry.

On the **W21: Waiting List – Services: Add/Change/Delete** header screen:

- Type the requested identifying information in the appropriate fields.

Rule: You must enter the Client ID (CARE ID) *or* the local case number.

- Type the MRA component code in the COMPONENT CODE field.
- Type **C** (Change) in the TYPE OF ENTRY field.
- Type **Y** (Yes) or **N** (No) in the ADD TO HCS LIST field to indicate whether individual is to be added to the HCS Interest List.
- Press **Enter**.

Step 3 – Change the status to Declined.

On the **W21: Waiting List - Services: Change** screen:

- Type **2** (Declined) in the TXHML STATUS field.
- Type **Y** in the READY TO CHANGE? field.
- Press **Enter**.

MR/RC Assessments – Summary (C68)

Step 1 – Access the MR/RC Assessments - Summary option.

- Type **C68** in the ACT: field of any screen.
- Press **Enter**.

Step 2 – Identify the individual.

On the **C68: MR/RC Assessments-Summary** header screen:

- Type the requested identifying information in the appropriate fields.

Rule: You must enter the Client ID *or* the local case number.

- Type the MRA component code in the COMPONENT CODE field.
- Press **Enter**.

Step 3 – Verify that an individual has a current MR/RC Assessment with an existing LOC/LON.

If the **C68: MR/RC Assessments-Summary** screen displays an existing Level of Care in the individual's record that will not expire for 60 days from the enrollment date, and the record is correct, *no MR/RC Assessment is required at this time*.

Note: If there is not an existing LOC in the individual's record:

- The **C68: MR/RC Assessments-Summary** screen is displayed with the message, *"No Records Found."*
- See the *Waiver MR/RC Assessment* procedure to complete the MR/RC Assessment. An MR/RC Assessment must be authorized by State Office *before* the entry of **L02: Individual Plan of Care**.

Note: If an existing Level of Care/Level of Need is not accurate the MRA must enter the correct information. See *Waiver MR/RC Assessment* procedures.

MRA Assignment Notification (L30)
Sending MRA

The sending MRA will use these steps to initiate the MRA assignment notification process.

Step 1 – Access the MRA Assignment Notification option.

- Type **L30** in the ACT: field of any screen.
- Press **Enter**.

Step 2 – Identify the individual and indicate the type of entry.

On the **L30: MRA Assignment Notification: Add/Change/Delete** header screen:

- Type the requested identifying information in the appropriate fields.

Rule: You must enter the Client ID, the local case number, *or* the Medicaid number.

- Type the provider's component code in the COMPONENT CODE field.
- Type the ***sending*** MRA's code in the MRA field.
- Type **A** (Add) in the TYPE OF ENTRY field.
- Press **Enter**.

Step 3 – Initiate the MRA assignment notification process.

On the **L30: MRA Assignment Notification: Add** screen:

- Type the location code in the MOVE TO LOCATION field.
- Type the county code of the new location in the COUNTY field.

Note: For TxHmL, the Move to Location must be **OHFH** and the MOVE TO LOCATION and COUNTY code fields are required.

- Type the date of the move in the MOVE DATE field.

In the **Sending Authority** section of the screen:

- Type the name of the MRA contact person in the CONTACT NAME field.
- Type the contact person's area code and telephone number in the PHONE fields.
- Type the date the data is entered in the DATE field.
- Type **Y** in the READY TO ADD? field.
- Press **Enter**.

MRA Assignment Notification (L30)
Receiving MRA

The receiving MRA will use these steps to continue and complete the MRA assignment notification process.

Step 1 – Access the MRA Assignment Notification option.

- Type **L30** in the ACT: field of any screen.
- Press **Enter**.

Step 2 – Identify the individual and indicate the type of entry.

On the **L30: MRA Assignment Notification: Add/Change/Delete** header screen:

- Type the requested identifying information in the appropriate fields.

Rule: You must enter the Client ID, the local case number, *or* the Medicaid number.

- Type the provider's component code in the COMPONENT CODE field.
- Type the ***receiving*** MRA's code in the MRA field.
- Type **C** (Change) in the TYPE OF ENTRY field.
- Press **Enter**.

Step 3 – Initiate the MRA assignment notification process.

