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

Mental Retardation Authority

User Guide

Department of Aging and Disability Services
June 2008
# Home and Community-based Services (HCS)
& Texas Home Living (TxHmL) Programs

## Mental Retardation Authority (MRA)

### User Guide

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MRA User Guide
# Introduction

## Overview

### About the HCS and TxHmL Programs

The Texas Department Aging and Disability Services (DADS) currently operates two waiver programs for eligible individuals as an alternative to the Intermediate Care Facilities for Persons with Mental Retardation or Related Conditions (ICF/MR). The Home and Community-based Services (HCS) program and the Texas Home Living (TxHmL) program provide community-based services and supports for eligible individuals.

The local Mental Retardation Authority (MRA) is responsible for completing all enrollment activities for these individuals prior to the provision of any waiver services. The MRA is also responsible for providing service coordination to all individuals receiving HCS or TxHmL services.

### Consumer Directed Services Option

Consumer Directed Services is a service delivery option in which an individual or legally authorized representative (LAR) employs and retains service providers and directs the delivery of program services. An individual who chooses the CDS option is supported by a consumer directed services agency (CDSA) chosen by the individual to provide financial management services, and, at the individual’s request, support consultation services if offered by the program in which the individual is enrolled.

### Provider-managed Services Option

The traditional agency model (provider-managed) service delivery option is available to provide approved services that the individual/LAR elects not to self-direct. In the traditional agency option, the individual or his or her legally authorized representative (LAR) choose a certified and contracted HCS Program provider capable of delivering the full array of HCS Program service components. The program provider employs and retains service providers, and directs the delivery of program services.

### Forms/Written Processes

Forms and written processes can be found in the HCS handbook at [http://dadsview.dads.state.tx.us/handbooks/](http://dadsview.dads.state.tx.us/handbooks/).
Data Entry Functions  The following table displays the CARE on-line data entry functions available to the MRA for the HCS, TxHmL, and CDS (Consumer Directed Services) programs.

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

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

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

In this Guide

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

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

Introduction

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

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

Becoming a VPN or Dial-up User

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

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

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

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

Network

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

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

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

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

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

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

- **L01** - CONSUMER ENROLLMENT
- **L02** - INDIVIDUAL PLAN OF CARE
- **L03** - ENROLLMENT PACKET CHECKLIST
- **L05** - PROVIDER CHOICE
- **L06** - CONSUMER TRANSFER
- **L09** - REGISTER CLIENT UPDATE
- **L10** - CLIENT CORRESPONDENT UPDATE
- **L11** - CLIENT NAME UPDATE
- **L12** - CLIENT ADDRESS UPDATE
- **L13** - CONSUMER DISCHARGE
- **L20** - GUARDIAN INFORMATION UPDATE

**ACT:** (A/NA MAIN MENU, Q/QUIT, HLP(PF1)/SCRN DOC)

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

- **A03** - CONSUMER TRANSFER
- **C01** - CONSUMER DEMOGRAPHICS
- **C02** - INDIVIDUAL PLAN OF CARE (IPC)
- **C03** - CMS MEDICAID ELIGIBILITY SEARCH
- **C06** - CONSUMER DISCHARGES
- **C08** - PROVIDER/CONTRACT ROSTER
- **C09** - MR/AR ASSESSMENTS
- **C10** - PROVIDER LOCATION
- **C11** - PROVIDER LIST
- **C13** - PROVIDER LIST SUMMARY
- **C14** - CONSUMER ROSTER
- **C70** - CONTRACT INFORMATION
- **C71** - PROVIDER/CONTRACT LIST
- **C72** - SERVICE DELIVERY BY IPC
- **C73** - SERVICE DELIVERY BY PROVIDER
- **C74** - CHECKLIST
- **C75** - PRIOR APPROVAL
- **C77** - REIMBURSEMENT AUTHORIZATION

**ACT:** (A/NA MAIN MENU, Q/QUIT, HLP(PF1)/SCRN DOC)

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

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

Add/Change/Delete
When using the data entry screens, you will add, change, and delete records.

<table>
<thead>
<tr>
<th>Use</th>
<th>to…</th>
</tr>
</thead>
<tbody>
<tr>
<td>Add</td>
<td>add a new record.</td>
</tr>
<tr>
<td>Change or Correct</td>
<td>change or correct incorrect information on a record.</td>
</tr>
<tr>
<td>Delete</td>
<td>delete a record entered in error.</td>
</tr>
</tbody>
</table>

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

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

Introduction

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

Web Addresses

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

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

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

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

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

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

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

Introduction

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

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

In this Section

This section contains information on the following processes:

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<th>Page</th>
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<td>Exiting the Automated System</td>
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</tr>
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</tr>
<tr>
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<td>37</td>
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<tr>
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<td>Service Coordinator Review of IPC (L31) - HCS Only</td>
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<td>MRA Assignment Notification (L30)</td>
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<tr>
<td>Client Assignments (L26)</td>
<td>91</td>
</tr>
<tr>
<td>Consumer Demographic Update</td>
<td>95</td>
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<tr>
<td>Consumer Transfer (L06)</td>
<td>103</td>
</tr>
<tr>
<td>Critical Incident Data (686) HCS</td>
<td>129</td>
</tr>
<tr>
<td>Critical Incident Data (686) TxHmL</td>
<td>141</td>
</tr>
<tr>
<td>MRA/MHA Contacts (L28)</td>
<td>153</td>
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<tr>
<td>Permanency Planning Review (309) - HCS</td>
<td>161</td>
</tr>
<tr>
<td>Consumer Discharge</td>
<td>167</td>
</tr>
</tbody>
</table>
## Accessing the Automated System

### Logon Procedure

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

<table>
<thead>
<tr>
<th>Step</th>
<th>View</th>
<th>Action</th>
</tr>
</thead>
</table>
| 1    | A sample SuperSession **MHMR-NET** screen is shown below. | • Type your User ID in the **USERID** field.  
• Tab to the **PASSWORD** field and type your password.  
• Press **Enter**.  
Result: A broadcast message screen is displayed. |

<table>
<thead>
<tr>
<th>Step</th>
<th>View</th>
<th>Action</th>
</tr>
</thead>
</table>
| 2    | A sample broadcast message screen is shown below. | A broadcast message screen is provided to display network information.  
• Read the screen for messages concerning system availability.  
• Press **Enter**.  
Result: The system displays the **CL/SUPERSESSION Main Menu** screen. |
### Logon Procedure, continued

<table>
<thead>
<tr>
<th>Step</th>
<th>View</th>
<th>Action</th>
</tr>
</thead>
</table>
| 3 | A sample **CL/SUPERSESSION Main Menu** screen is shown below. | The **CL/SUPERSESSION Main Menu** provides a listing of your menu applications and will vary according to the applications to which you have access.  
- Review the **CL/SUPERSESSION Main Menu**.  
- Type S (Select) in the field next to CARE. |
| | ![CL/SUPERSESSION Main Menu](image) | Result: The **CARE Access Verification Screen** is displayed. |
| 4 | A sample **CARE Access Verification Screen** is shown below. | The **CARE Access Verification Screen** allows you to enter your social security number, which is linked to your User ID number.  
- Type your social security number.  
- Press Enter. |
| | ![CARE Access Verification Screen](image) | Result: The **CARE Access Verification Display** screen is displayed. |
| 5 | A sample **CARE Access Verification Display** screen is shown below. | The **CARE Access Verification Display** screen lists the functions you are authorized to access.  
- Press Enter.  
Result: A message screen is displayed. |

**continued on next page**
### Accessing the Automated System, Continued

**Logon Procedure, continued**

<table>
<thead>
<tr>
<th>Step</th>
<th>View</th>
<th>Action</th>
</tr>
</thead>
</table>
| 6    | A sample message screen is shown below. | • Read the screen for messages concerning system or application issues.  
• Press Enter to proceed.  
**Result:** The M: CARE Main Menu is displayed. |

Message: April 14, 2008: ATTN SSG Providers: see TAMHP.com  
http://www.tamhp.com TC/P: Information Letter 2008-06,  
Daily Claim Processing for IC/CS SSG Providers.  
NEW MESSAGE May 8, 2008: Same HCS, TC/SMR & TFD: Providers: Effective June 8, 2008, maintenance security will become password usage changes. See DAUS Information Letter 2008-02 on the DAUS website regarding this matter to avoid potential delay in accessing the CARE system. If you experience problems, please continue to follow your normal problem reporting procedures or call the HHS Consolidated Help Desk at 512-386-4720 or 1-888-952-4357 for assistance.

| 7    | A sample M: CARE Main Menu is shown below. | A sample M: CARE Main Menu is shown below.  
The M: CARE Main Menu displays the action codes and descriptions of the CARE functions.  
To access the A: Medicaid Administration Main Menu:  
• Type A in the ACT: field.  
• Press Enter.  
**Result:** The A: Medicaid Administration Main Menu is displayed.  
Note: To select a function listed on this menu:  
• Type the action code in the ACT: field.  
• Press Enter.  
**Result:** The screen containing the menu for the selected function is displayed.  

| 8    | A sample A: Medicaid Administration Main Menu is shown below. | A sample A: Medicaid Administration Main Menu is shown below.  
To access the HCS provider data entry menu:  
• Type C00 in the ACT: field.  
• Press Enter.  
**Result:** The C00: Provider Data Entry Menu is displayed.  
or  
To access the HCS provider inquiry menu:  
• Type C60 in the ACT: field.  
• Press Enter.  
**Result:** The C60: Provider Inquiry Menu is displayed. |
## Exiting the Automated System

**Exit Procedure**

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

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

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

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

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

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

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

Your password must contain:
• six to eight characters (letters or numbers),
• no spaces,
• no special characters (#, $, ;),
• nothing associated with your user number,
• no double characters, and
• passwords cannot be reused.

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

<table>
<thead>
<tr>
<th>Step</th>
<th>View</th>
<th>Action</th>
</tr>
</thead>
</table>
| 1    | A sample SuperSession MHMR-NET screen is shown below. | To change your password:  
• Type your User ID in the USERID field.  
• Tab to the PASSWORD field and type your password.  
• Tab to the CHANGE PASSWORD? field.  
• Type Y (Yes).  
• Press Enter.  
Result: The Change Password screen is displayed. |
|      | ![SuperSession MHMR-NET Screen](image1) |  |
| 2    | A sample Change Password screen is shown below. | • Type your new password in the ENTER NEW PASSWORD field.  
• Type your password again in the VERIFY NEW PASSWORD field.  
• Press Enter.  
Result: A message stating that your password has changed is displayed. |
|      | ![Change Password Screen](image2) |  |
# Enrollment in a Waiver Program

## Introduction

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

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

## Enrolling in a Waiver Program

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

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

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

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

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

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

<table>
<thead>
<tr>
<th>Step</th>
<th>View</th>
<th>Action</th>
</tr>
</thead>
</table>
| 1 | _ _ | • Type 410 in the ACT: field of any screen.  
  • Press Enter.  
  Result: The 410: Add Case to ID/Demographic Update header screen is displayed. |
| 2 | A sample 410: Add Case to ID/Demographic Update header screen is shown below.  
  06-01-08  410:ADD CASE TO ID/DEMOGRAPHIC UPDATE  06-01-08  
  PLEASE ENTER AT LEAST ONE OF THE FOLLOWING:  
  CLIENT ID  :  
  COMPONENT CODE/LOCAL CASE NUMBER: 300 /  
  TYPE OF ENTRY  :  (ADD CASE. CHANGE DEMOGRAPHICS FOR EXISTING CASE)  
  *** PRESS ENTER ***  
  TO ADD A CASE, LEAVE THE CASE FIELD BLANK, AND USE AN ACTION CODE OF "A"  
  TO CHANGE A CASE, ENTER ID AND COMP, OR COMP AND CASE, AND USE AN ACTION CODE OF "G"  
  *NEW ETHNIC CODES WILL BE CALLED UP AS NEW FED RACE/ETHNICITY CODES  
  *NEW ETHNIC CODES ENTERED WILL BE STORED AS ETHNIC AND FED RACE/ETHNICITY CODES  
  *NEW FED RACE/ETHNICITY CODES ENTERED WILL ALSO BE STORED AS THE OLD ETHNIC  
  ACT: (ADD/CLIENT DATA UPDATE MENU, N/MENU) | • Type the Client ID in the CLIENT ID field.  
• Type the MRA component code in the COMPONENT CODE field.  
• Type A (Add Case) in the TYPE OF ENTRY field.  
• Press Enter.  
Result: The 410: Add Case to ID/Demographic Update screen is displayed. |
| 3 | A sample 410: Add Case to ID/Demographic Update screen is shown below.  
  06-01-08  410:ADD CASE TO ID/DEMOGRAPHIC UPDATE  06-01-08  
  CLIENT LAST NAME/SURNAME  :  MOUNTAIN  
  CLIENT ID  :  10920201  
  CLIENT FIRST NAME  :  RICKY  
  COMPONENT  :  300  
  CLIENT MIDDLE NAME  :  
  LOCAL CASE NUMBER  :  N  
  ETHNIC/NEW FED RACE  :  U  
  NEW FED ETHNICITY  :  U-HISPANIC, U-M NOT HISPANIC  
  CLIENT BIRTHDATE (MM/DD/YYYY): 05/12/1960  
  SEX  :  M  
  SOCIAL SECURITY NUMBER  :  23854544A (M-NAME, D-SSN)  
  PRESENTING PROBLEM  :  ?  
  D-DIAG, ?-DIAG/RO, 4-DIA, 5-OC  
  DOCUMENTATION DATE: 06/2008  
  ENROLLMENT EFFECTIVE DATE: 06/2008  
  LOCAL GUARDIANSHIP  :  N  
  MARITAL STATUS  :  S  
  FAMILY SIZE  :  5  
  ESTIMATED ANNUAL GROSS FAMILY INCOME  :  $35,000  
  READY TO UPDATE? (Y/N)  
  ACT:  (ADD/RESPONDENT APTK, N/MENU) | To add a local case number for the MRA component:  
• Type the local case number for the MRA in the LOCAL CASE NUMBER field.  
• Type Y in the READY TO UPDATE? field to submit the data to the system.  
• Press Enter.  
Result: The 410: Add Case to ID/Demographic Update header screen is displayed with the message, “Case has been Added.” |

Continue with the Interest List - Services procedure.
Introduction

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

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

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

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

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

Procedure

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

<table>
<thead>
<tr>
<th>Step</th>
<th>View</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>_ _</td>
<td>Access W26: Interest List - Services Inquiry by Person to determine whether the person is currently on the Interest List.</td>
</tr>
</tbody>
</table>
| 2    | _ _  | • Type W21 in the ACT: field of any screen.  
     |      | • Press Enter.  

continued on next page
<table>
<thead>
<tr>
<th>Step</th>
<th>View</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>3</td>
<td>A sample <strong>W21: Interest List - Services: Add/Change/Transfer</strong> header screen is shown below.</td>
<td>• Type the requested identifying information in the appropriate fields. Rule: You must enter the Client ID or the local case number. • Type the MRA component code in the COMPONENT CODE field. • Type C (Change) in the TYPE OF ENTRY field. • Type Y (Yes) or N (No) in the ADD TO HCS LIST field to indicate whether the individual is to be added to the HCS Interest List. • Press Enter. Result: The <strong>W21: Interest List - Services: Change</strong> screen is displayed.</td>
</tr>
<tr>
<td>4</td>
<td>A sample <strong>W21: Interest List - Services: Change</strong> screen is shown below. To change the person’s status to declined: • Type 2 (Declined) in the TXHML STATUS field. • Type Y in the READY TO CHANGE? field to submit the data to the system. • Press Enter. Result: The <strong>W21: Interest List - Services</strong> header screen is displayed with the message, “Previous Information Changed.”</td>
<td></td>
</tr>
</tbody>
</table>
Enrollment in a Waiver Program
Service Coordination Assignment (490)

Introduction

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

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

Procedure

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

<table>
<thead>
<tr>
<th>Step</th>
<th>View</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>A sample 490: Svc Coordination Assignment: Add/Change/Delete header screen is shown below.</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>A sample 490: Svc Coordination Assignment: Add screen is shown below.</td>
<td></td>
</tr>
</tbody>
</table>

Continue with the Consumer Enrollment procedure.
Enrollment in a Waiver Program
Consumer Enrollment (L01)

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

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

<table>
<thead>
<tr>
<th>Step</th>
<th>View</th>
<th>Action</th>
</tr>
</thead>
</table>
| 1 | ___ | • Type L01 in the ACT: field of any screen.  
    • Press Enter.  
    Result: The L01: Consumer Enrollment: Add/Change/Delete header screen is displayed. |
| 2 | A sample L01: Consumer Enrollment: Add/Change/Delete header screen is shown below. | • Type the requested identifying information in the appropriate fields.  
    Rule: You must enter the Client ID or the local case number.  
    • Type the MRA component code in the COMPONENT CODE field.  
    • Type A (Add) in the TYPE OF ENTRY field.  
    • Press Enter.  
    Result: The L01: Consumer Enrollment: Add screen is displayed. |
| 3 | A sample L01: Consumer Enrollment: Add screen is shown below. | • Type the code for the waiver type in which the applicant is to be enrolled in the WAIVER TYPE field.  
    • Type Y (Yes) or N (No) in the PRIOR DISCHARGE FROM A MEDICAID CERTIFIED NF OR ICF-MR? field.  
    • Type the code for where the person was living prior to entering the waiver program in the ADMIT FROM field.  
    • Type either the Slot Type (for new allocation slots) in the SLOT TYPE field or the Slot Tracking Number (for recycled slots) in the SLOT TRACKING NUMBER field.  
    • Type Y (Yes) or N (No) to indicate whether the person qualifies for the Money Follows the Person Demonstration Project in the MFP DEMO? field.  
    • Type the county code of the county in which the individual will receive services in the COUNTY OF SERVICE field.  
    • Type Y in the READY TO ADD? field.  
    • Press Enter.  
    Result: The L01: Consumer Enrollment header screen is displayed with the message, “Previous Information Added.” |

Continue with the MR/RC Assessments - Summary procedure.
Enrollment in a Waiver Program
DHS Medicaid Eligibility Search (C63)

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

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

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

<table>
<thead>
<tr>
<th>Step</th>
<th>View</th>
<th>Action</th>
</tr>
</thead>
</table>
| 1    | _ _  | • Type C63 in the ACT: field of any screen.  
|      |      | • Press Enter.  
|      |      | Result: The C63: DHS Medicaid Eligibility Search header screen is displayed. |
| 2    | A sample **C63: DHS Medicaid Eligibility Search** header screen is shown below.  
|      |      | • Type the Client ID in the CLIENT ID field to scan the Medicaid eligibility file for matches to the demographic fields entered in CARE, *or*  
|      |      | • Type the Medicaid Number in the MEDICAID RECIP NO field to search the Medicaid file directly, *or*  
|      |      | • Type at least two of Name, SSN, and Birthdate.  
|      |      | • Press Enter.  
|      |      | Result: The C63: Medicaid Recipient Information screen is displayed.  
|      |      | Note: If the individual does not have Medicaid, the message, “No matches were found to the Medicaid Eligibility file” is displayed. |
| 3    | A sample **C63: Medicaid Recipient Information** screen is shown below.  
|      |      | • View the information from the Medicaid file.  
|      |      | • For further information, type a line number (1 in this example) in the ENTER A LINE NUMBER field.  
|      |      | • Press Enter.  
|      |      | Result: The Medicaid Eligibility Information screen is displayed.  
|      |      | Note: If multiple names are displayed on this screen, contact the Program Enrollment section of DADS. |

continued on next page
### Enrollment in a Waiver Program
#### DHS Medicaid Eligibility Search (C63), Continued

**Procedure, continued**

<table>
<thead>
<tr>
<th>Step</th>
<th>View</th>
<th>Action</th>
</tr>
</thead>
</table>
| 4    | A sample **Medicaid Eligibility Information** screen is shown below. | • View the DHS Demographics, including the Medicaid Certification date.  
• Press Enter.  
**Result:** The **Medicaid Eligibility Information** (Screen 2) is displayed. |
|      | ![Example Screen 1](image1.png) | |
| 5    | A sample **Medicaid Eligibility Information** (Screen 2) is shown below. | • View the Medicaid eligibility information for the selected DHS Recipient Number, including the coverage code, type program, and begin date.  
  **Note:** An individual **must** have one of the following Coverage Codes and Type Programs to be Medicaid eligible for the HCS or TxHmL waiver program. If not, contact Program Enrollment. |
|      | ![Example Screen 2](image2.png) | |

<table>
<thead>
<tr>
<th>Waiver</th>
<th>Coverage Code</th>
<th>Type Program</th>
</tr>
</thead>
<tbody>
<tr>
<td>TxHmL</td>
<td>R</td>
<td>01, 02, 03, 08, 09, 10, 12, 13, 15, 18, 19, 21, 22, 29, 44, 47, 48, 61</td>
</tr>
<tr>
<td>HCS</td>
<td>R</td>
<td>01, 02, 03, 07, 08, 09, 10, 12, 13, 14, 15, 18, 19, 21, 22, 29, 37, 44, 47, 48, 51, 61</td>
</tr>
</tbody>
</table>

• Press Enter to display the **C63: Medicaid Recipient Information** screen.  
• Press Enter.  
**Result:** The **C63: DHS Medicaid Eligibility Search** header screen is displayed.  

Continue with the **Waiver MR/RC Assessment** procedure.
Enrollment in a Waiver Program
MR/RC Assessments - Summary (C68)

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

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

<table>
<thead>
<tr>
<th>Step</th>
<th>View</th>
<th>Action</th>
</tr>
</thead>
</table>
| 1    | _ _  | • Type C68 in the ACT: field of any screen.  
• Press Enter.  
| 2    | A sample C68: MR/RC Assessments-Summary header screen is shown below.  
• Type the requested identifying information in the appropriate fields.  
Rule: You must enter the Client ID, the local case number, or the Medicaid Number.  
• Type the MRA component code in the COMPONENT CODE field.  
• Press Enter.  
| 3    | A sample C68: MR/RC Assessments-Summary screen is shown below.  
If the C68: MR/RC Assessments-Summary screen displays an existing Level of Care in the individual’s record that will not expire for 60 days from the enrollment date, and the record is correct, no MR/RC Assessment is required at this time.  
Note: If there is not an existing LOC in the individual’s record, the C68: MR/RC Assessments-Summary screen is displayed with the message, “No Records Found.”  
• See the Waiver MR/RC Assessment procedure to complete the MR/RC Assessment. An MR/RC Assessment must be authorized by DADS before the entry of L02: Individual Plan of Care.  
Note: If an existing Level of Care/Level of Need is not accurate the MRA must enter the correct information. See Waiver MR/RC Assessment procedures. |

Continue with the DHS Medicaid Eligibility Search procedure.
**Introduction**

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

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

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

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

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

continued on next page
Enrollment in a Waiver Program
Waiver MR/RC Assessment (L23), Continued

Procedure

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

<table>
<thead>
<tr>
<th>Step</th>
<th>View</th>
<th>Action</th>
</tr>
</thead>
</table>
| 1    |      | • Type L23 in the ACT: field of any screen.  
|      |      | • Press Enter.  
| 2    | A sample L23: Waiver MR/RC Assessment: Add/Change/Delete header screen is shown below.  
|      |      | • Type the requested identifying information in the appropriate fields.  
|      |      | Rule: You must enter the Client ID, the local case number, or the Medicaid Number.  
|      |      | • Type the MRA component code in the COMPONENT CODE field.  
|      |      | • Type 2 (No Current Assessment) in the PURPOSE CODE field.  
|      |      | • Type A (Add) in the TYPE OF ENTRY field.  
|      |      | • Type the MR/RC Assessment begin date in the REQUESTED BEGIN DATE field.*  
|      |      | • Press Enter.  

