5 - A. Screen Field Tables

Screen Field Tables

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

Table Columns

Each table contains three columns as described below.

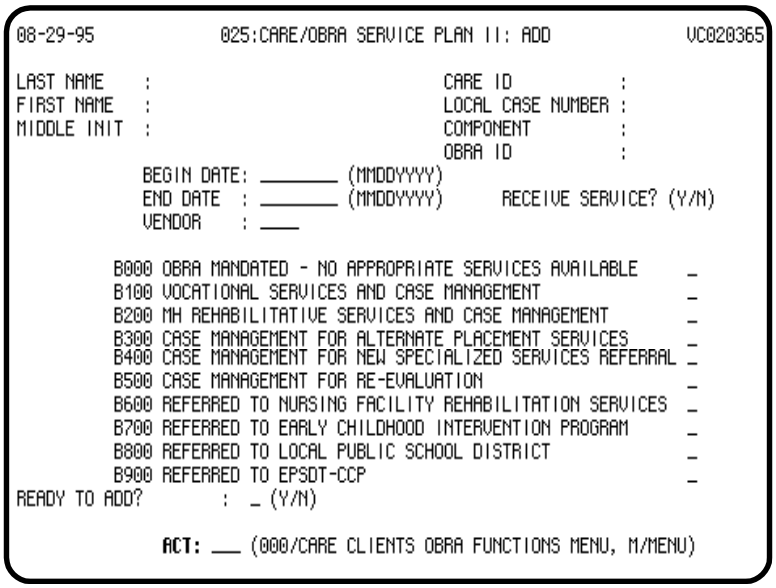
Column	Description
Field Name	The name of the field as it is displayed on the screen.
Type	The field's type (see descriptions below).
Contents	An explanation of the information to be entered in the field. If the information for the field is found elsewhere in this reference manual, that fact is noted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

Field Types

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

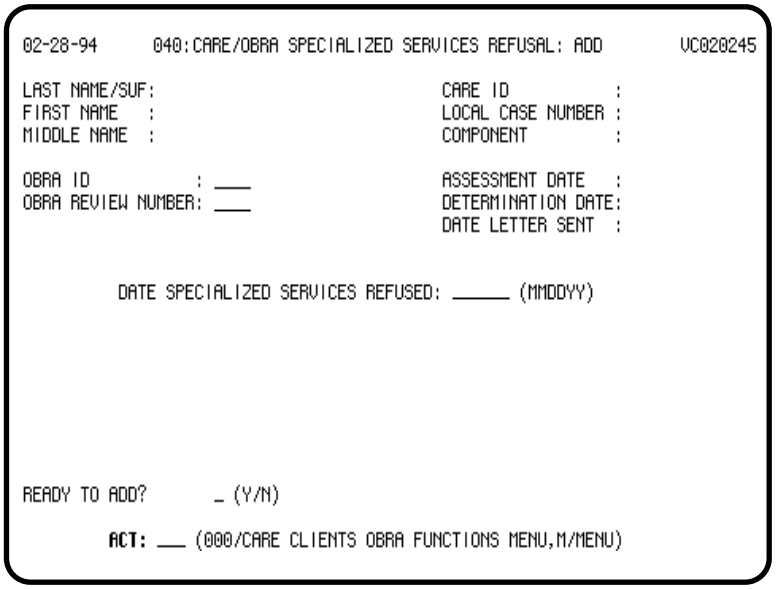
Type	Description
R (Required)	Data is required. You must enter appropriate data in the field.
D (Displayed)	Data displayed is supplied by CARE and cannot be changed.
O (Optional)	Optional data. If data is available, it should be entered.
D/R (Displayed/Required)	Data displayed is supplied by CARE/Required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

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



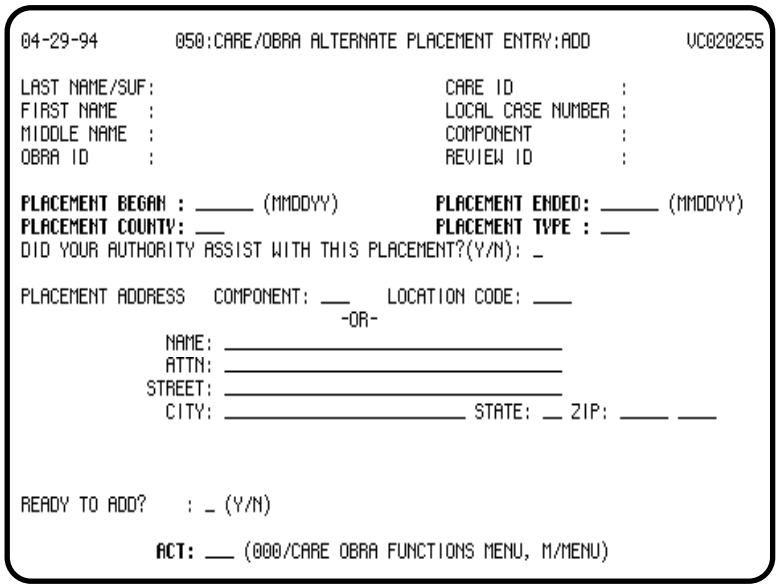
Field Name	Type	Contents
LAST NAME	D	Person's last name.
FIRST NAME	D	Person's first name.
MIDDLE INIT	D	Person's middle initial.
CARE ID	D	Person's statewide identification number.
LOCAL CASE NUMBER	D	Person's local case number.
COMPONENT	D	Three-digit code of the component to which the person is assigned.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

CARE/OBRA Specialized Services Refusal (VC020245)
(Action Code 040)



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

CARE/OBRA Alternate Placement Entry (VC020255)
(Action Code 050)



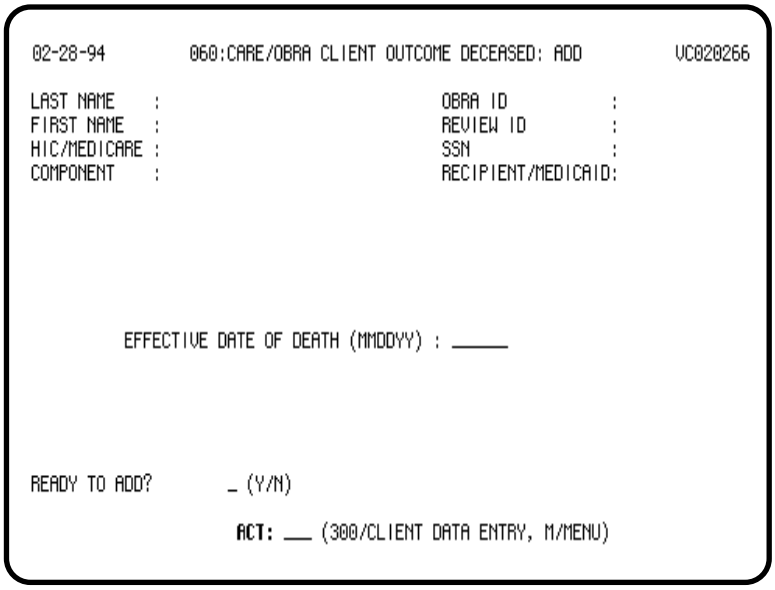
Field Name	Type	Contents
LAST NAME/SUF	D	Person's last name and suffix, if any.
FIRST NAME	D	Person's first name.
MIDDLE NAME	D	Person's middle name.
OBRA ID	D	Person's OBRA identification number.
CARE ID	D	Person's statewide identification number.
LOCAL CASE NUMBER	D	Person's local case number.
COMPONENT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

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

CARE/OBRA Client Outcome Deceased (VC020266)

(Action Code 060)

1 - Client Deceased Option

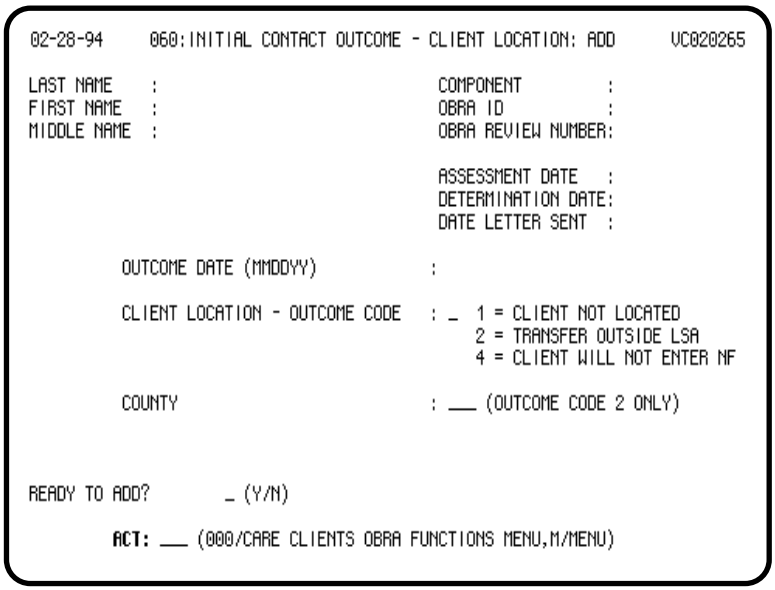


Field Name	Type	Contents
LAST NAME	D	Person's last name and suffix, if any.
FIRST NAME	D	Person's first name.
HIC/MEDICARE	D	The 1 - 12 character Medicare/HIC number.
COMPONENT	D	Three-digit component code entered on the request screen.
OBRA ID	D	Person's OBRA identification number.
REVIEW ID	D	Number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

Initial Contact Outcome — Client Location (VC020265)

(Action Code 060)

2 - Client Location Option

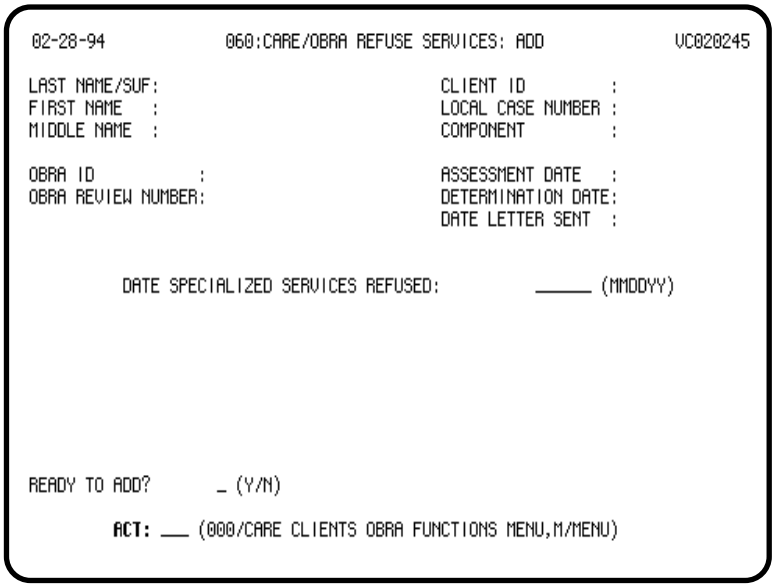


Field Name	Type	Contents
LAST NAME	D	Person's last name and suffix, if any.
FIRST NAME	D	Person's first name.
MIDDLE NAME	D	Person's middle name.
COMPONENT	D	Three-digit component code.
OBRA ID	D	Person's OBRA identification number.
OBRA REVIEW NUMBER	D	Number assigned to the person's OBRA review.
ASSESSMENT DATE	D	Date of the assessment.
DETERMINATION DATE	D	Date of the determination.
DATE LETTER SENT	D	Date the determination letter was sent.
OUTCOME DATE	R	The date • the person actually left the local service area, • the person said he/she was not going into the facility, ***or*** • the authority gave up looking for the person.
CLIENT LOCATION — OUTCOME CODE	R	Code indicating the outcome. 1 = Client Not Located 2 = Transfer Outside LSA 4 = Client Will Not Enter NF
COUNTY	R	Code for the county to which the person is moving. Note: County code cannot be entered unless the OUTCOME CODE is 2.

CARE/OBRA Refuse Services (VC020245)

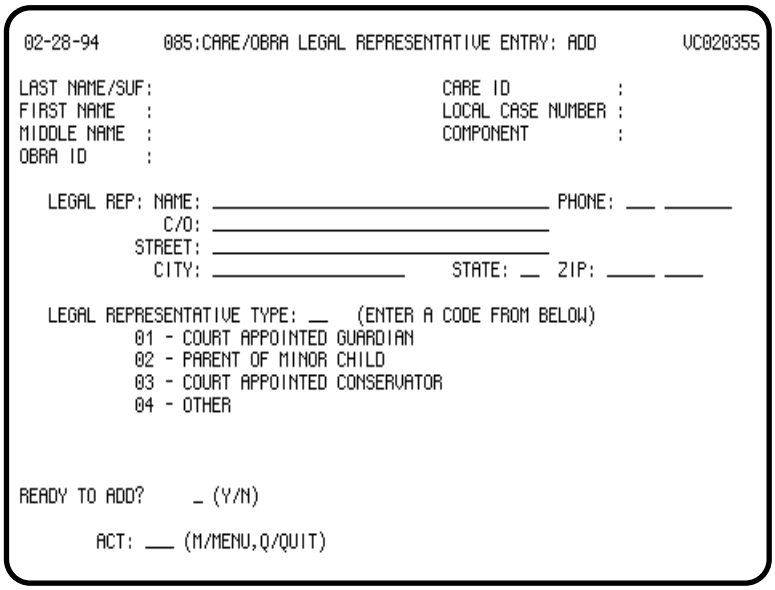
(Action Code 060)

3 - Refuse Services Option



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

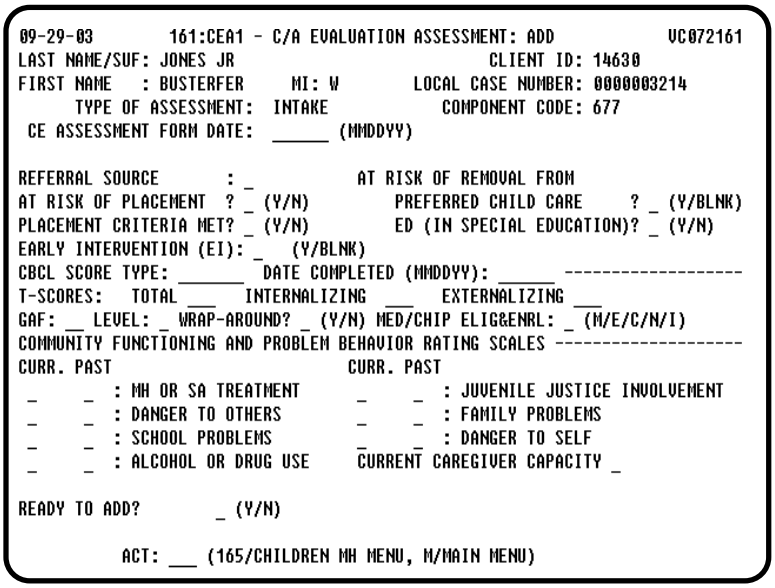
CARE/OBRA Legal Representative Entry (VC020355)
(Action Code 085)



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

CEA1 – C/A Evaluation Assessment (VC072161)

(Action Code 160)



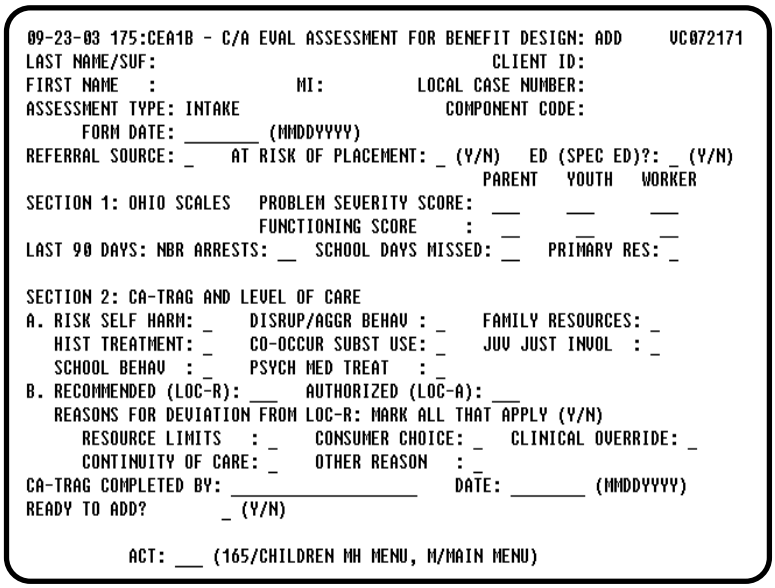
Field Name	Type	Contents
LAST NAME/SUF	D	Person's last name and suffix, if any.
FIRST NAME	D	Person's first name.
MI	D	Person's middle initial.
CLIENT ID	D	Person's statewide identification number assigned by CARE.
LOCAL CASE NUMBER	D	Person's local case number.
COMPONENT CODE	D	Three-digit code of the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

Field Name	Type	Contents
CBCL Score Type	O/R	Indicates type as CBCL, CBCL 2-3, YSR, TRF.
Date Completed	O/R	Date the CBCL/YSR/TRF was completed.
T-Scores		
Total	O/R	CBCL/YSR/TRF score for Total.
Internalizing	O/R	CBCL/YSR/TRF score for Internalizing.
Externalizing	O/R	CBCL/YSR/TRF score for Externalizing.
GAF	O	One- or two-digit code for the person's global assessment functioning level on the assessment date.
Level	R	Person's Level of Need (1, 2, 3, or A).
Wrap-Around?	R	**Y** (Yes) or **N** (No) to indicate whether the child is receiving wrap-around services.
Med/Chip Elig & Enrl	O	Indicates the child's Medicaid/CHIP eligibility and enrollment status. M = Medicaid eligible and enrolled E = Medicaid eligible and not enrolled C = CHIP eligible and not enrolled N = Not eligible for CHIP or Medicaid I = CHIP enrolled
Community Functioning and Problem Behavior Rating Scales	R	The appropriate rating (0 to 5) for any of the following Community Functioning and Problem Behavior Rating Scales that apply to the person (current or past): MH or SA Treatment Juvenile Justice Involvement Danger to Others Family Problems School Problems Danger to Self Alcohol or Drug Use
Current Caregiver Capacity	R	The appropriate rating (0 to 5) to indicate the current caregiver's capacity regarding treatment.