On the **L30: MRA Assignment Notification: Change** screen:

In the **Receiving Authority** section of the screen:

- Type the name of the MRA contact person in the ACCEPTED BY field.
- Type the date the data is entered in the DATE field.
- Type **Y** in the READY TO CHANGE? field.
- Press **Enter**.

If the date of the move is *today's date or in the past*, the **L26: Client Assignments: Add** screen is displayed.

- or -

If the date of the move is *in the future*, a message screen is displayed stating that because the movement date is in the future you will not be able to enter the client movement until that date.

The receiving MRA will complete **L26: Client Assignments** *on the date of the move* to complete the assignment.

Step 4 – Receiving MRA adds the client assignment.

On the **L26: Client Assignments: Add** screen:

- Type **Y** in the READY TO ADD? field to add the client assignment.
- Press **Enter**.

MRA/MHA Contacts (L28): Add

Step 1 – Access the MRA/MHA Contacts option.

- Type **L28** in the ACT: field of any screen.
- Press **Enter**.

Step 2 – Identify the component and contact type, and indicate the type of entry.

On the **L28: MRA/MHA Contacts: Add/ Change/Delete** header screen:

- Type the MRA component code in the COMP field.
- Type **MRA** in the CONTACT TYPE field.
- Type **A** (Add) in the TYPE OF ENTRY field.
- Press **Enter**.

Step 3 – View the sequence/type/contact description information.

On the **L28: MRA/MHA Contacts: Add Records** screen:

- Type **Y** in the READY TO CONTINUE? field.
- Press **Enter**.

Step 4 – Add MRA contact information.

On the **L28: MRA/MHA Contacts: Add Records** screen (screen 2):

- View the contact sequence number displayed and, if necessary, type the appropriate contact sequence number for the contact you are adding in the CONTACT SEQUENCE field.
- Type the contact description in the DESCRIPTION field.
- Type the contact person's name information in the CONTACT fields.
- Type the contact person's address information in the ADDRESS fields.
- Type the contact person's area code and telephone number in the PHONE fields.
- Type **Y** in the READY TO ADD? field.
- Press **Enter**.

MRA/MHA Contacts (L28): Change

Step 1 – Access the MRA/MHA Contacts option.

- Type **L28** in the ACT: field of any screen.
- Press **Enter**.

Step 2 – Identify the component and contact type, and indicate the type of entry.

On the **L28: MRA/MHA Contacts: Add/ Change/Delete** header screen:

- Type the MRA component code in the COMP field.
- Type **MRA** in the CONTACT TYPE field.
- Type **C** (Change) in the TYPE OF ENTRY field.
- Press **Enter**.

Step 3 – Select the record to be changed.

On the **L28: MRA/MHA Contacts Change Records** screen:

- View the sequence/type/contact description information.
- Type **X** in the SELECT field next to the record to be changed.
- Type **Y** in the READY TO SELECT? Field.
- Press **Enter**.

Step 4 – Change MRA contact information.

On the **L28: MRA/MHA Contacts Change Records** screen (screen 2):

- View the current information on the contact record selected.
- Type any changes in the appropriate fields.
- Type **Y** in the READY TO CHANGE? field.
- Press **Enter**.

MRA/MHA Contacts (L28): Delete

Step 1 – Access the MRA/MHA Contacts option.

- Type **L28** in the ACT: field of any screen.
- Press **Enter**.

Step 2 – Identify the component and contact type, and indicate the type of entry.

On the **L28: MRA/MHA Contacts: Add/ Change/Delete** header screen:

- Type the MRA component code in the COMP field.
- Type **MRA** in the CONTACT TYPE field.
- Type **D** (Delete) in the TYPE OF ENTRY field.
- Press **Enter**.

Step 3 – Select the record to be deleted.

On the **L28: MRA/MHA Contacts Delete Records** screen:

- View the sequence/type/contact description information.
- Type **X** in the SELECT field next to the record to be deleted.
- Type **Y** in the READY TO SELECT? Field.
- Press **Enter**.

Step 4 – Delete MRA contact information.

On the **L28: MRA/MHA Contacts Delete Records** screen (screen 2):

- View the current information on the contact record selected.
- Type **Y** in the READY TO DELETE? field.
- Press **Enter**.

Permanency Planning Review (309): Add

Step 1 – Access the Permanency Planning Review option.