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

<table>
<thead>
<tr>
<th>Step</th>
<th>View</th>
<th>Action</th>
</tr>
</thead>
</table>
| 3    | A sample L23: Waiver MR/RC Assessment Purpose Code 2: Add screen is shown below.  
|      |      | • Type the date the MR/RC Assessment was completed in the COMPLETED DATE field.  
|      |      | • Type the person’s legal status in the LEGAL STATUS field.  
|      |      | • Type the person’s previous residence location before the current enrollment in the PREV. RES. field.  
|      |      | • Type the recommended Level of Care in the REC. LOC field.  
|      |      | • Type the recommended Level of Need in the REC. LON field.  
|      |      | • Type the person’s current primary diagnosis code as determined by a physician in the PRIMARY DIAG field.  
|      |      | • Type the month and year that the person’s disabling condition was originally diagnosed in the ONSET field.  
|      |      | • Press Enter.  
|      |      | Result: The L23 Waiver MR/RC Assessment Purpose Code 2: Add (Screen 2) is displayed. |

continued on next page
Enrollment in a Waiver Program  
Waiver MR/RC Assessment (L23), Continued

<table>
<thead>
<tr>
<th>Step</th>
<th>View</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>4</td>
<td>A sample <strong>L23: Waiver MR/RC Assessment Purpose Code 2: Add</strong> (Screen 2) is shown below.</td>
<td></td>
</tr>
</tbody>
</table>
|      | ![Screen 2](image) | - View the client and MR/RC record information.  
- Verify that the diagnoses are correct (based on the codes entered on screen 1).  
- Press Enter to continue. |
|      | **Result:** The **L23: Waiver MR/RC Assessment Purpose Code 2: Add** (Screen 3) is displayed. |
| 5    | A sample **L23: Waiver MR/RC Assessment Purpose Code 2: Add** (Screen 3) is shown below. |
|      | ![Screen 3](image) | - Type information in the appropriate fields.  
Note: *All of the fields on this screen are required.*  
- Press Enter. |
|      | **Result:** The **L23 Waiver MR/RC Assessment Purpose Code 2: Add** (Screen 4) is displayed. |
| 6    | A sample **L23 Waiver MR/RC Assessment Purpose Code 2: Add** (Screen 4) is shown below. |
|      | ![Screen 4](image) | - Type information in the appropriate fields.  
Note: *All of the fields on this screen are required.*  
- Press Enter. |
|      | **Result:** The **L23 Waiver MR/RC Assessment Purpose Code 2: Add** (Screen 5) is displayed. |

continued on next page
Procedure, continued

### Step 7

**A sample L23: Waiver MR/RC Assessment Purpose Code 2: Add** (Screen 5) is shown below.

<table>
<thead>
<tr>
<th>View</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Code 2: Add</strong> (Screen 5) is shown below.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>The <strong>Physician’s Evaluation and Recommendation</strong> fields are <strong>not</strong> required for waiver programs.</td>
</tr>
</tbody>
</table>

**Note:**

- **If the physician has...**
- **then...**
- **signed the form**
  - you must complete all fields on the screen.
- **not signed the form**
  - **do not enter any** data on the screen.

- **Press Enter** to continue.

**Result:** The **L23: Waiver MR/RC Assessment Purpose Code 2: Add** (Screen 6) is displayed.

### Step 8

**A sample L23: Waiver MR/RC Assessment Purpose Code 2: Add** (Screen 6) is shown below.

<table>
<thead>
<tr>
<th>View</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Code 2: Add</strong> (Screen 6) is shown below.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>Type information in the appropriate fields.</td>
</tr>
<tr>
<td>Type <strong>Y (Yes)</strong> or <strong>N (No)</strong> in the <strong>READY TO SEND FOR AUTHORIZATION?</strong> field to indicate whether or not you are ready to send the MR/RC Assessment to Program Enrollment (PE) at State Office.</td>
</tr>
<tr>
<td><strong>Type Y (Yes) or N (No)</strong> in the <strong>READY TO ADD?</strong> field to indicate whether or not you are ready to add the record. You may want to add the record pending further modifications even if you are not ready to send it for authorization by PE. If you add the record, the system saves the data and you won’t have to reenter the information, <strong>but you will have to add needed information and send for authorization prior to proceeding further with the enrollment.</strong></td>
</tr>
<tr>
<td><strong>Press Enter.</strong></td>
</tr>
</tbody>
</table>

**Result:** The **L23: Waiver MR/RC Assessment Purpose** header screen is displayed with the message, **“Previous Information Added.”**

**Note:** The MR/RC Assessment must be authorized by Program Enrollment **before** entry of the **L02**. Continue with the **Individual Plan of Care** procedure.
Enrollment in a Waiver Program
Individual Plan of Care (L02) - Initial

Introduction

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

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

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

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

Consumer Directed Services (CDS)

The consumer directed services option is for those individuals in the own home/family home setting. It is an option that allows individuals or their legally authorized representatives to be the employer of their direct service providers by recruiting, hiring, training, supervising, and terminating their service providers. Services that can be self-directed vary depending on the DADS program. At the time of entry of the initial IPC into the CARE system, the MRA specifies if any services are to be self-directed.
Enrollment in a Waiver Program
Individual Plan of Care (L02) - HCS

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

<table>
<thead>
<tr>
<th>Step</th>
<th>View</th>
<th>Action</th>
</tr>
</thead>
</table>
| 1 | _ _ | • Type L02 in the ACT: field of any screen.  
• Press Enter.  
Result: The L02: Individual Plan of Care header screen is displayed. |
| 2 | A sample L02: Individual Plan of Care header screen is shown below. | • Type the requested identifying information in the appropriate fields.  
Rule: You must enter the Client ID, the local case number, or the Medicaid Number.  
• Type the MRA component code in the COMPONENT CODE field.  
• Type I (Initial) in the TYPE OF ENTRY field.  
• Type the date the provider began or will begin providing services in the BEGIN DATE field.  
Note: The IPC Begin Date cannot be prior to the enrollment request date reflected on screen L01.  
• Press Enter.  
Result: The L02: Individual Plan of Care Entry: Initial screen is displayed. |

continued on next page
Enrollment in a Waiver Program
Individual Plan of Care (L02) – HCS, Continued

Procedure, continued

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

continued on next page
### Procedure, continued

<table>
<thead>
<tr>
<th>Step</th>
<th>View</th>
<th>Action</th>
</tr>
</thead>
</table>
| 4 | A sample **L02: Individual Plan of Care Entry: Initial** (screen 2) is shown below. | This screen displays the CDS portion of the IPC. The units for services eligible to be self-directed are displayed **and cannot be changed**. Note: All services that are self-directed contain a V at the end of the service abbreviation on this screen. For example, the service abbreviation for Respite is REH. If that service is self-directed, the abbreviation becomes REHV.  
• Type N in the **CALCULATE?** field.  
• Type Y in the **READY TO CONTINUE?** field.  
• Press **Enter**.  
Result: The **L02: Individual Plan of Care Entry: Initial** (screen 3) is displayed. |

```
W1-21-10 L02:INDIVIDUAL PLAN OF CARE ENTRY (CDS 67.0): INITIAL 904A1520
NAME: SPANISH, SANG Y CLIN: 20248545 CLIENT ID: 1802570
IPC BEGIN DATE: 02-02-2010 REVISE DATE: 02-02-2010 END DATE: 02-01-2011
SERVICE CATEGORY UNITS SERVICE CATEGORY UNITS
SANG CDS SUPPORTED 00 08.00

WILL SERVICES BE SELF DIRECTED? Y (Y/N)
CALCULATE? Y (Y/N) COST ESTIMATED ANNUAL TOTAL: 5,015.20
READY TO CONTINUE? Y (Y/N) COST CEILING: 63,794.00
ACT: ___ (L02/INIT ENTRY MEMO,4/MN INMN MEMO,PLP(PF1)/SFRGOG)
```

| 5 | A sample **L02: Individual Plan of Care Entry: Initial** (screen 3) is shown below. | This screen displays the program provider portion of the IPC. Services not being self-directed are displayed and cannot be changed.  
• Type Y in the **READY TO CONTINUE?** field.  
• Press **Enter**.  
Result: The **L02: Individual Plan of Care Entry: Initial** (screen 4) is displayed. |

```
W1-31-10 L02:INDIVIDUAL PLAN OF CARE ENTRY (CDS 67.0): INITIAL 904A1520
NAME: SPANISH, SANG Y CLIN: 20248545 CLIENT ID: 1802570
IPC BEGIN DATE: 02-02-2010 REVISE DATE: 02-02-2010 END DATE: 02-01-2011
SERVICE CATEGORY UNITS SERVICE CATEGORY UNITS
SANG DAY INPATIENT 240 DAYS NOT NURSING 0 0.25 HRS
SANG NURSING LN 4.75 HRS S2 SUPPORTED EXP 62 HRS

PROGRAM PROVIDER ESTIMATED ANNUAL TOTAL: 6,345.74
READY TO CONTINUE? Y (Y/N) ANNUAL COST: 11,278.34 COST CEILING: 63,794.00
ACT: ___ (L02/INIT ENTRY MEMO,4/MN INMN MEMO,PLP(PF1)/SFRGOG)
```
**Procedure, continued**

<table>
<thead>
<tr>
<th>Step</th>
<th>View</th>
<th>Action</th>
</tr>
</thead>
</table>
| 6    | A sample L02: Individual Plan of Care Entry: Initial (screen 4) is shown below. | • Type Y (Yes) or N (No) to indicate whether any services are staffed by a relative or guardian.  
• Type the name of the provider representative (individual’s name) in the PROVIDER REPRESENTATIVE field and the date the provider representative signed the IPC in the DATE field.  
• Type the Service Coordinator’s name in the SERVICE COORDINATOR field and the date the Service Coordinator signed the IPC in the DATE field.  
• The name of the individual or legal representative is pre-filled based on whether or not a guardian has been identified (screen L20) in the CONSUMER/LEGAL REPRESENTATIVE field. Type the date the individual or legal representative signed the IPC in the DATE field.  
Note: Before you enter names in the fields on this screen, signatures must be on the IPC in the individual’s records. **All data entered into the CARE system should be entered from a paper copy (a hard copy) and match exactly.**  
• Type Y in the READY TO ADD? field to submit the data to the system.  
• Press Enter.  
Result: The L02: Individual Plan of Care header screen is displayed with the message, “Plan has been Added.” |
## Enrollment in a Waiver Program

### Individual Plan of Care (L02) - TxHmL

**Procedure**

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

<table>
<thead>
<tr>
<th>Step</th>
<th>View</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>-</td>
<td>-</td>
</tr>
</tbody>
</table>
| 2    | A sample **L02: Individual Plan of Care** header screen is shown below. | - Type **L02** in the ACT: field of any screen.  
- Press Enter.  
Result: The **L02: Individual Plan of Care** header screen is displayed. |
| 3    | A sample **L02: Individual Plan of Care Entry: Initial** screen is shown below. | - Type the requested identifying information in the appropriate fields.  
**Rule:** You must enter the Client ID, the local case number, or the Medicaid Number.  
- Type the MRA component code in the COMPONENT CODE field.  
- Type **I (Initial)** in the TYPE OF ENTRY field.  
- Type the date the provider began or will begin providing services in the BEGIN DATE field.  
**Note:** The IPC Begin Date cannot be prior to the enrollment request date reflected on screen **L01**.  
- Press Enter.  
Result: The **L02: Individual Plan of Care Entry: Initial** screen is displayed. |

### Note 1

If you enter units in the **SUPPORT CONSULTATION** or **FINANCIAL MANAGEMENT** fields, you must answer **Y** (Yes).  
**Note 2:** If **Y** (Yes) is entered and services are to be self-directed, the **FMS MONTHLY FEE** is required. You must then enter one unit per month of the IPC in the **FMS MONTHLY FEE** field.  
**Note 3:** If units have been entered for Adaptive Aids or Minor Home Modifications, no requisition fee is allowed when self-directing.  
- Type **3 (Own Home/Family Home)** in the **RES TYPE** field.  
- **Type Y** in the **READY TO CONTINUE?** field.  
- Press Enter.  
Result: **L02: Individual Plan of Care Entry: Initial** CDS screen is displayed.

### If you answered...  

<table>
<thead>
<tr>
<th>The...</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Y</strong> to the question, <strong>ANY SERVICES SELF DIRECTED?</strong></td>
</tr>
<tr>
<td><strong>N</strong> to the question, <strong>ANY SERVICES SELF DIRECTED?</strong></td>
</tr>
</tbody>
</table>

---

MRA Procedures  
April 2010 Revised  
Enrollment in a Waiver Program - 25
Enrollment in a Waiver Program  
Individual Plan of Care (L02) - TxHmL, Continued

### Procedure, continued

<table>
<thead>
<tr>
<th>Step</th>
<th>View</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>4</td>
<td>A sample L02: Individual Plan of Care Entry: Initial (screen 2) is shown below.</td>
<td>This screen displays the CDS portion of the IPC. The units for all services eligible to be self-directed are displayed. You can edit units for services not being self-directed on this screen by typing 0 (zero) in place of units. <strong>Note 1:</strong> Support Consultation and Financial Management Service fee units <em>cannot</em> be changed on this screen. <strong>Note 2:</strong> All services that are self-directed contain a V at the end of the service abbreviation on this screen. For example, the service abbreviation for Respite is REH. If that service is self-directed, the abbreviation becomes REHV.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Service Category</th>
<th>Units</th>
<th>Service Category</th>
<th>Units</th>
</tr>
</thead>
<tbody>
<tr>
<td>CDS</td>
<td></td>
<td>CDS</td>
<td></td>
</tr>
<tr>
<td>Community</td>
<td></td>
<td>Community</td>
<td></td>
</tr>
<tr>
<td>SU 10.00</td>
<td>HRS</td>
<td>Community</td>
<td></td>
</tr>
<tr>
<td>REH</td>
<td></td>
<td>Community</td>
<td></td>
</tr>
<tr>
<td>Services</td>
<td></td>
<td>Community</td>
<td></td>
</tr>
<tr>
<td>Dev</td>
<td></td>
<td>Dental</td>
<td></td>
</tr>
<tr>
<td>100.00</td>
<td>DL</td>
<td>Dental</td>
<td></td>
</tr>
<tr>
<td>Div</td>
<td></td>
<td>Dietary</td>
<td></td>
</tr>
<tr>
<td>2.00</td>
<td>HRS</td>
<td>Dietary</td>
<td></td>
</tr>
<tr>
<td>Med</td>
<td></td>
<td>Monthly Fee</td>
<td></td>
</tr>
<tr>
<td>12.00</td>
<td>HRS</td>
<td>Monthly Fee</td>
<td></td>
</tr>
<tr>
<td>Med</td>
<td></td>
<td>Nursing</td>
<td></td>
</tr>
<tr>
<td>3.75</td>
<td>HRS</td>
<td>Nursing</td>
<td></td>
</tr>
<tr>
<td>Med</td>
<td></td>
<td>Occupational</td>
<td></td>
</tr>
<tr>
<td>1.00</td>
<td>HRS</td>
<td>Occupational</td>
<td></td>
</tr>
</tbody>
</table>

WILL SERVICES BE SELF DIRECTED? Y (Y/N) CALCULATED? Y (Y/N) | CDS ESTIMATED ANNUAL TOTAL 9,041.91 |
| READY TO CONTINUE? _ (Y/N) | COST CEILING 15,000.00 |

The following screen shows the units that have been changed to 0 for each service that is to be provided by the program provider.

<table>
<thead>
<tr>
<th>Service Category</th>
<th>Units</th>
<th>Service Category</th>
<th>Units</th>
</tr>
</thead>
<tbody>
<tr>
<td>CDS</td>
<td></td>
<td>CDS</td>
<td></td>
</tr>
<tr>
<td>Community</td>
<td></td>
<td>Community</td>
<td></td>
</tr>
<tr>
<td>SU 10.00</td>
<td>HRS</td>
<td>Community</td>
<td></td>
</tr>
<tr>
<td>REH</td>
<td></td>
<td>Community</td>
<td></td>
</tr>
<tr>
<td>Services</td>
<td></td>
<td>Community</td>
<td></td>
</tr>
<tr>
<td>Dev</td>
<td></td>
<td>Dental</td>
<td></td>
</tr>
<tr>
<td>100.00</td>
<td>DL</td>
<td>Dental</td>
<td></td>
</tr>
<tr>
<td>Div</td>
<td></td>
<td>Dietary</td>
<td></td>
</tr>
<tr>
<td>2.00</td>
<td>HRS</td>
<td>Dietary</td>
<td></td>
</tr>
<tr>
<td>Med</td>
<td></td>
<td>Monthly Fee</td>
<td></td>
</tr>
<tr>
<td>12.00</td>
<td>HRS</td>
<td>Monthly Fee</td>
<td></td>
</tr>
<tr>
<td>Med</td>
<td></td>
<td>Nursing</td>
<td></td>
</tr>
<tr>
<td>3.75</td>
<td>HRS</td>
<td>Nursing</td>
<td></td>
</tr>
<tr>
<td>Med</td>
<td></td>
<td>Occupational</td>
<td></td>
</tr>
<tr>
<td>1.00</td>
<td>HRS</td>
<td>Occupational</td>
<td></td>
</tr>
</tbody>
</table>

WILL SERVICES BE SELF DIRECTED? Y (Y/N) CALCULATED? Y (Y/N) | CDS ESTIMATED ANNUAL TOTAL 9,058.20 |
| READY TO CONTINUE? _ (Y/N) | COST CEILING 15,000.00 |

If you want to continue to the Program Provider screen (screen 3) after calculating |
| Then... |
| * Type N in the CALCULATE? field. |
| * Type Y in the READY TO CONTINUE? field. |
| * Press Enter. |
| * Continue with Step 5. |

If you want to indicate that some of the services are not to be self-directed, but will be provided by the Program Provider |
| Then... |
| * Replace the displayed units of service with 0 (zero) for each service that is to be provided by the Program Provider. |
| * Press Enter to calculate. |
| * Type N in the CALCULATE? field. |
| * Type Y in the READY TO CONTINUE? field. |
| * Press Enter. |
| * Continue with Step 5. |

continued on next page
### Procedure, continued

<table>
<thead>
<tr>
<th>Step</th>
<th>View</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>5</td>
<td>A sample L02: Individual Plan of Care Entry: Initial (screen 3) is shown below.</td>
<td>This screen displays the program provider portion of the IPC. Services not being self-directed are displayed and cannot be changed.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Type Y in the READY TO CONTINUE? field.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Press Enter.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Result: The L02: Individual Plan of Care Entry: Initial (screen 4) is displayed.</td>
</tr>
<tr>
<td>6</td>
<td>A sample L02: Individual Plan of Care Entry: Initial (screen 4) is shown below.</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Type Y (Yes) or N (No) to indicate whether any services are staffed by a relative or guardian.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Type the name of the provider representative (individual’s name) in the PROVIDER REPRESENTATIVE field and the date the provider representative signed the IPC in the DATE field.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Type the Service Coordinator’s name in the SERVICE COORDINATOR field and the date the Service Coordinator signed the IPC in the DATE field.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- The name of the individual or legal representative is pre-filled based on whether or not a guardian has been identified (screen L20) in the CONSUMER/LEGAL REPRESENTATIVE field. Type the date the individual or legal representative signed the IPC in the DATE field.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Note: Before you enter names in the fields on this screen, signatures must be on the IPC in the individual’s record. All data entered into the CARE system should be entered from a paper copy (a hard copy) and match exactly.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Type Y in the READY TO ADD? field to submit the data to the system.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Press Enter.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Result: The L02: Individual Plan of Care header screen is displayed with the message, “Plan has been Added.”</td>
</tr>
</tbody>
</table>

Continue with the Enrollment Packet Checklist procedure.
Enrollment in a Waiver Program  
Enrollment Packet Checklist (L03)

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

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

<table>
<thead>
<tr>
<th>Step</th>
<th>View</th>
<th>Action</th>
</tr>
</thead>
</table>
| 1 | | • Type L03 in the ACT: field of any screen.  
• Press Enter.  
Result: The L03: Enrollment Packet Checklist: Add/Change/Delete header screen is displayed. |
| 2 | A sample L03: Enrollment Packet Checklist: Add/Change/Delete header screen is shown below. | • Type the Client ID in the CLIENT ID field.  
• Type the MRA component code in the COMPONENT CODE field.  
• Type A (Add) in the TYPE OF ENTRY field.  
• Press Enter.  
Result: The L03: Enrollment Packet Checklist: Add screen is displayed. |
| 3 | A sample L03: Enrollment Packet Checklist: Add screen is shown below. | • Type the date waiver services will begin in the SERVICES BEGIN DATE field.  
• Type the date the Freedom of Choice form was signed by the individual/legal representative in the FREEDOM OF CHOICE FORM field.  
• Type the date of the adaptive aids bid or, if unavailable, the date of the assessment in the ADAPTIVE AIDS ASSESSMENT/BID field, if applicable.  
Note: This date is necessary only if the amount of adaptive aids on the IPC exceeds what is approved in the billing guidelines.  
• Type the date of the minor home modification bid or, if unavailable, the date of the assessment in the MINOR HOME MODS ASSESSMENT/BID field.  
Note: This date is necessary only if the amount of minor home modifications on the IPC exceeds what is approved in the billing guidelines.  
• Type the date the Person Directed Plan/SMRF Community Living Plan was completed.  
• Type Y in the READY TO ADD? field.  
• Press Enter.  
Result: The L03: Enrollment Packet Checklist header screen is displayed with the message, “Previous Information Added.” |

Continue with the Register Client Update procedure.
Enrollment in a Waiver Program
Register Client Update (L09) – Program Provider

Introduction

The Register Client Update process allows the MRA to assign the selected program provider’s local case number for a new enrollment. The program provider is contacted for a local case number for the individual, and the MRA enters that local case number into the CARE system.