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

(Action Code 164)

To be completed by Pilot Sites Only



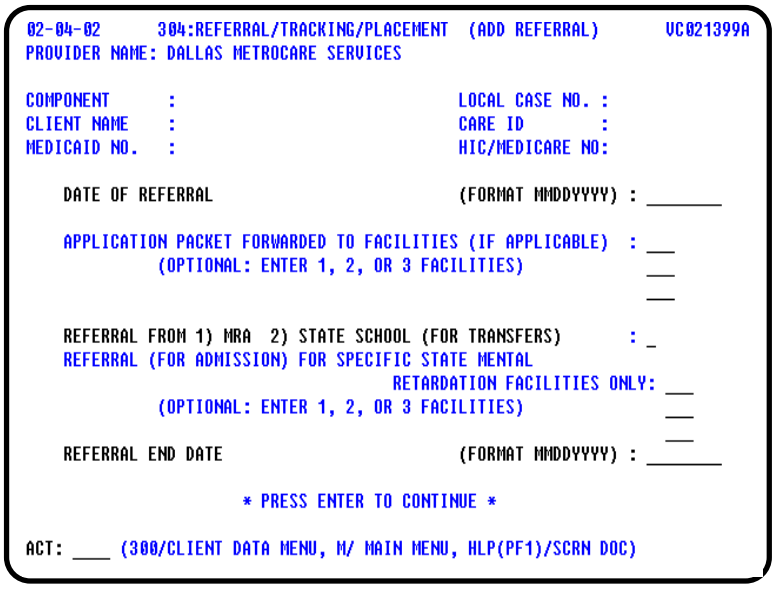
Field Name	Type	Contents
LAST NAME/SUF	D	Person's last name and suffix, if any.
FIRST NAME	D	Person's first name.
MI	D	Person's middle initial.
CLIENT ID	D	Person's statewide identification number assigned by CARE.
LOCAL CASE NUMBER	D	Person's local case number.
COMPONENT CODE	D	Three-digit code of the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

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

Referral/Tracking/Placement (VC021399A)

(Action Code 304)

Screen A - Referral

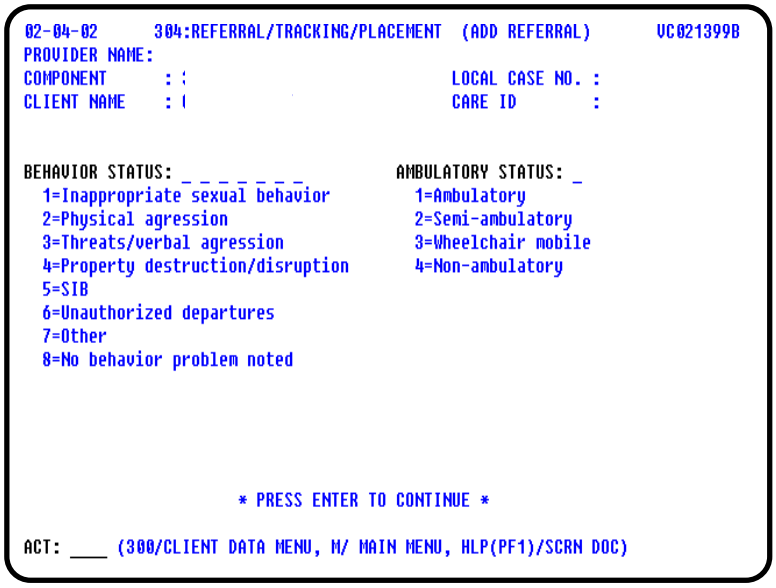


Field Name	Type	Contents
COMPONENT	D	Three-digit component code.
CLIENT NAME	D	Person's last and first names.
MEDICAID NO.	D	Person's Medicaid number.
LOCAL CASE NO.	D	Person's local case number.
CARE ID	D	Person's statewide identification number assigned by CARE.
HIC/MEDICARE NO.	D	Person's HIC/Medicare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

Referral/Tracking/Placement (VC021399B)

(Action Code 304)

Screen B - Referral

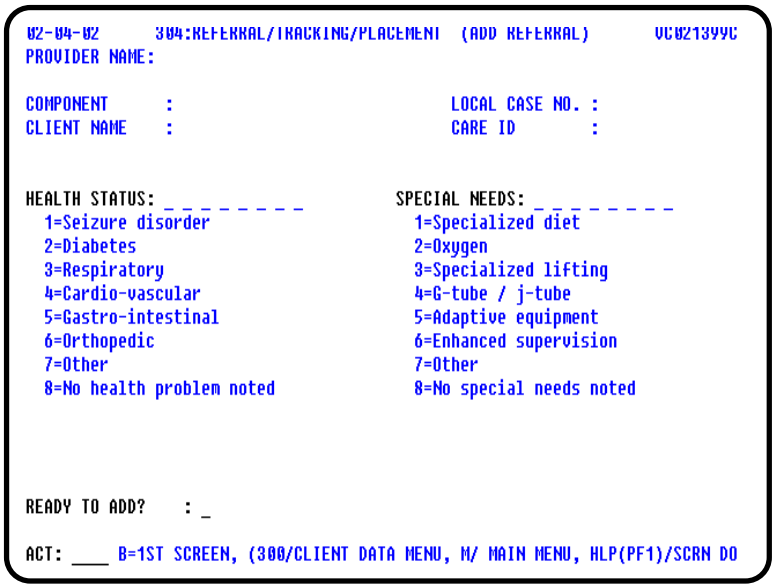


Field Name	Type	Contents
PROVIDER NAME	D	Name of the service provider.
COMPONENT	D	Three-digit component code.
CLIENT NAME	D	Person's last and first names.
LOCAL CASE NO.	D	Person's local case number.
CARE ID	D	Person's statewide identification number assigned by CARE.
BEHAVIOR STATUS	R	Code(s) to describe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

Referral/Tracking/Placement (VC021399C)

(Action Code 304)

Screen C - Referral

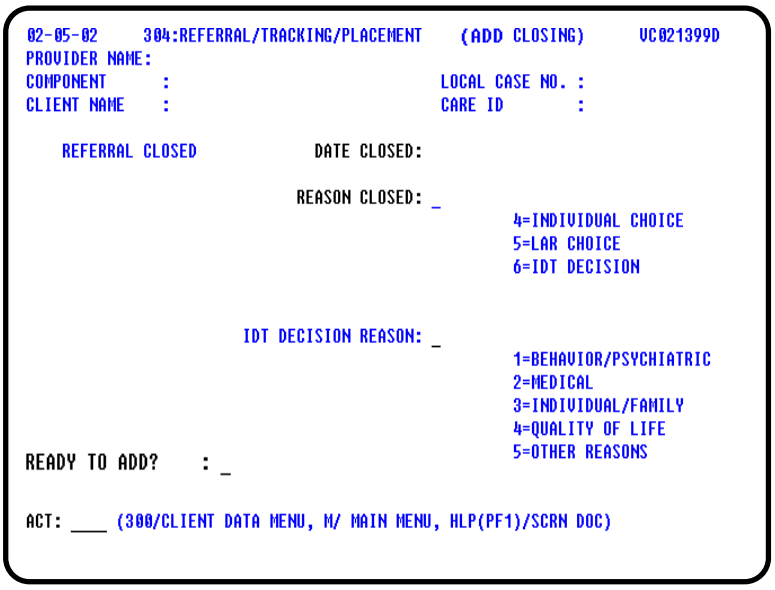


Field Name	Type	Contents
PROVIDER NAME	D	Name of the service provider.
COMPONENT	D	Three-digit component code.
CLIENT NAME	D	Person's last and first names.
LOCAL CASE NO.	D	Person's local case number.
CARE ID	D	Person's statewide identification number assigned by CARE.
HEALTH STATUS	R	Code(s) to describe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

Referral/Tracking/Placement (VC021399D)

(Action Code 304)

Screen D - Closing

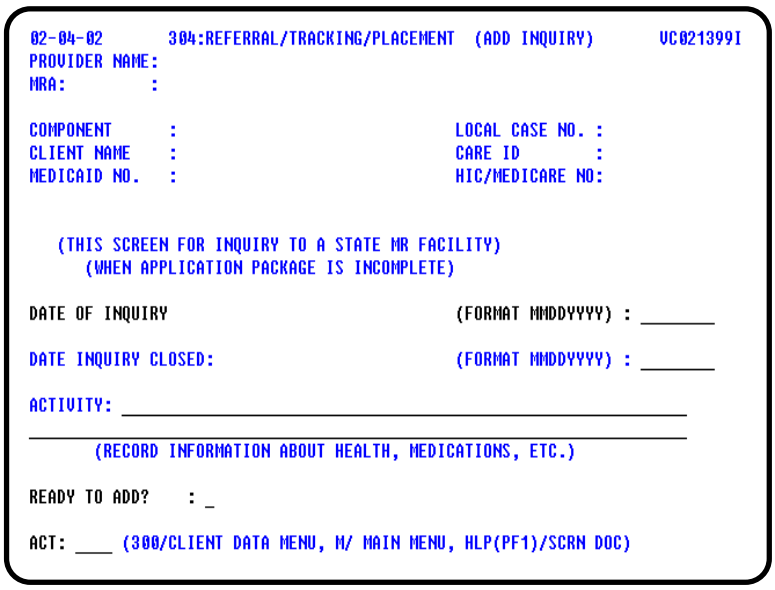


Field Name	Type	Contents
PROVIDER NAME	D	Name of the service provider.
COMPONENT	D	Three-digit component code.
CLIENT NAME	D	Person's last and first names.
LOCAL CASE NO.	D	Person's local case number.
CARE ID	D	Person's statewide identification number assigned by CARE.
DATE CLOSED	O	Date the referral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

Referral/Tracking/Placement (VC021399I)

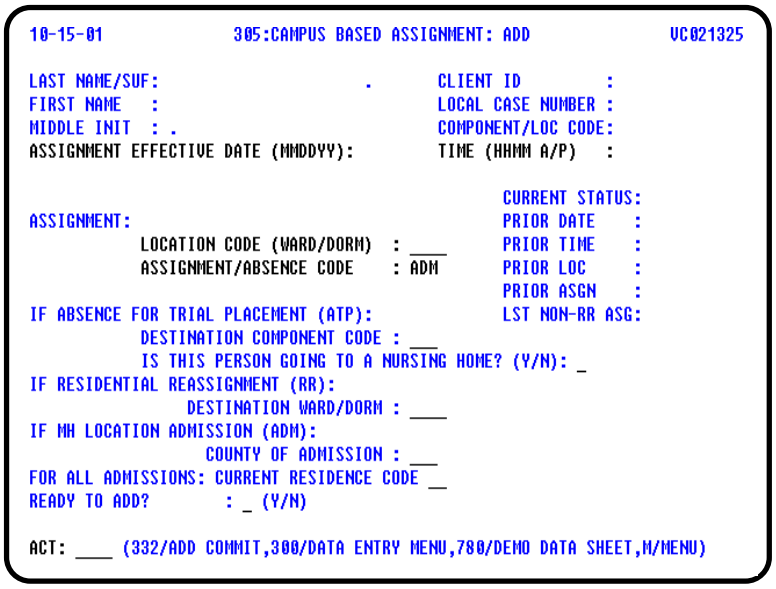
(Action Code 304)

Screen I - Inquiry

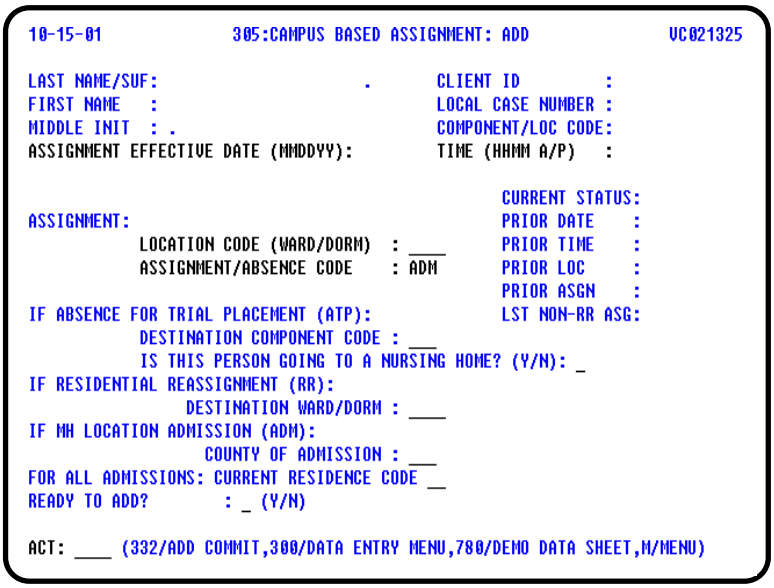


Field Name	Type	Contents
PROVIDER NAME	D	Name of the service provider.
MRA	D	Three-digit code and name of the Mental Health Authority.
COMPONENT	D	Three-digit component code.
CLIENT NAME	D	Person's last and first names.
MEDICAID NO.	D	Person's Medicaid number.
LOCAL CASE NO.	D	Person's local case number.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

Campus-based Assignments (VC021325)
(Action Code 305)



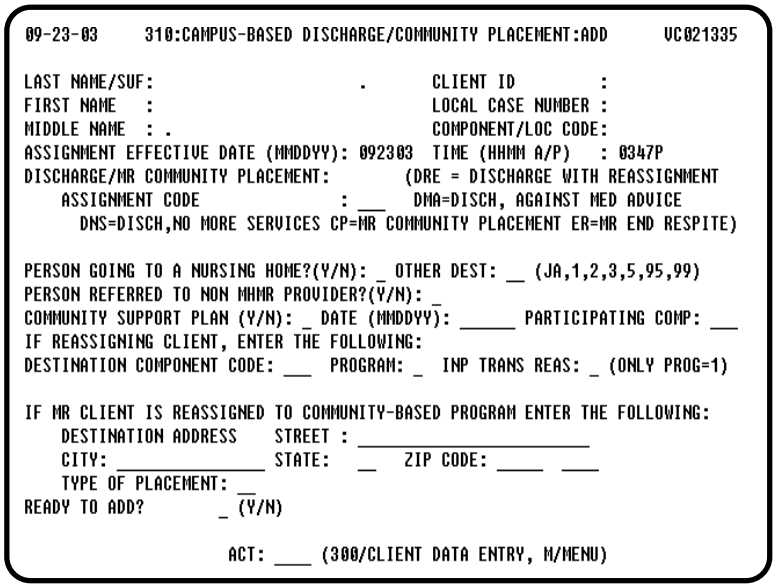
Field Name	Type	Contents
LAST NAME/SUF	D	Person's last name and (optional) suffix. (e.g., Jr, Sr)
FIRST NAME	D	Person's first name.
MIDDLE INIT	D	Person's middle initial.
CLIENT ID	D	Person's statewide identification number.
LOCAL CASE NUMBER	D	Person's local case number.
COMPONENT	D	Component code.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



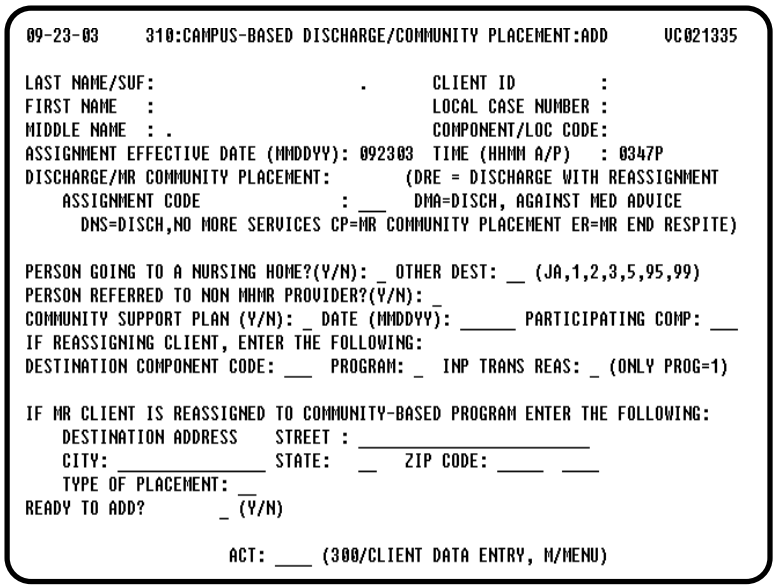
Field Name	Type	Contents
If Absence for Trial Placement (ATP):		
DESTINATION COMPONENT CODE	O/R	Three-digit code for component to which person is reassigned. Required if ASSIGNMENT/ABSENCE CODE is ATP. **Component Codes/LSAs**
IS THIS PERSON GOING TO A NURSING HOME? (Y/N)	O/R	*For state hospital use only.* **Y** (Yes) or **N** (No) to indicate whether a person is going to a nursing home when placed on ATP from a state hospital.
If Residential Reassignment (RR):		
DESTINATION WARD/DORM	O/R	Ward or dorm to which person is reassigned. Required for residential reassignments only.
If MH Location Admission (ADM):		
COUNTY OF ADMISSION	O/R	Code for county of admission. Required if ASSIGNMENT/ABSENCE CODE is ADM *and* the admission is to a state hospital or MH unit at a state center.
For All Admissions:		
CURRENT RESIDENCE CODE	R	Indicates where the person was living before admission. **Decode: Current Residence Code**

Campus-based Discharge/ Community Placement (VC021335)

(Action Code 310)

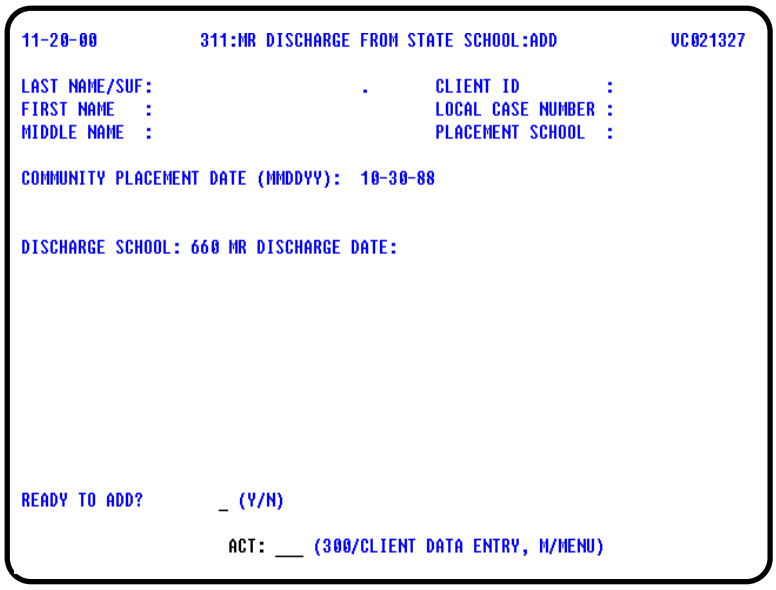


Field Name	Type	Contents
LAST NAME/SUF	D	Person's last name and (optional) suffix. (e.g., Jr, Sr)
FIRST NAME	D	Person's first name.
MIDDLE NAME	D	Person's middle name.
CLIENT ID	D	Person's statewide identification number.
LOCAL CASE NUMBER	D	Person's local case number.
COMPONENT	D	Component code.
LOC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



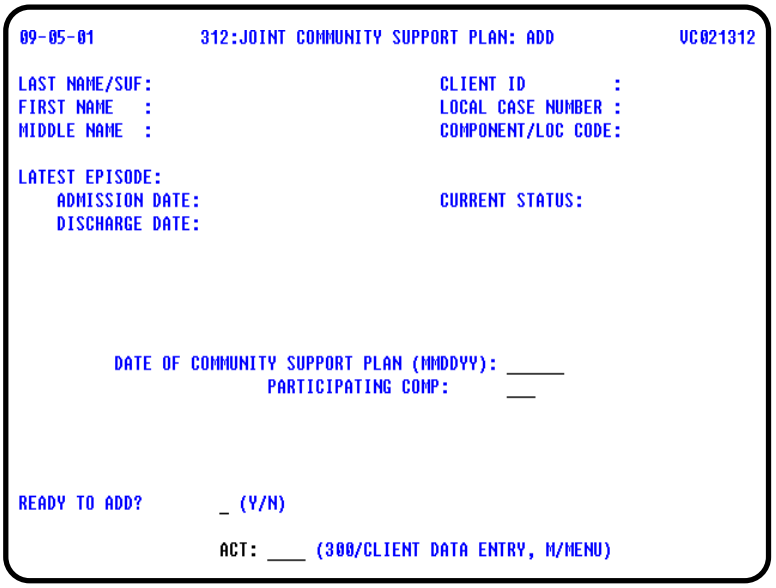
Field Name	Type	Contents
PERSON REFERRED TO NON-MHMR PROVIDER	O	**Y** (Yes) or **N** (No) to indicate whether a person is being referred to a non-MHMR provider.
COMMUNITY SUPPORT PLAN (Y/N)	R	**Y** (Yes) or **N** (No) to indicate whether a Joint Community Support Plan has been made.
DATE	O/R	Date the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

MR Discharge from State School (VC021327)
(Action Code 311)



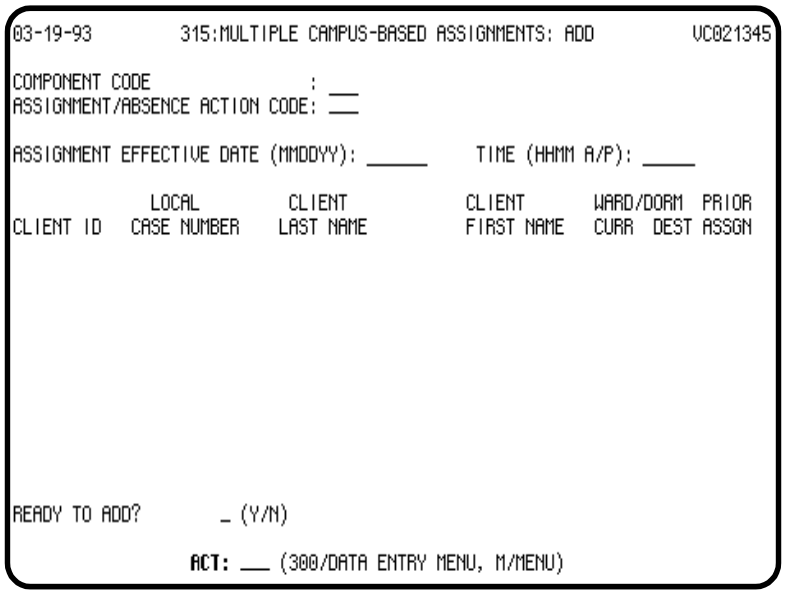
Field Name	Type	Contents
LAST NAME/SUF	D	Person's last name and (optional) suffix. (e.g., Jr, Sr)
FIRST NAME	D	Person's first name.
MIDDLE NAME	D	Person's middle name.
CLIENT ID	D	Person's statewide identification number.
LOCAL CASE NUMBER	D	Person's local case number.
PLACEMENT SCHOOL	D	Component code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

Joint Community Support Plan (VC021312)
(Action Code 312)