- Type **309** in the ACT: field of any screen.
- Press **Enter**.

Step 2 – Identify the individual and indicate the type of entry.

On the **309: Permanency Planning Review: Add/Change/Delete** header screen:

- Type the MRA component code in the COMPONENT CODE field.
- Type the individual's local case number in the LOCAL CASE NUMBER field.
- Type **A** (Add) in the TYPE OF ENTRY field.
- Press **Enter**.

Step 3 – Add a permanency plan for an HCS individual.

On the **309: Permanency Planning Review: Add** screen:

- Type the date of the individual's permanency planning review in the REVIEW DATE field.
- Type the code indicating the permanency plan goal in the PERMANENCY PLAN GOAL field.
- Type the code indicating the frequency of parent/guardian contact with the individual during the last six months in the CONTACT FREQ field.
- Type the number of visits to the facility by the parent/guardian in the # VISIT BY FAM field.
- Type the number of the resident's visits to the home in the # VISIT TO FAM field.
- Type **Y** (Yes) or **N** (No) to indicate whether the person has a history of traumatic brain injury in the TRAUMATIC BRAIN INJURY field.
- Type **Y** (Yes) or **N** (No) to indicate whether the family/LAR supports the goal in the DOES FAMILY/LAR SUPPORT GOAL field.
- Type **Y** (Yes), **N** (No), or NA (Not Applicable) to indicate whether the family/LAR participated in the initial or annual meeting to discuss the Plan of Care in the FAMILY PARTICIPATED/POC field.
- Type **Y** (Yes) or **N** (No) to indicate whether the family/LAR participated in this initial or review of the permanency plan in the FAMILY PARTICIPATED/PP field.
- Type **Y** (Yes) or **N** (No) to indicate whether the family could be located when needed within the last six months in the LOCATED FAMILY field.

Step 3, continued

- Type **Y** (Yes) or **N** (No) to indicate whether the family/LAR responded to requests to participate in permanency planning meetings within the last six months in the FAMILY RESPONDED field.
- Type **Y** (Yes) or **N** (No) or **leave blank** for each Family and Community Support.

Note: The **Family and Community Supports to Achieve Goal** section of the screen is not required for individuals 18 to 21 years of age with a Permanency Plan Goal of **4**.

- Type the name of the permanency planning staff contact in the CONTACT NAME field.
- Type the permanency planning staff contact person's telephone number in the CONTACT PHONE field.
- Type **Y** (Yes) or **N** (No) to indicate if the individual is enrolled or enrolling in any Medicaid Waiver or is currently living in a nursing home and has access to a Medicaid Waiver in the ENROLLED, IS ENROLLING, OR IS ELIGIBLE FOR MFP IN A MEDICAID WAIVER field.
- Type **Y** in the READY TO ADD? field.
- Press **Enter**.

Step 4 – Update client correspondent information.

On the **431: Client Correspondent Update** screen:

- Type primary and secondary correspondent information as appropriate.
- Type **Y** in the READY TO UPDATE? field.
- Press **Enter**.

Permanency Planning Review (309): Change

Step 1 – Access the Permanency Planning Review option.

- Type **309** in the ACT: field of any screen.
- Press **Enter**.

Step 2 – Identify the individual and indicate the type of entry.

On the **309: Permanency Planning Review: Add/Change/Delete** header screen:

- Type the MRA component code in the COMPONENT CODE field.
- Type the individual's local case number in the LOCAL CASE NUMBER field.
- Type **C** (Change) in the TYPE OF ENTRY field.
- Press **Enter**.

Step 3 – Change an HCS individual's permanency plan.

On the **309: Permanency Planning Review: Change** screen:

- Type changes to the permanency plan in the appropriate fields.
- Type **Y** in the READY TO CHANGE? field.
- Press **Enter**.

Permanency Planning Review (309): Delete

Step 1 – Access the Permanency Planning Review option.

- Type **309** in the ACT: field of any screen.
- Press **Enter**.

Step 2 – Identify the individual and indicate the type of entry.

On the **309: Permanency Planning Review: Add/Change/Delete** header screen:

- Type the MRA component code in the COMPONENT CODE field.
- Type the individual's local case number in the LOCAL CASE NUMBER field.
- Type **D** (Delete) in the TYPE OF ENTRY field.
- Press **Enter**.