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

Procedure

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

<table>
<thead>
<tr>
<th>Step</th>
<th>View</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>–</td>
<td>Type L09 in the ACT: field of any screen. Press Enter. Result: The L09: Register Client Update header screen is displayed.</td>
</tr>
<tr>
<td>2</td>
<td>A sample L09: Register Client Update header screen is shown below.</td>
<td>Type the Client ID in the CLIENT ID field. Type the program provider’s component code in the COMPONENT CODE field. Press Enter. Result: The L09: Register Client Update screen is displayed. Note: Once an individual has been assigned a local case number by a provider, it is not necessary to assign them another local case number.</td>
</tr>
<tr>
<td>3</td>
<td>A sample L09: Register Client Update screen is shown below.</td>
<td>Type the Local Case Number assigned to the individual by the program provider in the LOCAL CASE NUMBER field. Review all fields on the screen for accuracy and correctness if necessary. Note: Do not change the Registration Effective Date. Type Y in the READY TO UPDATE? field. Press Enter. Result: The L09: Register Client Update header screen is displayed with the message, “Previous Information Changed.” Note: You don’t have to change a local case number if an individual changes programs and leaves the provider, then later returns to the provider.</td>
</tr>
</tbody>
</table>

Continue with the CDSA L09 or the Provider Choice procedure.
Enrollment in a Waiver Program
Register Client Update (L09) – CDSA

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

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

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

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

<table>
<thead>
<tr>
<th>Step</th>
<th>View</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td></td>
</tr>
</tbody>
</table>

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

Result: The L09: Register Client Update header screen is displayed.

| 2    | A sample L09: Register Client Update header screen is shown below. |

- Type the Client ID in the CLIENT ID field.
- Type the CDSA’s component code in the COMPONENT CODE field.
- Press Enter.

Result: The L09: Register Client Update screen is displayed.

Note: Once an individual has been assigned a local case number by a CDSA, it is not necessary to assign them another local case number.

| 3    | A sample L09: Register Client Update screen is shown below. |

- Type the Local Case Number assigned to the individual by the CDSA in the LOCAL CASE NUMBER field.
- Review all fields on the screen for accuracy and correct if necessary.

Note: Do not change the Registration Effective Date.
- Type Y in the READY TO UPDATE? field.
- Press Enter.

Result: The L09: Register Client Update header screen is displayed with the message, “Previous Information Changed.”

Note: You don’t have to change a local case number if an individual changes programs and leaves the provider, then later returns to the provider.

Continue with the Provider Choice procedure.
Enrollment in a Waiver Program  
Provider Choice (L05)  

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

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

<table>
<thead>
<tr>
<th>Step</th>
<th>View</th>
<th>Action</th>
</tr>
</thead>
</table>
| 1 | _ _ | • Type L05 in the ACT: field of any screen.  
• Press Enter.
Result: The L05: Provider Choice: Add/Delete header screen is displayed. |
| 2 | A sample L05: Provider Choice: Add/Delete header screen is shown below.  
06-31-08  
L05: PROVIDER CHOICE: ADD/DL  
V5968377  
PLEASE ENTER ONE OF THE FOLLOWING:  
CLIENT ID:  
COMPONENT CODE/LOCAL CASE NUMBER: _/______  
MEDicaid NUMBER: ______  

PLEASE ENTER THE FOLLOWING:  
TYPE OF ENTRY: _ (A ADD/DL DELETE)  
""PRESS ENTER""  

ACT: __ (LWMAUTH DATA ENTRY MEMO, ARA MAIN MENU, HLPPF(SCHN DOC)  
• Type the Client ID in the CLIENT ID field.  
• Type the MRA component code in the COMPONENT CODE field.  
• Type A (Add) in the TYPE OF ENTRY field.  
• Press Enter.
Result: The L05: Provider Choice: Add screen is displayed. |

continued on next page
## Enrollment in a Waiver Program
### Provider Choice (L05), Continued

-- Procedure, continued --

<table>
<thead>
<tr>
<th>Step</th>
<th>View</th>
<th>Action</th>
</tr>
</thead>
</table>
| 3 A sample L05: Provider Choice: Add screen is shown below. | **Program Provider (PRGP):**  
- Type the component code of the program provider chosen by the individual in the Component field.  
- Type the local case number that the program provider assigned the individual in the Local Case Number field.  
- Type the contract number of the program provider chosen by the individual in the Contract Number field.  
- For TxHmL individuals, type OHFH (Own Home/Family Home) in the Location Code field. For HCS individuals, type the location code provided by the program provider in the Location Code field.  
  | **Note:** In HCS, when choosing a CDSA, the location code **must** be OHFH.  
| Consumer Directed Service Agency (CDSA):  
- Type the component code of the CDS Agency in the Component field.  
- Type the local case number assigned the individual by the CDS Agency in the Local Case Number field.  
- Type the contract number of the CDS Agency in the Contract Number field.  
- Type Y in the Ready To Add? field.  
- Press Enter.  
  | Result: The header screen is displayed with the message, “Previous Information Added.” |
Service Coordination Assignment (490)

Introduction

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

Note: Case Management Units (Action Code 660) and Case Management Positions (Action Code 670) for the MRA must have been identified in the CARE system before Service Coordinator assignments can be made.
Service Coordination Assignment (490): Add

Procedure

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

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

<table>
<thead>
<tr>
<th>Step</th>
<th>View</th>
<th>Action</th>
</tr>
</thead>
</table>
| 1 | ![490: Svc Coordination Assignment: Add/Change/Delete header screen](image) | - Type 490 in the ACT: field of any screen.
- Press Enter.
**Result:** The 490: Svc Coordination Assignment: Add/Change/Delete header screen is displayed. |
| 2 | ![A sample 490: Svc Coordination Assignment: Add/Change/Delete header screen is shown below.](image) | - Type the requested identifying information in the appropriate fields.
- Rule: You must enter the Client ID or the local case number.
- Type the MRA component code in the COMPONENT CODE field.
- Type A (Add) in the TYPE OF ENTRY field.
- Press Enter.
**Result:** The 490: Svc Coordination Assignment: Add screen is displayed. |
| 3 | ![A sample 490: Svc Coordination Assignment: Add screen is shown below.](image) | - Type the date the assignment begins in the ASSIGNMENT BEGIN DATE field.
- Type the code for the Service Coordinator position in the CASE MANAGER POSITION field.
- Type the Case Management unit code in the CASE MANAGEMENT UNIT field.
- Type Y in the READY TO ADD? field.
**Note:** You can type N in the READY TO ADD? field to take no action and return to the header screen.
- Press Enter.
**Result:** The 490: Svc Coordination Assignment header screen is displayed with the message, “Previous Information Added.” |
Service Coordination Assignment (490): Change

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

<table>
<thead>
<tr>
<th>Step</th>
<th>View</th>
<th>Action</th>
</tr>
</thead>
</table>
| 1    | -    | • Type 490 in the ACT: field of any screen.  
      |      | • Press Enter.  
      |      | Result: The 490: Svc Coordination Assignment: Add/Change/Delete header screen is displayed. |
| 2    | A sample 490: Svc Coordination Assignment: Add/Change/Delete header screen is shown below.  
      |      | • Type the requested identifying information in the appropriate fields.  
      |      | Rule: You must enter the Client ID or the local case number.  
      |      | • Type the MRA component code in the COMPONENT CODE field.  
      |      | • Type C (Change) in the TYPE OF ENTRY field.  
      |      | • Press Enter.  
      |      | Result: The 490: Svc Coordination Assignment: Change screen is displayed. |
| 3    | A sample 490: Svc Coordination Assignment: Change screen is shown below.  
      |      | • Type changes to the Service Coordination assignment in the appropriate fields.  
      |      | • Type Y in the READY TO CHANGE? field.  
      |      | Note: You can type N in the READY TO CHANGE? field to take no action and return to the header screen.  
      |      | • Press Enter.  
      |      | Result: The 490: Svc Coordinator Assignment header screen is displayed with the message, “Previous Information Changed.” |
## Service Coordination Assignment (490): Delete

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

<table>
<thead>
<tr>
<th>Step</th>
<th>View</th>
<th>Action</th>
</tr>
</thead>
</table>
| 1    |      | • Type 490 in the ACT: field of any screen.  
      |      | • Press Enter.  
      |      | Result: The 490: Svc Coordination Assignment: Add/Change/Delete header screen is displayed. |
| 2    | A sample 490: Svc Coordinator Assignment: Add/Change/Delete header screen is shown below.  
      |      | • Type the requested identifying information in the appropriate fields.  
      |      | Rule: You must enter the Client ID or the local case number.  
      |      | • Type the MRA component code in the COMPONENT CODE field.  
      |      | • Type D (Delete) in the TYPE OF ENTRY field.  
      |      | • Press Enter.  
      |      | Result: The 490: Svc Coordination Assignment: Add/Change/Delete header screen is displayed. |
| 3    | A sample 490: Svc Coordination Assignment: Delete screen is shown below.  
      |      | • Type Y in the READY TO DELETE? field.  
      |      | Note: You can type N in the READY TO DELETE? field to take no action and return to the header screen.  
      |      | • Press Enter.  
      |      | Result: The 490: Case Management Assignment header screen is displayed with the message, “Previous Information Deleted.” |
Introduction

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

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

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

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

There must be a paper (hard) copy of all information entered into the CARE system. This documentation should be kept in the individual’s record and match data entered exactly.
Waiver MR/RC Assessment Purpose Code 3 (L23): Add

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

<table>
<thead>
<tr>
<th>Step</th>
<th>View</th>
<th>Action</th>
</tr>
</thead>
</table>
| 1    | _ _  | • Type `L23` in the `ACT:` field of any screen.  
      |      | • Press `Enter`.  
| 2    | A sample `L23: Waiver MR/RC Assessment: Add/Chg/Del` header screen is shown below.  
      |      | • Type the requested identifying information in the appropriate fields.  
      |      | Rule: You must enter the Client ID, the local case number, or the Medicaid Number.  
      |      | • Type the MRA component code in the `COMPONENT CODE` field.  
      |      | • Type the contract number under which services are provided to this individual in the `CONTRACT NO` field.  
      |      | • Type `3` (Continued Stay Assessment) in the `PURPOSE CODE` field.  
      |      | • Type `A` (Add) in the `TYPE OF ENTRY` field.  
      |      | • Type the requested begin date in the `REQUESTED BEGIN DATE` field. (Within 60 days prior to the current expiration date, the begin date can be the day after the expiration date. Other than during this 60-day window, the begin date must be the date of data entry.)  
      |      | • Press `Enter`.  
| 3    | A sample `L23: Waiver MR/RC Assessment Purpose Code 3: Add` screen is shown below.  
      |      | • Type the date the MR/RC Assessment was completed in the `COMPLETED DATE` field.  
      |      | • Type in the latest physical examination date in the `PHYS EXAM DATE` field.  
      |      | • Type additional information in the appropriate fields.  
      |      | Note 1: All data entered into the CARE system should be entered from a paper copy (a hard copy) and match exactly.  
      |      | Note 2: The `LEGAL STATUS` and `PREV. RES.` fields are required.  
      |      | • Press `Enter`.  
      |      | Result: The `L23: Waiver MR/RC Assessment Purpose Code 3: Add` (Screen 2) is displayed. |

If you need to add or change information on these screens, you can page backward to correct any entry on previous screens. Use `F7` (function key) or type `B` in the `ACT:` field to page backward to the previous screen. You will not lose the information you have already entered.

continued on next page
## Waiver MR/RC Assessment Purpose Code 3 (L23): Add, Continued

### Procedure, continued

<table>
<thead>
<tr>
<th>Step</th>
<th>View</th>
<th>Action</th>
</tr>
</thead>
</table>
| 4    | A sample **L23: Waiver MR/RC Assessment Purpose Code 3: Add** (Screen 2) is shown below. | This screen is a view screen that allows you to view client information and available MR/RC record information. It displays the Client Comp/Case, Client Name, Client Address, and diagnosis descriptions for codes entered for primary, medical, and psychiatric diagnoses. Information from the latest LOC record is also included. This screen also shows the current level of care information.  
* View and verify the client and MR/RC record information.  
* Press **Enter** to continue.  
**Result**: The **L23: Waiver MR/RC Assessment Purpose Code 3: Add** (Screen 3) is displayed. |
|      | ![Screenshot of Screen 2](image) |    |
| 5    | A sample **L23: Waiver MR/RC Assessment Purpose Code 3: Add** (Screen 3) is shown below. | - Type information in the appropriate fields.  
* Required fields on this screen are IQ, ABL (Adaptive Behavior Level), BROAD INDEPENDENCE, GEN. MALADAPTIVE, ICAP SERVICE LEVEL, BEHAVIOR PROGRAM (YES or NO), SELF-INJURY BEHAVIOR, SERIOUS DISRUP BEH, AGGRESSIVE BEHAVIOR, and SEX. AGRESS. BEH. (See MR/RC instructions for codes and how they affect the LON)  
**Note**: For the 32. GEN. MALADAPTIVE field, if the number is negative, you must use the – (minus) sign just above the alpha section of the keyboard, not the – sign on the 10-key pad.  
* Press **Enter**.  
**Result**: The **L23: Waiver MR/RC Assessment Purpose Code 3: Add** (Screen 4) is displayed. |
|      | ![Screenshot of Screen 3](image) |    |

*continued on next page*
### Waiver MR/RC Assessment Purpose Code 3 (L23): Add, Continued

#### Procedure, continued

<table>
<thead>
<tr>
<th>Step</th>
<th>View</th>
<th>Action</th>
</tr>
</thead>
</table>
| 6    | A sample L23: Waiver MR/RC Assessment Purpose Code 3: Add (Screen 4) is shown below. | • Type information in the appropriate fields.  
  Note: All of the fields on this screen are required.  
  (See instructions for codes)  
  • Press Enter.  
  Result: The L23: Waiver MR/RC Assessment Purpose Code 3: Add (Screen 5) is displayed. |
| 7    | A sample L23: Waiver MR/RC Assessment Purpose Code 3: Add (Screen 5) is shown below. | • Type information in the appropriate fields.  
  • If any data is entered or shown on this screen, all fields must be correctly entered (not required for waiver programs).  
  Note: The fields (48-55) on this screen are not required to be completed. If you choose to enter information in the fields, they must be completed completely and accurately.  
  • Press Enter.  
  Result: The L23: Waiver MR/RC Assessment Purpose Code 3: Add (Screen 6) is displayed. |
| 8    | A sample L23: Waiver MR/RC Assessment Purpose Code 3: Add (Screen 6) is shown below. | • Type information in the appropriate fields.  
  • Type Y (Yes) or N (No) in the READY TO ADD? field to indicate whether or not you are ready to add the record. You may want to add the record pending further modifications even if you are not ready to send it for authorization by UR.  
  Note: You may type N in the READY TO ADD? field to take no action and return to the header screen.  
  No data entered will be saved.  
  • Press Enter.  
  Result: The L23: Waiver MR/RC Assessment header screen is displayed with the message, “Previous Information Added.” |
Waiver MR/RC Assessment Purpose Code 4 (L23): Add

Procedure

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

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

<table>
<thead>
<tr>
<th>Step</th>
<th>View</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Type L23 in the ACT: field of any screen.</td>
<td>• Type L23 in the ACT: field of any screen.</td>
</tr>
<tr>
<td></td>
<td>Press Enter.</td>
<td>• Press Enter.</td>
</tr>
<tr>
<td>2</td>
<td>A sample L23: Waiver MR/RC Assessment: Add/Chg/Del header screen is shown below.</td>
<td>• Type the requested identifying information in the appropriate fields.</td>
</tr>
<tr>
<td></td>
<td>Rule: You must enter the Client ID, the local case number, or the Medicaid Number.</td>
<td>Rule: You must enter the Client ID, the local case number, or the Medicaid Number.</td>
</tr>
<tr>
<td></td>
<td>Note: Your component code is displayed based on your logon account number.</td>
<td>Note: Your component code is displayed based on your logon account number.</td>
</tr>
<tr>
<td></td>
<td>• Type the contract number under which services are provided to this individual in the CONTRACT NO field.</td>
<td>• Type the contract number under which services are provided to this individual in the CONTRACT NO field.</td>
</tr>
<tr>
<td></td>
<td>• Type 4 (Change LON on Existing Assessment) in the PURPOSE CODE field.</td>
<td>• Type 4 (Change LON on Existing Assessment) in the PURPOSE CODE field.</td>
</tr>
<tr>
<td></td>
<td>• Type A (Add) in the TYPE OF ENTRY field.</td>
<td>• Type A (Add) in the TYPE OF ENTRY field.</td>
</tr>
<tr>
<td></td>
<td>• Type the requested begin date in the REQUESTED BEGIN DATE field.</td>
<td>• Type the requested begin date in the REQUESTED BEGIN DATE field.</td>
</tr>
<tr>
<td></td>
<td>Note: For a Purpose Code 4, the begin date must equal the date of data entry. The end date will be the date that the current LOC/LON expires.</td>
<td>Note: For a Purpose Code 4, the begin date must equal the date of data entry. The end date will be the date that the current LOC/LON expires.</td>
</tr>
<tr>
<td></td>
<td>• Press Enter.</td>
<td>• Press Enter.</td>
</tr>
</tbody>
</table>

This screen allows you to select the appropriate purpose code and type of entry for the individual’s data. This documentation describes the procedure for adding a Purpose Code 4 (Change LON on Existing Assessment).
### Procedure, continued

<table>
<thead>
<tr>
<th>Step</th>
<th>View</th>
<th>Action</th>
</tr>
</thead>
</table>
| 3 A sample **L23: Waiver MR/RC Assessment Purpose Code 4: Add** screen is shown below. | | - Type the date the MR/RC Assessment was completed in the **COMPLETED DATE** field.  
- Type the recommended Level of Need (LON) in the **REC. LON** field.  
- Type additional information in the appropriate fields.  
**Note:** All data entered into the CARE system should be entered from a paper copy (a hard copy) and match exactly.  
- Press **Enter** to continue.  
**Result:** The **L23: Waiver MR/RC Assessment Purpose Code 4: Add** (Screen 2) is displayed. |

If you need to add or change information on these screens, you can page backward to correct any entry on previous screens. Use F7 (function key) or type B in the Act: field to page backward to the previous screen. You will not lose the information you have already entered. |

4 A sample **L23: Waiver MR/RC Assessment Purpose Code 4: Add** (Screen 2) is shown below. | | This screen allows you to view client information and available MR/RC record information. It displays the Client Comp/Case, Client Name, Client Address, and diagnosis descriptions for codes entered for primary, medical, and psychiatric diagnoses. This screen also shows the current LOC information.  
- View the client and MR/RC record information.  
- Press **Enter** to continue.  
**Result:** The **L23: Waiver MR/RC Assessment Purpose Code 4: Add** (Screen 3) is displayed.  

If you need to add or change information on these screens, you can page backward to correct any entry on previous screens. Use F7 (function key) or type B in the Act: field to page backward to the previous screen. You will not lose the information you have already entered. |

continued on next page
### Waiver MR/RC Assessment Purpose Code 4 (L23): Add, Continued

#### Procedure, continued

<table>
<thead>
<tr>
<th>Step</th>
<th>View</th>
<th>Action</th>
</tr>
</thead>
</table>
| 5    | A sample L23: Waiver MR/RC Assessment Purpose Code 4: Add (Screen 3) is shown below. | - Type information in the appropriate fields.  
- Press **Enter** to continue.  
**Result:** The L23: Waiver MR/RC Assessment Purpose Code 4: Add (Screen 4) is displayed. |

#### Continued

<table>
<thead>
<tr>
<th>Step</th>
<th>View</th>
<th>Action</th>
</tr>
</thead>
</table>
| 6    | A sample L23: Waiver MR/RC Assessment Purpose Code 4: Add (Screen 4) is shown below. | - Type information in the appropriate fields.  
- Press **Enter** to continue.  
**Result:** The L23: Waiver MR/RC Assessment Purpose Code 4: Add (Screen 5) is displayed. |

#### Continued

<table>
<thead>
<tr>
<th>Step</th>
<th>View</th>
<th>Action</th>
</tr>
</thead>
</table>
| 7    | A sample L23: Waiver MR/RC Assessment Purpose Code 4: Add (Screen 5) is shown below. | - Type information in the appropriate fields. If any information is entered or shown, all fields on this screen must be correctly entered.  
**Note:** The fields (48-55) on this screen are not required to be completed. If you choose to enter information in the fields, they must be completed completely and accurately.  
- Press **Enter** to continue.  
**Result:** The L23: Waiver MR/RC Assessment Purpose Code 4: Add (Screen 6) is displayed. |
Waiver MR/RC Assessment Purpose Code 4 (L23): Add, Continued

Procedure, continued

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

A paper copy of the MR/RC purpose code 4 must be maintained in the individual’s record and exactly match the data entered.
Waiver MR/RC Assessment Purpose Code E (L23): Add

Procedure

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

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

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

continued on next page
### Waiver MR/RC Assessment Purpose Code E (L23): Add, Continued

#### Procedure, continued

<table>
<thead>
<tr>
<th>Step</th>
<th>View</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>4</td>
<td></td>
<td>• Type the requested identifying information in the appropriate fields.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Rule: You must enter the Client ID, the local case number, or the Medicaid Number.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Note: Your component code is displayed based on your logon account number.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Type the contract number under which services are provided to this individual in the CONTRACT NO field.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Type E (Gaps in Assessment) in the PURPOSE CODE field.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Type A (Add) in the TYPE OF ENTRY field.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Type the requested begin date in the REQUESTED BEGIN DATE field.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Type the requested end date in the REQUESTED END DATE field.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Note: For Purpose Code E, REQUESTED BEGIN DATE and REQUESTED END DATE are required.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Press Enter.</td>
</tr>
<tr>
<td>5</td>
<td></td>
<td>• Type the date the MR/RC Assessment was completed in the COMPLETED DATE field.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Note: The date must be on or after the gap end date.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Type the recommended Level of Need (LON) in the REC. LON field.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Type additional information in the appropriate fields.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Press Enter to continue.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Note: All data entered into the CARE system should be entered from a paper copy (a hard copy) and match exactly.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Result: The <strong>L23: Waiver MR/RC Assessment Purpose Code E: Add</strong> (Screen 2) is displayed.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Note: An LON increase cannot be authorized on a Purpose Code E.</td>
</tr>
</tbody>
</table>

This screen allows you to select the appropriate purpose code and type of entry for the individual’s data. This documentation describes the procedure for adding a Purpose Code E (Gaps in Assessment).

---

A sample **L23: Waiver MR/RC Assessment Purpose Code E: Add** screen is shown below.

- Please type the requested identifying information in the appropriate fields.
- Rule: You must enter the Client ID, the local case number, or the Medicaid Number.
- Note: Your component code is displayed based on your logon account number.
- Type the contract number under which services are provided to this individual in the CONTRACT NO field.
- Type E (Gaps in Assessment) in the PURPOSE CODE field.
- Type A (Add) in the TYPE OF ENTRY field.
- Type the requested begin date in the REQUESTED BEGIN DATE field.
- Type the requested end date in the REQUESTED END DATE field.
- Note: For Purpose Code E, REQUESTED BEGIN DATE and REQUESTED END DATE are required.
- Press Enter.