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

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

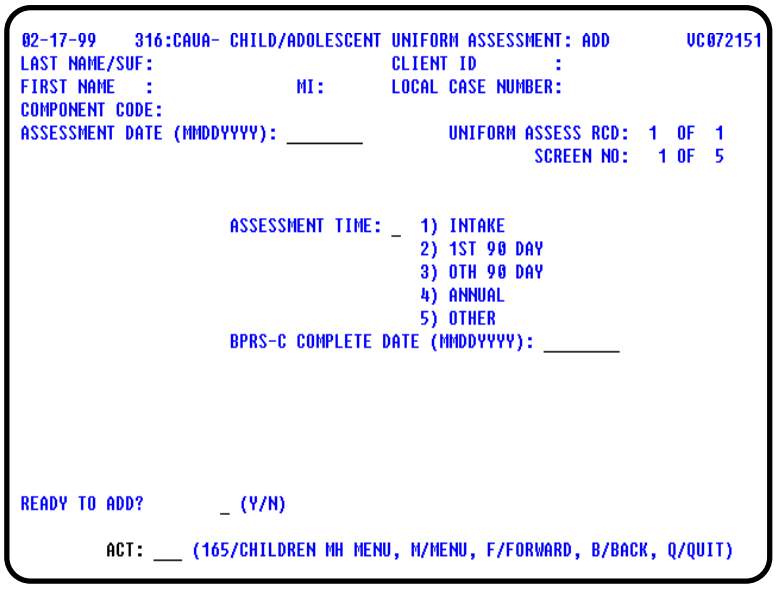


Field Name	Type	Contents
COMPONENT CODE	D	Component code.
ASSIGNMENT/ABSENCE ACTION CODE	R	Code for the type of reassignment or absence. (ATP *cannot* be used.) **Decode: Assignment/Absence Code**
ASSIGNMENT EFFECTIVE DATE	D/R	Date assignment is effective. MMDDYY format.
TIME	D/R	Time assignment is effective.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

CAUA-Child/Adolescent Uniform Assessment (VC072151)

(Action Code 316)

Screen 1

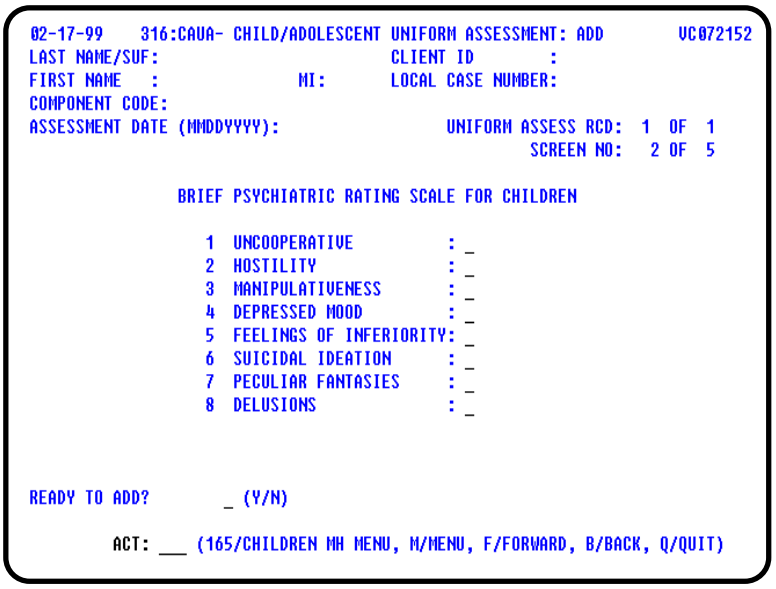


Field Name	Type	Contents
LAST NAME/SUF	D	Person's last name and (optional) suffix. (e.g., Jr, Sr)
FIRST NAME	D	Person's first name.
MI	D	Person's middle initial.
CLIENT ID	D	Person's statewide identification number.
LOCAL CASE NUMBER	D	Person's local case number.
COMPONENT CODE	D	Component code.
ASSESSMENT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

CAUA-Child/Adolescent Uniform Assessment (VC072152)

(Action Code 316)

Screen 2

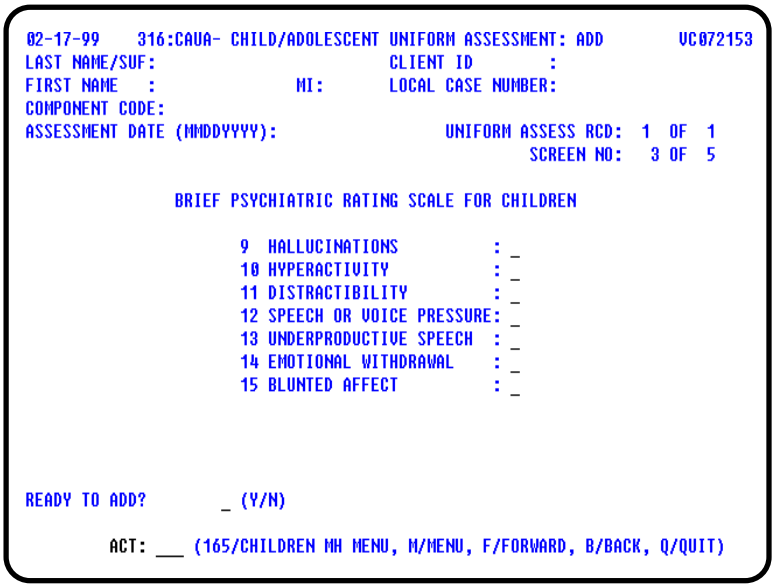


Field Name	Type	Contents
LAST NAME/SUF	D	Person's last name and (optional) suffix. (e.g., Jr, Sr)
FIRST NAME	D	Person's first name.
MI	D	Person's middle initial.
CLIENT ID	D	Person's statewide identification number.
LOCAL CASE NUMBER	D	Person's local case number.
COMPONENT CODE	D	Component code.
ASSESSMENT DATE	R	Date the assessment is begun.
BRIEF PSYCHIATRIC RATING SCALE FOR CHILDREN	R	0 – 6 to indicate the person's score for the following items: 1 Uncooperative 2 Hostility 3 Manipulativeness 4 Depressed Mood 5 Feelings of Inferiority 6 Suicidal Ideation 7 Peculiar Fantasies 8 Delusions Possible scores: 0=Not Present 1=Very Mild 2=Mild 3=Moderate 4=Moderately Severe 5=Severe 6=Extremely Severe

CAUA-Child/Adolescent Uniform Assessment (VC072153)

(Action Code 316)

Screen 3

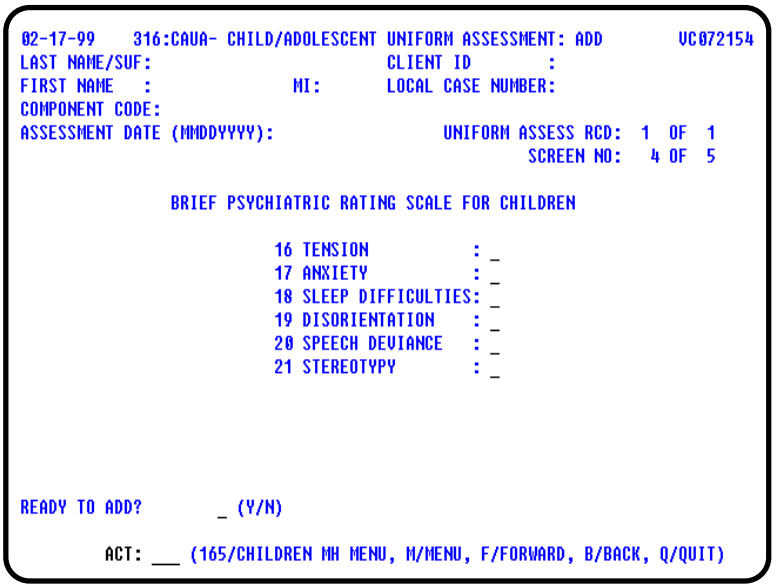


Field Name	Type	Contents
LAST NAME/SUF	D	Person's last name and (optional) suffix. (e.g., Jr, Sr)
FIRST NAME	D	Person's first name.
MI	D	Person's middle initial.
CLIENT ID	D	Person's statewide identification number.
LOCAL CASE NUMBER	D	Person's local case number.
COMPONENT CODE	D	Component code.
ASSESSMENT DATE	D	Date the assessment was begun.
BRIEF PSYCHIATRIC RATING SCALE FOR CHILDREN	R	0 – 6 to indicate the person's score for the following items: 9 Hallucinations 10 Hyperactivity 11 Distractibility 12 Speech or Voice Pressure 13 Underproductive Speech 14 Emotional Withdrawal 15 Blunted Affect Possible scores: 0=Not Present 1=Very Mild 2=Mild 3=Moderate 4=Moderately Severe 5=Severe 6=Extremely Severe

CAUA-Child/Adolescent Uniform Assessment (VC072154)

(Action Code 316)

Screen 4

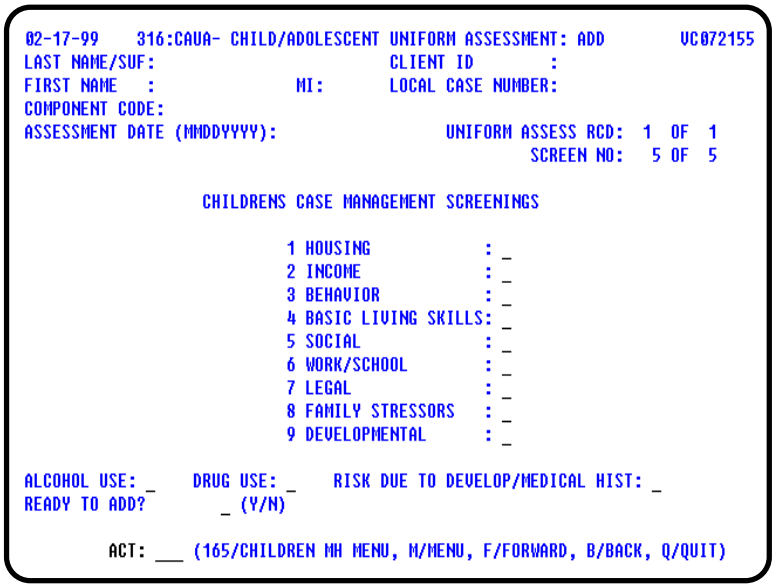


Field Name	Type	Contents
LAST NAME/SUF	D	Person's last name and (optional) suffix. (e.g., Jr, Sr)
FIRST NAME	D	Person's first name.
MI	D	Person's middle initial.
CLIENT ID	D	Person's statewide identification number.
LOCAL CASE NUMBER	D	Person's local case number.
COMPONENT CODE	D	Component code.
ASSESSMENT DATE	D	Date the assessment was begun.
BRIEF PSYCHIATRIC RATING SCALE FOR CHILDREN	R	0 – 6 to indicate the person's score for the following items: 16 Tension 17 Anxiety 18 Sleep Difficulties 19 Disorientation 20 Speech Deviance 21 Stereotypy Possible scores: 0=Not Present 1=Very Mild 2=Mild 3=Moderate 4=Moderately Severe 5=Severe 6=Extremely Severe

CAUA-Child/Adolescent Uniform Assessment (VC072155)

(Action Code 316)

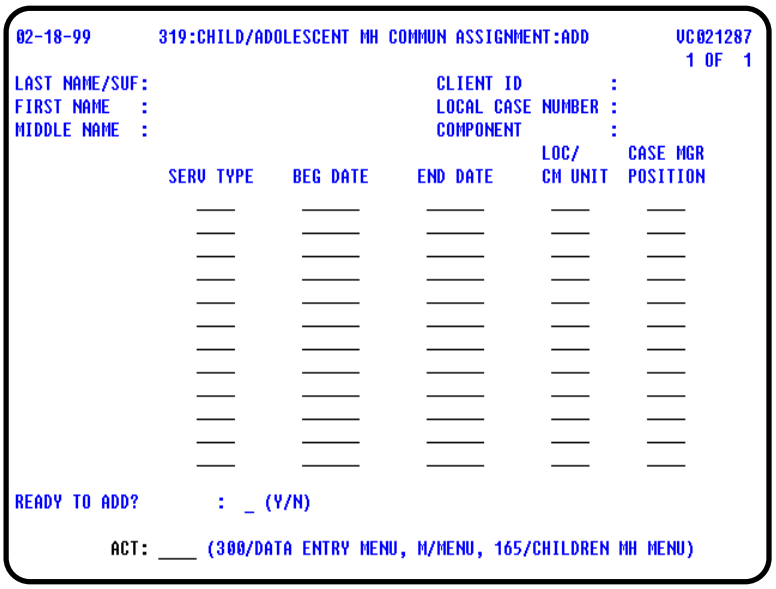
Screen 5



Field Name	Type	Contents
LAST NAME/SUF	D	Person's last name and (optional) suffix. (e.g., Jr, Sr)
FIRST NAME	D	Person's first name.
MI	D	Person's middle initial.
CLIENT ID	D	Person's statewide identification number.
LOCAL CASE NUMBER	D	Person's local case number.
COMPONENT CODE	D	Component code.
ASSESSMENT DATE	D	Date the uniform assessment was completed.
CHILDRENS CASE MANAGEMENT SCREENINGS	O/R	1 - 3 to indicate the person's score for the following items: 1 Housing 2 Income 3 Behavior 4 Basic Living Skills 5 Social 6 Work/School 7 Legal 8 Family Stressors 9 Developmental Possible scores: 1=Low 2=Moderate 3=High

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

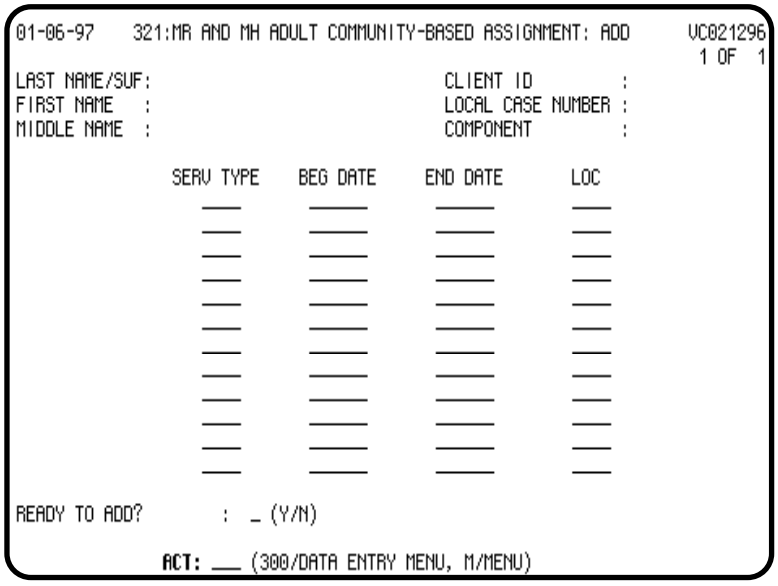
Child/Adolescent MH Community Assignment (VC021287)
(Action Code 319)



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

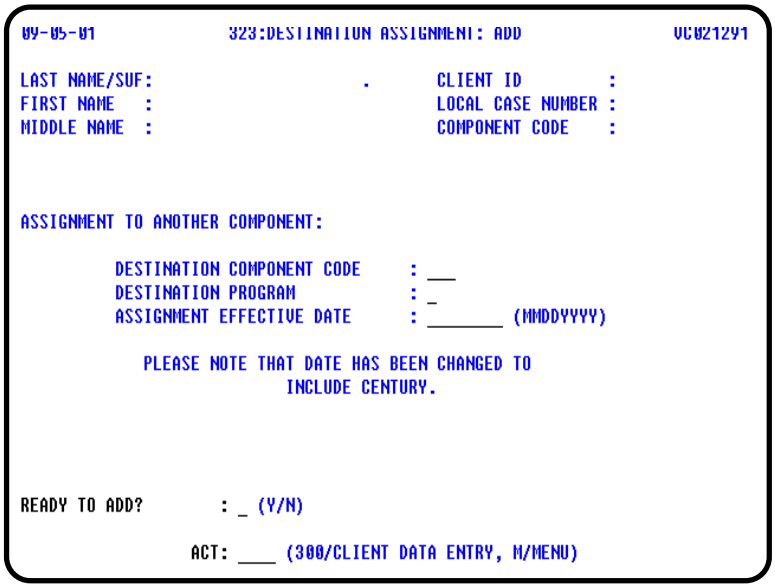
MR and MH Adult Community-based Assignment (VC021296)

(Action Code 321)



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

Destination Assignment (VC021291)
(Action Code 323)

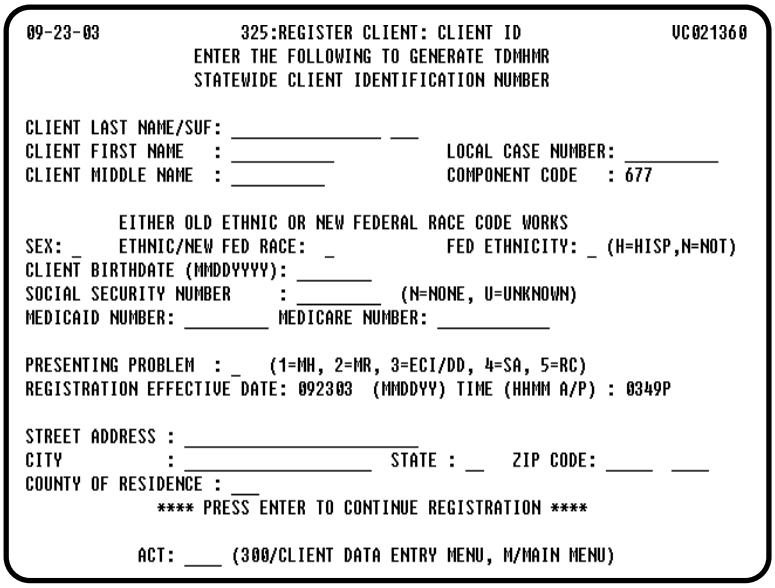


Field Name	Type	Contents
LAST NAME/SUF	D	Person's last name and (optional) suffix. (e.g., Jr, Sr)
FIRST NAME	D	Person's first name.
MIDDLE NAME	D	Person's middle name.
CLIENT ID	D	Person's statewide identification number.
LOCAL CASE NUMBER	D	Person's local case number.
COMPONENT CODE	D	Component code.

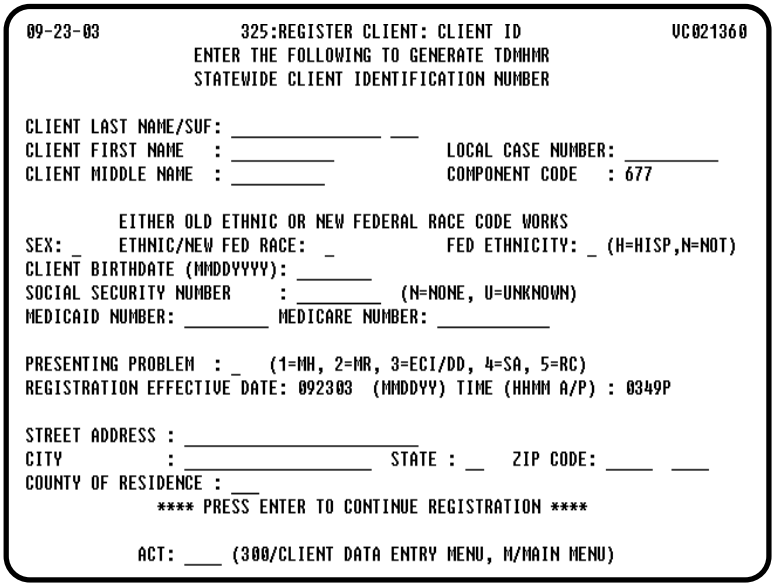
Assignment to Another Component:

DESTINATION COMPONENT CODE	R	Three-digit code for component to which the person is reassigned.
DESTINATION PROGRAM	R	Type of program to which the person is reassigned. **1**=Campus-based, **2**=Community-based. If designated as program **2**, no assignment is allowed to state hospitals or state schools, or to components 659 and 661.
ASSIGNMENT EFFECTIVE DATE	R	Effective date of the assignment. MMDDYYYY format.

