CARE

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

CARE-REG1	**Client Registration**	(Action Code 325)	Rev. 9/03

Action   Add: ☐   Update: ☐

Last Name/ ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐   Client ID ☐☐☐☐☐☐☐☐☐

Suffix ☐☐☐

First Name ☐☐☐☐☐☐☐☐☐☐☐   Local Case Number ☐☐☐☐☐☐☐☐☐☐

Middle Name ☐☐☐☐☐☐☐☐☐☐   Component Code ☐☐☐

Sex ☐ (M=Male, F=Female)   Federal Race ☐ (I=American Indian or Alaska Native, A=Asian, B=Black or African American, W=White, P=Native Hawaiian or Other Pacific Islander, M=More than One Race Reported)

Federal Ethnicity ☐ (H=Hispanic or Latino, N=Not Hispanic or Latino)

Birthdate ☐☐–☐☐–☐☐☐☐
MM   DD   YYYY

Social Security Number ☐☐☐–☐☐–☐☐☐☐
(N=None, U=Unknown)

Medicaid Number ☐☐☐☐☐☐☐☐☐   Medicare Number ☐☐☐☐☐☐☐☐☐☐☐☐

Presenting Problem ☐ (1=MH, 2=MR, 3=ECI/DD, 4=SA, 5=RC)

Registration Effective Date ☐☐–☐☐–☐☐
MM   DD   YY

Registration Effective Time ☐☐–☐☐–☐
HH   MM   A/P

Street Address _____ State ☐☐ Zip Code _____

City _____   County of Residence _____ Code ☐☐☐

Legal Guardianship ☐   Marital Status ☐

Family Size ☐☐   Estimated Annual Gross Family Income ☐☐☐☐☐☐

Primary Correspondent	Secondary Correspondent
Name _____	Name _____
Street _____	Street _____
City _____	City _____
State ☐☐ Zip Code _____	State ☐☐ Zip Code _____
Relationship ☐☐ Phone (____) _____	Relationship ☐☐ Phone (____) _____

Completed By: _____   Date: _____

Client Registration (CARE-REG1)

Field Name	Type	Contents
ACTION ADD	O/R	You must check this box if you believe the person *is not registered* in CARE.
ACTION UPDATE	O/R	You must check this box if person *is registered* in CARE.
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.
SEX	R	Person's sex.
FEDERAL RACE	R	Person's race.
FEDERAL ETHNICITY	R	Person's ethnicity.
BIRTHDATE	R	Person's date of birth. MMDDYYYY format.
SOCIAL SECURITY NUMBER	R	Person's social security number *or* N=None, U=Unknown.
MEDICAID NUMBER	O	Person's Medicaid number.
MEDICARE NUMBER	O	Person's Medicare number.
PRESENTING PROBLEM	R	One-digit code to indicate person's presenting problem. 1=MH (Mental Health), 2=MR (Mental Retardation), 3=ECI/DD (Early Childhood Intervention/ Developmentally Delayed), 4=SA (Substance Abuse), 5=RC (Related Condition-MR only).
REGISTRATION EFFECTIVE DATE	R	Date the registration is effective. MMDDYY format.
REGISTRATION EFFECTIVE TIME	R	Time the registration is effective. HHMM A/P format.
STREET ADDRESS	O	Person's street address.
CITY	O	Person's city of residence.
STATE	O	Person's state of residence.
ZIP CODE	O	Person's zip code and zip code suffix (if available).
COUNTY OF RESIDENCE	R	Name of person's county of residence.
CODE	R	Three-digit code for person's county of residence. **County Codes and Local Service Areas**
LEGAL GUARDIANSHIP	O	Person's legal status. 1=Minor, 2=Minor with Conservator, 3=Adult with Guardian of Estate and Person, 4=Adult with Guardian of Estate, 5=Adult with Guardian of Person, 6=Adult with Limited Guardian, 7=Adult with Temporary Guardian, 8=Adult, No Guardian, 9=Adult with Conservator
MARITAL STATUS	O	Person's marital status. 1=Married, 2=Widowed, 3=Divorced, 4=Separated, 5=Never Married, 6=Unknown/NA.

Field Name	Type	Contents
FAMILY SIZE	O	Number of persons supported on the person's family's estimated annual gross income. Includes 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.
ESTIMATED ANNUAL GROSS FAMILY INCOME	O	Total annual gross income of all family members living with the person, rounded to the nearest thousand. Do not enter commas or decimals.

Primary Correspondent:

Field Name	Type	Contents
NAME	O	Name of the first person to contact on behalf of the person in case of an emergency.
STREET	O	Primary correspondent's street address.
CITY	O	Primary correspondent's city of residence.
STATE	O	Primary correspondent's state of residence.
ZIP CODE	O	Zip code and zip code suffix (if available) of primary correspondent.
RELATIONSHIP	O/R	Relationship of the primary correspondent to the person. If a primary correspondent is named, this field is required. **Decode: Relationship**
PHONE	O	Telephone number of primary correspondent. If the telephone number is entered, the area code is required.

Secondary Correspondent:

Field Name	Type	Contents
NAME	O	Name of the person to contact on behalf of the person in case of an emergency if the primary correspondent cannot be reached.
STREET	O	Secondary correspondent's street address.
CITY	O	Secondary correspondent's city of residence.
STATE	O	Secondary correspondent's state of residence.
ZIP CODE	O	Zip code and zip code suffix (if available) of secondary correspondent.
RELATIONSHIP	O/R	Relationship of the secondary correspondent to the person. If a secondary correspondent is named, this field is required. **Decode: Relationship**
PHONE	O	Telephone number of secondary correspondent. If the telephone number is entered, the area code is required.
COMPLETED BY	R	Signature of person completing the form.
DATE	R	Date the form is completed.

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