If you need to add or change information on these screens, you can page backward to correct any entry on previous screens. Use F7 (function key) or type B in the Act: field to page backward to the previous screen. You will not lose the information you have already entered.
### Procedure, continued

<table>
<thead>
<tr>
<th>Step</th>
<th>View</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>6</td>
<td>A sample <strong>L23: Waiver MR/RC Assessment Purpose Code E: Add</strong> (Screen 2) is shown below.</td>
<td>• View the client and MR/RC record information. • Press Enter to continue. Result: The L23: Waiver MR/RC Assessment Purpose Code E: Add (Screen 3) is displayed.</td>
</tr>
</tbody>
</table>

This screen allows you to view client information and available MR/RC record information. It displays the Client Comp/Case, Client Name, Client Address, and diagnosis descriptions for codes entered for primary, medical, and psychiatric diagnoses.

| 7    | A sample **L23: Waiver MR/RC Assessment Purpose Code E: Add** (Screen 3) is shown below. | • Type information in the appropriate fields. • Press Enter to continue. Result: The L23: Waiver MR/RC Assessment Purpose Code E: Add (Screen 4) is displayed. |

continued on next page
### Procedure, continued

<table>
<thead>
<tr>
<th>Step</th>
<th>View</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>8</td>
<td>A sample <strong>L23: Waiver MR/RC Assessment Purpose Code E: Add</strong> (Screen 4) is shown below.  &lt;br&gt;<img src="image-url" alt="Image" /></td>
<td>• Type information in the appropriate fields.  &lt;br&gt;• Press Enter to continue.  &lt;br&gt;<strong>Result:</strong> The <strong>L23: Waiver MR/RC Assessment Purpose Code E: Add</strong> (Screen 5) is displayed.</td>
</tr>
<tr>
<td>9</td>
<td>A sample <strong>L23: Waiver MR/RC Assessment Purpose Code E: Add</strong> (Screen 5) is shown below.  &lt;br&gt;<img src="image-url" alt="Image" /></td>
<td>• Type information in the appropriate fields.  &lt;br&gt;Note: The fields (48-55) on this screen are not required to be completed. If you choose to enter information in the fields, they must be completed completely and accurately.  &lt;br&gt;• Press Enter.  &lt;br&gt;<strong>Result:</strong> The <strong>L23: Waiver MR/RC Assessment Purpose Code E: Add</strong> (Screen 6) is displayed.</td>
</tr>
</tbody>
</table>

continued on next page
**Procedure, continued**

<table>
<thead>
<tr>
<th>Step</th>
<th>View</th>
<th>Action</th>
</tr>
</thead>
</table>
| 10   | A sample **L23: Waiver MR/RC Assessment Purpose Code E: Add** (Screen 6) is shown below. | ✷ Type information in the appropriate fields.  
Note 1: The title of the person listed in the FULL NAME OF field (field 57) **must be on the list** displayed on this screen.  
Note 2: The signature date must be **on or after** the gap end date.  
• Type **Y** (Yes) or **N** (No) in the READY TO SEND FOR AUTHORIZATION? field to indicate whether or not you are ready to send the MR/RC Assessment to DADS Access & Intake, Program Enrollment (PE).  
• Type **Y** (Yes) or **N** (No) in the READY TO ADD? field to indicate whether or not you are ready to add the record. You may want to add the record pending further modifications even if you are not ready to send it for authorization by PE/UR.  
Note: You can type **N** in the READY TO ADD? field to take no action and return to the header screen. **The Purpose Code E information/changes will not be saved.**  
• Press **Enter**.  
• Result: The **L23: Waiver MR/RC Assessment** header screen is displayed with the message, “**Previous Information Added.**” |
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Service Coordinator Review of MR/RC (L32)

Introduction

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

Provider’s Responsibility

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

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

Service Coordinator Review

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

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

Assessment Not Reviewed in Timely Manner

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

LOC/LON Approval/Denial

DADS Program Enrollment (PE) will continue to approve or deny an individual’s LOC/LON. The Service Coordinator’s agreement or disagreement does not ensure any action will be taken or not taken by DADS PE. The Service Coordinator may be used as an informant if DADS Program Enrollment determines an LON review is necessary.
L32: Service Coordinator Review of MR/RC: Add

Procedure

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

<table>
<thead>
<tr>
<th>Step</th>
<th>View</th>
<th>Action</th>
</tr>
</thead>
</table>
| 1    | -    | • Type L32 in the ACT: field of any screen.  
• Press Enter.  
| 2    | A sample L32: Service Coordinator Review of MR/RC header screen is shown below.  
• Type the requested identifying information in the appropriate fields.  
• Press Enter.  
Result: The first L32: Service Coordinator Review of MR/RC screen is displayed. |
| 3    | A sample L32: Service Coordinator Review of MR/RC screen is shown below.  
Screen 1  
Screen 2 | • Review the data.  
• Press Enter to go to the next screen. |

The information that was entered by the program provider will be displayed in the first four screens followed by a screen for the Service Coordinator to enter their agreement or disagreement and add any comments.

<table>
<thead>
<tr>
<th>Step</th>
<th>View</th>
<th>Action</th>
</tr>
</thead>
</table>
| 1    | -    | • Type L32 in the ACT: field of any screen.  
• Press Enter.  
| 2    | A sample L32: Service Coordinator Review of MR/RC header screen is shown below.  
• Type the requested identifying information in the appropriate fields.  
• Press Enter.  
Result: The first L32: Service Coordinator Review of MR/RC screen is displayed. |
| 3    | A sample L32: Service Coordinator Review of MR/RC screen is shown below.  
Screen 1  
Screen 2 | • Review the data.  
• Press Enter to go to the next screen. |
Sample screens are shown below.

### Screen 3

<table>
<thead>
<tr>
<th>Step</th>
<th>View</th>
</tr>
</thead>
<tbody>
<tr>
<td>3, cont.</td>
<td>Sample screens are shown below.</td>
</tr>
</tbody>
</table>

**Screen 3**

<table>
<thead>
<tr>
<th>Field</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>DATE</td>
<td>02-16-10</td>
</tr>
<tr>
<td>MR/RC REVIEW</td>
<td>L32: SERVICE COORDINATOR REVIEW OF MR/RC</td>
</tr>
<tr>
<td>NAME</td>
<td>ROSEMARY, MARY</td>
</tr>
<tr>
<td>CLIENT ID</td>
<td>36261</td>
</tr>
<tr>
<td>COMPONENT</td>
<td>RHA LOCAL CASE NUMBER: 0500469565</td>
</tr>
<tr>
<td>40. DOES MENTAL HEALTH OF INDIVIDUAL NEED TO BE UNDER THE SUPERVISION OF AN MRA?</td>
<td>Y (V/M)</td>
</tr>
<tr>
<td>41. CAN THE HEALTH STATUS OF THE INDIVIDUAL PREVENT PARTICIPATION IN THE ACTIVE TREATMENT OF THE IC/HR PROGRAM?</td>
<td>N (V/M)</td>
</tr>
<tr>
<td>50. TO YOUR KNOWLEDGE DOES THE INDIVIDUAL HAVE A CONDITION MENTAL RATIONALITY AND/OR A RELATED CONDITION?</td>
<td>N (Y/M)</td>
</tr>
<tr>
<td>51. DO YOU CERTIFY THAT THIS INDIVIDUAL REQUIRE IC/HR OR IC/HR/RC CARE?</td>
<td>Y (V/M)</td>
</tr>
<tr>
<td>SIGNATURE</td>
<td></td>
</tr>
<tr>
<td>NAME</td>
<td>W. WILLIAMS</td>
</tr>
<tr>
<td>SIGNATURE DATE</td>
<td>02-16-10</td>
</tr>
<tr>
<td>PHYSICIAN LICENSE NO.:</td>
<td>PA-037A99</td>
</tr>
</tbody>
</table>

Screen 3 displays the status is **Waiting for MRA Review**.

- Press Enter to display the last screen.

### Screen 4

<table>
<thead>
<tr>
<th>Field</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>DATE</td>
<td>02-16-10</td>
</tr>
<tr>
<td>MR/RC REVIEW</td>
<td>L32: SERVICE COORDINATOR REVIEW OF MR/RC</td>
</tr>
<tr>
<td>NAME</td>
<td>ROSEMARY, MARY</td>
</tr>
<tr>
<td>CLIENT ID</td>
<td>36261</td>
</tr>
<tr>
<td>COMPONENT</td>
<td>RHA LOCAL CASE NUMBER: 0500469565</td>
</tr>
<tr>
<td>56. SIGNATURE OF AN/VM/RHA/PROVIDER REP/RHA SERVICE COORD</td>
<td></td>
</tr>
<tr>
<td>57. FULL NAME OF -</td>
<td></td>
</tr>
<tr>
<td>58. SIGNATURE DATE:</td>
<td>02-16-10</td>
</tr>
<tr>
<td>REQUESTED REVIEW DATE</td>
<td>64. END DATE</td>
</tr>
<tr>
<td>BEGIN DATE</td>
<td>02-16-10</td>
</tr>
<tr>
<td>FOR DEPARTMENTAL USE ONLY</td>
<td>62. LOCAL:</td>
</tr>
<tr>
<td>61. LOC</td>
<td></td>
</tr>
<tr>
<td>63. EFFECTIVE DATE</td>
<td>64. EXPIRATION DATE</td>
</tr>
<tr>
<td>65. REVIEWER NAME</td>
<td>66. DATE REVIEWED</td>
</tr>
<tr>
<td>67. NAME OF PHYSICIAN:</td>
<td></td>
</tr>
<tr>
<td>PROVIDER COMMENTS</td>
<td></td>
</tr>
</tbody>
</table>

### Screen 5

<table>
<thead>
<tr>
<th>Field</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>DATE</td>
<td>02-16-10</td>
</tr>
<tr>
<td>MR/RC REVIEW</td>
<td>L32: SERVICE COORDINATOR REVIEW OF MR/RC</td>
</tr>
<tr>
<td>NAME</td>
<td>ROSEMARY, MARY</td>
</tr>
<tr>
<td>CLIENT ID</td>
<td>36261</td>
</tr>
<tr>
<td>COMPONENT</td>
<td>RHA LOCAL CASE NUMBER: 0500469565</td>
</tr>
<tr>
<td>STATUS:</td>
<td>WAITING FOR MRA REVIEW</td>
</tr>
</tbody>
</table>

Screen 5 displays that the status is **Waiting for MRA Review**.

- Press Enter to display the last screen.

continued on next page
L32: Service Coordinator Review of MR/RC: Add, Continued

Procedure, continued

<table>
<thead>
<tr>
<th>Step</th>
<th>View</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>4</td>
<td>A sample screen (Screen 6) is shown below.</td>
<td>This screen is used by the Service Coordinator to enter their agreement or disagreement and add any comments.</td>
</tr>
<tr>
<td></td>
<td><img src="image" alt="Sample Screen" /></td>
<td>If the Service Coordinator believes that an error was made in the data entry of the MR/RC Assessment:</td>
</tr>
<tr>
<td></td>
<td><img src="image" alt="Sample Screen" /></td>
<td>• Type N in the SEND TO DADS FOR AUTHORIZATION? field.</td>
</tr>
<tr>
<td></td>
<td><img src="image" alt="Sample Screen" /></td>
<td>• Type a comment as to why it is being returned to the provider in the COMMENTS section. Comment is required if returned to provider.</td>
</tr>
<tr>
<td></td>
<td><img src="image" alt="Sample Screen" /></td>
<td>Note: SC must call the provider to let them know that they have returned an MR/RC Assessment.</td>
</tr>
<tr>
<td></td>
<td><img src="image" alt="Sample Screen" /></td>
<td>• Type Y in the READY TO ADD? field.</td>
</tr>
<tr>
<td></td>
<td><img src="image" alt="Sample Screen" /></td>
<td>• Press Enter.</td>
</tr>
<tr>
<td></td>
<td><img src="image" alt="Sample Screen" /></td>
<td>If the Service Coordinator agrees that the information on the assessment is correct and is ready to send it for authorization:</td>
</tr>
<tr>
<td></td>
<td><img src="image" alt="Sample Screen" /></td>
<td>• Type Y in the READY TO ADD? field.</td>
</tr>
<tr>
<td></td>
<td><img src="image" alt="Sample Screen" /></td>
<td>• Press Enter.</td>
</tr>
<tr>
<td></td>
<td><img src="image" alt="Sample Screen" /></td>
<td>If the Service Coordinator does not agree that the information is accurate:</td>
</tr>
<tr>
<td></td>
<td><img src="image" alt="Sample Screen" /></td>
<td>• Type Y in the READY TO ADD? field.</td>
</tr>
<tr>
<td></td>
<td><img src="image" alt="Sample Screen" /></td>
<td>• Press Enter.</td>
</tr>
<tr>
<td></td>
<td><img src="image" alt="Sample Screen" /></td>
<td>Note: Any time a disagreement is noted, the Service Coordinator must notify DADS UR and the program provider on the same day as data entry by:</td>
</tr>
<tr>
<td></td>
<td><img src="image" alt="Sample Screen" /></td>
<td>• completing a Notification of SC Disagreement form (form 8579),</td>
</tr>
<tr>
<td></td>
<td><img src="image" alt="Sample Screen" /></td>
<td>• faxing it to DADS Program Enrollment (PE),</td>
</tr>
<tr>
<td></td>
<td><img src="image" alt="Sample Screen" /></td>
<td>• and sending a copy to the program provider.</td>
</tr>
</tbody>
</table>

Errors made on the L32: Service Coordinator Review of MR/RC screen may only be corrected during the MRA Review time period (within seven days of the data entry).
L32: Service Coordinator Review of MR/RC: Change

Procedure

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

<table>
<thead>
<tr>
<th>Step</th>
<th>View</th>
<th>Action</th>
</tr>
</thead>
</table>
| 1    |      | • Type L32 in the ACT: field of any screen.  
|      |      | • Press Enter.  
|      |      | Result: The L32: Service Coordinator Review of  
|      |      | MR/RC header screen is displayed. |
| 2    | A sample L32: Service Coordinator Review of MR/RC  
|      | header screen is shown below. | • Type the requested identifying information in  
|      |      | the appropriate fields.  
|      |      | • Type C in the TYPE OF ENTRY field.  
|      |      | • Press Enter.  
|      |      | Result: The first L32: Service Coordinator  
|      |      | Review of MR/RC Change screen is displayed.  
| 3    | A sample L32: Service Coordinator Review of MR/RC  
|      | Change is shown below. | • Type X in the SELECT column beside the  
|      |      | assessment that needs to be changed.  
|      |      | • Press Enter.  
|      |      | Result: The L32: Service Coordinator Review of  
|      |      | MR/RC screens are displayed. The only fields that  
|      |      | can be changed are the questions and comments  
|      |      | on the last screen. Press Enter to move through  
|      |      | the screens. |

continued on next page
### L32: Service Coordinator Review of MR/RC: Change, Continued

#### Procedure, continued

<table>
<thead>
<tr>
<th>Step</th>
<th>View</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>4</td>
<td>A sample screen (Screen 6) is shown below.</td>
<td>This screen is used by the Service Coordinator to enter their agreement or disagreement and add any comments.</td>
</tr>
</tbody>
</table>

- See Step 4 of the **L32: Service Coordinator Review of MR/RC: Add** procedure for descriptions of the fields on this screen.
- Complete the changes to the review by typing the review information in the appropriate fields.
- Type Y in the READY TO CHANGE? field.
- Press Enter.

Result: The **L32: Service Coordinator Review of MR/RC** header screen is displayed with the message, “Previous Information Changed.”
**L32: Service Coordinator Review of MR/RC: Delete**

**Procedure**

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

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

<table>
<thead>
<tr>
<th>Step</th>
<th>View</th>
<th>Action</th>
</tr>
</thead>
</table>
| 1    |       | • Type L32 in the ACT: field of any screen.  
• Press Enter.  
| 2    | A sample L32: Service Coordinator Review of MR/RC header screen is shown below. |
|      |       | • Type the requested identifying information in the appropriate fields.  
• Type D in the TYPE OF ENTRY field.  
• Press Enter.  
Result: The first L32: Service Coordinator Review of MR/RC Change screen is displayed. |
| 3    | A sample L32: Service Coordinator Review of MR/RC Change is shown below. |
|      |       | • Type X in the SELECT column beside the assessment to be deleted.  
• Press Enter.  
Result: The L32: Service Coordinator Review of MR/RC screens are displayed.  
• Press Enter to move through the screens until you reach the last screen. |
L32: Service Coordinator Review of MR/RC: Delete, Continued

Procedure, continued

<table>
<thead>
<tr>
<th>Step</th>
<th>View</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>4</td>
<td>A sample L32: Service Coordinator Review of MR/RC screen is shown below.</td>
<td></td>
</tr>
</tbody>
</table>

To delete the review:
- Type **Y** in the **READY TO DELETE?** field.
- Press **Enter**.

**Result:** The L32: Service Coordinator Review of MR/RC header screen is displayed with the message, “Previous Information Deleted.”
Individual Plan of Care (L02)

**Introduction**

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

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

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

**Notes**

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

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

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

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

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

An MRA can view the current authorized amount by viewing the C62, IPC inquiry screen.
Individual Plan of Care (L02), Continued

IPC Types and Editing Options

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

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

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

Editing options for the three types of IPCs:

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

**Introduction**

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

<table>
<thead>
<tr>
<th>Community Living Service Category</th>
<th>The annual service category limit is $12,000 and includes:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>• Community Support</td>
</tr>
<tr>
<td></td>
<td>• Day Habilitation</td>
</tr>
<tr>
<td></td>
<td>• Employment Assistance</td>
</tr>
<tr>
<td></td>
<td>• Supported Employment</td>
</tr>
<tr>
<td></td>
<td>• Respite</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Professional Technical Service Category</th>
<th>The annual service category limit is $3,000 and includes:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>• Skilled Nursing</td>
</tr>
<tr>
<td></td>
<td>• Behavioral Support</td>
</tr>
<tr>
<td></td>
<td>• Specialized Services</td>
</tr>
<tr>
<td></td>
<td>• Physical and Occupational Therapy (PT, OT)</td>
</tr>
<tr>
<td></td>
<td>• Dietary (DI)</td>
</tr>
<tr>
<td></td>
<td>• Audiology (AU)</td>
</tr>
<tr>
<td></td>
<td>• Speech and Language Pathology (SP)</td>
</tr>
<tr>
<td></td>
<td>• Adaptive Aids (AA) (Limited to $6,000 per IPC year)</td>
</tr>
<tr>
<td></td>
<td>• AA Requisition Fee</td>
</tr>
<tr>
<td></td>
<td>• Minor Home Modifications (MHM) (Limited to a lifetime maximum of $7,500; once that lifetime maximum is reached, $300 per IPC year may be used for additional modifications or repairs of modifications)</td>
</tr>
<tr>
<td></td>
<td>• Dental Treatment (Limited to $1,000 per IPC year)</td>
</tr>
</tbody>
</table>
Over Service Category Limit, Continued

Data Entry Warning Message

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

Procedure

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

In the example below, an IPC is being revised.

<table>
<thead>
<tr>
<th>Step</th>
<th>View</th>
<th>Action</th>
</tr>
</thead>
</table>
| 1 | <Blank> | • Type L02 in the ACT: field of any screen.  
• Press Enter.  
Result: The L02: Individual Plan of Care header screen is displayed. |
| 2 | A sample L02: Individual Plan of Care header screen is shown below. | • Type the requested identifying information in the appropriate fields.  
Rule: You must enter the Client ID, the local case number, or the Medicaid Number.  
• Type the component code of the individual’s current component in the COMPONENT CODE field.  
• Type the type of entry (R – Revision was used in this sample) in the TYPE OF ENTRY field.  
• Type the effective date of the revision to the IPC in the REVISE DATE field.  
• Press Enter. |
| 3 | A sample L02: Individual Plan of Care Entry: Revise screen is shown below. | The provider will modify the total plan with the required revisions to service units. You cannot reduce the units where it would leave a current provider without any service authorizations for their service delivery option.  
• Enter the number of units of each service type in the appropriate fields and the dollar amounts in the ADAPTIVE AIDS, MINOR HOME MOD, and DENTAL fields.  
• Type Y in the READY TO CONTINUE? field.  
• Press Enter.  
Result: If an IPC is entered that exceeds the current authorized amount, an “IPC Plan Cost Categories Have Exceeded” warning screen is displayed when calculating the IPC cost. |
### Over Service Category Limit, Continued

#### Procedure, continued

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

continued on next page
Over Service Category Limit, Continued

Procedure, continued

<table>
<thead>
<tr>
<th>Step</th>
<th>View</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>7</td>
<td>A sample screen is shown below.</td>
<td>This screen displays the program provider portion of the IPC. Services not being self-directed are displayed on this screen and cannot be changed.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Step</th>
<th>View</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>8</td>
<td>A sample screen is shown below.</td>
<td>- <strong>Type Y</strong> in the READY TO CONTINUE? field.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- <strong>Press</strong> Enter.</td>
</tr>
</tbody>
</table>

- **Type Y** (Yes) or **N** (No) to indicate whether any services are staffed by a relative or guardian.
- Type the name of the provider representative (individual’s name) in the PROVIDER REPRESENTATIVE field and the date the provider representative signed the IPC in the DATE field.
- Type or verify the Service Coordinator’s name in the SERVICE COORDINATOR field and the date the Service Coordinator signed the IPC in the DATE field.
- The name of the individual or legal representative is pre-filled based on whether or not a guardian has been identified (screen L20) in the CONSUMER/LEGAL REPRESENTATIVE field. Type the date the individual or legal representative signed the IPC in the DATE field.

Note: Before you enter names in the fields on this screen, signatures **must** be on the IPC in the individual’s chart. **All data entered into the CARE system should be entered from a paper copy (a hard copy) and must match exactly.**

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

Result: The **L02: Individual Plan of Care** header screen is displayed with the message, “Plan has been Revised.”
**Individual Plan of Care (L02): Revision**

**Procedure**

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

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

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

<table>
<thead>
<tr>
<th>Step</th>
<th>View</th>
<th>Action</th>
</tr>
</thead>
</table>
| 1    | _ _  | • Type L02 in the ACT: field of any screen.  
    |      | • Press Enter.  
    |      | Result: The L02: Individual Plan of Care header screen is displayed. |
| 2    | A sample L02: Individual Plan of Care header screen is shown below.  
    |      | • Type the requested identifying information in the appropriate fields.  
    |      | Rule: You must enter the Client ID, the local case number, or the Medicaid Number.  
    |      | • Type the component code of the individual’s current component in the COMPONENT CODE field.  
    |      | • Type R (Revision) in the TYPE OF ENTRY field.  
    |      | • Type the revision date in the REVISE field.  
    |      | • Press Enter.  
    |      | Result: The L02: Individual Plan of Care Entry: Revise screen is displayed. |
Note: The MRA can revise the plan as long as services on the plan are not changed to an amount that is less than what has already been entered for service delivery.

For an IPC revision, the units of service are cumulative. The MRA must include the number of units previously used plus the number of units that will be provided from the revision date through the end of the plan year.

If the MRA enters a plan that exceeds a cost ceiling, the increased services are placed on billing hold and the provider will be unable to enter service delivery claims for these increases until the plan no longer exceeds any cost ceiling. If this occurs, the MRA should submit an IPC packet for review to Program Enrollment.

### L02: Individual Plan of Care Entry: Revise

<table>
<thead>
<tr>
<th>Step</th>
<th>View</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>3</td>
<td>3 A sample L02: Individual Plan of Care Entry: Revise screen is shown below.</td>
<td>The provider will modify the total plan with the required revisions to service units. You cannot reduce the units where it would leave a current provider without any service authorizations for their service delivery option.</td>
</tr>
</tbody>
</table>

- Enter the number of units of each service type in the appropriate fields and the dollar amounts in the ADAPTIVE AIDS, MINOR HOME MOD, and DENTAL fields.
- Type Y (Yes) or N (No) in the ANY SERVICES SELF DIRECTED? field, if necessary.
- Type 3 (OHFH) in the RES TYPE field.
- Type Y in the READY TO CONTINUE? field.
- Press Enter.