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

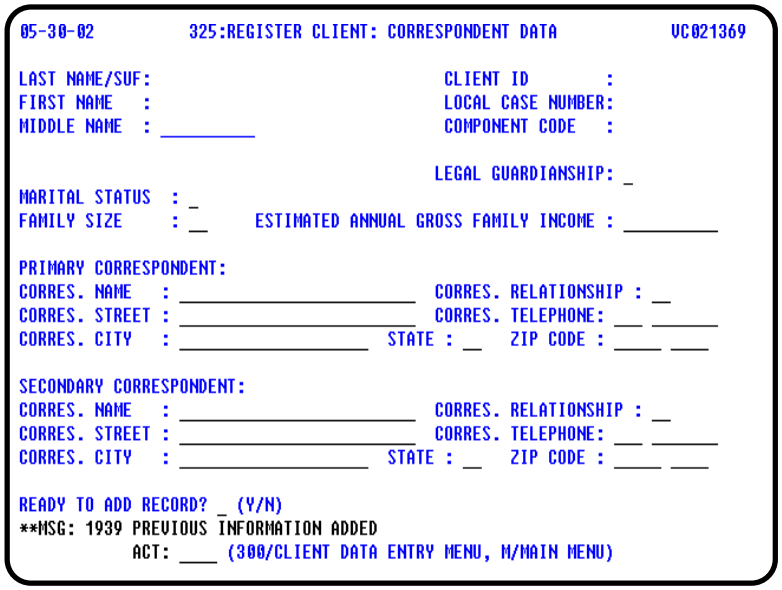


Field Name	Type	Contents
CLIENT LAST NAME/SUF	R	Person's last name and (optional) suffix. (e.g., Jr, Sr)
CLIENT FIRST NAME	R	Person's first name.
CLIENT MIDDLE NAME	O	Person's middle name.
CLIENT ID	D	Person's statewide identification number will be displayed in this field when the registration process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

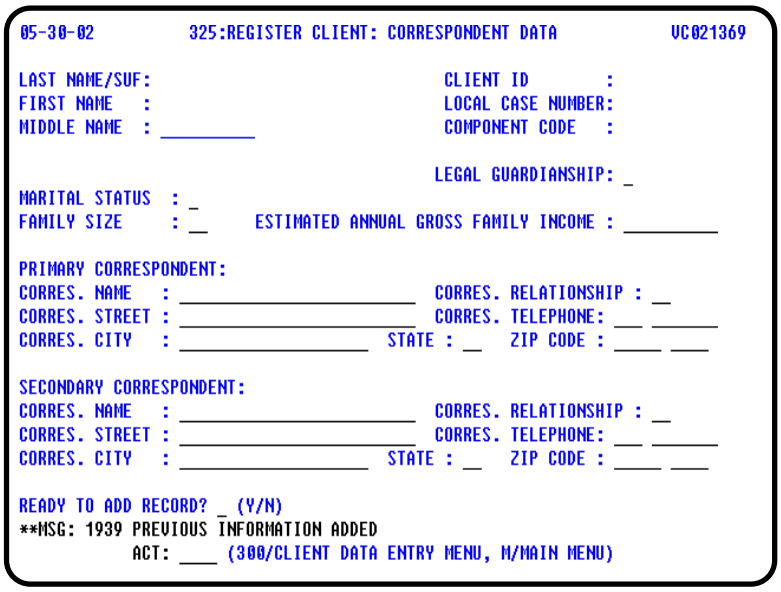


Field Name	Type	Contents
PRESENTING PROBLEM	R	One-digit code to indicate person's presenting problem. **1**=MH (Mental Health), **2**=MR (Mental Retardation), **3**=ECI/DD (Early Childhood Intervention/Developmentally Delayed), **4**=SA (Substance Abuse), **5**=RC (Related Condition-MR only).
REGISTRATION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

Register Client: Correspondent Data (VC021369)



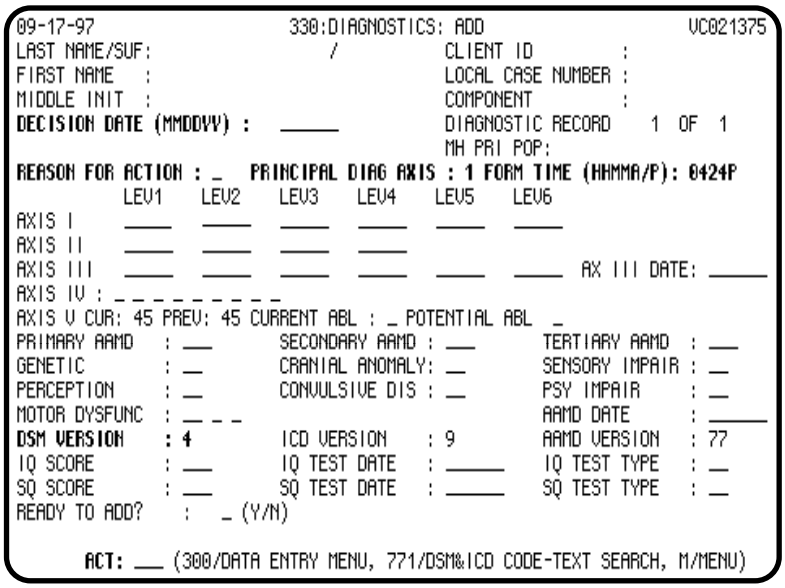
Field Name	Type	Contents
LAST NAME/SUF	D	Person's last name and (optional) suffix. (e.g., Jr, Sr)
FIRST NAME	D	Person's first name.
MIDDLE NAME	D	Person's middle name.
CLIENT ID	D	Person's statewide identification number.
LOCAL CASE NUMBER	D	Person's local case number.
COMPONENT CODE	D	Component code.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



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

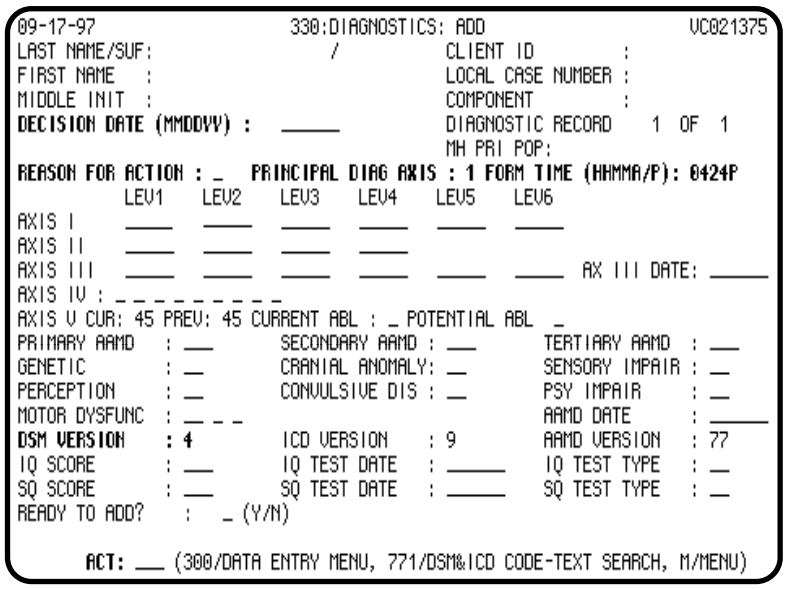
ZIP CODE	O	Zip code and zip code suffix (if available) of Secondary Correspondent.

Diagnostics (VC021375)
(Action Code 330)



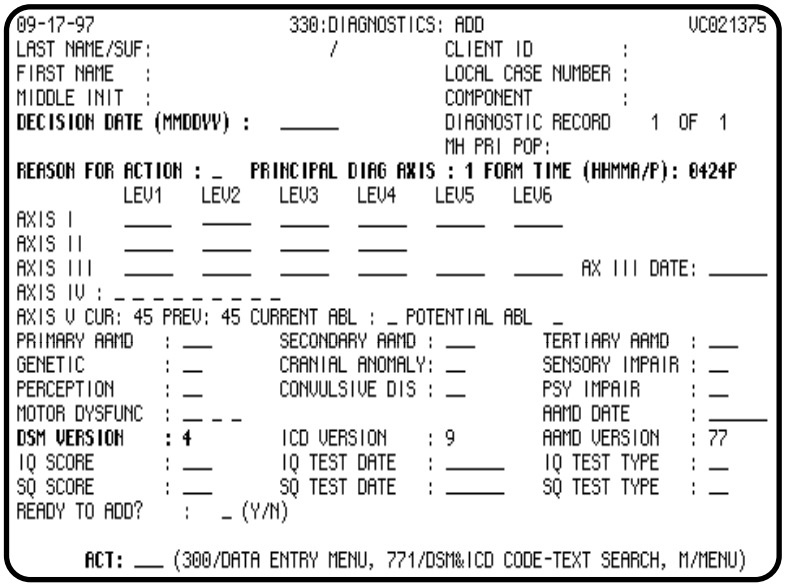
Field Name	Type	Contents
LAST NAME/SUF	D	Person's last name and (optional) suffix. (e.g. Jr, Sr)
FIRST NAME	D	Person's first name.
MIDDLE INIT	D	Person's middle initial.
CLIENT ID	D	Person's statewide identification number.
LOCAL CASE NUMBER	D	Person's local case number.
COMPONENT	D	Component code.
DIAGNOSTIC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

FORM TIME	D/R	Time recorded on the CARE-DG-1 form. HHMM A/P format.



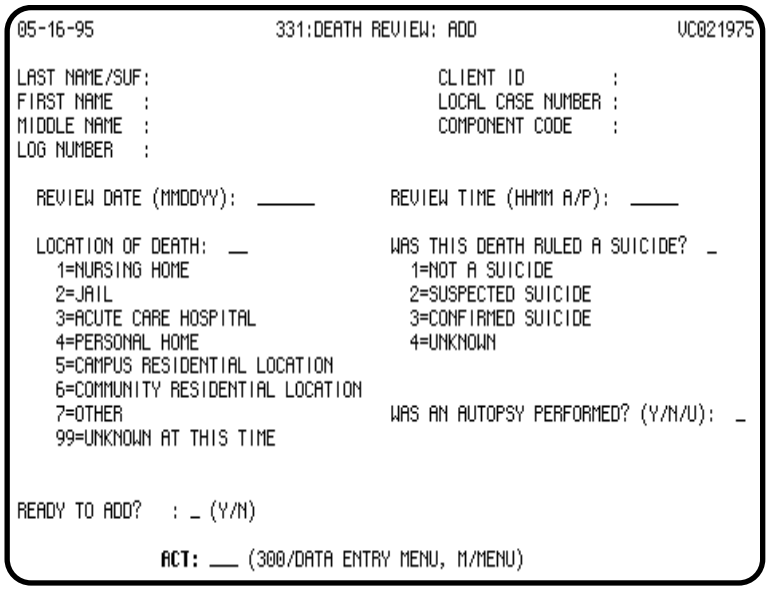
Field Name	Type	Contents
AXIS I: LEVELS 1-6	O/R	Up to six fields for recording DSM-IV codes representing the person's diagnosis on Axis 1. Axis 1, Level 1 is required if PRINCIPAL DIAG AXIS is 1. Level 1 is for most significant, Level 6 least significant. **DSM Codes**
AXIS II: LEVELS 1-4	O/R	Up to four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

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



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

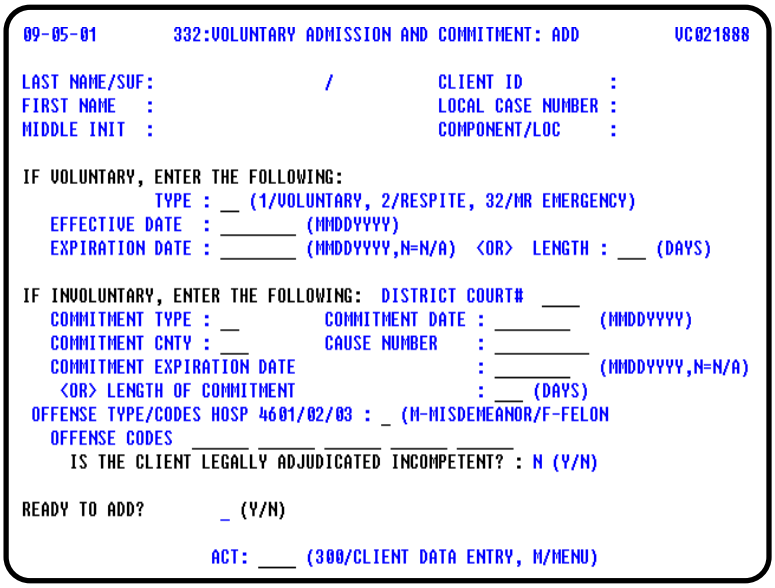
Death Review (VC021975)
(Action Code 331)



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

Voluntary Admission & Commitment (VC021888)

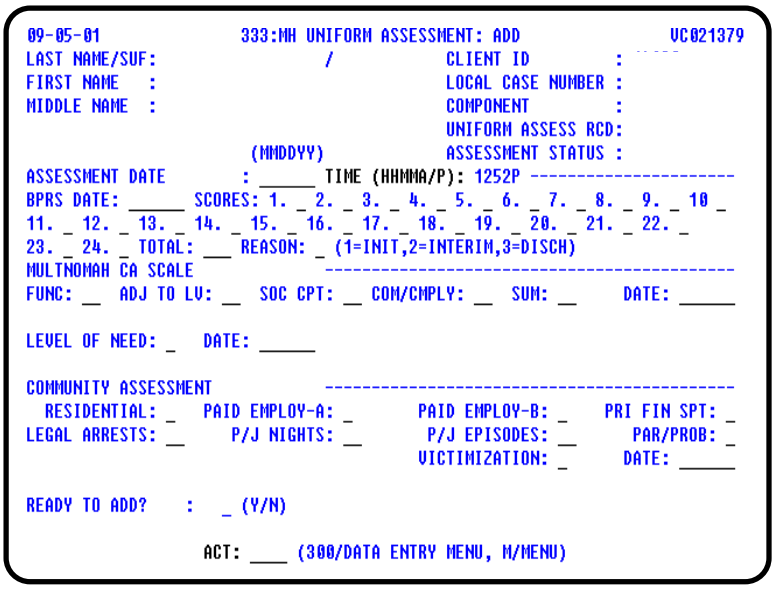
(Action Code 332)



Field Name	Type	Contents
LAST NAME/SUF	D	Person's last name and (optional) suffix. (e.g. Jr, Sr)
FIRST NAME	D	Person's first name.
MIDDLE INIT	D	Person's middle initial.
CLIENT ID	D	Person's statewide identification number.
LOCAL CASE NUMBER	D	Person's local case number.
COMPONENT/LOC	D	Component code/Location code.
If Voluntary, Enter the Following:		
TYPE	O/R	Code to indicate the type of admission. 1=Voluntary, 2=Respite, 32=MR Emergency.
EFFECTIVE DATE	O/R	Effective date of the admission. MMDDYYYY format. Required for Voluntary or Respite admissions.
EXPIRATION DATE	O/R	Date the episode expires. Enter a date in MMDDYYYY format *or* enter **N** (not available).
LENGTH (DAYS)	O/R	Number of days the episode is to last. Required if a date in MMDDYYYY format is not entered in the EXPIRATION DATE field.

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

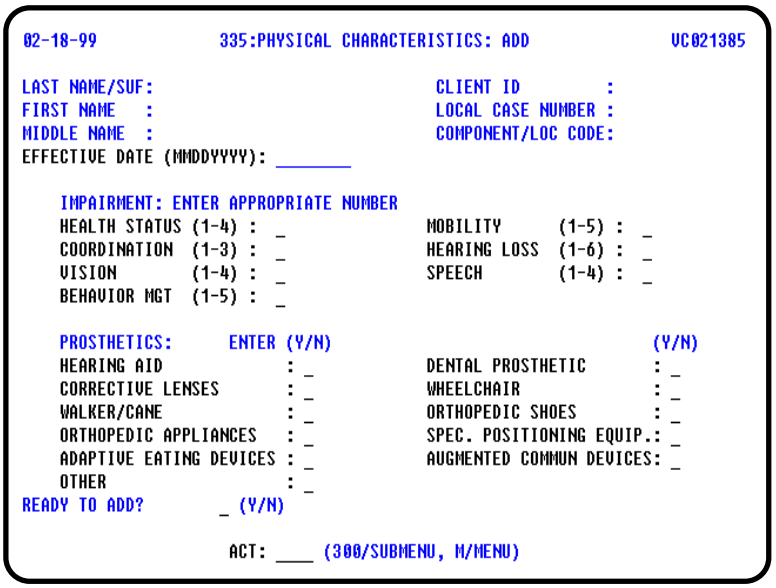
MH Uniform Assessment (VC021379)
(Action Code 333)



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

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

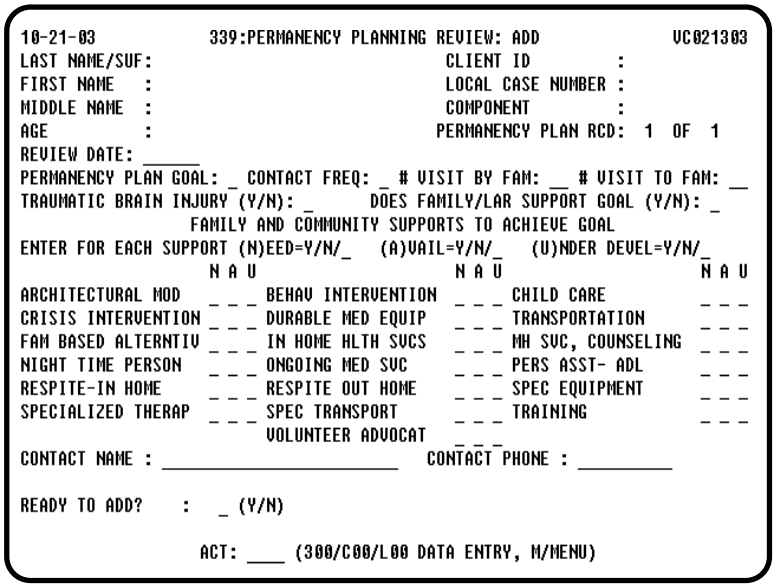
Physical Characteristics (VC021385)
(Action Code 335)



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

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

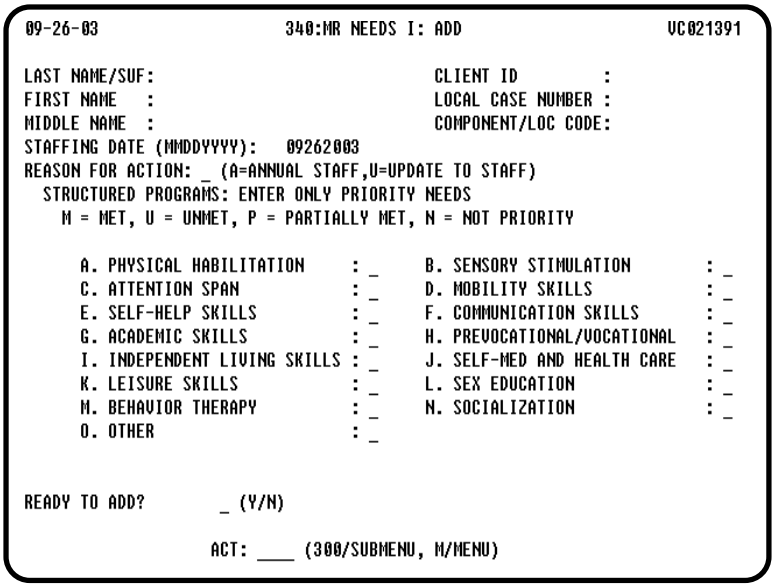
Permanency Planning Review (VC021303)
(Action Code 339)



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

Field Name	Type	Contents
# VISIT BY FAM	R	Number of visits to the facility by the parent/guardian.
# VISIT TO FAM	R	Number of the resident's visits to the home.
TRAUMATIC BRAIN INJURY	O	**Y** (Yes) or **N** (No) to indicate if the person has a history of traumatic brain injury.
DOES THE FAMILY/LAR SUPPORT GOAL?	R	**Y** (Yes) if the family/LAR agrees with the goal *if and when the needed supports can be accessed* and supports activities to achieve it; **N** (No) if the family/LAR chooses for the individual to remain in the current residence even if needed supports can be accessed.
Family and Community Supports to Achieve Goal (N=Needed, A=Available, U=Under Development) *<u>Note</u>: This section must be completed for all individuals under age 18 and for individuals 18 to 21 years of age who have a Permanency Plan Goal of 1, 2, or 3. This section is not required for individuals 18 to 21 years of age with a Permanency Plan Goal of 4.*		**Y** (Yes), **N** (No), or **Blank** for each support. (The system records a blank as No.) If Yes, indicate if support need is available or under development. Architectural Modifications Behavioral Intervention Child Care Crisis Intervention Durable Medical Equipment Transportation Family/LAR Support Family Based Alternative In Home Health Services MH Services, Counseling Night Time Person Ongoing Medical Services Personal Assistance-ADL Respite – In-Home Respite – Out of Home Special Equipment Specialized Therapies Specialized Transportation Training Volunteer Advocate
CONTACT NAME	R	Name of the person responsible for conducting permanency planning activities.
CONTACT PHONE	R	Telephone number of the person responsible for conducting permanency planning activities.