Step 3 – Delete an HCS individual's permanency plan.

On the **309: Permanency Planning Review: Delete** screen:

- Type **Y** in the READY TO DELETE? field.
- Press **Enter**.

Provider Choice (L05)

Step 1 – Access the Provider Choice option.

- Type **L05** in the ACT: field of any screen.
- Press **Enter**.

Step 2 – Identify the individual and indicate the type of entry.

On the **L05: Provider Choice: Add/Delete** header screen:

- Type the Client ID in the CLIENT ID field.
- Type the ***MRA*** component code in the COMPONENT CODE field.
- Type **A** (Add) in the TYPE OF ENTRY field.
- Press **Enter**.

Step 3 – Enter provider choice.

On the **L05: Provider Choice: Add** screen:

Program Provider (PRGP)

- Type the component code of the program provider chosen by the individual in the PROVIDER COMPONENT field.
- Type the local case number that the program provider assigned the individual in the PROVIDER LOCAL CASE NUMBER field.
- Type the contract number of the program provider chosen by the individual in the PROVIDER CONTRACT NUMBER field.
- For **TxHmL** individuals, type **OHFH** (Own Home/Family Home) in the LOCATION CODE field. For **HCS** individuals, type the location code provided by the program provider in the LOCATION CODE field.

Note: In HCS, when choosing a CDSA, the location code ***must*** be **OHFH**.

Consumer Directed Service Agency (CDSA):

- Type the component code of the CDS Agency in the COMPONENT field.
- Type the local case number assigned the individual by the CDS Agency in the LOCAL CASE NUMBER field.
- Type the contract number of the CDS Agency in the CONTRACT NUMBER field.
- Type **Y** in the READY TO ADD? field.
- Press **Enter**.

Register Client Update (L09) – CDSA

The CDSA is contacted for a local case number for the individual, and the MRA enters that local case number into the CARE system.

Note: You will enter information on **L09** twice if both the program provider and CDSA are involved.

Step 1 – Access the Register Client Update option.

- Type **L09** in the ACT: field of any screen.
- Press **Enter**.

Step 2 – Identify the individual.

On the **L09: Register Client Update** header screen:

- Type the Client ID in the CLIENT ID field.
- Type the ***CDSA's* component code** in the COMPONENT CODE field.
- Press **Enter**.

Note: Once an individual has been assigned a local case number by a CDSA, it is not necessary to assign them another local case number.

Step 3 – Assign the selected program provider's local case number for the new enrollment.

On the **L09: Register Client Update** screen:

- Type the Local Case Number assigned to the individual by the **CDSA** in the LOCAL CASE NUMBER field.
- Review all fields on the screen for accuracy and correct, if necessary.

Note: **Do *not* change the Registration Effective Date.**

- Type **Y** in the READY TO UPDATE? field.
- Press **Enter**.

Note: You don't have to change a local case number if an individual changes programs and leaves the provider, then later returns to the provider.

Register Client Update (L09) – Program Provider

Note: You will enter information on **L09** twice if both the provider and CDSA are involved.

Step 1 – Access the Register Client Update option.

- Type **L09** in the ACT: field of any screen.
- Press **Enter**.

Step 2 – Identify the individual.

On the **L09: Register Client Update** header screen:

- Type the Client ID in the CLIENT ID field.
- Type the ***program provider's*** component code in the COMPONENT CODE field.
- Press **Enter**.

Note: Once an individual has been assigned a local case number by a provider, it is not necessary to assign them another local case number.

Step 3 – Assign the selected program provider's local case number for the new enrollment.

On the **L09: Register Client Update** screen:

- Type the Local Case Number assigned to the individual by the program provider in the LOCAL CASE NUMBER field.
- Review all fields on the screen for accuracy and correctness, if necessary.

Note: **Do *not* change the Registration Effective Date.**

- Type **Y** in the READY TO UPDATE? field.
- Press **Enter**.

Note: You don't have to change a local case number if an individual changes programs and leaves the provider, then later returns to the provider.

Service Coordination Assignment (490): Add

The **Add** option is used to add the ***original*** Service Coordinator assignment for an individual **or** to ***change to a different*** Service Coordinator.