Result: The L02: Individual Plan of Care Entry: Revise screen (screen 2) is displayed.

continued on next page
## Procedure, continued

<table>
<thead>
<tr>
<th>Step</th>
<th>View</th>
<th>Action</th>
</tr>
</thead>
</table>
| 4    | A sample **L02: Individual Plan of Care Entry: Revise** screen (screen 2) is shown below. | Services currently being self-directed and new services added to the plan which are eligible to be self-directed are displayed on this screen. The units of new services added to the plan must be changed to zero if they are not being self-directed. **Note 1:** The units for services currently being self-directed are displayed and cannot be changed. **Note 2:** All services that are self-directed contain a V at the end of the service abbreviation on this screen. For example, the service abbreviation for Respite is REH. If that service is self-directed, the abbreviation becomes REHV.  
- Make any necessary changes.  
- Press **Enter** to calculate.  
  Result: The system calculates and displays the total annual cost for the IPC, and the message, “*Please verify the new plan cost*” is displayed.  
  Once the system has calculated the IPC  
  - Type **N** in the **CALCULATE?** field.  
  - Type **Y** in the **READY TO CONTINUE?** field.  
  - Press **Enter**.  
  **Result:** The **L02: Individual Plan of Care Entry: Revise** screen (screen 3) is displayed. |
|      | ![Image of L02: Individual Plan of Care Entry: Revise screen (screen 2)](image) | ![Image of L02: Individual Plan of Care Entry: Revise screen (screen 3)](image) |
| 5    | A sample **L02: Individual Plan of Care Entry: Revise** screen (screen 3) is shown below. | This screen displays the program provider portion of the IPC. Services not being self-directed are displayed on this screen and cannot be changed.  
- Type **Y** in the **READY TO CONTINUE?** field.  
- Press **Enter**.  
**Result:** The **L02: Individual Plan of Care Entry: Revise** screen (screen 4) is displayed. |
|      | ![Image of L02: Individual Plan of Care Entry: Revise screen (screen 3)](image) | ![Image of L02: Individual Plan of Care Entry: Revise screen (screen 4)](image) |

---

continued on next page
### Procedure, continued

<table>
<thead>
<tr>
<th>Step</th>
<th>View</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>6</td>
<td>A sample <strong>L02: Individual Plan of Care Entry: Revise</strong> screen (Screen 4) is shown below.</td>
<td></td>
</tr>
</tbody>
</table>

- Type **Y** (Yes) or **N** (No) to indicate whether any services are staffed by a relative or guardian.
- Type the name of the provider representative (individual’s name) in the **PROVIDER REPRESENTATIVE** field and the date the provider representative signed the IPC in the **DATE** field.
- Type or verify the Service Coordinator’s name in the **SERVICE COORDINATOR** field and the date the Service Coordinator signed the IPC in the **DATE** field.
- The name of the individual or legal representative is pre-filled based on whether or not a guardian has been identified (screen L20) in the **CONSUMER/LEGAL REPRESENTATIVE** field.
- Type the date the individual or legal representative signed the IPC in the **DATE** field.

**Note:** Before you enter names in the fields on this screen, signatures **must** be on the IPC in the individual’s chart. **All data entered into the CARE system should be entered from a paper copy (a hard copy) and must match exactly.**

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

**Result:** The **L02: Individual Plan of Care** header screen is displayed with the message, “Plan has been Revised.”
Individual Plan of Care (L02): Renewal

Procedure

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

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

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

<table>
<thead>
<tr>
<th>Step</th>
<th>View</th>
<th>Action</th>
</tr>
</thead>
</table>
| 1    | – –  | • Type L02 in the ACT: field of any screen.  
|      |      | • Press Enter.  
|      |      | Result: The L02: Individual Plan of Care header screen is displayed. |
| 2    | A sample L02: Individual Plan of Care header screen is shown below. | • Type the requested identifying information in the appropriate fields.  
|      |      | Rule: You must enter the Client ID, the local case number, or the Medicaid Number.  
|      |      | • Type the component code of the individual’s current component in the COMPONENT CODE field.  
|      |      | • Type N (Renewal) in the TYPE OF ENTRY field.  
|      |      | • Press Enter.  
|      |      | Result: The L02: Individual Plan of Care Entry: Renewal screen is displayed. |

continued on next page
Procedure, continued

<table>
<thead>
<tr>
<th>Step</th>
<th>View</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>3</td>
<td>A sample <strong>L02: Individual Plan of Care Entry: Renewal</strong> screen is shown below.</td>
<td></td>
</tr>
</tbody>
</table>
|      | ![Screen Screenshot](image-url) | - Type the number of units of each service category in the appropriate fields and the dollar amounts in the ADAPTIVE AIDS, MINOR HOME MOD, and DENTAL fields.  
- Type **Y** (Yes) or **N** (No) in the **ANY SERVICES SELF DIRECTED?** field to indicate whether any of the services will be self-directed.  
  **Note 1:** If you enter units in the SUPPORT CONSULTATION or FINANCIAL MANAGEMENT fields, you must answer **Y** (Yes).  
  **Note 2:** If **Y** (Yes) is entered and services are to be self-directed, the FMS MONTHLY FEE is required. You must enter one unit per month of the IPC in the FMS MONTHLY FEE field.  
  - Type **3** (Own Home/Family Home) in the RESIDENTIAL TYPE field.  
  - Type **Y** in the **READY TO CONTINUE?** field.  
  - Press **Enter**.  
  **Result:**  
  - **If you answered** **Y** (Yes) **to the question, ANY SERVICES SELF DIRECTED?**  
    - **L02: Individual Plan of Care Entry: Renewal** CDS screen is displayed.  
  - **If you answered** **N** (No) **to the question, ANY SERVICES SELF DIRECTED?**  
    - **L02: Individual Plan of Care Entry: Renewal** program provider screen is displayed. Skip to Step 5. |

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

<table>
<thead>
<tr>
<th>Step</th>
<th>View</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>4</td>
<td></td>
<td>Services currently being self-directed and new services added to the plan which are eligible to be self-directed are displayed on this screen. The units of new services added to the plan must be changed to zero if they are not being self-directed.</td>
</tr>
<tr>
<td></td>
<td></td>
<td><strong>Note 1:</strong> Support Consultation and Financial Management Service fee units <strong>cannot</strong> be changed on this screen.</td>
</tr>
<tr>
<td></td>
<td></td>
<td><strong>Note 2:</strong> All services that are self-directed contain a <strong>V</strong> at the end of the service abbreviation on this screen. For example, the service abbreviation for Respite is REH. If that service is self-directed, the abbreviation becomes REHV.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>The following sample screen displays the way the screen appears when some of the services are not to be self-directed.</td>
</tr>
<tr>
<td></td>
<td></td>
<td><strong>If you …</strong></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Verify the new plan cost.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Type <strong>Y</strong> in the <strong>READY TO CONTINUE?</strong> field.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Continue with Step 5.</td>
</tr>
<tr>
<td>5</td>
<td></td>
<td>A sample <strong>L02: Individual Plan of Care Entry:</strong> <strong>Renewal</strong> screen (screen 3) is shown below.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>This screen displays the program provider portion of the IPC. Services not being self-directed are displayed and cannot be changed.</td>
</tr>
<tr>
<td></td>
<td></td>
<td><strong>Type <strong>Y</strong> in the <strong>READY TO CONTINUE?</strong> field.</strong></td>
</tr>
<tr>
<td></td>
<td></td>
<td><strong>Press <strong>Enter</strong>.</strong></td>
</tr>
</tbody>
</table>

continued on next page
Procedure, continued

<table>
<thead>
<tr>
<th>Step</th>
<th>View</th>
<th>Action</th>
</tr>
</thead>
</table>
| 6    | A sample **L02: Individual Plan of Care Entry: Renewal** screen (Screen 4) is shown below. | - Type Y (Yes) or N (No) to indicate whether any services are staffed by a relative or guardian.  
- Type the name of the provider representative (individual’s name) in the PROVIDER REPRESENTATIVE field and the date the provider representative signed the IPC in the DATE field.  
- Type or verify the Service Coordinator’s name in the SERVICE COORDINATOR field and the date the Service Coordinator signed the IPC in the DATE field.  
- The name of the individual or legal representative is pre-filled based on whether or not a guardian has been identified (screen L20) in the CONSUMER/LEGAL REPRESENTATIVE field. Type the date the individual or legal representative signed the IPC in the DATE field.  
Note: Before you enter names in the fields on this screen, signatures must be on the IPC in the individual’s chart. **All data entered into the CARE system should be entered from a paper copy (a hard copy) and must match exactly.**  
- Type Y in the READY TO RENEW? field to submit the data to the system.  
Note: You can type N in the READY TO RENEW? field to take no action and return to the header screen. **The renewal IPC will not be saved.**  
- Press Enter.  
Result: The **L02: Individual Plan of Care** header screen is displayed with the message, “Previous Information Added.” |
**Individual Plan of Care (L02): Error Correction**

**Procedure**

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

<table>
<thead>
<tr>
<th>Step</th>
<th>View</th>
<th>Action</th>
</tr>
</thead>
</table>
| 1    | _ _  | • Type L02 in the ACT: field of any screen.  
    |      | • Press Enter.  
    |      | Result: The L02: Individual Plan of Care header screen is displayed. |
| 2    | A sample L02: Individual Plan of Care header screen is shown below.  
    |      | • Type the requested identifying information in the appropriate fields.  
    |      | Rule: You must enter the Client ID, the local case number, or the Medicaid Number.  
    |      | • Type the component code of the individual’s current component in the COMPONENT CODE field.  
    |      | • Type E (Error Correction) in the TYPE OF ENTRY field.  
    |      | • Type the effective date if error correcting a revision to the IPC in the REVISE DATE field.  
    |      | • Press Enter.  
    |      | Result: The L02: Individual Plan of Care Entry: Correct screen is displayed. |
| 3    | A sample L02: Individual Plan of Care Entry: Correct screen is shown below.  
    |      | • Enter the correct number of units of each service type in the appropriate fields and the dollar amounts in the ADAPTIVE AIDS, MINOR HOME MOD, and DENTAL fields.  
    |      | • Type or verify Y in the ANY SERVICES SELF DIRECTED? field, if services are to be self-directed.  
    |      | Note 1: If you enter units in the SUPPORT CONSULTATION or FINANCIAL MANAGEMENT fields, you must answer Y (Yes).  
    |      | Note 2: If Y (Yes) is entered and services are to be self-directed, the FMS MONTHLY FEE is required.  
    |      | You must enter one unit per month of the IPC in the FMS MONTHLY FEE field.  
    |      | • Type or verify 3 (Own Home/Family Home) in the RESIDENTIAL TYPE field.  
    |      | • Type Y in the READY TO CONTINUE? field.  
    |      | • Press Enter.  
    |      | Result: The L02: Individual Plan of Care Entry: Correct screen (screen 2) is displayed.  
    |      | Note: To cancel your request to correct data, type N in the READY TO CONTINUE? field, and press Enter to return to the header screen. |

---

Note: If the MRA enters a plan that exceeds the cost ceiling, the increased services are on billing hold and the provider will be unable to receive payment for those increased services until the plan no longer exceeds the cost ceiling. If this occurs, the MRA should submit an IPC packet to Program Enrollment.

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Individual Plan of Care (L02): Error Correction, Continued

Procedure, continued

<table>
<thead>
<tr>
<th>Step</th>
<th>View</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>4</td>
<td></td>
<td>Services currently being self-directed and new services added to the plan which are eligible to be self-directed are displayed on this screen. The units of new services added to the plan must be changed to zero if they are not being self-directed. Note 1: Support Consultation and Financial Management Service fee units cannot be changed on this screen. Note 2: All services that are self-directed contain a V at the end of the service abbreviation on this screen. For example, the service abbreviation for Respite is RE. If that service is self-directed, the abbreviation becomes REV. • Type Y in the CALCULATE? field. • Press Enter. Result: The system calculates and displays the total annual cost for this IPC, and the message, “Please verify the new plan cost” is displayed. To continue to the program provider screen (screen 3) • Type N in the CALCULATE? field. • Type Y in the READY TO CONTINUE? field. • Press Enter.</td>
</tr>
<tr>
<td>5</td>
<td></td>
<td>This screen displays the program provider portion of the IPC. Services not being self-directed are displayed and cannot be changed. • Type Y in the READY TO CONTINUE? field. • Press Enter.</td>
</tr>
</tbody>
</table>

continued on next page
Individual Plan of Care (L02): Error Correction, Continued

Procedure, continued

<table>
<thead>
<tr>
<th>Step</th>
<th>View</th>
<th>Action</th>
</tr>
</thead>
</table>
| 6    | A sample **L02: Individual Plan of Care Entry: Correct** screen (Screen 4) is shown below. | • Type **Y** (Yes) or **N** (No) to indicate whether any services are staffed by a relative or guardian.  
• Type the name of the provider representative (individual’s name) in the **PROVIDER REPRESENTATIVE** field and the date the provider representative signed the IPC in the **DATE** field.  
• Type or verify the Service Coordinator’s name in the **SERVICE COORDINATOR** field and the date the Service Coordinator signed the IPC in the **DATE** field.  
• The name of the individual or legal representative is pre-filled based on whether or not a guardian has been identified (screen L20) in the **CONSUMER/LEGAL REPRESENTATIVE** field.  
Type the date the individual or legal representative signed the IPC in the **DATE** field.  
Note: Before you enter names in the fields on this screen, signatures must be on the IPC in the individual’s chart. **All data entered into the CARE system should be entered from a paper copy (a hard copy) and must match exactly.**  
• Type **Y** in the **READY TO CORRECT?** field to submit the data to the system.  
Note: You can type **N** in the **READY TO CORRECT?** field to take no action and return to the header screen. **Information entered will not be saved.**  
• Press **Enter**.  
Result: The **L02: Individual Plan of Care** header screen is displayed with the message, “Plan has been corrected.” |

**MRA Procedures April 2010 Revised Individual Plan of Care - 75**
## Individual Plan of Care (L02): Delete

### Procedure

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

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

<table>
<thead>
<tr>
<th>Step</th>
<th>View</th>
<th>Action</th>
</tr>
</thead>
</table>
| 1    | 1    | • Type L02 in the ACT: field of any screen.  
      |      | • Press Enter.  
      |      | **Result:** The L02: Individual Plan of Care header screen is displayed. |
| 2    | A sample L02: Individual Plan of Care header screen is shown below.  
      | A sample L02: Individual Plan of Care header screen is shown below.  
      | • Type the requested identifying information in the appropriate fields.  
      |      | **Rule:** You must enter the Client ID, the local case number, or the Medicaid Number.  
      |      | • Type the component code of the individual’s current component in the COMPONENT CODE field.  
      |      | • Type D (Delete) in the TYPE OF ENTRY field.  
      |      | • Press Enter.  
      |      | **Result:** The L02: Individual Plan of Care Entry: Delete screen is displayed. |
| 3    | A sample L02: Individual Plan of Care Entry: Delete screen is shown below.  
      | A sample L02: Individual Plan of Care Entry: Delete screen is shown below.  
      | • Type Y in the READY TO DELETE? field.  
      |      | **Note:** You can type N in the READY TO DELETE? field to take no action and return to the header screen.  
      |      | • Press Enter.  
      |      | **Result:** The L02: Individual Plan of Care header screen is displayed with the message, “Previous information deleted.” |
Service Coordinator Review of IPC (L31)

Introduction

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

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

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

Provider’s Responsibility

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

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

Service Coordinator Review

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

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

- not available through other resources, and do not replace existing and natural supports;
- necessary to assure the individual’s health and safety and prevent institutionalization; and
- based on the outcomes in the individual’s PDP.
Service Coordinator Review of IPC (L31), Continued

Service Coordinator Review, continued

The MRA may access the **L83: Pending IPC MRA Reviews: MRA Inquiry** screen which assists the MRA with tracking IPCs that need to be reviewed by the Service Coordinator and displays all renewal and revised IPCs waiting for the Service Coordinator review. MRAs are expected to review each IPC and must determine how frequently they will need to produce the list in order to meet this expectation.

Assessment Not Program providers will not be prevented from entering billing because a service Coordinator does not review the IPC in a timely manner. If a service coordinator does not review an IPC within seven (7) days of data entry, CARE will automatically send the IPC to DADS for authorization without a Service Coordinator review. Reports will be available for state office and MRA management staff noting those IPCs not reviewed by the Service Coordinator.

DADS Program DADS Program Enrollment (PE) will continue to authorize, reduce, or deny Enrollment (PE) services on an individual’s IPC. The Service Coordinator’s agreement or disagreement does not ensure any action will be taken or not taken by DADS PE. The Service Coordinator’s agreement or disagreement does not ensure any action will be taken or not taken by DADS PE. The Service Coordinator may be used as an informant if DADS PE determines an LON review is necessary.
L31: Service Coordinator Review of IPC: Add

Procedure

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

<table>
<thead>
<tr>
<th>Step</th>
<th>View</th>
<th>Action</th>
</tr>
</thead>
</table>
| 1    | _ _  | • Type L31 in the ACT: field of any screen.  
      |      | • Press Enter.  
      |      | Result: The L31: Service Coordinator Review of IPC header screen is displayed. |
| 2    | A sample L31: Service Coordinator Review of IPC header screen is shown below.  
      |      | • Type the requested identifying information in the appropriate fields.  
      |      | Rule: You must enter the Client ID or the local case number.  
      |      | • Type the component code of the individual’s current provider component in the COMPONENT CODE field.  
      |      | • Type the IPC effective date in the IPC EFFECTIVE DATE field, if necessary.  
      |      | Note: This field is required if more than one IPC is waiting to be reviewed.  
      |      | • Type A in the Type of Entry field.  
      |      | • Press Enter.  
      |      | Result: The L31: Service Coordinator Review of IPC screen is displayed. |
| 3    | A sample L31: Service Coordinator Review of IPC screen is shown below.  
      |      | The information that was entered by the program provider will be displayed in the first three screens followed by a screen for the Service Coordinator to enter their agreement or disagreement and add any comments.  
      |      | • Review the data.  
      |      | • Press Enter to go to the next screen.  

continued on next page
### L31: Service Coordinator Review of IPC: Add, Continued

Procedure, continued

<table>
<thead>
<tr>
<th>Step</th>
<th>View</th>
<th>Action</th>
</tr>
</thead>
</table>
| 3, cont. | Sample screens are shown below. | - Review the data.  
- Press Enter to review each screen. |

**Screen 2**

```
03-17-10   L31: SERVICE COORDINATOR REVIEW OF IPC VC004971
NAME: ROSENWALD, MARILYN  CLIENT ID: 087261
REFERRAL NUMBER: 99465493  CLINIC: 480000000456  COUNTY: TROY/AL
LOCAL CASE NUMBER: 000000456  CONTRACT NO: 001007555  COMPONENT: O/A
LOCAL CASE NUMBER: 000000456  CONTRACT NO: 001008295  CDS COMPONENT: R/M
RESIDENTIAL TYPE: ONLY/NURSING HOME  REC 1 OF 1
MOTION TYPE: NAS  LOCATION: H/D  END/DUE: 1/1
BEGIN DATE: 03-21-2010  REVISION DATE: 03-21-2010  END DATE: 02-28-2011
IPC GATING manifesto REVIEW
*** CDS ESTIMATED ANNUAL TOTAL: 79,587.00
******************************** PROGRAM PROVIDER SUMMARY ********************************
ADD ADMISSION/adm  100  DAD  AN  MEDICARE  3  HRS
DENTAL  1000  SOL  ON  DAY HOSPITALIZATION  250  DAYS
DIETARY  2  HRS  NURSING DIN  2  HRS
NURSING CMN  2  HRS  OT  OCCUPATIONAL THERAPY  2  HRS
PS  BEHAVIORAL SUPPORT  4  HRS  PT  PHYSICAL THERAPY  3  HRS
SP  SPEECH/LANGUAG  1  HRS
*** PAP ESTIMATED ANNUAL TOTAL: 8,907.20

ARE ANY SERVICES STAFFED BY A RELATIVE/GUARDIAN (Y/N): N
PROVIDER REPRESENTATIVE: ALAN SHEPHERD  03-17-2010
```

**Screen 3**

```
03-17-10   L31: SERVICE COORDINATOR REVIEW OF IPC VC004971
NAME: ROSEMARY, MARILYN  CLIENT ID: 383081
REFERRAL NUMBER: 960055943  CLINIC: 480000000456  COUNTY: TROY/AL
LOCAL CASE NUMBER: 000000456  CONTRACT NO: 001007555  COMPONENT: O/A
LOCAL CASE NUMBER: 000000456  CONTRACT NO: 001008295  CDS COMPONENT: R/M
RESIDENTIAL TYPE: OAN/FAMILY RATE  REC 1 OF 1
MOTION TYPE: NAS  LOCATION: 1/400  END/DUE: 1/1
BEGIN DATE: 03-21-2010  REVISION DATE: 03-21-2010  END DATE: 02-28-2011
IPC GATING manifesto REVIEW
CASE COORDINATOR: DONALD W. B.  03-17-2010
CONSUMER/LEGAL REPRESENTATIVE: ROSEMARY, MARILYN  03-17-2010
CONSUMER INFORMATION  CURRENT ADDRESS: H/STREET
COORDINATE: 1905-0/0101  ZIP CODE: 60666
SS NUMBER: U
```

continued on next page
L31: Service Coordinator Review of IPC: Add, Continued

Procedure, continued

<table>
<thead>
<tr>
<th>Step</th>
<th>View</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>4</td>
<td>A sample screen (Screen 4) is shown below.</td>
<td>This screen is used by the Service Coordinator to enter their agreement or disagreement and to add any comments.</td>
</tr>
<tr>
<td></td>
<td><img src="image" alt="Screen 4" /></td>
<td><strong>If the Service Coordinator believes that an error was made in the data entry of the IPC (return to provider):</strong></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Type N in the <strong>Send to DADS for Authorization?</strong> field.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Type a comment as to why it is being returned to the provider in the <strong>Comments</strong> section.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Note: SC must call the provider to let them know that they have returned an IPC.</td>
</tr>
<tr>
<td></td>
<td></td>
<td><strong>If the Service Coordinator agrees with the statement and is ready to send for authorization:</strong></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Type Y in the <strong>Send to DADS for Authorization?</strong> field.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Type Y in the <strong>MRA Agrees with Information on this IPC?</strong> field.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Type Y in the <strong>Ready to Add?</strong> field.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Press <strong>Enter</strong>.</td>
</tr>
<tr>
<td></td>
<td></td>
<td><strong>If the Service Coordinator does not agree with the statement:</strong></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Type Y in the <strong>Send to DADS for Authorization?</strong> field.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Type N in the <strong>MRA Agrees with Information on this IPC?</strong> field.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>The Service Coordinator may enter a comment in the <strong>Comment</strong> field.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Type the Service Coordinator’s name in the <strong>Service Coordinator Reviewer Name</strong> field.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Type Y in the <strong>Ready to Add?</strong> field.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Press <strong>Enter</strong>.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Note: Any time a disagreement is noted, the Service Coordinator must notify DADS UR and the program provider on the same day as data entry by:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• completing a Notification of SC Disagreement form (form 8579),</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• faxing it to DADS Program Enrollment (PE),</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• and sending a copy to the program provider.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Errors made on the <strong>L31: Service Coordinator Review of IPC</strong> screen may only be corrected during the MRA Review time period (within seven days of the data entry).</td>
</tr>
</tbody>
</table>

continued on next page
L31: Service Coordinator Review of IPC: Change

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

<table>
<thead>
<tr>
<th>Step</th>
<th>View</th>
<th>Action</th>
</tr>
</thead>
</table>
| 1    | _    | - Type L31 in the ACT: field of any screen.  
      |      | - Press Enter.  
      |      | Result: The **L31: Service Coordinator Review of IPC** header screen is displayed. |
| 2    | A sample L31: **Service Coordinator Review of IPC** header screen is shown below.  
      |      | - Type the requested identifying information in the appropriate fields.  
      |      | Rule: You must enter the Client ID *or* the local case number.  
      |      | - Type the component code of the individual’s current component in the **COMPONENT CODE** field.  
      |      | - Type C in the **TYPE OF ENTRY** field.  
      |      | - Press Enter.  
      |      | Result: The first **L31: Service Coordinator Review of IPC** screen is displayed. |
| 3    | A sample L31: **Service Coordinator Review of IPC** is shown below.  
      |      | The only fields that can be changed are the questions and comments on the last screen.  
      |      | - Press Enter to move through the screens.  
      |      | continued on next page |
L31: Service Coordinator Review of IPC: Change, Continued

Procedure, continued

<table>
<thead>
<tr>
<th>Step</th>
<th>View</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>4</td>
<td>A sample screen is shown below.</td>
<td>This screen is used by the Service Coordinator to enter their agreement or disagreement and to add any comments.</td>
</tr>
<tr>
<td></td>
<td>![Sample Screen]</td>
<td>See Step 4 of the L31: Service Coordinator Review of IPC procedure for descriptions of the fields on this screen.</td>
</tr>
<tr>
<td></td>
<td>• Complete the changes to the review by typing the review information in the appropriate fields.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Type Y in the READY TO CHANGE? field.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Press Enter.</td>
<td>Result: The L31: Service Coordinator Review of IPC header screen is displayed with the message, “Previous Information Changed.”</td>
</tr>
</tbody>
</table>
L31: Service Coordinator Review of IPC: Delete

Procedure

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

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

<table>
<thead>
<tr>
<th>Step</th>
<th>View</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>2</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>3</td>
<td>-</td>
<td>-</td>
</tr>
</tbody>
</table>

continued on next page
### Procedure, continued

<table>
<thead>
<tr>
<th>Step</th>
<th>View</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>4</td>
<td></td>
<td>A sample <strong>L31</strong>: Service Coordinator Review of IPC screen is shown below.</td>
</tr>
</tbody>
</table>

#### L31: Service Coordinator Review of IPC

- **View**
  
  ![Screen Shot](image)

- **Action**
  
  **To delete the review:**
  
  - Type **Y** in the **READY TO DELETE?** field.
  - Press **Enter**.