MR Needs I (VC021391)
(Action Code 340)



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

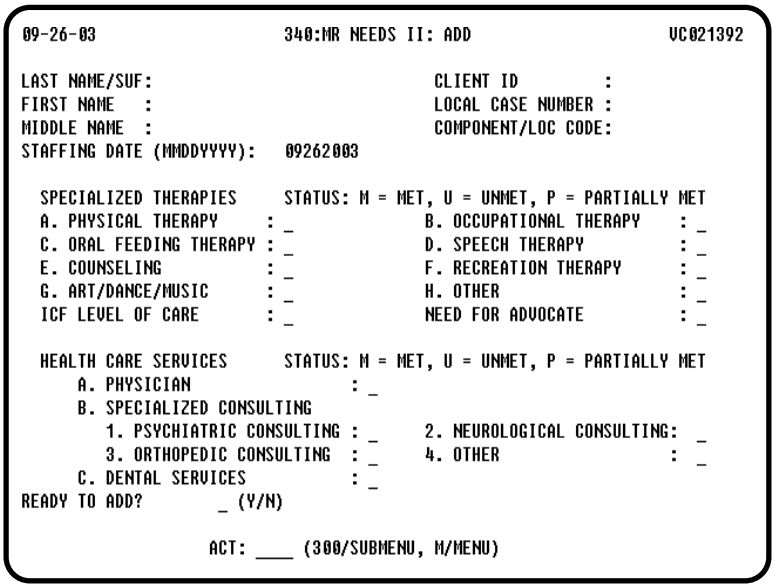
Structured Programs: Enter only Priority Needs

Client's needs in the categories below are: **M**=Met, **U**=Unmet, **P**=Partially Met, **N**=Not Priority
Note: Do not enter an N if the need is not a priority. The N is supplied by CARE.

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

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

MR Needs II (VC021392)



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

Specialized Therapies

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

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

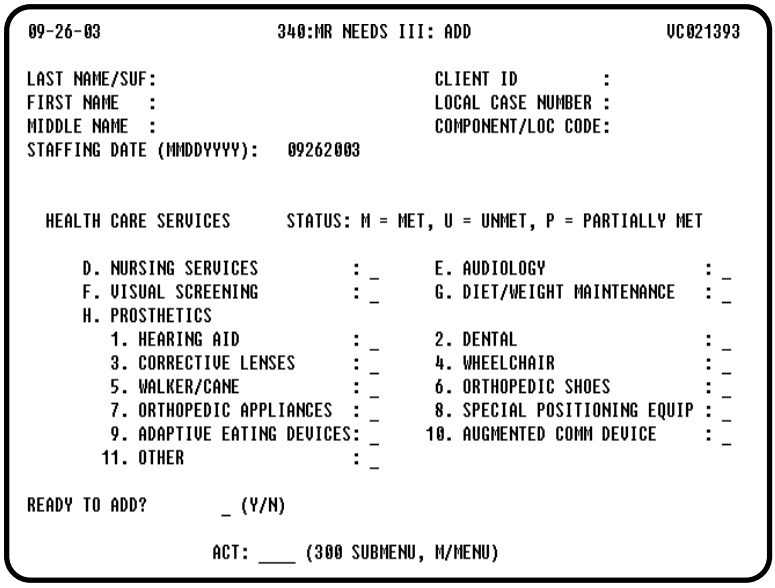
Field Name	Type	Contents
E. COUNSELING	O	Indicates the status of the person's need for counseling.
F. RECREATION THERAPY	O	Indicates the status of the person's need for recreation therapy.
G. ART/DANCE/MUSIC	O	Indicates the status of the person's need for art/dance/music.
H. OTHER	O	Indicates the status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

Health Care Services

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

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

MR Needs III (VC021393)



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

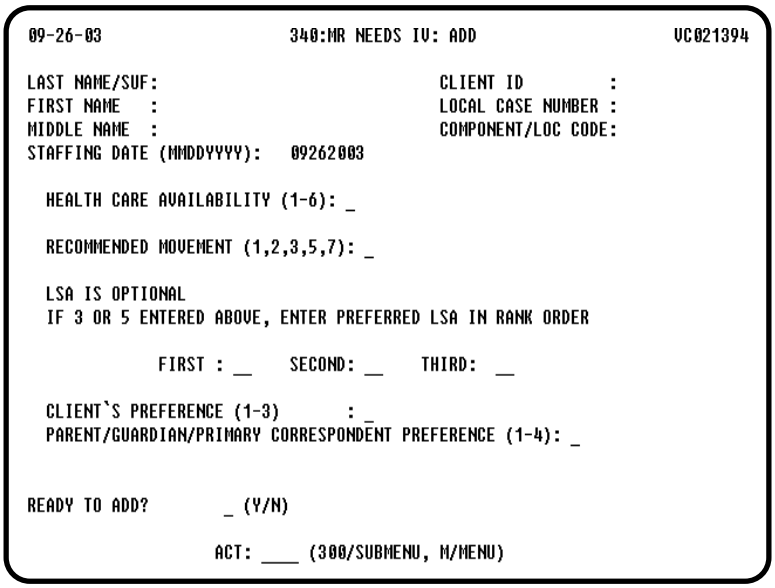
Health Care Services

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

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

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

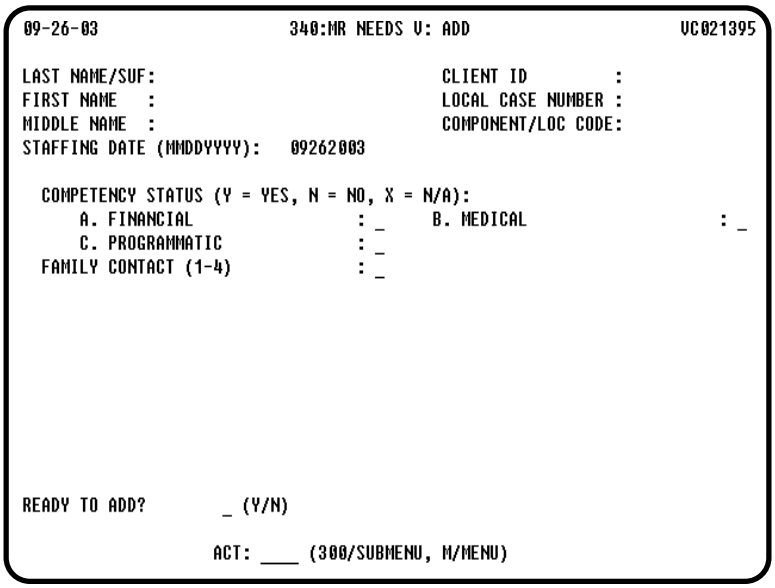
MR Needs IV (VC021394)



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

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

MR Needs V (VC021395)

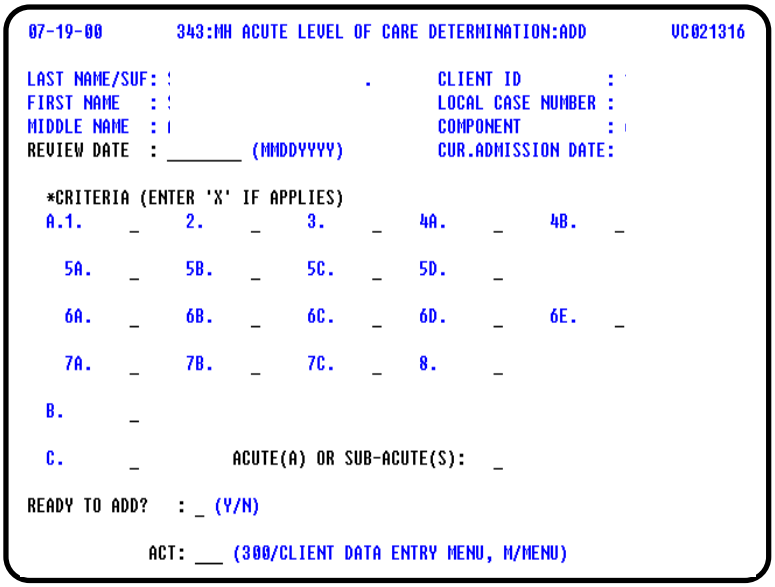


Field Name	Type	Contents
LAST NAME/SUF	D	Person's last name and (optional) suffix. (e.g. Jr, Sr)
FIRST NAME	D	Person's first name.
MIDDLE NAME	D	Person's middle name.
CLIENT ID	D	Person's statewide identification number.
LOCAL CASE NUMBER	D	Person's local case number.
COMPONENT	D	Component code.
LOC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

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

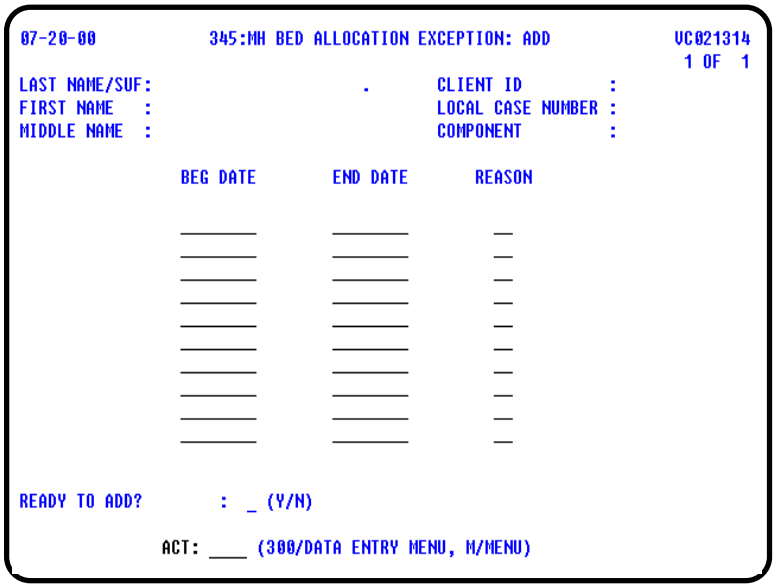
A. FINANCIAL	R	Indicates the person's competency for making financial decisions.
B. MEDICAL	R	Indicates the person's competency for making medical decisions.
C. PROGRAMMATIC	R	Indicates the person's competency for making programmatic decisions.
FAMILY CONTACT (1-4)	R	One-digit code indicating the degree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

MH Acute Level of Care Determination (VC021316)
(Action Code 343)



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

MH Bed Allocation Exception (VC021314)
(Action Code 345)

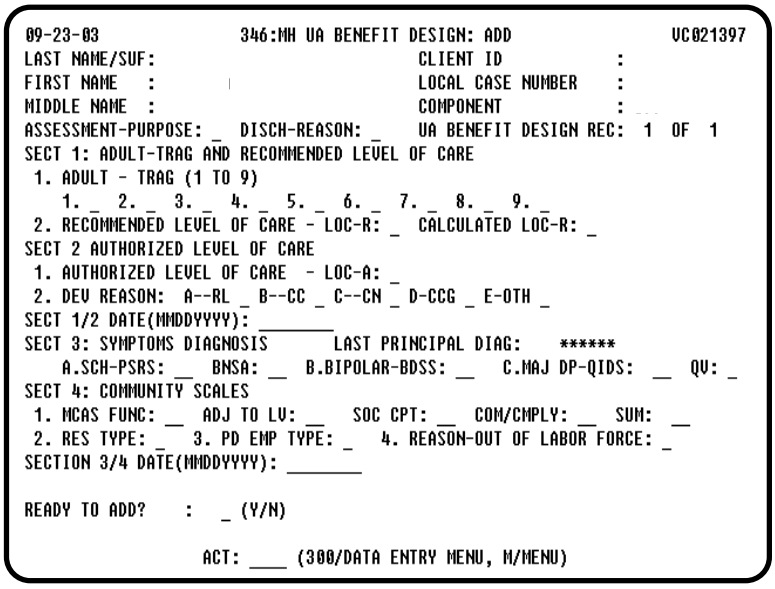


Field Name	Type	Contents
LAST NAME/SUF	D	Person's last name and (optional) suffix. (e.g., Jr, Sr)
FIRST NAME	D	Person's first name.
MIDDLE NAME	D	Person's middle name.
CLIENT ID	D	Person's statewide identification number.
LOCAL CASE NUMBER	D	Person's local case number.
COMPONENT	D	Component code.
BEG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

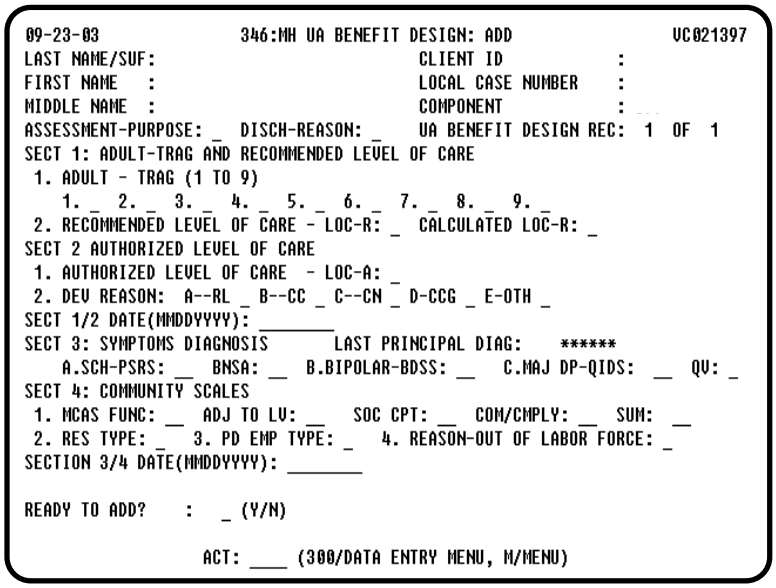
MH Adult Uniform Assessment for Benefit Design (VC021397)

(Action Code 346)

To be completed by Pilot Sites Only



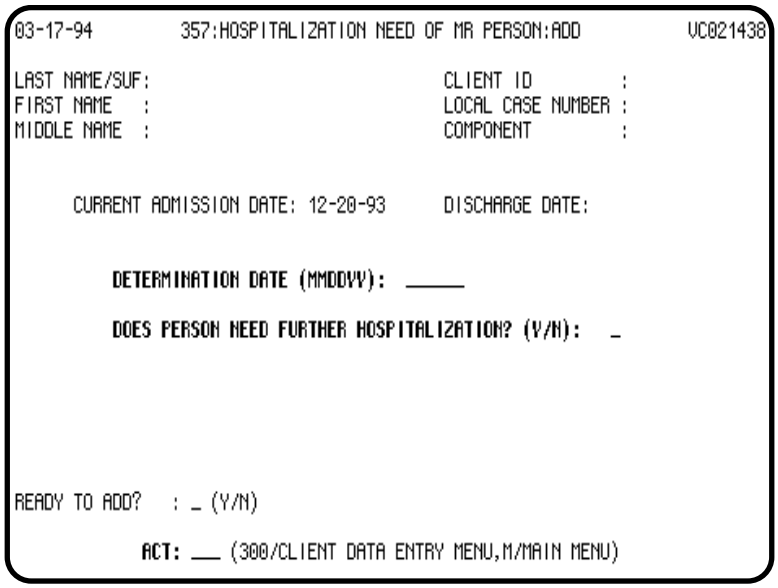
Field Name	Type	Contents
LAST NAME/SUF	D	Person's last name and suffix, if any.
FIRST NAME	D	Person's first name.
MIDDLE NAME	D	Person's middle name.
CLIENT ID	D	Person's statewide identification number assigned by CARE.
LOCAL CASE NUMBER	D	Person's local case number.
COMPONENT	D	Three-digit code of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



Field Name	Type	Contents
SECT 2: AUTHORIZED LEVEL OF CARE		
1. AUTHORIZED LEVEL OF CARE - LOC-A	R	Indicates the authorized Level of Care (LOC-A).
2. DEV REASON	R	If LOC-A is different from LOC-R, indicates **Y** (Yes) or **N** (No) for all the reasons for the deviation. A=RL (Resource Limitations) B=CC (Consumer Choice) C=CN (Consumer Need) D=CCG (Continuity of Care per UM Guidelines) E=Oth (Other)
SECT 1/2 DATE	R	Date of the completion of Section 1 and/or Section 2 of the form.
SECT 3: SYMPTOMS DIAGNOSIS		*Choose one algorithm and complete all items for that algorithm.*
A. SCH-PSRS	R	Total Positive Symptom Rating Scale (PSRS).
BNSA	R	Total Brief Negative Symptom Assessment (BNSA).
B. BIPOLAR-BDSS	R	Total Brief Bipolar Disorder Symptom Scale (BDSS).
C. MAJ DP-QIDS	R	Total Quick Inventory of Depressive Symptomatology (QIDS)
QV	R	QIDS version.
SECT 4: COMMUNITY SCALES		*Complete all subscales and total of Multnomah Community Ability Scale (MCAS) subscales.*
1. MCAS FUNC	R	Person's score on the Functioning Subscale of the Multnomah CA Scale.
ADJ TO LV	R	Person's score on the Adjustment to Living Subscale of the Multnomah CA Scale.
SOC CPT	R	Person's score on the Social Competence Subscale of the Multnomah CA Scale.
COM/CMPLY	R	Person's score on the Community/Compliance Subscale of the Multnomah CA Scale.
SUM	R	Total sum of all subscales of the Multnomah CA Scale.

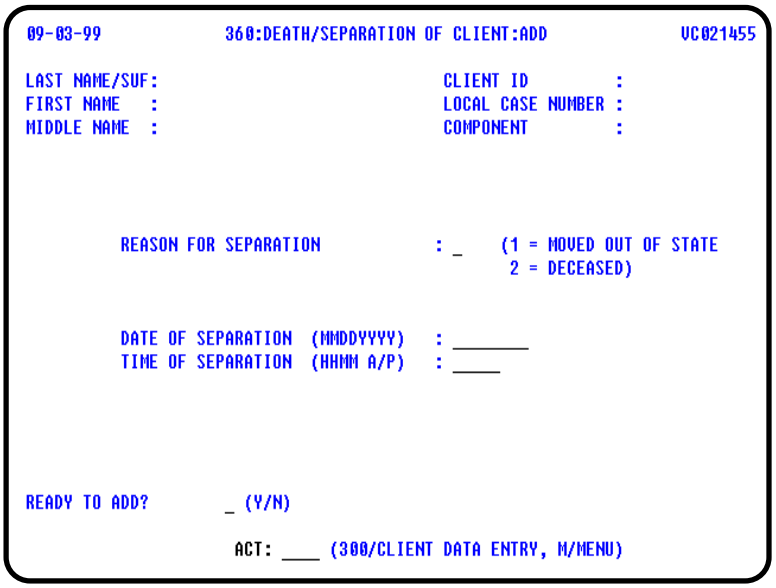
Field Name	Type	Contents
2. RES TYPE	R	Person's current type of residence. 1=Independent/Dependent in Family Home/Supported Housing 2=Group Home/Assisted Living/Treatment-Training-Rehab Center 3=Nursing Home/Intermediate Care Facility (ICF)/Hospital 4=Homeless 5=Correctional Facility
3. PD EMP TYPE	R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

Hospitalization Need of MR Person (VC021438)
(Action Code 357)



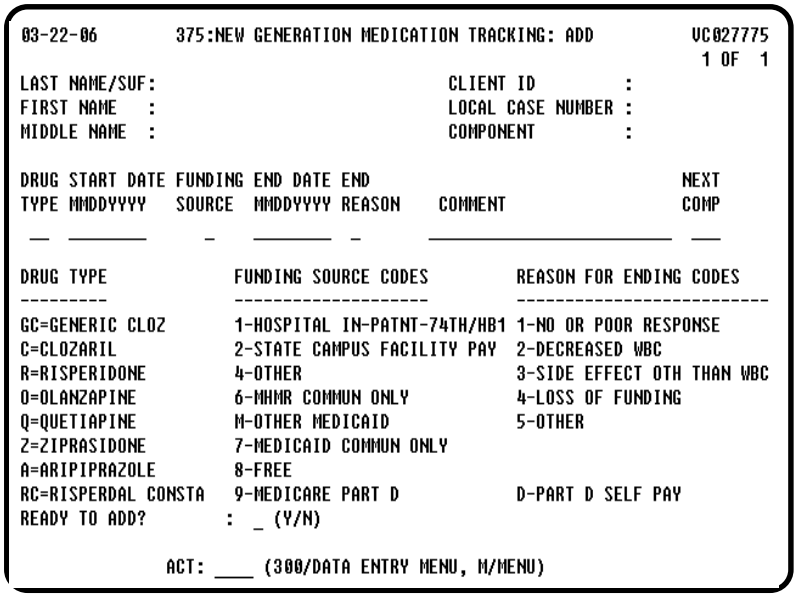
Field Name	Type	Contents
LAST NAME/SUF	D	Person's last name and (optional) suffix. (e.g., Jr, Sr)
FIRST NAME	D	Person's first name.
MIDDLE NAME	D	Person's middle name.
CLIENT ID	D	Person's statewide identification number.
LOCAL CASE NUMBER	D	Person's local case number.
COMPONENT	D	Component code.
CURRENT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

