CARE

Client Assignment and Registration System
Texas Department of Mental Health and Mental Retardation

CARE-PROV

ICF/MR Provider Characteristics (Action Code 683)

Rev. 1/04

Component ☐☐☐ Contract Number ☐☐☐☐☐☐☐☐☐☐

Type of Entry Add: ☐ Change: ☐ Delete: ☐

Contact Person for Public Inquiries

Contact Name _____

Contact Telephone _____

Contact Email _____

Person to Receive Email Notifications

Notify Name _____

Notification Email _____

Vacancy Adjustment

Reserved Beds _____

Client Gender Information

Gender of Individuals Served by Facility: ☐ M=Male F=Female B=Both

Client Age Information

Can Individuals Under 18 be Served by Facility? ☐ (Y=Yes, N=No)

Can Individuals 18 to 21 be Served by Facility? ☐ (Y=Yes, N=No)

Can Individuals Over 21 be Served by Facility? ☐ (Y=Yes, N=No)

Staff Training Information

Is Staff Trained to Handle Medical Needs? ☐ (Y=Yes, N=No)

Is Staff Trained to Handle Behavioral Needs? ☐ (Y=Yes, N=No)

Is Staff Trained for Pervasive Developmental Disorders? ☐ (Y=Yes, N=No)

Is Staff Able to Serve Clients Requiring 2-man Lift? ☐ (Y=Yes, N=No)

Wheelchair Access

Is Facility Able to Serve Clients Requiring Wheelchair? ☐ (Y=Yes, N=No)

Staffing Information

	Staff	Client
Most Typical Staff-Client Ratio (Awake Hrs):	_____	_____
Most Typical Staff-Client Ratio (Sleep Hrs):	_____	_____

Medication Administration Options

Self Administration? ☐ (Y=Yes, N=No)

Self Administration with Supervision? ☐ (Y=Yes, N=No)

Administered by Licensed or Registered Nurse? ☐ (Y=Yes, N=No)

Information Verification

Have you verified the information on this form? ☐ (Y=Yes, N=No)

Completed by: _____ Date: _____

ICF/MR Provider Characteristics **(CARE-PROV)**

Field Name	Type	Contents
COMPONENT	R	3-digit component code defined by your Login ID.
CONTRACT NUMBER	R	Contract number.
Type of Entry		
ADD	O/R	Check this box to add provider characteristics.
CHANGE	O/R	Check this box to change provider characteristics previously entered.
DELETE	O/R	Check this box to delete provider characteristics previously entered.
Contact Person for Public Inquiries		
CONTACT NAME	R	Contact person's name. Required for new adds *or* changes.
CONTACT TELEPHONE	R	Contact person's telephone number. ### - ### - #### format. Required for new adds *or* changes.
CONTACT EMAIL	R	Contact person's email address. Must contain one **@** in other than the first position and at least one period in other than the first three positions. Required for new adds *or* changes.
Person to Receive Email Notifications		
NOTIFY NAME	R	Name of the person who is to receive email notifications.
NOTIFICATION EMAIL	R	Email address of the person who is to receive email notifications.
Vacancy Adjustment		
RESERVED BEDS	O	Number of beds to exclude from vacancy count.
Client Gender Information		
GENDER OF INDIVIDUALS SERVED BY FACILITY	R	M=Male, F=Female, B=Both
Client Age Information		
CAN INDIVIDUALS UNDER 18 BE SERVED BY FACILITY?	R	**Y** (yes) or **N** (no) to indicate whether individuals under 18 can be served by the facility.
CAN INDIVIDUALS 18 TO 21 BE SERVED BY FACILITY?	R	**Y** (yes) or **N** (no) to indicate whether individuals 18 to 21 can be served by the facility.
CAN INDIVIDUALS OVER 21 BE SERVED BY FACILITY?	R	**Y** (yes) or **N** (no) to indicate whether individuals over 21 can be served by the facility.
Staff Training Information		
IS STAFF TRAINED TO HANDLE MEDICAL NEEDS?	R	**Y** (yes) or **N** (no) to indicate whether staff is trained to handle medical conditions that require 24-hour nursing services.
IS STAFF TRAINED TO HANDLE BEHAVIORAL NEEDS?	R	**Y** (yes) or **N** (no) to indicate whether staff is trained to handle behaviors that require formal, systematic application of behavioral techniques.
IS STAFF TRAINED FOR PERVASIVE DEVELOPMENTAL DISORDERS?	R	**Y** (yes) or **N** (no) to indicate whether staff is trained to handle pervasive developmental disorders, e.g., Autistic Disorder.
IS STAFF ABLE TO SERVE CLIENTS REQUIRING 2-MAN LIFT?	R	**Y** (yes) or **N** (no) to indicate whether staff is able to serve clients requiring 2-man lift.
Wheelchair Access		
IS FACILITY ABLE TO SERVE CLIENTS REQUIRING WHEELCHAIR?	R	**Y** (yes) or **N** (no) to indicate whether the facility is able to serve clients requiring a wheelchair.
Staffing Information		
MOST TYPICAL STAFF-CLIENT RATIO (AWAKE HRS)	R	Indicates most typical staff to client ratio during awake hours.
MOST TYPICAL STAFF-CLIENT RATIO (SLEEP HRS)	R	Indicates most typical staff to client ratio during sleep hours.
Medication Administration Options		
SELF ADMINISTRATION?	R	**Y** (yes) or **N** (no) to indicate whether the method of medication administration is self-administration.
SELF ADMINISTRATION WITH SUPERVISION?	R	**Y** (yes) or **N** (no) to indicate whether the method of medication administration is self-administration with supervision.
ADMINISTERED BY LICENSED OR REGISTERED NURSE?	R	**Y** (yes) or **N** (no) to indicate whether the method of medication administration is by licensed or registered nurse.
Information Verification		
HAVE YOU VERIFIED THE INFORMATION ON THIS FORM?	R	**Y** (yes) or **N** (no) to indicate whether all of the information on the form has been verified.
COMPLETED BY	R	Signature of person completing form.
DATE	R	Date form is completed.