**Result:** The **L31**: Service Coordinator Review of IPC header screen is displayed with the message, “Previous Information Deleted.”
This page was intentionally left blank.
MRA Assignment Notification (L30)

Introduction

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

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

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

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

If the date of the move is today or in the past, the receiving MRA is automatically moved to L26 to complete the assignment.
**MRA Assignment Notification (L30), Continued**

**Procedure**

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

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

### Sending MRA

<table>
<thead>
<tr>
<th>Step</th>
<th>View</th>
<th>Action</th>
</tr>
</thead>
</table>
| 1    | _ _  | • Type L30 in the ACT: field of any screen.  
|      |      | • Press Enter.  
|      |      | Result: The L30: MRA Assignment Notification: Add/Change/Delete header screen is displayed. |
| 2    | A sample L30: MRA Assignment Notification: Add/Change/Delete header screen is shown below. | • Type the requested identifying information in the appropriate fields.  
|      |      | Rule: You must enter the Client ID, the local case number, or the Medicaid number.  
|      |      | • Type the provider’s component code in the COMPONENT CODE field.  
|      |      | • Type the *sending* MRA’s code in the MRA field.  
|      |      | • Type A (Add) in the TYPE OF ENTRY field.  
|      |      | • Press Enter.  
|      |      | Result: The L30: MRA Assignment Notification: Add screen is displayed. |
| 3    | A sample L30: MRA Assignment Notification: Add screen is shown below. | • Type the location code in the MOVE TO LOCATION field.  
|      |      | • Type the county code of the new location in the COUNTY field.  
|      |      | Note: For TxHmL, the Move to Location must be OHFH and the MOVE TO LOCATION and COUNTY code fields are required.  
|      |      | • Type the date of the move in the MOVE DATE field.  
|      |      | In the Sending Authority section of the screen:  
|      |      | • Type the name of the MRA contact person in the CONTACT NAME field.  
|      |      | • Type the contact person’s area code and telephone number in the PHONE fields.  
|      |      | • Type the date the data is entered in the DATE field.  
|      |      | • Type Y in the READY TO ADD? field.  
|      |      | Note: You can type N in the READY TO ADD? field to take no action and return to the header screen.  
|      |      | • Press Enter.  
|      |      | Result: The L30: MRA Assignment Notification header screen is displayed with the message, “Previous Information Added.” |
MRA Assignment Notification (L30), Continued

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

<table>
<thead>
<tr>
<th>Receiving MRA</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Step</strong></td>
</tr>
</tbody>
</table>
| 1 | • Type L30 in the ACT: field of any screen.  
  • Press Enter.  
  **Result:** The L30: MRA Assignment Notification: Add/Change/Delete header screen is displayed. |
| 2 | A sample L30: MRA Assignment Notification: Add/Change/Delete header screen is shown below. |
| 3 | A sample L30: MRA Assignment Notification: Change screen is shown below. |

In the Receiving Authority section of the screen:
• Type the name of the MRA contact person in the Accepted By field.
• Type the date the data is entered in the Date field.
• Type Y in the Ready to Change? field.

Note: You can type N in the Ready to Change? field to take no action and return to the header screen.
• Press Enter.

If the date of the move is today’s date or in the past, the L26: Client Assignments: Add screen is displayed. **Continue with Step 4.**

- or -

If the date of the move is in the future, a message screen is displayed stating that because the movement date is in the future you will not be able to enter the client movement until that date.
• Press Enter.

**Result:** The L30: MRA Assignment Notification header screen is displayed with the message “Previous Information Changed.” The receiving MRA will complete L26: Client Assignments on the date of the move to complete the assignment. If the move date is in the future, the receiving MRA must wait until the date of the move to complete the assignment.

continued on next page
Procedure, continued

## Receiving MRA

<table>
<thead>
<tr>
<th>Step</th>
<th>View</th>
<th>Action</th>
</tr>
</thead>
</table>
| 4    | A sample **L26: Client Assignments: Add** screen is shown below. | • Type Y in the READY TO ADD? field to add the client assignment.  
• Press Enter.  
Result: The **L30: MRA Assignment Notification** header screen is displayed with the message, “Previous Information Added.” |

![Screen Capture](image-url)
Introduction

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

Client assignments are also created when individuals are:
- enrolled into the waiver program by the MRA,
- transferred between service provider contracts, and
- returned from a temporary discharge status.

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

The Client Assignments process allows the MRA to add, correct, or delete a client assignment record.
## Client Assignments (L26): Add

**Procedure**

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

<table>
<thead>
<tr>
<th>Step</th>
<th>View</th>
<th>Action</th>
</tr>
</thead>
</table>
| 1 | _ _ | • Type L26 in the ACT: field of any screen.  
  • Press Enter.  
  **Result:** The L26: Client Assignments: Add/Correct/Delete header screen is displayed. |
| 2 | A sample L26: Client Assignments: Add/Correct/Delete header screen is shown below.  
  ![L26 Screen](image)  
  **Rule:** You must enter the Client ID, the local case number, or the Medicaid Number.  
  • Type the provider’s Component Code in the COMPONENT CODE field.  
  • Type A (Add) in the TYPE OF ENTRY field.  
  • Press Enter.  
  **Result:** The L26: Client Assignments: Add screen is displayed. |
| 3 | A sample L26: Client Assignments: Add screen is shown below.  
  ![L26 Screen](image)  
  **Note:** You can type N in the READY TO ADD? field to take no action and return to the header screen.  
  • Press Enter.  
  **Result:** The header screen is displayed with the message, “Previous Information Added.”  
  ![Header Screen](image) | • Type the requested identifying information in the appropriate fields.  
  • Type the effective date of the new assignment in the EFFECTIVE DATE field.  
  • Type OHFH (Own Home/Family Home) in the LOCATION CODE field.  
  • Type the county code of the new assignment in the COUNTY field.  
  • Type Y in the READY TO ADD? field to submit the data to the system.  
  **Note:** You can type N in the READY TO ADD? field to take no action and return to the header screen.  
  • Press Enter.  
  **Result:** The header screen is displayed with the message, “Previous Information Added.” |
**Client Assignments (L26): Correct**

**Procedure**

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

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

<table>
<thead>
<tr>
<th>Step</th>
<th>View</th>
<th>Action</th>
</tr>
</thead>
</table>
| 1    |      | • Type L26 in the ACT: field of any screen.  
                  • Press Enter.  
                  Result: The **L26: Client Assignments: Add/Correct/Delete** header screen is displayed. |
| 2    | A sample **L26: Client Assignments: Add/Correct/Delete** header screen is shown below.  
                  **01-04-08**  
                  L26: CLIENT ASSIGNMENTS: ADD/CORRECT/DELETE  
                  00061088  
                  PLEASE ENTER ONE OF THE FOLLOWING:  
                  CLIENT ID:  
                  COMPONENT CODE/LOCAL CASE NUMBER:  
                  MED/CHIP NUMBER:  
                  PLEASE ENTER THE FOLLOWING:  
                  TYPE OF ENTRY: **(A/ADD,C/CORRECT,D/DELETE)**  
                  "A" TO CORRECT ERRORS ON EXISTING ASSIGNMENTS ONLY. USE "C" TO ADD A NEW ASSIGNMENT.  
                  (MOVING A CLIENT FROM ONE HOUSE TO ANOTHER IS A NEW ASSIGNMENT, AND MUST BE AN ADD)  
                  ***PRESS ENTER***  
                  ACT: ___ (LBB/MAIL DATA ENTRY HEMI, A/W MAIN HEMI, ILP/SP/OG/DO) |
| 3    | A sample **L26: Client Assignments: Correct** screen is shown below.  
                  **09-24-07**  
                  L26: CLIENT ASSIGNMENTS: ADD/CORRECT  
                  00061085  
                  NAME: CHF BRYANSE  
                  CLIENT ID: 6657  
                  COMPONENT: QEB  
                  LOCATION: 020401616  
                  CONTRACT: 00168085  
                  previous: EFFECTIVE DATE: 01-01-2007  END DATE: 01-01-2007  
                  ASSIGNMENT LOCATION CODE: G16A  
                  COUNTY: BEXAR  
                  CURRENT: EFFECTIVE DATE: 01122007  (MMDPYY)  
                  ASSIGNMENT LOCATION CODE: G16A  
                  COUNTY: BEXAR (SMA/FAMILY RENEWAL)  
                  READY TO CHANGE? **(Y/N)**  
                  ACT: ___ (LBB/MAIL DATA ENTRY HEMI, A/W MAIN HEMI, ILP/SP/OG/DO) |

The screen displays previous enrollment and current assignment information.

**MRA Procedures April 2010 Revised Client Assignments - 93**
## Client Assignments (L26): Delete

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

<table>
<thead>
<tr>
<th>Step</th>
<th>View</th>
<th>Action</th>
</tr>
</thead>
</table>
| 1    |     | • Type **L26** in the ACT: field of any screen.  
      |     | • Press Enter.  
      |     | **Result**: The **L26: Client Assignments: Add/Correct/Delete** header screen is displayed. |
| 2    | A sample **L26: Client Assignments: Add/Correct/Delete** header screen is shown below.  
      |     | • Type the requested identifying information in the appropriate fields.  
      |     | **Rule**: You must enter the Client ID, the local case number, or the Medicaid Number.  
      |     | • Type the provider’s Component Code in the **COMPONENT CODE** field.  
      |     | • Type **D** (Delete) in the **TYPE OF ENTRY** field.  
      |     | • Press Enter.  
      |     | **Result**: The **L26: Client Assignments: Delete** screen is displayed. |
| 3    | A sample **L26: Client Assignments: Delete** screen is shown below.  
      |     | • Type **Y** in the **READY TO DELETE?** field to submit the data to the system.  
      |     | **Note**: You can type **N** in the **READY TO DELETE?** field to take no action and return to the header screen.  
      |     | • Press Enter.  
      |     | **Result**: The header screen is displayed with the message, "Previous Information Deleted." |
Consumer Demographic Update

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

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

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

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

<table>
<thead>
<tr>
<th>Screen</th>
<th>Authority Code</th>
<th>CARE Code</th>
<th>Procedure</th>
</tr>
</thead>
<tbody>
<tr>
<td>Client Name Update</td>
<td>L11</td>
<td>420</td>
<td>Add, change, or delete individual’s name information</td>
</tr>
<tr>
<td>Client Address Update</td>
<td>L12</td>
<td>430</td>
<td>Update individual’s address information</td>
</tr>
<tr>
<td>Client Correspondent Update</td>
<td>L10</td>
<td>431</td>
<td>Update individual’s correspondent information</td>
</tr>
<tr>
<td>Guardian Information Update</td>
<td>L20</td>
<td>_ _</td>
<td>Update individual’s guardian information</td>
</tr>
</tbody>
</table>
Introduction

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

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

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

**Client Name Update (L11): Add**

**Procedure**

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

<table>
<thead>
<tr>
<th>Step</th>
<th>View</th>
<th>Action</th>
</tr>
</thead>
</table>
| 1    | _ _  | - Type L11 in the ACT: field of any screen.  
|      |      | - Press Enter.  
|      |      | Result: The L11: Client Name Update header screen is displayed. |
| 2    | A sample L11: Client Name Update header screen is shown below.  
|      | ![L11: Client Name Update Screenshot](image)  
|      | - Type the requested identifying information in the appropriate fields.  
|      | - Rule: You must enter the Client ID or the local case number.  
|      | - Type the component code of the individual’s current component in the Component Code field.  
|      | - Type A (Add) in the Type of Entry field.  
|      | - Press Enter.  
|      | Result: The L11: Client Name Update screen is displayed. |
| 3    | A sample L11: Client Name Update screen is shown below.  
|      | ![L11: Client Name Update Screenshot](image)  
|      | - Type the information you are updating (last name/suffix, first name, middle name) in the appropriate Add Client Name fields.  
|      | - Type Y in the Ready To Add? field to submit the data to the system.  
|      | - Note: You can type N in the Ready To Add? field to take no action and return to the header screen.  
|      | - Press Enter.  
|      | Result: The L11: Client Name Update header screen is displayed with the message, “Previous Information Added.” |
## Consumer Demographic Update
### Client Name Update (L11): Change

**Procedure**

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

<table>
<thead>
<tr>
<th>Step</th>
<th>View</th>
<th>Action</th>
</tr>
</thead>
</table>
| 1 | _ _ | • Type L11 in the ACT: field of any screen.  
   • Press Enter.  
   **Result:** The L11: Client Name Update header screen is displayed. |
| 2 | A sample L11: Client Name Update header screen is shown below.  
   ![L11: Client Name Update Header Screen](image1)  
   • Type the requested identifying information in the appropriate fields.  
   **Rule:** You must enter the Client ID or the local case number.  
   • Type the component code of the individual’s current component in the Component Code field.  
   • Type C (Change) in the Type of Entry field.  
   • Press Enter.  
   **Result:** The L11: Client Name Update screen is displayed. |
| 3 | A sample L11: Client Name Update screen is shown below.  
   ![L11: Client Name Update Screen](image2)  
   • Type the information you are updating (last name/suffix, first name, middle name) in the appropriate Change Client Name fields.  
   • Type Y in the Ready to Change? field to submit the data to the system.  
   **Note:** You can type N in the Ready to Change? field to take no action and return to the header screen.  
   • Press Enter.  
   **Result:** The L11: Client Name Update header screen is displayed with the message, “Previous Information Changed.” |
Consumer Demographic Update  
Client Name Update (L11): Delete

Procedure

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

<table>
<thead>
<tr>
<th>Step</th>
<th>View</th>
<th>Action</th>
</tr>
</thead>
</table>
| 1    | _ _  | • Type L11 in the ACT: field of any screen.  
     |      | • Press Enter.  
     |      | Result: The L11: Client Name Update header screen is displayed. |
| 2    | A sample L11: Client Name Update header screen is shown below.  
     |      | • Type the requested identifying information in the appropriate fields.  
     |      | Rule: You must enter the Client ID or the local case number.  
     |      | • Type the component code of the individual’s current component in the COMPONENT CODE field.  
     |      | • Type D (Delete) in the TYPE OF ENTRY field.  
     |      | • Press Enter.  
     |      | Result: The L11: Client Name Update screen is displayed. |
| 3    | A sample L11: Client Name Update screen is shown below.  
     |      | Note: If there is more than one name update record, the system displays the most recent name update record.  
     |      | • Type Y in the READY TO DELETE? field to delete the record displayed.  
     |      | • Press Enter.  
     |      | Result: The next record is displayed with the message, “Previous Information Deleted.”  
     |      | • Repeat the action to delete the record displayed or  
     |      | • Type N in the READY TO DELETE? field to take no action and return to the header screen.  
     |      | • Press Enter.  
     |      | Result: The L11: Client Name Update header screen is displayed. |
Consumer Demographic Update
Client Address Update (L12)

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

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

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

<table>
<thead>
<tr>
<th>Step</th>
<th>View</th>
<th>Action</th>
</tr>
</thead>
</table>
| 1    | _ _  | • Type L12 in the ACT: field of any screen.  
      |      | • Press Enter.  
      |      | Result: The L12: Client Address Update header screen is displayed. |
| 2    | A sample L12: Client Address Update header screen is shown below.  
      |      | • Type the requested identifying information in the appropriate fields.  
      |      | Rule: You must enter the Client ID or the local case number.  
      |      | • Type the component code of the individual’s current component in the COMPONENT CODE field.  
      |      | • Press Enter.  
      |      | Result: The L12: Client Address Update screen is displayed. |
| 3    | A sample L12: Client Address Update screen is shown below.  
      |      | • Type the information you are updating (street address, city, state, zip code) in the appropriate Client’s Current Address fields.  
      |      | • Type the date the individual’s address record is being updated in the ADDRESS DATE field.  
      |      | • Type Y in the READY TO UPDATE? field to submit the data to the system.  
      |      | Note: You can type N in the READY TO UPDATE? field to take no action and return to the header screen.  
      |      | • Press Enter.  
      |      | Result: The L12: Client Address Update header screen is displayed with the message, “Previous Information Changed.” |
Consumer Demographic Update  

Client Correspondent Update (L10)

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

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

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

<table>
<thead>
<tr>
<th>Step</th>
<th>View</th>
<th>Action</th>
</tr>
</thead>
</table>
| 1    | _ _  | • Type **L10** in the ACT: field of any screen.  
      |      | • Press **Enter**.  
      |      | Result: The **L10: Client Correspondent Update** header screen is displayed. |
| 2    | A sample **L10: Client Correspondent Update** header screen is shown below.  
      | | • Type the requested identifying information in the appropriate fields.  
      | | **Rule:** You must enter the Client ID or the local case number.  
      | | • Type the component code of the individual’s current component in the **COMPONENT CODE** field.  
      | | • Press **Enter**.  
      | | Result: The **L10: Client Correspondent Update** screen is displayed. |
| 3    | A sample **L10: Client Correspondent Update** screen is shown below.  
      | | • Type Primary Correspondent and/or Secondary Correspondent information (name, relationship, street, telephone, city, state, zip code) in the appropriate **PRIMARY CORRESPONDENT** and/or **SECONDARY CORRESPONDENT** fields.  
      | | **Note:** If you enter a name in the **CORRES. NAME** field, you **must** enter a code for the correspondent’s relationship in the **CORRES. RELATIONSHIP** field. (Refer to the **Screen Fields** section in the back of this guide for Correspondent Relationship codes.)  
      | | • Type **Y** in the **READY TO UPDATE?** field to submit the data to the system.  
      | | **Note:** You can type **N** in the **READY TO UPDATE?** field to take no action and return to the header screen.  
      | | • Press **Enter**.  
      | | Result: The **L10: Client Correspondent Update** header screen is displayed with the message, "**Previous Information Changed."** |
Consumer Demographic Update
Guardian Information Update (L20)

Introduction

The Guardian Information Update process allows the MRA to update information about an individual’s guardian.

Procedure

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

<table>
<thead>
<tr>
<th>Step</th>
<th>View</th>
<th>Action</th>
</tr>
</thead>
</table>
| 1    | -    | • Type L20 in the ACT: field of any screen.  
      |      | • Press Enter.  
      |      | Result: The L20: Guardian Information Update header screen is displayed. |
| 2    | A sample L20: Guardian Information Update header screen is shown below.  
      |      | • Type the requested identifying information in the appropriate fields.  
      |      | Rule: You must type the Client ID, Local Case Number, or Medicaid Number.  
      |      | • Type the component code of the individual’s current component in the COMPONENT CODE field.  
      |      | • Press Enter.  
      |      | Result: The L20: Guardian Information Update header screen is displayed. |
| 3    | A sample L20: Guardian Information Update screen is shown below.  
      |      | In the Guardian’s Name section:  
      |      | • The system displays the guardian’s name if the individual has a guardian. Update the guardian’s name in the name fields, if appropriate.  
      |      | • The system displays *SELF* in the LAST NAME field if the individual does not have a guardian.  
      |      | Rule: If *SELF* is displayed, the individual must have an address on file in the system. Use L12: Client Address Update to verify the individual’s address.  
      |      | • The guardian code in the Type field.  
      |      | If the guardian is someone other than the individual:  
      |      | • Type the guardian’s name in the LAST NAME, LAST NAME SUFFIX, FIRST NAME, and MIDDLE INITIAL fields.  
      |      | • Type the guardian’s current address in the STREET ADDRESS, CITY, STATE, and ZIP CODE fields.  
      |      | • Type the guardian’s telephone number in the PHONE field.  
      |      | • Type Y in the READY TO UPDATE? field to submit the data to the system.  
      |      | Note: You can type N in the READY TO UPDATE? field to take no action and return to the header screen.  
      |      | • Press Enter.  
      |      | Result: The L20: Guardian Information Update header screen is displayed with the message, “Previous Information Changed.” |
Consumer Transfer (L06)

Introduction

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

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

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

Before an individual can transfer, he/she must:

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

MRA Reassignment

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

Suspension of Waiver Services

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

In this Section

The Transfer section has been divided into the following:

- Transfers Involving a Program Provider Only - describes the procedures involved when transferring an individual from one Program Provider another Program Provider or from contract to contract within a Program Provider’s component code. No services are or will be self-directed.