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



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

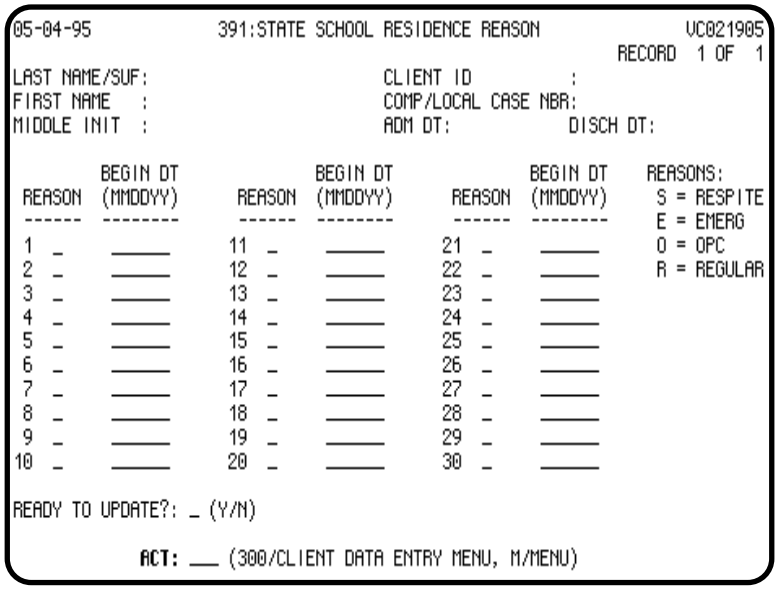
New Generation Medication Tracking (VC027775)
(Action Code 375)



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

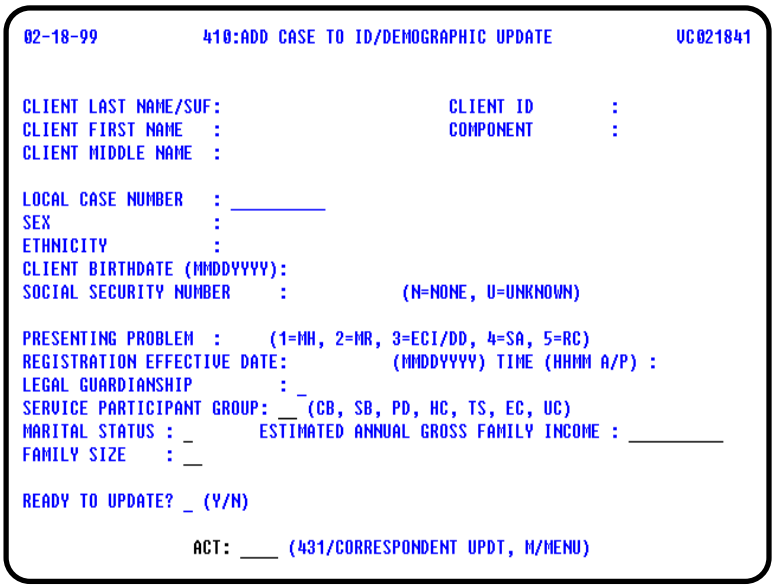
Field Name	Type	Contents
END REASON	O/R	One-digit code that explains why the person has stopped receiving the drug therapy. *END REASON is required if END DATE is entered.* **Decode: Reason for Ending (New Generation Medications)**
COMMENT	O	Text (up to 25 characters) to describe the reason for ending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

State School Residence Reason (VC021905)
(Action Code 391)

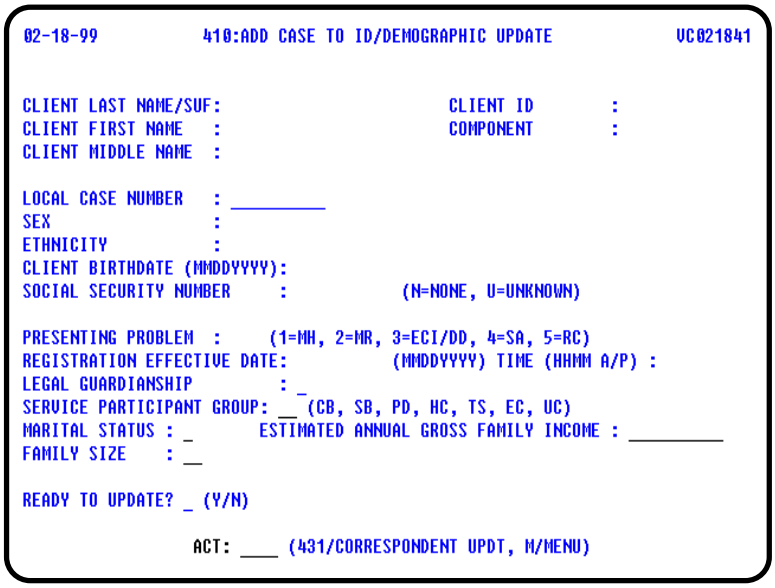


Field Name	Type	Contents
RECORD	D	Number of admission episodes. Note: If a person has more than one admission to a state school, the episodes are displayed in descending order. To view prior admission episodes (records), key **N** in the READY TO UPDATE? field, **F** (forward) in the ACT field, and press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

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

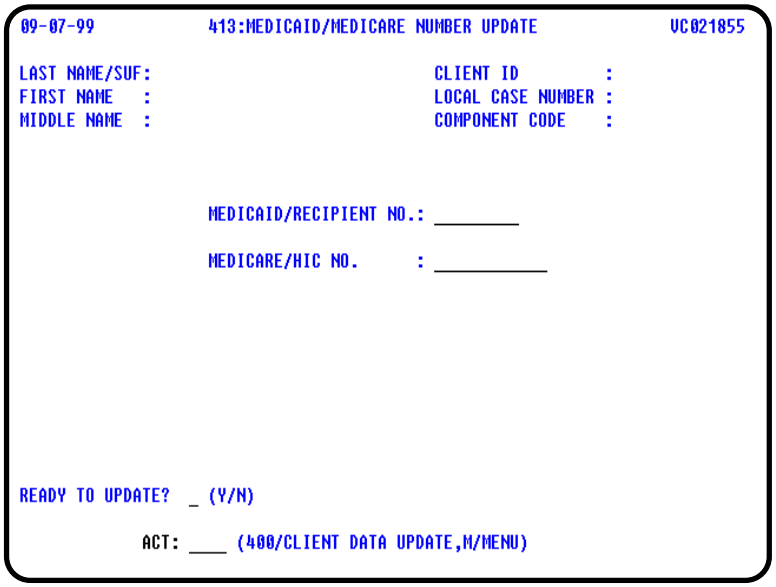


Field Name	Type	Contents
CLIENT LAST NAME/SUF	D	Person's last name and (optional) suffix. (e.g., Jr, Sr)
CLIENT FIRST NAME	D	Person's first name.
CLIENT MIDDLE NAME	D	Person's middle name.
CLIENT ID	D	Person's statewide identification number.
COMPONENT	D	Component code.
LOCAL CASE NUMBER	R	Person's local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



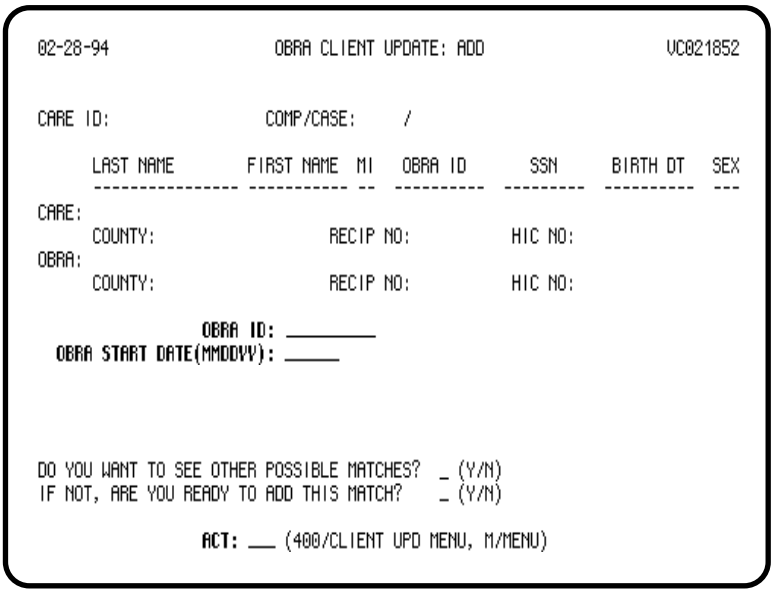
Field Name	Type	Contents
SERVICE PARTICIPANT GROUP	O	Person's MR service participant group. **Decode: Service Participant Groups (MR)**
MARITAL STATUS	O	Person's marital status. **Decode: Marital Status**
ESTIMATED ANNUAL GROSS FAMILY INCOME	O	Total annual gross income of all family members living with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

Medicaid/Medicare Number Update (VC021855)
(Action Code 413)



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

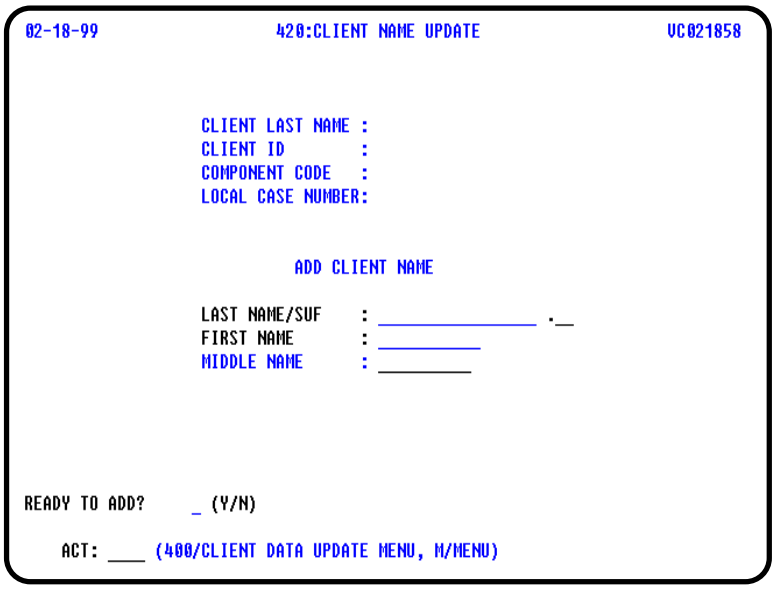
OBRA Client Update (VC021852)
(Action Code 415)



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

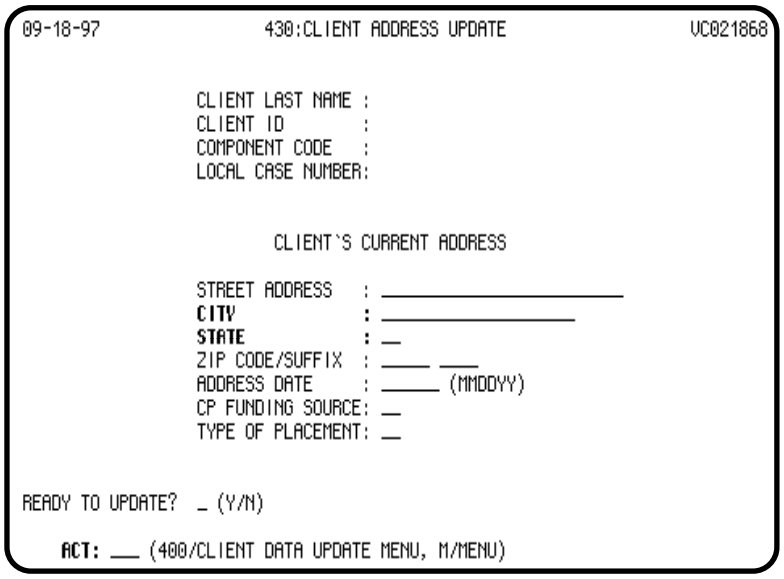
Field Name	Type	Contents
OBRA START DATE	D/R	Date of the letter notifying the authority that the person needs specialized services and is eligible to receive OBRA services. MMDDYY format.
DO YOU WANT TO SEE OTHER POSSIBLE MATCHES?	R	Refer to OBRA/CARE instructions for detailed description.
IF NOT, ARE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

Client Name Update (VC021858)
(Action Code 420)



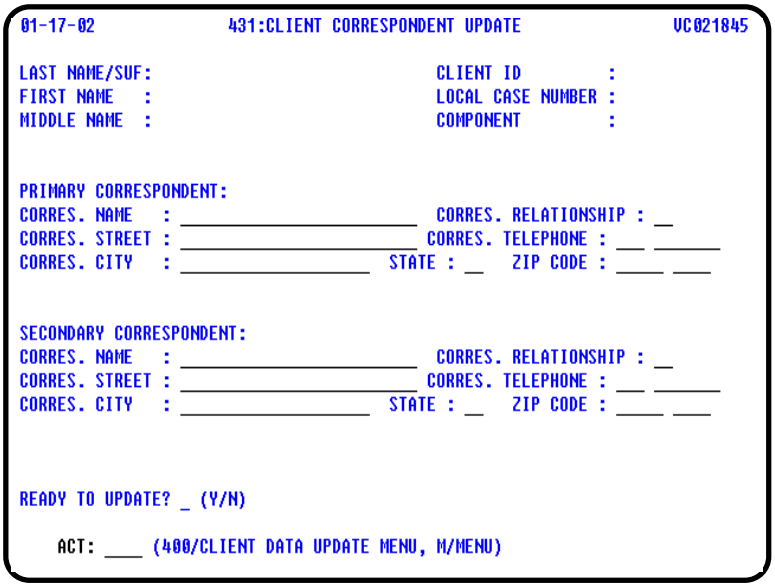
Field Name	Type	Contents
CLIENT LAST NAME	D	Person’s last name.
CLIENT ID	D	Person’s statewide identification number.
COMPONENT CODE	D	Component code.
LOCAL CASE NUMBER	D	Person's local case number.
LAST NAME/SUF	O	Person's last name/suffix.
FIRST NAME	O	Person’s first name.
MIDDLE NAME	O	Person’s middle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

Client Address Update (VC021868)
(Action Code 430)



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

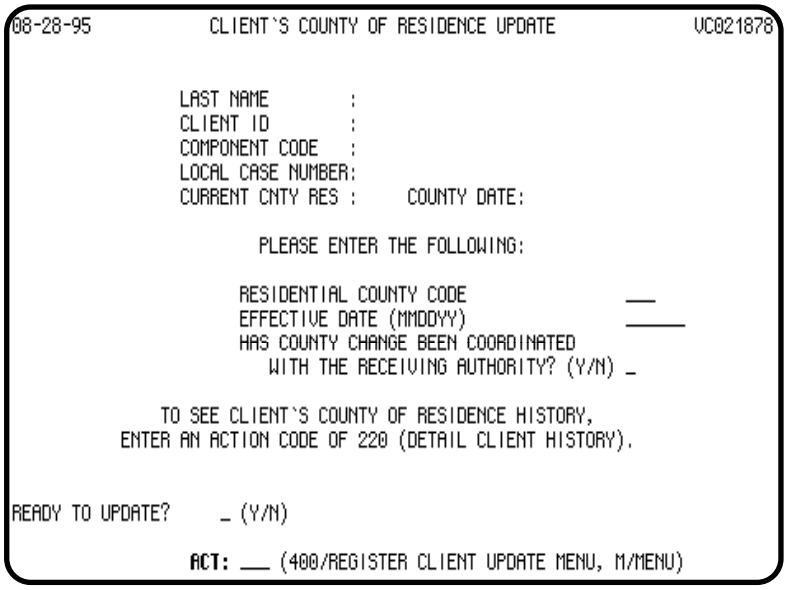
Client Correspondent Update (VC021845)
(Action Code 431)



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

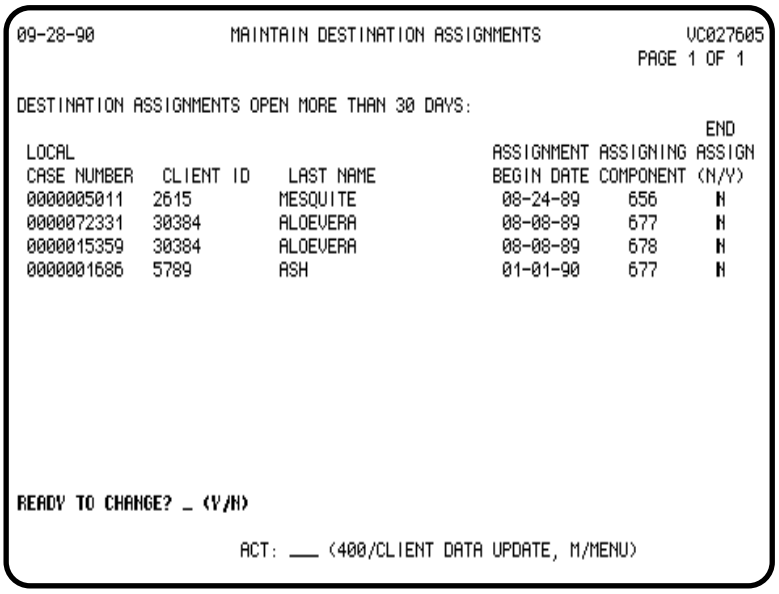
Field Name	Type	Contents
Secondary Correspondent:		
CORRES. NAME	O	Name of the person to contact on behalf of the person in case of an emergency if the primary correspondent cannot be reached.
CORRES. RELATIONSHIP	O	Relationship of the secondary correspondent to the person. **Decode: Relationship**
CORRES.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

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



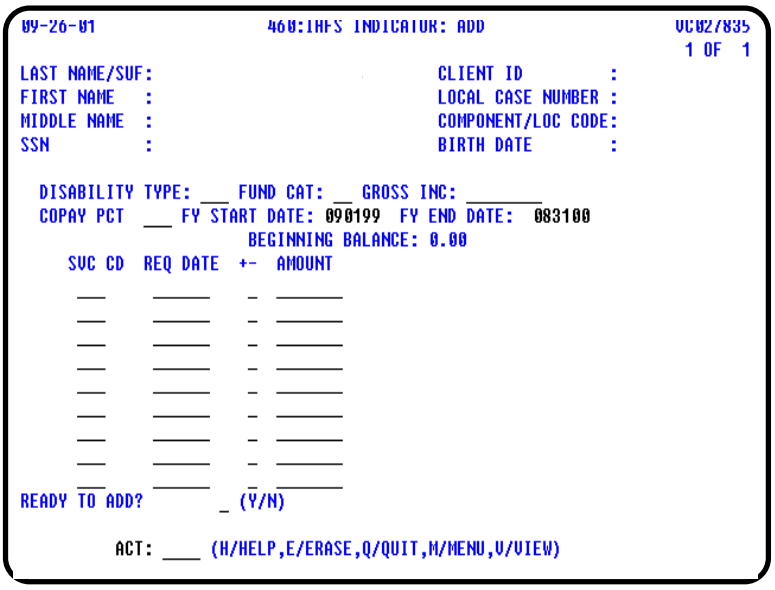
Field Name	Type	Contents
LAST NAME	D	Person’s last name.
CLIENT ID	D	Person’s statewide identification number.
COMPONENT CODE	D	Component code.
LOCAL CASE NUMBER	D	Person's local case number.
CURRENT CNTY RES	D	Three-digit code of the person’s current county of residence.
COUNTY DATE	D	Effective date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

Maintain Destination Assignments (VC027605)
(Action Code 450)



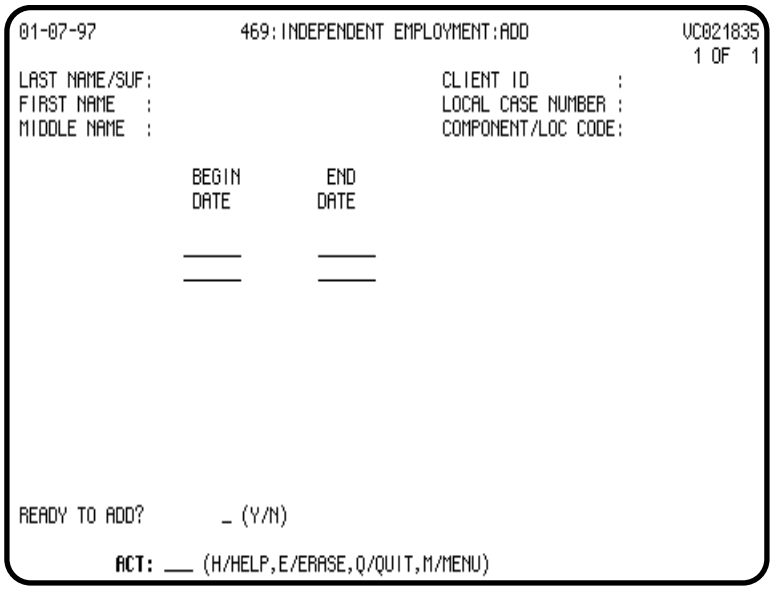
Field Name	Type	Contents
LOCAL CASE NUMBER	D	Local case number of person with a destination assignment open for more than 30 days.
CLIENT ID	D	Person's statewide identification number.
LAST NAME	D	Person's last name.
ASSIGNMENT BEGIN DATE	D	Date the destination assignment began.
ASSIGNING COMPONENT	D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

IHFS Indicator (VC027835)
(Action Code 460)



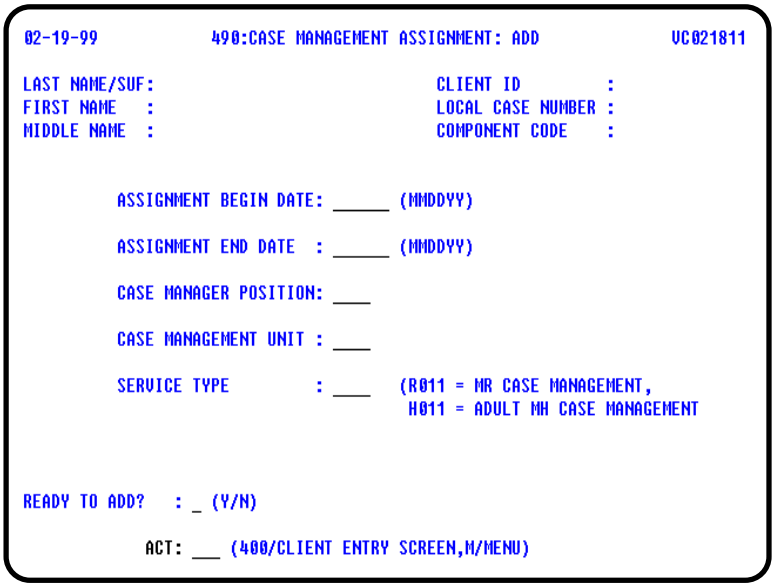
Field Name	Type	Contents
LAST NAME/SUF	D	Person's last name and (optional) suffix. (e.g., Jr, Sr)
FIRST NAME	D	Person's first name.
MIDDLE NAME	D	Person's middle name.
SSN	D	Person's social security number.
CLIENT ID	D	Person's statewide identification number.
LOCAL CASE NUMBER	D	Person's local case number.
COMPONENT/LOC CODE	D	Component code/Location code.
BIRTH DATE	D	Person's date of birth.
DISABILITY TYPE	R	Indicates disability type of either MH *or* MR.
FUND CAT	R	Indicates fund category as either MH *or* MR.
GROSS INC	O	Indicates person's gross income.
COPAY PCT	R	Indicates copay percentage and must be between 01 – 99.
FY START DATE	D	Date the requested fiscal year started.
FY END DATE	D	Date the requested fiscal year ended.
BEGINNING BALANCE	D	Beginning balance as defaulted by CARE.
SVC CD	R	Must be a valid IHFS Service Code.
REQ DATE	R	Date that must fall within the selected quarter fiscal year.
+ -	R	Indicates either + or -.
AMOUNT	R	Indicates the amount. Real dollars must be entered; zero amounts are not allowed.