Note: Case Management Units (Action Code **660**) and Case Management Positions (Action Code **670**) for the MRA must have been identified in the CARE system before Service Coordinator assignments can be made.

Step 1 – Access the Service Coordination Assignment option.

- Type **490** in the ACT: field of any screen.
- Press **Enter**.

Step 2 – Identify the individual and indicate the type of entry.

On the **490: Svc Coordination Assignment: Add/Change/Delete** header screen:

- Type the requested identifying information in the appropriate fields.

Rule: You must enter the Client ID *or* the local case number.

- Type the MRA component code in the COMPONENT CODE field.
- Type **A** (Add) in the TYPE OF ENTRY field.
- Press **Enter**.

Step 3 – Add a Service Coordinator assignment for a TxHmL individual.

On the **490: Svc Coordination Assignment: Add** screen:

- Type the date the assignment begins in the ASSIGNMENT BEGIN DATE field.
- Type the code for the Service Coordinator position in the CASE MANAGER POSITION field.
- Type the Case Management unit code in the CASE MANAGEMENT UNIT field.
- Type **Y** in the READY TO ADD? field.
- Press **Enter**.

Service Coordination Assignment (490): Change

The following table describes the steps used to change an individual's Service Coordinator assignment record ***if an assignment was added in error and it must be corrected***. This option is ***not*** to be used to *change* service coordinators.

Step 1 – Access the Service Coordination Assignment option.

- Type **490** in the ACT: field of any screen.
- Press **Enter**.

Step 2 – Identify the individual and indicate the type of entry.

On the **490: Svc Coordination Assignment: Add/Change/Delete** header screen:

- Type the requested identifying information in the appropriate fields.

Rule: You must enter the Client ID *or* the local case number.

- Type the MRA component code in the COMPONENT CODE field.
- Type **C** (Change) in the TYPE OF ENTRY field.
- Press **Enter**.

Step 3 – Change a TxHmL individual's Service Coordinator assignment record.

On the **490: Svc Coordination Assignment: Change** screen:

- Type changes to the Service Coordination assignment in the appropriate fields.
- Type **Y** in the READY TO CHANGE? field.
- Press **Enter**.

Service Coordination Assignment (490): Delete

Step 1 – Access the Service Coordination Assignment option.

- Type **490** in the ACT: field of any screen.
- Press **Enter**.

Step 2 – Identify the individual and indicate the type of entry.

On the **490: Svc Coordination Assignment: Add/Change/Delete** header screen:

- Type the requested identifying information in the appropriate fields.

Rule: You must enter the Client ID *or* the local case number.

- Type the MRA component code in the COMPONENT CODE field.
- Type **D** (Delete) in the TYPE OF ENTRY field.
- Press **Enter**.

Step 3 – Delete a TxHmL individual's Service Coordinator assignment record.

On the **490: Svc Coordination Assignment: Delete** screen:

- Type **Y** in the READY TO DELETE? field.
- Press **Enter**.

Waiver MR/RC Assessment Purpose Code 2 (L23)

Step 1 – Access the Waiver MR/RC Assessment option.

- Type **L23** in the ACT: field of any screen.
- Press **Enter**.

Step 2 – Identify the individual and indicate the purpose code, type of entry, and requested begin date.

On the **L23: Waiver MR/RC Assessment: Add/Chg/Del** header screen:

- Type the requested identifying information in the appropriate fields.

Rule: You must enter the Client ID, the local case number, *or* the Medicaid Number.

- Type the MRA component code in the COMPONENT CODE field.
- Type **2** (No Current Assessment) in the PURPOSE CODE field.
- Type **A** (Add) in the TYPE OF ENTRY field.
- Type the MR/RC Assessment begin date in the REQUESTED BEGIN DATE field.

Note: The Purpose Code 2 MR/RC Assessment must begin on or before the enrollment date. If an MRA fails to enter a Purpose Code 2 by this date, they must enter a comment in the PROVIDER COMMENTS field requesting DADS Program Enrollment staff to backdate the MR/RC to the date of enrollment.

- Press **Enter**.

Step 3 – Enter an MR/RC Assessment.