- Transfers Involving a CDSA - describes the procedures involved when transferring an individual from one Program Provider and/or CDSA to another Program Provider and/or CDSA or from contract to contract within a Program Provider’s and/or CDSA’s component code. At least one service is or will be self-directed.
Consumer Transfer (L06), Continued

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

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

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

Completing a transfer requires answering three initial questions on the L06: Consumer Transfer header screen and then, based on those answers, possibly responding to follow-up questions.
L06: Consumer Transfer Header Screen Questions/Follow-up Questions & Answers

Introduction

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

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

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

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

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

<table>
<thead>
<tr>
<th>Scenario A</th>
<th>Individual has a PRGP Only</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Specific Action:</strong></td>
<td><strong>Answers to Initial Questions on the L06 Consumer Transfer Header Screen:</strong></td>
</tr>
<tr>
<td>Change the PRGP contract</td>
<td>Y,N,N</td>
</tr>
<tr>
<td>Keep the current PRGP contract and add a CDSA contract</td>
<td>N,Y,Y (if REH and/or SHL is already on the IPC) N,Y,N (if REH and/or SHL is NOT already on the IPC)</td>
</tr>
<tr>
<td>Change the PRGP contract and add a CDSA contract</td>
<td>Y,Y,Y (if REH and/or SHL is already on the IPC) Y,Y,N (if REH and/or SHL is NOT already on the IPC)</td>
</tr>
</tbody>
</table>
L06: Consumer Transfer Header Screen Questions/Follow-up Questions & Answers, Continued

Introduction, continued

<table>
<thead>
<tr>
<th>Scenario A</th>
<th>Individual has a PRGP Only</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Specific Action:</strong></td>
<td>End all PRGP services &amp; add a CDSA contract</td>
</tr>
<tr>
<td><strong>Answers to Initial Questions on the L06 Consumer Transfer Header Screen:</strong></td>
<td>Y,Y,Y (if REH and/or SHL is already on the IPC)</td>
</tr>
<tr>
<td><strong>Follow-up Question(s) and Answer(s):</strong></td>
<td>Are all PRGP services ending? <strong>Y</strong></td>
</tr>
<tr>
<td><strong>Statement Confirming the Requested Action and Answer:</strong></td>
<td>Based on your answers, the PRGP services are ending, a CDSA contract is being added, and all services will be self-directed. Continue? <strong>Y</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Scenario B</th>
<th>Individual has a CDSA Only</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Specific Action:</strong></td>
<td>Change the CDSA contract</td>
</tr>
<tr>
<td><strong>Answers to Initial Questions on the L06 Consumer Transfer Header Screen:</strong></td>
<td>Y,N,N</td>
</tr>
<tr>
<td><strong>Follow-up Question(s) and Answer(s):</strong></td>
<td>NA</td>
</tr>
<tr>
<td><strong>Statement Confirming the Requested Action and Answer:</strong></td>
<td>NA</td>
</tr>
</tbody>
</table>

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

| Specific Action: | Add a PRGP contract and change the CDSA contract |
| **Answers to Initial Questions on the L06 Consumer Transfer Header Screen:** | Y,Y,Y |
| **Follow-up Question(s) and Answer(s):** | Are all CDSA services ending? **N** |
| **Statement Confirming the Requested Action and Answer:** | Based on your answers, a PRGP contract is being added, the CDSA contract is changing, and at least 1 service will be self-directed. Continue? **Y** |

| Specific Action: | Add a PRGP contract and end the CDSA contract |
| **Answers to Initial Questions on the L06 Consumer Transfer Header Screen:** | Y,Y,Y |
| **Follow-up Question(s) and Answer(s):** | Are all CDSA services ending? **Y** |
| **Statement Confirming the Requested Action and Answer:** | Based on your answers, a PRGP contract is being added, the CDSA services are ending, and no services will be self-directed. Continue? **Y** |
**Scenario C**  
Individual has a PRGP & CDSA

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

<table>
<thead>
<tr>
<th>Scenario C, continued</th>
<th>Answers to Initial Questions on the L06 Consumer Transfer Header Screen</th>
<th>Follow-up Question(s) and Answer(s):</th>
<th>Statement Confirming the Requested Action and Answer</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individual has a PRGP &amp; CDSA</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Specific Action:</strong></td>
<td>Change the PRGP contract and end the CDSA contract</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Y,N,Y</td>
<td>Are you transferring to a different PRGP contract? Y</td>
<td>Based on your answers, the PRGP contract is changing, the CDSA services are ending, and no services will be self-directed. Continue? Y</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Are you transferring to a different CDSA contract? N</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Are you ending the CDSA contract? Y</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Keep the PRGP and CDSA contracts but change a Service Delivery Option (SDO)</td>
<td>N,N,Y</td>
<td>NA</td>
</tr>
</tbody>
</table>
Transfers Involving a Program Provider Only (L06)

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

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

**Before an individual can transfer**, he/she must have:
- a current Level of Care and
- a current IPC

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

<table>
<thead>
<tr>
<th>Step</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1</strong></td>
</tr>
<tr>
<td><strong>2</strong></td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>View</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1</strong></td>
<td>You cannot transfer an individual if she/he is currently on hold status. Before you begin the transfer process, you should access the <strong>C88: Consumer Hold Inquiry</strong> screen to see if the individual has been placed on Hold. • Type <strong>C88</strong> in the <strong>ACT:</strong> field of any screen. • Press <strong>Enter.</strong> Result: The <strong>C88: Consumer Hold Inquiry</strong> header screen is displayed.</td>
</tr>
<tr>
<td><strong>2</strong></td>
<td>A sample <strong>C88: Consumer Hold Inquiry</strong> screen is shown below. • Type the requested identifying information in the appropriate fields. <strong>Rule:</strong> You must enter the Client ID, the local case number, or the Medicaid Number. • Type <strong>T</strong> in the <strong>HOLD TYPE</strong> field. • Type <strong>O</strong> in the <strong>HOLD STATUS</strong> field. • Leave the <strong>OVERRIDES</strong> field blank. <strong>Note:</strong> Permanent Holds cannot be corrected. • Press <strong>Enter.</strong> Result: The <strong>C88: Consumer Hold Inquiry</strong> screen is displayed.</td>
</tr>
</tbody>
</table>
Transfers Involving a Program Provider Only (L06), Continued

Procedure, continued

<table>
<thead>
<tr>
<th>Step</th>
<th>View</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>3</td>
<td>Sample <strong>C88: Consumer Hold Inquiry</strong> screens are shown below. The following screen is displayed when no hold records are found.</td>
<td>• View the data displayed.</td>
</tr>
<tr>
<td></td>
<td><img src="image1.png" alt="Image" /></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>The message, “No Hold Records Found” is displayed</td>
</tr>
<tr>
<td></td>
<td></td>
<td>The individual has been placed on Hold,</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Once the errors have been corrected, access the <strong>C88</strong> screen again to verify that there are no current holds. If all errors have been corrected, the message, “No Hold Records Found” is displayed.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Continue with the transfer process.</td>
</tr>
<tr>
<td></td>
<td></td>
<td><img src="image2.png" alt="Image" /></td>
</tr>
<tr>
<td>4</td>
<td><img src="image3.png" alt="Image" /></td>
<td>• Type <strong>L09</strong> in the ACT: field of any screen. • Press Enter. Result: The <strong>L09: Register Client Update</strong> header screen is displayed.</td>
</tr>
</tbody>
</table>

continued on next page
Procedure, continued

<table>
<thead>
<tr>
<th>Step</th>
<th>View</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>5</td>
<td>A sample <strong>L09: Register Client Update</strong> header screen is shown below.</td>
<td>The MRA must assign a local case number for the receiving Program Provider.</td>
</tr>
<tr>
<td></td>
<td><img src="image1" alt="Sample Header Screen" /></td>
<td>- Type the Client ID in the <strong>CLIENT ID</strong> field.</td>
</tr>
<tr>
<td></td>
<td><img src="image2" alt="Sample Header Screen" /></td>
<td>- Type the <strong>Component Code</strong> of the receiving provider in the <strong>COMPONENT CODE</strong> field.</td>
</tr>
<tr>
<td></td>
<td><img src="image3" alt="Sample Header Screen" /></td>
<td>- Press <strong>Enter</strong>.</td>
</tr>
<tr>
<td></td>
<td><img src="image4" alt="Sample Header Screen" /></td>
<td><strong>Result:</strong> The <strong>L09: Register Client Update</strong> screen is displayed. This screen is used to assign a local case number and update individual information.</td>
</tr>
<tr>
<td></td>
<td><img src="image5" alt="Sample Header Screen" /></td>
<td><strong>Note:</strong> <strong>DO NOT</strong> enter the local case number that you are assigning on the <strong>Header screen</strong>.</td>
</tr>
<tr>
<td>6</td>
<td>A sample <strong>L09: Register Client Update</strong> screen is shown below.</td>
<td>- Type the individual’s local case number obtained from the receiving Program Provider in the <strong>LOCAL CASE NUMBER</strong> field.</td>
</tr>
<tr>
<td></td>
<td><img src="image6" alt="Sample Screen" /></td>
<td><strong>Note:</strong> The <strong>LOCAL CASE NUMBER</strong> field <strong>cannot</strong> be blank.</td>
</tr>
<tr>
<td></td>
<td><img src="image7" alt="Sample Screen" /></td>
<td>- Type updated information in the appropriate fields, if necessary.</td>
</tr>
<tr>
<td></td>
<td><img src="image8" alt="Sample Screen" /></td>
<td>- Type <strong>Y</strong> in the <strong>READY TO UPDATE?</strong> field to submit the data to the system.</td>
</tr>
<tr>
<td></td>
<td><img src="image9" alt="Sample Screen" /></td>
<td>- Press <strong>Enter</strong>.</td>
</tr>
<tr>
<td></td>
<td><img src="image10" alt="Sample Screen" /></td>
<td><strong>Result:</strong> The <strong>L09: Register Client Update</strong> header screen is displayed with the message, “<strong>Previous Information Changed.</strong>”</td>
</tr>
</tbody>
</table>

continued on next page
### Transfers Involving a Program Provider Only (L06), Continued

#### Procedure, continued

<table>
<thead>
<tr>
<th>Step</th>
<th>View</th>
<th>Action</th>
</tr>
</thead>
</table>
| 7 | _ _ | The MRA must now access the **L06: Consumer Transfer** screen to add the transfer record. On the **L09: Register Client Update** header screen:  
  - Type **L06** in the **ACT** field.  
  - Press **Enter**.  
  Result: The **L06: Consumer Transfer: Contract Services: A/C/D** header screen is displayed. |

| 8 | A sample **L06: Consumer Transfer: A/C/D** header screen is shown below. |  
  - Type the requested identifying information in the appropriate fields.  
  **Rule**: You must enter the Client ID, the local case number, or the Medicaid Number.  
  - Type the Component Code of the transferring (current) Program Provider in the **COMPONENT CODE** field.  
  - Type the contract number in the **CONTRACT** field.  
  - Type the transfer effective date in the **TRANSFER EFFECTIVE DATE** field.  
  - Type **A** (Add) in the **TYPE OF ENTRY** field.  
  - Type **Y** (Yes) as the answer to question 1. **CHANGING A PROGRAM PROVIDER OR CDS AGENCY?**  
  - Type **N** (No) as the answer to question 2. **ADDING A PROGRAM PROVIDER OR CDS AGENCY?**  
  - Type **N** (No) as the answer to question 3. **CHANGING SERVICE DELIVERY OPTIONS?**  
  - Press **Enter**.  
  Result: The **L06: Consumer Transfer: Contract/Services: Add** screen is displayed.  
  **continued on next page**

---

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June 2010 Revised  
MRA Procedures
Procedure, continued

<table>
<thead>
<tr>
<th>Step</th>
<th>View</th>
<th>Action</th>
</tr>
</thead>
</table>
| 9    |      | This screen displays services listed on the current IPC, the current service delivery option for each service, the authorized IPC units for the plan year, the total of all paid and unpaid services to the transfer effective date, and any units remaining on IPC to the transfer effective date.  
*Note:* Press the **PF1** key to view column definitions.  
*Note 2:* The transferring Program Provider calculates the amount of units/dollars to be reserved for services that will be provided by them prior to the transfer effective date and/or have been provided by them but not yet claimed and indicates those units/dollars on Form 3617.  
- Type the units/dollars to be reserved in the **TO USE** column.  
*Note 1:* If no units/dollars are entered in the fields of the **TO USE** column, the transferring Program Provider will be prevented from entering any additional claims for the individual.  
*Note 2:* If no units/dollars need to be reserved, enter zeroes in the fields of the **TO USE** column.  
Typing a number greater than 0 represents the amount of units/dollars reserved for the transferring program provider to claim.  
- Type **Y** in the **READY TO ADD?** field.  
- Press **Enter**.  
*Result:* The **L06: Consumer Transfer: Add** screen is displayed.  

continued on next page
Transfers Involving a Program Provider Only (L06), Continued

Procedure, continued

<table>
<thead>
<tr>
<th>Step</th>
<th>View</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>10</td>
<td>A sample <strong>L06: Consumer Transfer: Add</strong> screen is shown below.</td>
<td>• Type the new service county code in the <strong>SERVICE COUNTY</strong> field. • Type the location code in the <strong>LOCATION CODE</strong> field. • Type the residential type in the <strong>RESIDENTIAL TYPE</strong> field, if necessary. <strong>Complete the following fields as they apply to the receiving provider.</strong> • Type the component code of the new Program Provider in the <strong>COMP</strong> field. • Type the local case number in the <strong>LCN</strong> field. • Type the contract number of the new Program Provider in the <strong>CONTRACT NUMBER</strong> field, • Type <strong>Y</strong> in the <strong>READY TO ADD?</strong> field. • Press Enter. Result: A screen containing the transfer effective date is displayed. If the date is incorrect, do not proceed. You must delete the transfer record and begin again. • Press Enter. Result: The <strong>L06: Consumer Transfer: Contract/Services: A/C/D</strong> header screen is displayed with the message “Previous Information Added.”</td>
</tr>
</tbody>
</table>

| 11   | | The MRA must now access the **L02: Individual Plan of Care** screen to enter a transfer IPC for the individual. On the **L06: Consumer Transfer** header screen: • Type **L02** in the **ACT:** field. • Press Enter. Result: The **L02: Individual Plan of Care** header screen is displayed. |

continued on next page
**Transfers Involving a Program Provider Only (L06), Continued**

**Procedure, continued**

<table>
<thead>
<tr>
<th>Step</th>
<th>View</th>
<th>Action</th>
</tr>
</thead>
</table>
| 12   | A sample **L02: Individual Plan of Care** header screen is shown below. | • Type the requested identifying information in the appropriate fields.  
**Rule:** You **must** enter the Client ID, the local case number, or the Medicaid Number.  
• Type the Component Code of the **receiving** provider in the **COMPONENT CODE** field.  
• Type **T** (Transfer) in the **TYPE OF ENTRY** field.  
• Press **Enter.**  
**Result:** The **L02: Individual Plan of Care Entry: Transfer** screen is displayed. |

```
   L02: INDIVIDUAL PLAN OF CARE (CGS 02.0)  UCM00328

   PLEASE ENTER ONE OF THE FOLLOWING:
   CLIENT ID:
   COMPONENT CODE/LOCAL CASE NUMBER: / 
   RESIDENT NUMBER: 

   PLEASE ENTER THE FOLLOWING:
   TYPE OF ENTRY: T=INITIAL R=RENEWAL U=REVISION E=ERROR CORRECTION T=TRANSFER D=DELETE

   PLEASE ENTER FOR REVISION OR ERROR CORRECT OF REVISION:
   REVISION DATE: (MMDDYYYY)

   PLEASE ENTER FOR INITIAL PLANS ONLY:
   BEGIN DATE: (MMDDYYYY)

   *** PRESS ENTER ***

   ACT: (L201/AUTH DATA ENTRY MENU, A/MA MAIN MENU, MIP(FF)/SCHD DOC)  
```

| 13   | A sample **L02: Individual Plan of Care Entry: Transfer** screen is shown below. | You can use this screen to make the adjustments to the IPC that were agreed upon in the Transfer IPC meeting.  
**Note:** You cannot reduce services below what has already been claimed.  
• Type **Y** in the **READY TO CONTINUE?** field.  
• Press **Enter.**  
**Result:** The **L02: Individual Plan of Care Entry: Transfer** screen (screen 2) is displayed. |

```
   L02: INDIVIDUAL PLAN OF CARE (CGS 02.0): TRANSFER UCM00328

   NAME: TERRY, TERRY
   CLIN: N/A 00000000055 CLIENT ID: 18021321
   RES DT: 20120910 RES DT: 20120910 (MMDDYYYY) END DT: 081201

   SERVICE CATEGORY UNITS SERVICE CATEGORY UNITS
   CAN CASE MANAGEMENT 12 HRS CAN ADAPTIVE AIDS 2 DOL
   CAN AIDING AID RE 4 DOL CAN ADAPTED REH 2 AHS
   PS BEHAVIORAL SUPP 10 HRS PS RES PASTER CARE 4 DAYS
   DCH DAILY ADULTILIZATION 24 HRS DCH DCH DENTAL 150 DOL
   DCH DENTAL RAI, FEE 3 DOL DCH DCH DENTAL 1 DOL
   HME HME HME HME 1 DOL HME HME HME HME 1 DOL
   NUR NUR S. NUR 20 HRS NUR NUR S. NUR 20 HRS
   NURS NURS NURS 10 HRS NURS NURS NURS 10 HRS
   PH DR PH DR 10 HRS PH DR DR 10 HRS
   SUPPORTED HD 5 DOL SUPPORTED HD 5 DOL
   SV SOCIAL WORK 10 HRS SV SPEECH/LANGUAGE 10 HRS
   S. S. SUPPORTED S. S. 10 DYS S. S. SUPPORTED S. S. 10 DYS
   SUD SUPPORTED SUD 10 HRS SUD SUD SUD 10 HRS
   SCI SUPPORT SCIC 10 HRS

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

   ACT: ___/FF/AD/A/MA/AUTH DATA ENTRY MENU,A/MA MAIN MENU,MIP(FF)/SCHD DOC)  
```

**Note:** The service units/dollars are cumulative for each IPC year. Therefore, the receiving provider must have an accurate account of the units/dollars for each service that has already been claimed and include those units/dollars on the transfer IPC.

**Example:** If 3 units of NUR have been claimed and the receiving provider plans to provide 6 units of NUR, you would need 9 units for NUR on the transfer IPC.

continued on next page
## Procedure, continued

<table>
<thead>
<tr>
<th>Step</th>
<th>View</th>
<th>Action</th>
</tr>
</thead>
</table>
| 14   | A sample L02: Individual Plan of Care Entry: Transfer screen (screen 2) is shown below. | This screen displays the Program Provider portion of the IPC. Services are *displayed and cannot be changed*.
- Type Y in the READY TO CONTINUE? field.
- Press Enter.
Result: The L02: Individual Plan of Care Entry: Transfer screen (screen 3) is displayed. |

![Program Provider Estimated Annual Total: 36,192.76 Total Annual Cost: 36,192.76 Conflict Ceiling: 80,792.48](image)

| 15   | A sample L02: Individual Plan of Care Entry: Transfer screen (screen 3) is shown below. | - Type Y (Yes) or N (No) to indicate whether any services are staffed by a relative or guardian.
- You must change the date in the DATE fields. The dates must be after the previous REVISE DATE and on or before the current TRANSFER date.
- Change the names if necessary.
- Type Y in the READY TO TRANSFER? field to submit the data to the system.
- Press Enter.
Result: You are informed that the transfer IPC has been entered and that you must return to the L06 screen to complete the transfer.
- Press Enter.

The L02: Individual Plan of Care header screen is displayed with the message, "Transfer Plan has been Added."

| 16   | - - | The MRA must now access the L06: Consumer Transfer screen to accept the transfer data entry. On the L02: Individual Plan of Care header screen: 
- Type L06 in the ACT: field.
- Press Enter.
Result: The L06: Consumer Transfer: Contract Services: A/C/D header screen is displayed. |

continued on next page
### Transfers Involving a Program Provider Only (L06), Continued

**Procedure, continued**

<table>
<thead>
<tr>
<th>Step</th>
<th>View</th>
<th>Action</th>
</tr>
</thead>
</table>
| 17   | A sample **L06: Consumer Transfer** header screen is shown below. | • Type the requested identifying information in the appropriate fields.  
|      | **[Image](image1.png)** | Rule: You must enter the Client ID, the local case number, or the Medicaid Number.  
|      | **[Image](image2.png)** | • Type the Component Code of the *receiving* provider in the COMPONENT CODE field.  
|      | **[Image](image3.png)** | • Type the contract number in the CONTRACT field.  
|      | **[Image](image4.png)** | • Type the transfer effective date in the TRANSFER EFFECTIVE DATE field.  
|      | **[Image](image5.png)** | • Type C (Change) in the TYPE OF ENTRY field.  
|      | **[Image](image6.png)** | Note: **DO NOT** attempt to answer the three questions on the header screen for this action. **Leave the fields blank.**  
|      | **[Image](image7.png)** | • Press Enter.  
|      | **[Image](image8.png)** | Result: The L06: Consumer Transfer: Change screen is displayed.  
| 18   | A sample **L06: Consumer Transfer: Change** screen is shown below. | • Type Y in the TRANSFER ACCEPTED field.  
|      | **[Image](image9.png)** | • Type the name of the person accepting the transfer data entry in the By field.  
|      | **[Image](image10.png)** | • If the:  
|      | **[Image](image11.png)** | - Transfer will occur in the future, type the date of data entry in the Date field.  
|      | **[Image](image12.png)** | - Transfer occurred in the past, type the date of the transfer in the Date field.  
|      | **[Image](image13.png)** | • Type Y in the READY TO CHANGE? field.  
|      | **[Image](image14.png)** | • Press Enter.  
|      | **[Image](image15.png)** | Result: A screen containing the transfer effective date is displayed. If the date is incorrect, the entire transfer record must be deleted and the transfer must be re-entered.  
|      | **[Image](image16.png)** | • Press Enter.  
|      | **[Image](image17.png)** | Result: The sample L06: Consumer Transfer: **Contract Services: A/C/D** header screen is displayed with the message, “Previous Information Changed.”  