Independent Employment (VC021835)
(Action Code 469)



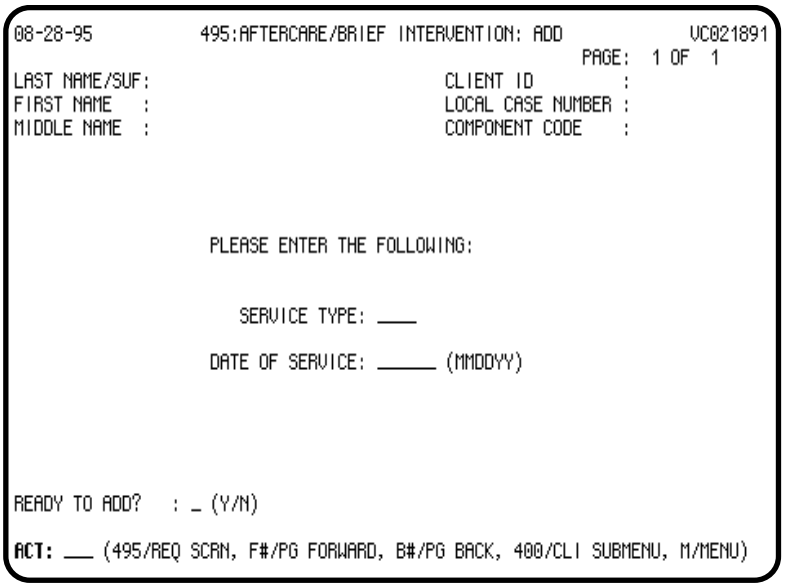
Field Name	Type	Contents
LAST NAME/SUF	D	Person's last name and (optional) suffix. (e.g., Jr, Sr)
FIRST NAME	D	Person's first name.
MIDDLE NAME	D	Person's middle name.
CLIENT ID	D	Person's statewide identification number.
LOCAL CASE NUMBER	D	Person's local case number.
COMPONENT/LOC CODE	D	Component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

Case Management Assignment (VC021811)
(Action Code 490)



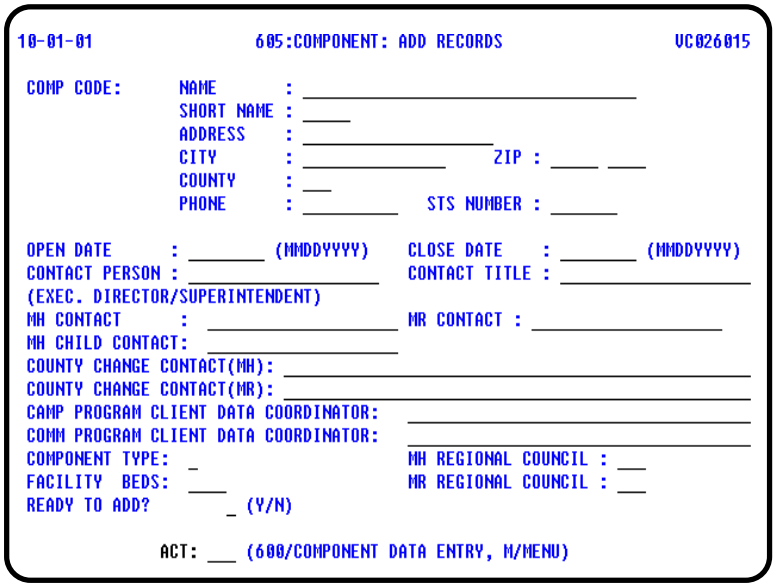
Field Name	Type	Contents
LAST NAME/SUF	D	Person's last name and (optional) suffix. (e.g. Jr, Sr)
FIRST NAME	D	Person's first name.
MIDDLE NAME	D	Person's middle name.
CLIENT ID	D	Person's statewide identification number.
LOCAL CASE NUMBER	D	Person's local case number.
COMPONENT CODE	D	Component code.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

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



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

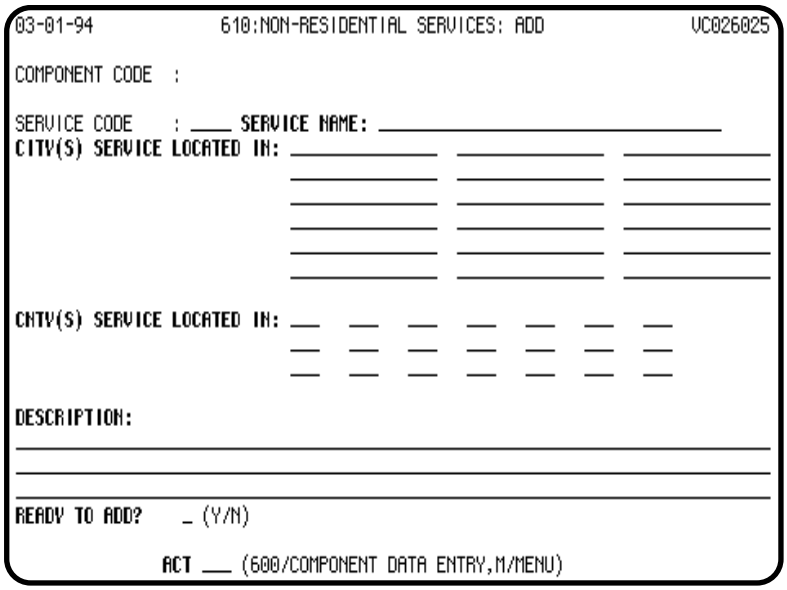
Component (VC026015)
(Action Code 605)



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

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

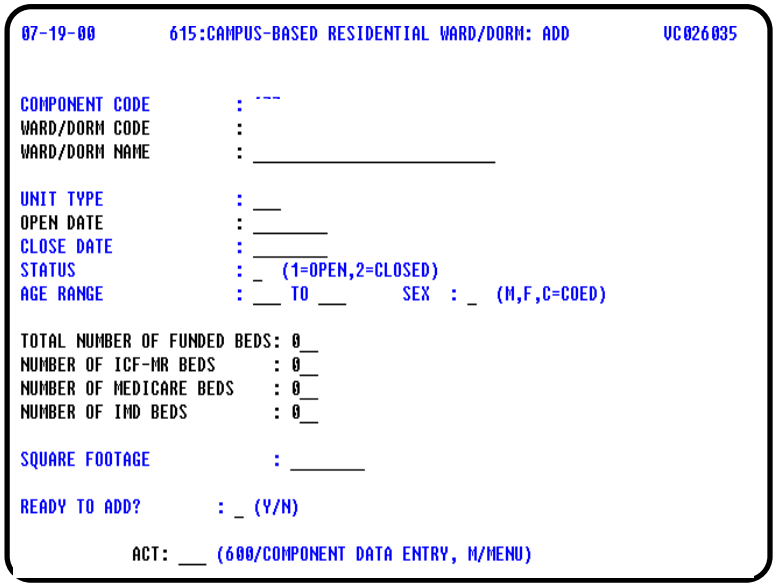
Non-Residential Services (VC026025)
(Action Code 610)



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

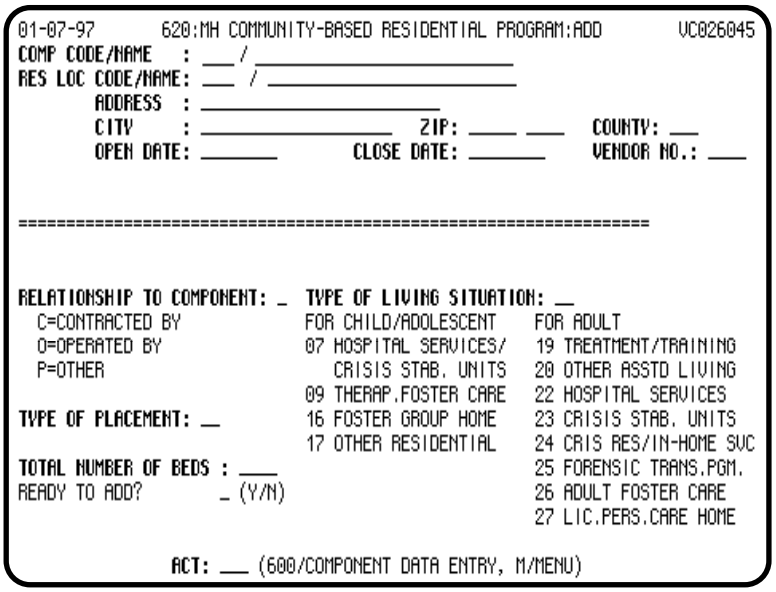
Campus-based Residential Ward/Dorm (VC026035)

(Action Code 615)



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

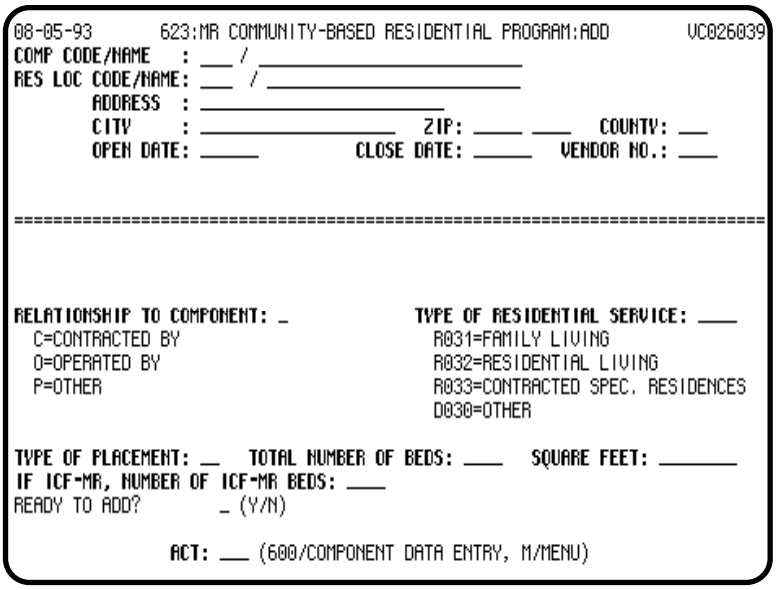
MH Community-based Residential Program (VC026045)
(Action Code 620)



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

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

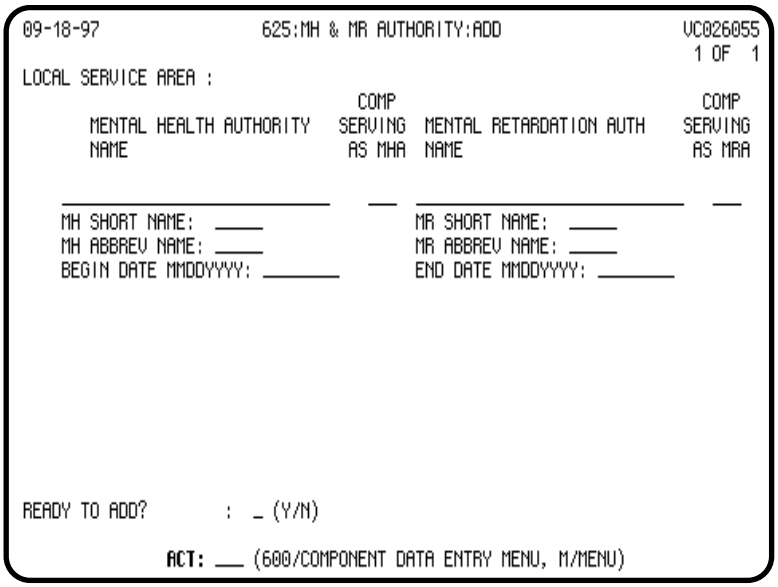
MR Community-based Residential Program (VC026039)
(Action Code 623)



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

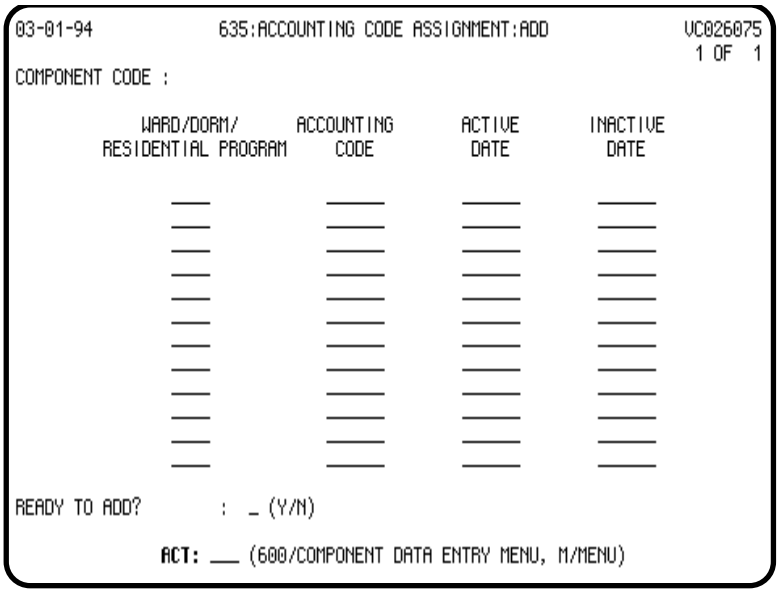
Field Name	Type	Contents
For Changes Only: *These fields are displayed only when you use the change function.*		
REASON FOR MODIFICATION OF THE FOLLOWING ITEM(S)	R	A one-digit code to indicate the reason for modification of any of the following items. (**1**=Error Correction, **2**=Change of Description)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

MH & MR Authority (VC026055)
(Action Code 625)



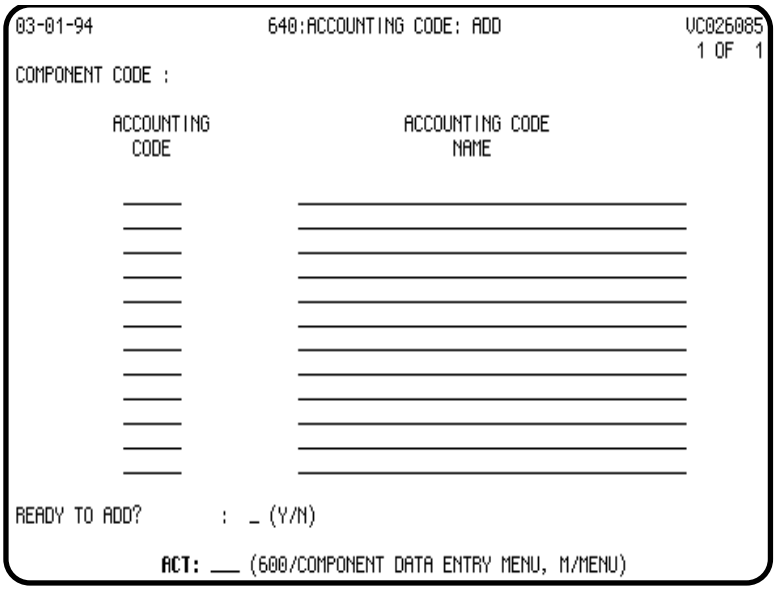
Field Name	Type	Contents
LOCAL SERVICE AREA	D	Service area code.
MENTAL HEALTH AUTHORITY NAME	R	Name of the Mental Health Authority.
COMP SERVING AS MHA	R	Component code of the component serving as the Mental Health Authority.
MENTAL RETARDATION AUTHORITY NAME	R	Name of the Mental Retardation Authority.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

Accounting Code Assignment (VC026075)
(Action Code 635)



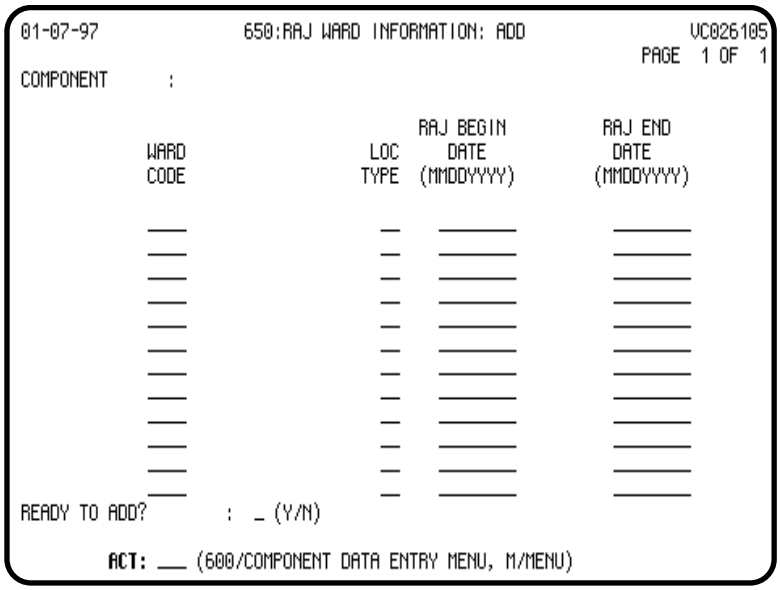
Field Name	Type	Contents
COMPONENT CODE	D	Component code and component name.
WARD/DORM/RESIDENTIAL PROGRAM	R	Code for ward, dorm or residential program.
ACCOUNTING CODE	R	Accounting code of ward, dorm or residential program.
ACTIVE DATE	R	Date the accounting code becomes active. MMDDYY format.
INACTIVE DATE	O/R	Date the accounting code becomes inactive. MMDDYY format.

Accounting Code (VC026085)
(Action Code 640)



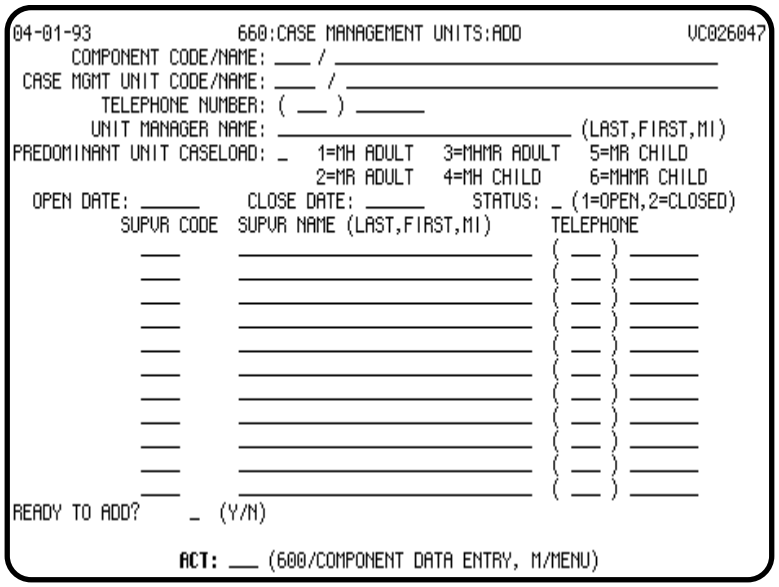
Field Name	Type	Contents
COMPONENT CODE	D	Component code and component name.
ACCOUNTING CODE	R	Accounting code.
ACCOUNTING CODE NAME	R	Accounting code name.