On the **L23: Waiver MR/RC Assessment Purpose Code 2: Add** screen:

- Type the date the MR/RC Assessment was completed in the COMPLETED DATE field.
- Type the person's legal status in the LEGAL STATUS field.
- Type the person's previous residence location before the current enrollment in the PREV. RES. field.
- Type the recommended Level of Care in the REC. LOC field.
- Type the recommended Level of Need in the REC. LON field.
- Type the person's current primary diagnosis as determined by a physician in the PRIMARY DIAG field.
- Type the month and year that the person's disabling condition was originally diagnosed in the ONSET field.
- Press **Enter**.

Step 4 – View client and MR/RC information.

On the **L23: Waiver MR/RC Assessment Purpose Code 2: Add** (screen 2):

- View the client and MR/RC record information.
- Press **Enter**.

Step 5 – Add the cognitive functioning, ICAP data, behavioral status, and nursing information.

On the **L23: Waiver MR/RC Assessment Purpose Code 2: Add** (screen 3):

- Type information in the appropriate fields.

Note: *All of the fields* on this screen are required.

- Press **Enter**.

Step 6 – Add the day services and functional assessment information.

On the **L23: Waiver MR/RC Assessment Purpose Code 2: Add** (screen 4):

- Type information in the appropriate fields.

Note: *All of the fields* on this screen are required.

- Press **Enter**.

Step 7 – Add the physician's evaluation and recommendation information, if appropriate.

On the **L23: Waiver MR/RC Assessment Purpose Code 2: Add** (screen 5):

- The **Physician's Evaluation and Recommendation** fields are ***not*** required for waiver programs.

Note: If the physician has signed the form, you must complete all fields on the screen. If the physician has *not* signed the form, ***do not any enter*** data on this screen.

- Press **Enter** to continue.

Step 8 – Add the provider certification and provider comments.

On the **L23: Waiver MR/RC Assessment Purpose Code 2: Add** (screen 6):

- Type information in the appropriate fields.
- Type **Y** (Yes) *or* **N** (No) in the READY TO SEND FOR AUTHORIZATION? field to indicate whether or not you are ready to send the MR/RC Assessment to Program Enrollment (PE) at State Office.
- Type **Y** (Yes) *or* **N** (No) in the READY TO ADD? field to indicate whether or not you are ready to add the record. You may want to add the record pending further modifications even if you are not ready to send it for authorization by PE. If you add the record, the system saves the data and you won't have to reenter the information, ***but you will have to add needed information and send for review prior to proceeding further with the enrollment.***
- Press **Enter**.

Waiver MR/RC Assessment Purpose Code 3 (L23): Add

Step 1 – Access the Waiver MR/RC Assessment option.

- Type **L23** in the ACT: field of any screen.
- Press **Enter**.

Step 2 – Identify the individual and indicate the purpose code and type of entry.

On the **L23: Waiver MR/RC Assessment: Add/Change/Delete** header screen:

- Type the requested identifying information in the appropriate fields.
- Type the MRA component code in the COMPONENT CODE field.
- Type the contract number under which services are provided to this individual in the CONTRACT NO field.
- Type **3** (Continued Stay Assessment) in the PURPOSE CODE field.
- Type **A** (Add) in the TYPE OF ENTRY field.
- Type the requested begin date in the REQUESTED BEGIN DATE field. (Within 45 days prior to the current expiration date, the begin date can be the day after the expiration date. Other than during this 45-day window, the begin date must be the date of data entry.)
- Press **Enter**.

Step 3 – Add an MR/RC continued stay assessment (Purpose Code 3) for a TxHmL individual.

On the **L23: Waiver MR/RC Assessment Purpose Code 3: Add** screen:

- Type the date the MR/RC Assessment was completed in COMPLETED DATE field.
- Type in the latest physical examination date in the PHYS EXAM DATE field.
- Type additional information in the appropriate fields.

Note 1: **All data entered into the CARE system should be entered from a paper copy (a hard copy) and match exactly**.

Note 2: The LEGAL STATUS and PREV. RES. fields are required.

- Press **Enter**.

Step 4 – View client and MR/RC record information.

On the **L23: Waiver MR/RC Assessment Purpose Code 3: Add** (screen 2):

- View and verify the client and MR/RC record information.
- Press **Enter**.

Step 5 – Continue the MR/RC Assessment entry.

