CARE

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

CARE-MRHOSPNEED

# Hospitalization Need of MR Person

(Action Code 357)

3/17/94

Last Name/ Suffix

First Name

Middle Name

Client ID

Local Case Number

Component Code

**Action** Add ☐ Change ☐ Delete ☐

Determination Date ☐☐–☐☐–☐☐
MM DD YY

Does person need further hospitalization? Yes ☐ No ☐

Completed By: _____ Date: _____

# Hospitalization Need of MR Person
## (CARE-MRHOSPNEED)

| Field Name | Type | Contents |
|---|---|---|
| LAST NAME | R | Person's last name. |
| SUFFIX | O | Person's last name suffix. (e.g., Jr, Sr, II) |
| FIRST NAME | R | Person's first name. |
| MIDDLE NAME | O | Person's middle name. |
| CLIENT ID | O | Person's statewide identification number. |
| LOCAL CASE NUMBER | R | Person's local case number. |
| COMPONENT CODE | R | Component code. |
| ACTION ADD | O/R | You must check this box if data is to be added to CARE. |
| ACTION CHANGE | O/R | You must check this box if data is a change to data already in CARE. |
| ACTION DELETE | O/R | You must check this box if data is to be deleted from CARE. |
| DETERMINATION DATE | R | Date of determination for person's need for hospitalization. MMDDYY format. |
| DOES PERSON NEED FURTHER HOSPITALIZATION? | R | **Y** (Yes) or **N** (No) to indicate if the person needs further hospitalization. |
| COMPLETED BY | R | Signature of person completing form. |
| DATE | R | Date form is completed. |