RAJ Ward Information (VC026105)
(Action Code 650)



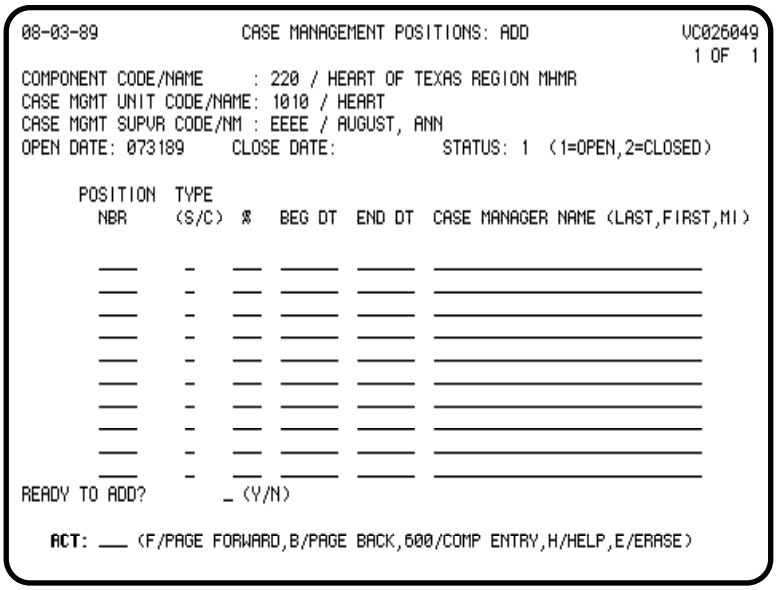
Field Name	Type	Contents
COMPONENT	D	Component code and component name.
WARD CODE	R	Ward code.
LOC TYPE	R	Type of RAJ Ward. MH=Mental Health, SA=Substance Abuse. **Decode: Location Type (RAJ)**
RAJ BEGIN DATE	R	Date the ward became part of RAJ. MMDDYYYY format. Must be later than open date of ward.
RAJ END DATE	O	Date the ward ceased being part of RAJ. MMDDYYYY format. Must be same as or later than begin date.

Case Management Units (VC026047)
(Action Code 660)



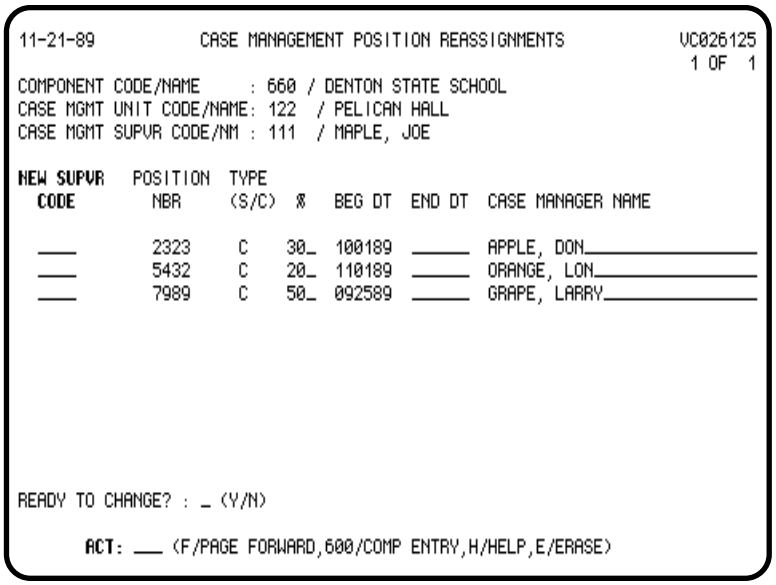
Field Name	Type	Contents
COMPONENT CODE/NAME	D	Component code and name of component.
CASE MGMT UNIT CODE/ NAME	D	Case management unit code and name.
TELEPHONE NUMBER	O	Telephone number. If entered, must be ten digits.
UNIT MANAGER NAME	O	Unit manager name, up to 45 characters.
PREDOMINANT UNIT CASELOAD	R	Predominant unit caseload. 1=MH Adult; 2=MR Adult; 3=MHMR Adult; 4=MH Child; 5=MR Child; 6=MHMR Child
OPEN DATE	R	Opening date of the unit. MMDDYY format.
CLOSE DATE	O/R	Closing date required if unit is closed. MMDDYY format. If a close date is entered, there can be no open case management assignments to this unit.
STATUS	R	Unit status. 1=Open; 2=Closed. Must agree with the OPEN and CLOSE dates.
SUPVR CODE	O/R	Supervisor code, if added, must be one- to four-digit code.
SUPVR NAME	O	Name of the supervisor, up to 30 characters.
TELEPHONE	O/R	Telephone number. If entered, must be 10 digits.

Case Management Positions (VC026049)
(Action Code 670)



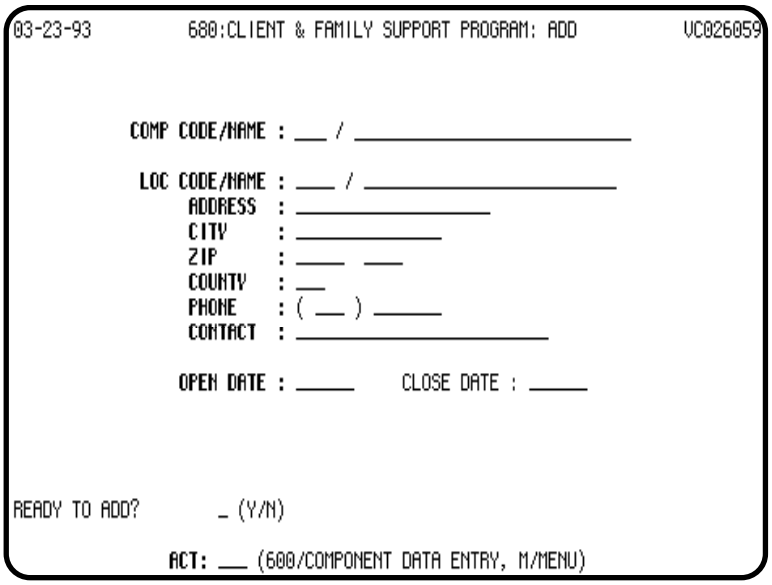
Field Name	Type	Contents
COMPONENT CODE/NAME	D	Component code and name.
CASE MGMT UNIT CODE/NAME	D	Case management unit code and name.
CASE MGMT SUPVR CODE/NM	D	Case management supervisor code and name.
OPEN DATE	D	Date unit opened.
CLOSE DATE	D/R	Date unit is closed.
STATUS	D	Status of unit. 1=Open, 2=Closed
POSITION NBR	R	One- to four-digit position code.
TYPE S/C	R	Type of position. S=Supervisor, C=Case Manager
%	R	Numeric percentage for the position.
BEG DT	R	Beginning date of the position. MMDDYY format. Must be within the unit's open/close range.
END DT	R	Ending date of the position is entered when the position closes. MMDDYY format. There can be no open case management assignments for that position. The end date must be within the unit's open/close date.
CASE MANAGER NAME	O	Case manager name, up to 28 characters.

Case Management Position Reassignments (VC02625)
(Action Code 675)



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

Client & Family Support Program (VC026059)
(Action Code 680)

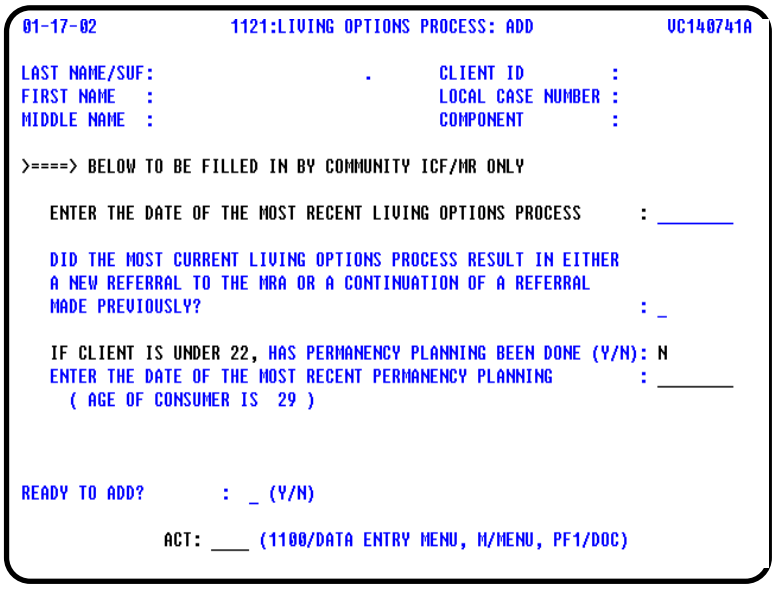


Field Name	Type	Contents
COMP CODE	D	Component code.
NAME	D	Component name.
LOC CODE	D	Location code.
NAME	O	Location name.
ADDRESS	R	Location address.
CITY	R	Location city.
ZIP	R	Location zip code.
COUNTY	R	Three-digit county code of the location.
PHONE	O	Telephone number of the location.
CONTACT	O	Name of a contact person at the location.
OPEN DATE	R	Date the location opened. MMDDYY format.
CLOSE DATE	O	Date the location closed. MMDDYY format. Note: If a close date is entered, there can be no open assignments to this location.

Living Options Process (VC140741A)

(Action Code 1121)

To be completed by Community ICF/MR Facilities Only

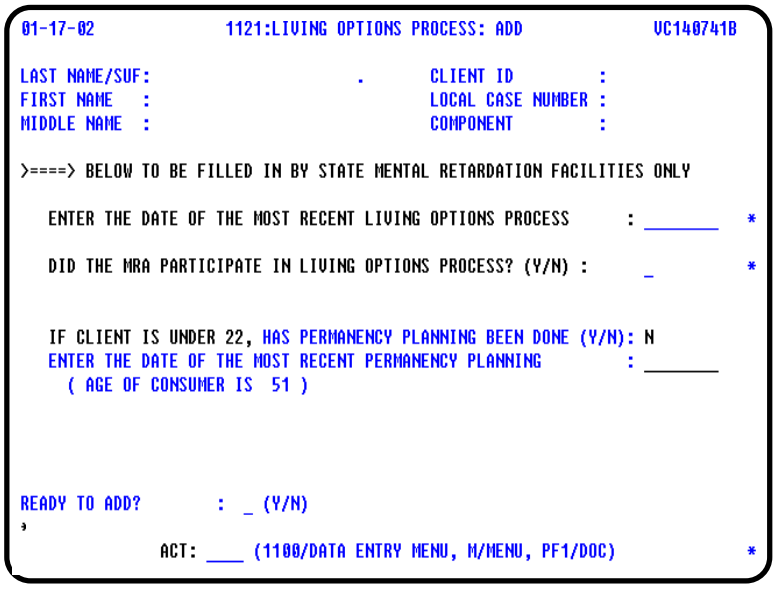


Field Name	Type	Contents
Last Name/Suf	D	Person's last name and (optional) suffix. (e.g., Jr, Sr)
First Name	D	Person's first name.
Middle Name	D	Person's middle name.
Client ID	D	Person's statewide identification number.
Local Case Number	D	Person's local case number.
Component	D	Component code.
Enter the Date of the Most Recent Living Options Process	R	Date of the person's most recent living options process.
Did the Most Current Living Options Process Result in Either a New Referral to the MRA or a Continuation of a Referral Made Previously?	R	**Y** (Yes) or **N** (No) to indicate whether the most current living options process resulted in a new referral to the MRA or a continuation of a referral made previously.
If Client Is Under 22, Has Permanency Planning Been Done?	R	If the client is under 22, **Y** (Yes) or **N** (No) to indicate whether permanency planning has been done.
Enter the Date of the Most Recent Permanency Planning	R	If permanency planning has been done, date of the most recent permanency planning.

Living Options Process (VC140741B)

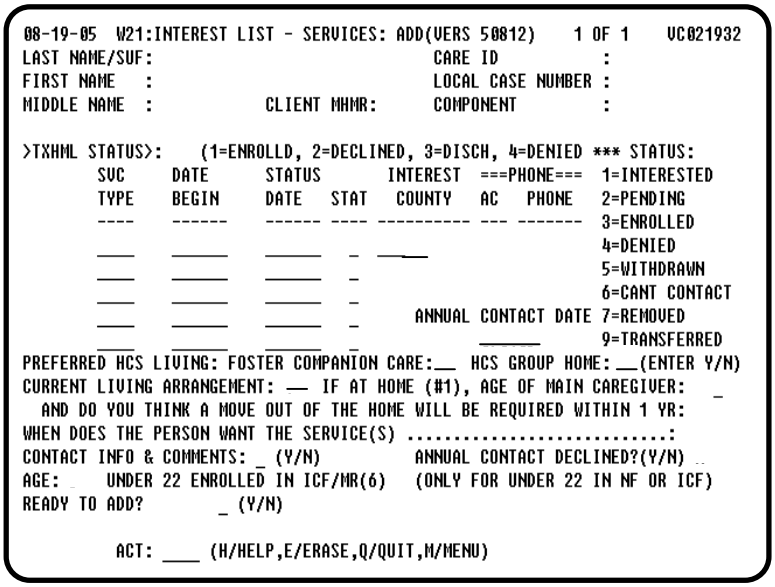
(Action Code 1121)

To be completed by State Mental Retardation Facilities Only



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

Interest List – Services (VC021932)
(Action Code W21)

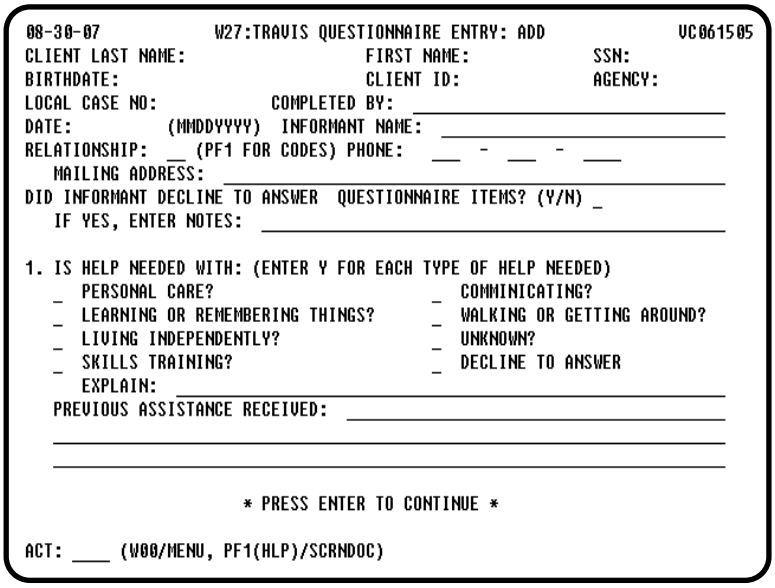


Field Name	Type	Contents
LAST NAME/SUF	D	Person's last name and (optional) suffix. (e.g., Jr, Sr)
FIRST NAME	D	Person's first name.
MIDDLE NAME	D	Person's middle name.
CLIENT MHMR	D	Indicates if the person is to receive mental health (MH) or mental retardation (MR) services.
CARE ID	D	Person's statewide identification number.
LOCAL CASE NUMBER	D	Person's local case number.
COMPONENT	D	Component code.
TXHML STATUS	O/R	One-digit code to indicate the person's TXHML (Texas Home Living) status. If the person is offered TXHML waiver services and declines, **2** must be entered.
SVC TYPE	R	Code for the type of service the person is interested in receiving.
DATE BEGIN	R	Date the person was placed on the interest list to receive the specified service.
STATUS DATE	O/R	Date the person's status is effective.
STAT	O/R	One-digit code to indicate the person's interest list status.
INTEREST COUNTY	R	Three-digit code to indicate the county in which the LAR resides or, if there is not an LAR, where the intended service recipient resides.
AC	O/R	The area code of the residence of the intended service recipient.
PHONE	O/R	The telephone number of the residence of the intended service recipient.
ANNUAL CONTACT DATE	R	Date of required annual contact. Indicates the last date that *all* services (i.e., HCD, GR services including IHFS) in the interest list record were reviewed with the primary correspondent.

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

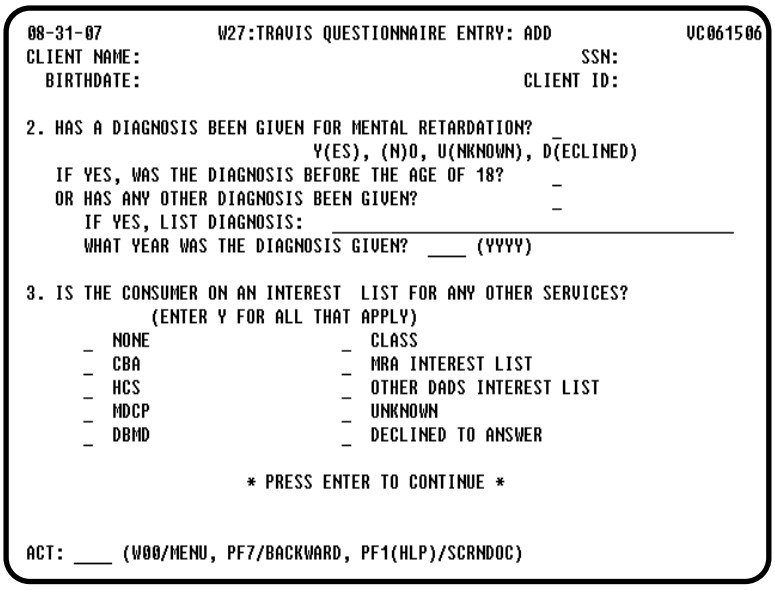
Travis Questionnaire Entry (VC061505)

(Action Code W27)



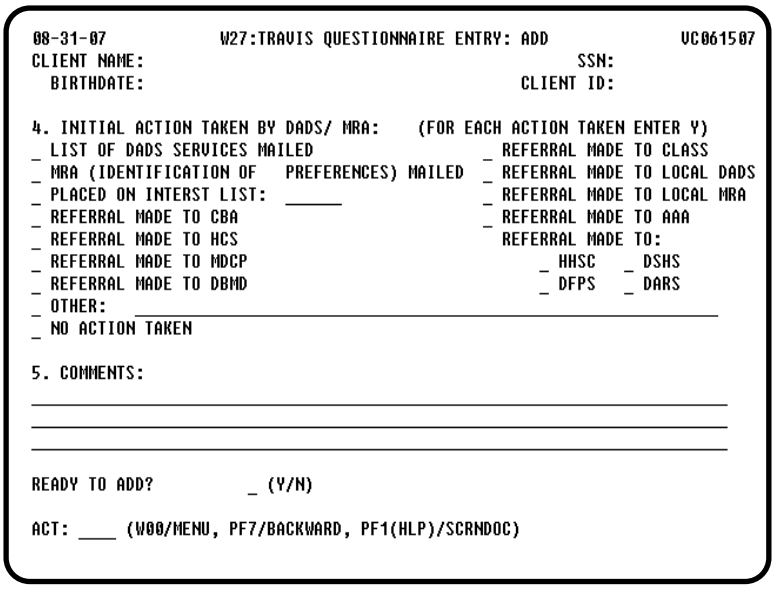
Field Name	Type	Contents
CLIENT LAST NAME	D	Person's last name.
FIRST NAME	D	Person's first name.
SSN	D	Person's social security number.
BIRTHDATE	D	Person's date of birth.
CLIENT ID	D	Person's statewide identification number.
AGENCY	D	"MRA" component code
LOCAL CASE NUMBER	D	Person's local case number.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

Travis Questionnaire Entry (VC061506)
(Action Code W27)



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

Travis Questionnaire Entry (VC061507)
(Action Code W27)



Field Name	Type	Contents
CLIENT NAME	D	Person's name.
SSN	D	Person's social security number.
BIRTHDATE	D	Person's date of birth.
CLIENT ID	D	Person's statewide identification number.
4. INITIAL ACTION TAKEN BY DADS/MRA	R	**Y** for all applicable referrals. (If **Y** is entered for NO ACTION TAKEN, no other responses for this question are accepted. If PLACED ON INTEREST LIST is selected, the name of the interest list to which the consumer is added.)
5. COMMENTS	O	Any comments that the informant wants to make or user wants to include.