On the **L23: Waiver MR/RC Assessment Purpose Code 3: Add** (screen 3):

- Type information in the appropriate fields.

Note: For the 32. GEN. MALADAPTIVE field, if the number is negative, you *must* use the **–** (minus) sign just above the alpha section of the keyboard, not the **–** sign on the 10-key pad.

- Press **Enter**.

Step 6 – Continue the MR/RC Assessment entry.

On the **L23: Waiver MR/RC Assessment Purpose Code 3: Add** (screen 4):

- Type information in the appropriate fields.

Note: *All of the fields* on this screen are required.

- Press **Enter**.

Step 7 – Continue the MR/RC Assessment entry.

On the **L23: Waiver MR/RC Assessment Purpose Code 3: Add** (screen 5):

- Type information in the appropriate fields.
- If **any** data is entered or shown on this screen, all fields must be correctly entered (not required for waiver programs).

Note: The fields (48-55) on this screen are not required to be completed. If you choose to enter information in the fields, **they must be completed completely and accurately**.

- Press **Enter**.

Step 8 – Complete the MR/RC Assessment entry.

On the **L23: Waiver MR/RC Assessment Purpose Code 3: Add** (screen 6):

- Type information in the appropriate fields.

Note: The title of the person listed on the FULL NAME OF field (field 57) **must be on the list** displayed on this screen.

- Type **Y** (Yes) or **N** (No) in the READY TO SEND FOR AUTHORIZATION? field to indicate whether or not you are ready to send the MR/RC Assessment to DADS Access & Intake, Program Enrollment (PE).
- Type **Y** (Yes) or **N** (No) in the READY TO ADD? field to indicate whether or not you are ready to add the record. You may want to add the record pending further modifications even if you are not ready to send it for authorization by UR.
- Press **Enter**.

Waiver MR/RC Assessment Purpose Code 4 (L23): Add

Step 1 – Access the Waiver MR/RC Assessment option.

- Type **L23** in the ACT: field of any screen.
- Press **Enter**.

Step 2 – Identify the individual and indicate the purpose code and type of entry.

On the **L23: Waiver MR/RC Assessment: Add/Change/Delete** header screen:

- Type the requested identifying information in the appropriate fields.

Rule: You must enter the Client ID, the local case number, *or* the Medicaid Number.

- Type the contract number under which services are provided to this individual in the CONTRACT NO field.
- Type **4** (Change LON on Existing Assessment) in the PURPOSE CODE field.
- Type **A** (Add) in the TYPE OF ENTRY field.
- Type the requested begin date in the REQUESTED BEGIN DATE field.

Note: For a Purpose Code 4, the begin date *must* equal the date of data entry. The end date will be the date that the current LOC/LON expires.

- Press **Enter**.

Step 3 – Add a change LON on an existing MR/RC assessment (Purpose Code 4) for a TxHmL individual.

On the **L23: Waiver MR/RC Assessment Purpose Code 4: Add** screen:

- Type the date the MR/RC Assessment was completed in the COMPLETED DATE field.
- Type the recommended Level of Need in the REC. LON field.
- Type additional information in the appropriate fields.

Note: **All data entered into the CARE system should be entered from a paper copy (a hard copy) and match exactly**.

- Press **Enter**.

Step 4 – View client and MR/RC record information.

On the **L23: Waiver MR/RC Assessment Purpose Code 4: Add** (screen 2):

- View the client and MR/RC record information.
- Press **Enter**.

Step 5 – Continue the MR/RC Assessment entry.

On the **L23: Waiver MR/RC Assessment Purpose Code 4: Add** (screen 3):

- Type information in the appropriate fields.
- Press **Enter**.

Step 6 – Continue the MR/RC Assessment entry.

On the **L23: Waiver MR/RC Assessment Purpose Code 4: Add** (screen 4):

- Type information in the appropriate fields.
- Press **Enter**.

Step 7 – Continue the MR/RC Assessment entry.

On the **L23: Waiver MR/RC Assessment Purpose Code 4: Add** (screen 5):

- Type information in the appropriate fields.

Note: The fields (48-55) on this screen are not required to be completed. If you choose to enter information in the fields, **they must be completed completely and accurately**.

- Press **Enter**.

Step 8 – Complete the MR/RC Assessment entry.

On the **L23: Waiver MR/RC Assessment Purpose Code 4: Add** (screen 6):

- Type or verify correctness of information in the appropriate fields.

Note: The title of the person listed on the FULL NAME OF field (field 57) **must be on the list** displayed on this screen.

- Type **Y** (Yes) or **N** (No) in the READY TO SEND FOR AUTHORIZATION? field to indicate whether or not you are ready to send the MR/RC Assessment to DADS Access & Intake, Program Enrollment (PE).
- Type **Y** (Yes) or **N** (No) in the READY TO ADD? field to indicate whether or not you are ready to add the record. You may want to add the record pending further modifications even if you are not ready to send it for authorization by PE.
- Press **Enter**.

Waiver MR/RC Assessment Purpose Code E (L23): Add

Important: The begin date of the gap is the day after the previous LOC/LON expired, and the end date is the day before the current LOC/LON begins.

Step 1 – Access the MR/RC Assessment Summary

- Type **C68** in the ACT: field of any screen.
- Press **Enter**.

Step 2 – Identify the gap dates

- Review information from the two most recent MR/RC Assessments to determine the gap dates.

Step 3 – Access the Waiver MR/RC Assessment option.

- Type **L23** in the ACT: field of any screen.
- Press **Enter**.

Step 4 – Identify the individual and indicate the purpose code and type of entry.

On the **L23: Waiver MR/RC Assessment: Add/Change/Delete** header screen:

- Type the requested identifying information in the appropriate fields.

Rule: You must enter the Client ID, the local case number, *or* the Medicaid Number.

- Type the contract number under which services are provided to this individual in the CONTRACT NO field.
- Type **E** (Gaps in Assessment) in the PURPOSE CODE field.
- Type **A** (Add) in the TYPE OF ENTRY field.
- Type the requested begin date in the REQUESTED BEGIN DATE field.
- Type the requested end date in the REQUESTED END DATE field.

Note: For Purpose Code E, REQUESTED BEGIN DATE and REQUESTED END DATE are required fields.

- Press **Enter**.

Step 5 – Add an MR/RC gaps in assessment (Purpose Code E) for a TxHmL individual.

On the **L23: Waiver MR/RC Assessment Purpose Code E: Add** screen:

- Type the date the MR/RC Assessment was completed in COMPLETED DATE field.

Note: The date must be **on or after** the gap end date.

- Type the recommended Level of Need in the REC. LON field.
- Type additional information in the appropriate fields.
- Press **Enter** to continue.

Note: An LON increase cannot be authorized on a Purpose Code E.

Step 6 – View the client and MR/RC record information.

On the **L23: Waiver MR/RC Assessment Purpose Code E: Add** (screen 2):

- Press **Enter**.

Step 7 – Continue the MR/RC Assessment entry.

On the **L23: Waiver MR/RC Assessment Purpose Code E: Add** (screen 3):

- Type information in the appropriate fields.
- Press **Enter**.

Step 8 – Continue the MR/RC Assessment entry.

On the **L23: Waiver MR/RC Assessment Purpose Code E: Add** (screen 4):

- Type information in the appropriate fields.
- Press **Enter**.

Step 9 – Continue the MR/RC Assessment entry.

On the **L23: Waiver MR/RC Assessment Purpose Code E: Add** (screen 5):

- Type information in the appropriate fields.

Note: The fields (48-55) on this screen are not required to be completed. If you choose to enter information in the fields, **they must be completed completely and accurately**.

- Press **Enter**.

Step 10 – Continue the MR/RC Assessment entry.

On the **L23: Waiver MR/RC Assessment Purpose Code E: Add** (screen 6):

- Type information in the appropriate fields.

Note 1: The title of the person listed in the FULL NAME OF field (field 57) **must be on the list** displayed on this screen.

Note 2: The signature date must be **on or after** the gap end date.

- Type **Y** (Yes) or **N** (No) in the READY TO SEND FOR AUTHORIZATION? field to indicate whether or not you are ready to send the MR/RC Assessment to DADS Access & Intake, Program Enrollment (PE).
- Type **Y** (Yes) or **N** (No) in the READY TO ADD? field to indicate whether or not you are ready to add the record. You may want to add the record pending further modifications even if you are not ready to send it for authorization by PE.
- Press **Enter**.

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