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

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

Use the **A63** screen to view the status of the transfer.
Transfers Involving a CDSA

Introduction

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

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

**Before an individual can transfer,** he/she must have:
- a current Level of Care and
- a current IPC

Procedure

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

<table>
<thead>
<tr>
<th>Step</th>
<th>View</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td></td>
<td>You cannot transfer an individual if s/he is currently on hold status. Before you begin the transfer process, you should access the <strong>C88: Consumer Hold Inquiry</strong> screen to see if the individual has been placed on Hold.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Type <strong>C88</strong> in the <strong>ACT:</strong> field of any screen.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Press <strong>Enter</strong>.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Result: The <strong>C88: Consumer Hold Inquiry</strong> screen is displayed.</td>
</tr>
<tr>
<td>2</td>
<td>A sample <strong>C88: Consumer Hold Inquiry</strong> screen is shown below.</td>
<td>• Type the requested identifying information in the appropriate fields.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Rule: You must enter the Client ID, the local case number, or the Medicaid Number.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Type the transferring provider’s component code in the <strong>COMPONENT CODE</strong> field.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Type <strong>T</strong> in the <strong>HOLD TYPE</strong> field.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Type <strong>O</strong> in the <strong>HOLD STATUS</strong> field.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Leave the <strong>OVERRIDES</strong> field blank.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Note: Permanent Holds cannot be corrected.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Press <strong>Enter</strong>.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Result: The <strong>C88: Consumer Hold Inquiry</strong> screen is displayed.</td>
</tr>
</tbody>
</table>

continued on next page
## Transfers Involving a CDSA, Continued

### Procedure, continued

<table>
<thead>
<tr>
<th>Step</th>
<th>View</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>3</td>
<td>Sample <strong>C88: Consumer Hold Inquiry</strong> screens are shown below. The following screen is displayed when no hold records are found.</td>
<td>• View the data displayed.</td>
</tr>
</tbody>
</table>

**C88: Consumer Hold Inquiry**

- **06-22-10**
- **C88: CONSUMER HOLD INQUIRY-BOTH TEMP AND PERM HOLDS**
- **COMP: 06F CLIENT ID: 11822540 TEMP HOLD STATUS: ALL**

```
+------------------------------------------+
| 06-22-10 C88: CONSUMER HOLD INQUIRY-BOTH TEMP AND PERM HOLDS COMP: 06F CLIENT ID: 11822540 TEMP HOLD STATUS: ALL |
| +------------------------------------------+|
| CLIENT NAME: MOUNTAIN, ROCKY |
| CLIENT ID: 11822540 |
| TEMP HOLD BEGIN DATE: 06-21-10 |
| TEMP HOLD END DATE: 06-21-10 |
| REASON FOR HOLD: IFG EXCEEDS AUTHORIZED AMOUNT |
| TOTAL CONSUMERS: 1 |
```

The following screen is displayed when a hold record is found.

<table>
<thead>
<tr>
<th>06-14-10</th>
<th>C88: CONSUMER HOLD INQUIRY-BOTH TEMP AND PERM HOLDS</th>
<th><strong>C88</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>CLIENT NAME: MOUNTAIN, ROCKY</td>
<td></td>
<td></td>
</tr>
<tr>
<td>CLIENT ID: 11822540</td>
<td></td>
<td></td>
</tr>
<tr>
<td>TEMP HOLD BEGIN DATE: 06-21-10</td>
<td></td>
<td></td>
</tr>
<tr>
<td>TEMP HOLD END DATE: 06-21-10</td>
<td></td>
<td></td>
</tr>
<tr>
<td>REASON FOR HOLD: IFG EXCEEDS AUTHORIZED AMOUNT</td>
<td></td>
<td></td>
</tr>
<tr>
<td>TOTAL CONSUMERS: 1</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

- If… Then…
  - The message, “No Hold Records Found” is displayed
    - Proceed with the transfer.
  - The individual has been placed on Hold,
    - You **must** correct the error **before** you proceed with the transfer.
  - Once the errors have been corrected, access the **C88** screen again to verify that there are no current holds. If all errors have been corrected, the message, “No Hold Records Found” is displayed.
  - Continue with the transfer process.

<table>
<thead>
<tr>
<th>4</th>
<th>-- --</th>
<th>• Type <strong>L09</strong> in the ACT: field of any screen.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>• Press <strong>Enter</strong>.</td>
</tr>
<tr>
<td></td>
<td></td>
<td><strong>Result:</strong> The <strong>L09: Register Client Update</strong> header screen is displayed.</td>
</tr>
</tbody>
</table>

---

MRA Procedures  
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### Transfers Involving a CDSA, Continued

Procedure, continued

<table>
<thead>
<tr>
<th>Step</th>
<th>View</th>
<th>Action</th>
</tr>
</thead>
</table>
| 5    | A sample **L09: Register Client Update** header screen is shown below. | The MRA must assign a local case number for the receiving Program Provider and/or CDSA.  
- Type the Client ID in the **CLIENT ID** field.  
- Type the Component Code of the *receiving* provider in the **COMPONENT CODE** field.  
- Press **Enter**.  
**Result:** The **L09: Register Client Update** screen is displayed. This screen is used to assign a local case number and update information, if necessary.  
**Note 1:** *DO NOT* enter the local case number that you are assigning on the header screen.  
**Note 2:** You must repeat this step for each receiving Program Provider and/or CDSA. |
| 6    | A sample **L09: Register Client Update** screen is shown below. | Type the individual’s local case number obtained from the receiving provider and/or CDSA in the **LOCAL CASE NUMBER** field.  
- Type updated information in the appropriate fields, if necessary.  
- Type **Y** in the **READY TO UPDATE?** field to submit the data to the system.  
- Press **Enter**.  
**Result:** The **L09: Register Client Update** header screen is displayed with the message, “Previous Information Changed.”  
**Note:** You must repeat this step for each receiving Program Provider and/or CDSA. |

continued on next page
Transfers Involving a CDSA, Continued

Procedure, continued

<table>
<thead>
<tr>
<th>Step</th>
<th>View</th>
<th>Action</th>
</tr>
</thead>
</table>
| 7    | The MRA must now access the **L06: Consumer Transfer** screen to add the transfer record. On the **L09: Register Client Update** header screen:  
• Type **L06** in the **ACT:** field.  
• Press Enter. Result: The **L06: Consumer Transfer: Contract Services:** **A/C/D** header screen is displayed. |
| 8    | A sample **L06: Consumer Transfer: A/C/D** header screen is shown below.  

```
06-23-18  L06:CONSUMER TRANSFER: CONTRACT SERVICES: A/C/D (CDS) AGENCY
PLEASE ENTER ONE OF THE FOLLOWING:
   CLIENT ID: __________
   COMPONENT CODE/LOCAL CASE NUMBER: __________
   INDICATOR NUMBER: _____

PLEASE ENTER THE FOLLOWING:
   CONTRACT NUMBER: __________
   TRANSFER EFFECTIVE DATE: __________
   TYPE OF ENTRY: _ (A/ADD),C/CHANGE,D/DELETE)

   FOR ADD ONLY:
1. CHANGING/ENDING PROGRAM PROVIDER OR CDSA AGENCY? _ (Y/N)
2. ADDING A PROGRAM PROVIDER OR CDSA AGENCY? _ (Y/N)
3. CHANGING SERVICE DELIVERY OPTIONS?
   Refer to the charts in this section for help in answering the questions correctly.

   Press Enter. Result: A screen containing follow up questions is displayed. |
```

continued on next page
Transfers Involving a CDSA, Continued

Procedure, continued

<table>
<thead>
<tr>
<th>Step</th>
<th>View</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>9</td>
<td>A sample screen is shown below. In this example, the individual is</td>
<td>• Answer Y or N to each question and press Enter after each question.</td>
</tr>
<tr>
<td></td>
<td>changing CDSAs and the questions on the header screen were</td>
<td>Refer to the charts in this section for help in answering the questions</td>
</tr>
<tr>
<td></td>
<td>answered Y N N.</td>
<td>correctly.</td>
</tr>
<tr>
<td></td>
<td><code>$ARE YOU TRANSFERRING TO A DIFFERENT PROGRAM PROVIDER CONTRACT? y/n</code></td>
<td>• Verify that the last statement is correct.</td>
</tr>
<tr>
<td></td>
<td><code>$ARE YOU TRANSFERRING TO A DIFFERENT CDSA CONTRACT? y/n</code></td>
<td></td>
</tr>
<tr>
<td></td>
<td><code>$ARE ALL PROGRAM PROVIDER SERVICES ENDING Y/N</code></td>
<td></td>
</tr>
<tr>
<td></td>
<td>BASED ON YOUR ANSWERS, THE PROGRAM PROVIDER'S CONTRACT IS NOT</td>
<td></td>
</tr>
<tr>
<td></td>
<td>CHANGING, THE CDSA CONTRACT IS CHANGING, AND AT LEAST 1 SERVICE</td>
<td></td>
</tr>
<tr>
<td></td>
<td>WILL BE SELF DIRECTED.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>&gt; y</td>
<td></td>
</tr>
</tbody>
</table>

If the statement is...

<table>
<thead>
<tr>
<th>Correct</th>
<th>Then...</th>
</tr>
</thead>
<tbody>
<tr>
<td>Type Y.</td>
<td>Press Enter.</td>
</tr>
<tr>
<td>Result:</td>
<td>The L06: Consumer Transfer: Contract/Services: Add screen is displayed.</td>
</tr>
<tr>
<td></td>
<td>Continue with Step 10.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Incorrect</th>
<th>Then...</th>
</tr>
</thead>
<tbody>
<tr>
<td>Type N.</td>
<td>Press Enter.</td>
</tr>
<tr>
<td>Result:</td>
<td>The L06: Consumer Transfer: A/C/D header screen is displayed with the</td>
</tr>
<tr>
<td></td>
<td>information you just entered.</td>
</tr>
<tr>
<td></td>
<td>Check the information and make any necessary changes.</td>
</tr>
<tr>
<td></td>
<td>Press Enter.</td>
</tr>
<tr>
<td></td>
<td>Repeat this step.</td>
</tr>
</tbody>
</table>

continued on next page
**Procedural Instructions (continued)**

<table>
<thead>
<tr>
<th>Step</th>
<th>View</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>10</td>
<td>A sample <strong>L06: Consumer Transfer: Contract/Services: Add</strong> screen is shown below.</td>
<td></td>
</tr>
</tbody>
</table>

![Sample L06 screen](image)

**This screen displays services listed on the current IPC, the current service delivery option for each service, the authorized IPC units for the plan year, the total of all paid and unpaid services to the transfer effective date, and any units remaining on IPC to the transfer effective date.**

**Note:** Press the **PF1** key to view column definitions.

**Note 2:** The transferring program provider and/or CDSA calculates the amount of units/dollars to be reserved for services that will be provided by them prior to the transfer effective date and/or have been provided by them but not yet claimed and indicates those units/dollars on Form 3617.

- **Type** the units/dollars to be reserved in the **TO USE** column. Enter **NA** if the service is not impacted by the transfer.

  **Note 1:** If no units/dollars are entered in the fields of the **TO USE** column, the transferring Program Provider and/or CDSA will be prevented from entering any additional service claims for the individual.

  **Note 2:** If no units/dollars need to be reserved, enter zeroes in the fields of the **TO USE** column.

**Typing:**

- **0** indicates that this service is being transferred to a new contract or changing to a new SDO and no units/dollars are being reserved.

- **A number greater than 0** represents the amount of units/dollars reserved for the transferring program provider and/or CDSA to claim.

- **NA** indicates that the service is not included in the transfer.

- **Type** the receiving Program Provider and/or CDSA’s service delivery option (P - Program Provider or C - CDSA) for the service after the transfer in the **NEW SDO** field.

**Note:** You may require two screens to list all services. CDS services will list units and dollars.

- **Type** **Y** in the **READY TO ADD?** field.

- **Press** Enter.

**Result:** The **L06: Consumer Transfer: Add** screen is displayed.  

---

*Continued on next page*
## Transfers Involving a CDSA, Continued

### Procedure, continued

<table>
<thead>
<tr>
<th>Step</th>
<th>View</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>11</td>
<td></td>
<td>- Type the new service county code in the SERVICE COUNTY field.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Type the location code in the LOCATION CODE field.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Type the residential type in the RESIDENTIAL TYPE field.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Complete the following fields as they apply to the receiving provider(s).</td>
</tr>
<tr>
<td></td>
<td></td>
<td><strong>If the individual is transferring to a different Program Provider or adding a Program Provider:</strong></td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Type the component code of the new Program Provider in the COMP field.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Type the local case number in the LCN field.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Type the contract number of the new Program Provider in the CONTRACT NUMBER field.</td>
</tr>
<tr>
<td></td>
<td></td>
<td><strong>If the individual is transferring to a different CDSA or adding a CDSA:</strong></td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Type the component code of the new CDSA in the COMP field.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Type the local case number in the LCN field.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Type the contract number of the new CDSA in the CONTRACT NUMBER field.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Type Y in the READY TO ADD? field.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Press Enter.</td>
</tr>
<tr>
<td></td>
<td></td>
<td><strong>Result:</strong> A screen containing the transfer effective date is displayed. If the date is incorrect, do not proceed. You must delete the transfer record and begin again.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Press Enter.</td>
</tr>
<tr>
<td></td>
<td></td>
<td><strong>Result:</strong> The L06: Consumer Transfer: Contract/Services: A/C/D header screen is displayed with the message “Previous Information Added.”</td>
</tr>
<tr>
<td>12</td>
<td></td>
<td>The MRA must now access the L02: Individual Plan of Care screen to enter a transfer IPC for the individual.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>On the L06: Consumer Transfer header screen:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Type L02 in the ACT: field.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Press Enter.</td>
</tr>
<tr>
<td></td>
<td></td>
<td><strong>Result:</strong> The L02: Individual Plan of Care header screen is displayed.</td>
</tr>
</tbody>
</table>

continued on next page
Transfers Involving a CDSA, Continued

Procedure, continued

<table>
<thead>
<tr>
<th>Step</th>
<th>View</th>
<th>Action</th>
</tr>
</thead>
</table>
| 13   | L02: Individual Plan of Care header screen is shown below. | • Type the requested identifying information in the appropriate fields.  
**Rule:** You must enter the Client ID, the local case number, or the Medicaid Number. 
• Type the Component Code of the receiving provider in the Component Code field.  
• Type T (Transfer) in the Type of Entry field. 
• Press Enter.  
**Result:** The L02: Individual Plan of Care Entry: Transfer screen is displayed. |

| 14   | L02: Individual Plan of Care Entry: Transfer screen is shown below. | You can use this screen to make the adjustments to the IPC that were agreed upon in the Transfer IPC meeting.  
**Note:** You cannot reduce services below what has already been claimed.  
• Type Y in the Ready to Continue? field. 
• Press Enter.  
**Result:** The L02: Individual Plan of Care Entry: Transfer screen (screen 2) is displayed. |

Note: The service units/dollars are cumulative for each IPC year. Therefore, the receiving provider must have an accurate account of the units/dollars for each service that has already been claimed and include those units/dollars on the transfer IPC.

Example: If 3 units of NUR have been claimed and the receiving provider plans to provide 6 units of NUR you would need 9 units of NUR on the transfer IPC.

continued on next page
## Transfers Involving a CDSA, Continued

### Procedure, continued

<table>
<thead>
<tr>
<th>Step</th>
<th>View</th>
<th>Action</th>
</tr>
</thead>
</table>
| 15   | A sample **L02: Individual Plan of Care Entry: Transfer** screen (screen 2) is shown below. | This screen displays the CDS portion of the IPC. Services currently being self-directed and new services added to the plan which are eligible to be self-directed are displayed on this screen. **Note:** All services that are self-directed contain a V at the end of the service abbreviation on this screen. For example, the service abbreviation for Respite is RE. If that service is self-directed, the service abbreviation becomes REV.  
- Type **N** in the **CALCULATE?** field.  
- Type **Y** in the **READY TO CONTINUE?** field.  
- Press **Enter**.  
**Result:** The **L02: Individual Plan of Care Entry: Transfer** screen (screen 3) is displayed. |
| 16   | A sample **L02: Individual Plan of Care Entry: Transfer** screen (screen 3) is shown below. | This screen displays the Program Provider portion of the IPC. Services not being self-directed are *displayed and cannot be changed*.  
- Type **Y** in the **READY TO CONTINUE?** field.  
- Press **Enter**.  
**Result:** The **L02: Individual Plan of Care Entry: Transfer** screen (screen 4) is displayed. |

---

Continued on next page
### Transfers Involving a CDSA, Continued

#### Procedure, continued

<table>
<thead>
<tr>
<th>Step</th>
<th>View</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>17</td>
<td>A sample L02: Individual Plan of Care Entry: Transfer screen (screen 4) is shown below.</td>
<td></td>
</tr>
</tbody>
</table>

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The MRA must now access the L06: Consumer Transfer screen to accept the transfer data entry. On the L02: Individual Plan of Care header screen:

- Type L06 in the Act: field.
- Press Enter.

**Result:** The L06: Consumer Transfer: Contract Services: A/C/D header screen is displayed.

- Type the requested identifying information in the appropriate fields.
- Rule: You must enter the Client ID, the local case number, or the Medicaid Number.
- Type the Component Code of the receiving provider in the COMPONENT CODE field.
- Type the contract number in the CONTRACT field.
- Type the transfer effective date in the TRANSFER EFFECTIVE DATE field.
- Type C (Change) in the TYPE OF ENTRY field.
- Type **Do Not** attempt to answer the three questions on the header screen for this action. Leave the fields blank.
- Press Enter.

**Result:** The L06: Consumer Transfer: Change screen is displayed.

continued on next page
Transfers Involving a CDSA, Continued

Procedure, continued

<table>
<thead>
<tr>
<th>Step</th>
<th>View</th>
<th>Action</th>
</tr>
</thead>
</table>
| 20   | A sample **L06: Consumer Transfer: Change** screen is shown below. | - Type **Y** in the **TRANSFER ACCEPTED** field.  
- Type the name of the person accepting the transfer data entry in the **By** field.  
- If the:  
  - Transfer will occur in the future, type the date of data entry in the **Date** field.  
  - Transfer occurred in the past, type the date of the transfer in the **Date** field.  
- Type **Y** in the **READY TO CHANGE?** field.  
- Press **Enter**.  
  **Result:** A screen containing the transfer effective date is displayed. If the date is incorrect, the entire transfer record must be deleted and the transfer must be re-entered.  
- Press **Enter**.  
  **Result:** The sample **L06: Consumer Transfer: Contract Services: A/C/D** header screen is displayed with the message, “**Previous Information Changed.**” |

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

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

Use the **A63** screen to view the status of the transfer.
Critical Incident Data (686) – HCS

Introduction

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

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

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

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

---

Reportable Data

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

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

continued on next page
Reportable Data, continued

<table>
<thead>
<tr>
<th>Term</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Behavior Intervention Plan</td>
<td>A behavior intervention plan is reported if it authorizes a personal, mechanical or psychoactive medication, as defined below, for an individual.</td>
</tr>
<tr>
<td>Authorizing Restraint</td>
<td>- <strong>Personal restraint</strong> - the application of pressure, except physical guidance or prompting of brief duration that restricts the free movement of part or all of an individual’s body.</td>
</tr>
<tr>
<td></td>
<td>- <strong>Mechanical restraint</strong> - the use of a device that restricts the free movement of part or all of an individual’s body. Such a device includes an anklet, a wristlet, a camisole, a helmet with fasteners, a mitt with fasteners, a posey, a waist strap, a head strap, and a restraining sheet. Such a device does not include one used to provide support for functional body position or proper balance, such as a wheelchair belt, or one used for medical treatment, such as a helmet to prevent injury during a seizure.</td>
</tr>
<tr>
<td></td>
<td>- <strong>Psychoactive medication</strong> - the use of a chemical, including a pharmaceutical, through topical application, oral administration, injection, or other means, to control an individual’s activity and which is not a standard treatment for the individual’s medical or psychiatric condition.</td>
</tr>
<tr>
<td>Emergency Personal Restraint</td>
<td>An emergency personal restraint is reported when the Program Provider uses a personal restraint, as defined above, and such restraint is not authorized in a written behavior intervention plan approved by the individual’s IDT.</td>
</tr>
<tr>
<td>Emergency Mechanical Restraint</td>
<td>An emergency mechanical restraint is reported when the Program Provider uses a mechanical restraint, as defined above, and such restraint is not authorized in a written behavior intervention plan approved by the individual’s IDT.</td>
</tr>
<tr>
<td>Emergency Psychoactive Medication</td>
<td>An emergency psychoactive medication is reported when the Program Provider uses a psychoactive medication, as defined above and such restraint is not authorized in a written behavior intervention plan approved by the individual’s IDT.</td>
</tr>
<tr>
<td>Individual Requiring Emergency</td>
<td>An individual is reported as requiring emergency restraint if the individual is restrained (by either personal or mechanical restraint or psychoactive medication) at least once during a calendar month. If an individual is restrained more than once during a calendar month, the individual is reported only once for that month.</td>
</tr>
<tr>
<td>Restraint Related Injury</td>
<td>A restraint related injury is a serious injury sustained by an individual that is clearly related to the application of a personal restraint, an emergency mechanical restraint, or an emergency psychoactive medication administered to an individual. Reportable injuries in this category are not due to self-injury that occurred prior to the application of restraint. Serious injuries sustained during the application of a restraint that are investigated by DFPS as an allegation of abuse, neglect or exploitation must be included in CIRS reporting for this category.</td>
</tr>
</tbody>
</table>
Critical Incident Data (686): Add – HCS

Procedure

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

<table>
<thead>
<tr>
<th>Step</th>
<th>View</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>• Type 686 in the ACT: field of any screen. • Press Enter. Result: The 686: Critical Incident Data: Add/Change/Delete header screen is displayed.</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>A sample 686: Critical Incident Data: Add/Change/Delete header screen is shown below.</td>
<td>Your component code is displayed based on your logon account number. • Type the month and year being reported in the MONTH AND YEAR field. (MMYYYY format) • Type the contract number in the CONTRACT NUMBER field. • Type A (Add) in the TYPE OF ENTRY field. • Press Enter. Result: The 686: Critical Incident Data: Add screen is displayed.</td>
</tr>
</tbody>
</table>

continued on next page
### Procedure, continued

<table>
<thead>
<tr>
<th>Step</th>
<th>View</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>3</td>
<td>A sample 686: Critical Incident Data: Add screen is shown below.</td>
<td>The contract number that was entered on the header screen is displayed but can be changed.</td>
</tr>
</tbody>
</table>

![Screen Screenshot](image)

- Type the contract number in the **CONTRACT NUMBER** field, if the contract for which you are entering data is other than the one entered on the header screen.
- Type the number of medication errors during the report month for every person served in your contract in the **MEDICATION ERRORS** field.
- Type the number of serious injuries during the report month for every person served in your contract in the **SERIOUS INJURIES** field.
- Type the number of behavior intervention plans authorizing personal, mechanical, or psychoactive medication restraint during the report month in the **BEHAVIOR INTERVENTION PLANS AUTHORIZING RESTRAINT** field.

#### Number Of Emergency Restraints Used
- Type the number of emergency restraints used by category during the report month in the **PERSONAL RESTRAINTS**, **MECHANICAL RESTRAINTS**, and **PSYCHOACTIVE MEDICATION** fields.
- Type the total number of emergency restraints used in the **TOTAL** field.

#### Number Of Individuals Requiring Emergency Restraint
- Type the number of individuals requiring emergency restraint during the report month in the **PERSONAL RESTRAINTS**, **MECHANICAL RESTRAINTS**, and **PSYCHOACTIVE MEDICATION** fields.
- Type the total number of individuals requiring emergency restraints in the **TOTAL** field.

#### Number Of Restraint Related Injuries
- Type the number of restraint related injuries during the report month in the **PERSONAL RESTRAINTS**, **MECHANICAL RESTRAINTS**, and **PSYCHOACTIVE MEDICATION** fields.
- Type the total number of restraint related injuries in the **TOTAL** field.
- Type Y in the **READY TO ADD?** field.
- Press **Enter**.

**Result:** The screen is redisplayed with cleared fields to allow for the entry of data for additional contracts, and the message, “**Previous Information Added**” is displayed.

- Repeat this step for all contracts.

---

See the note and example on the following page.

---

The top of the screen displays the component code and name, the contract number for which you are reporting incidents, and the incident month and year. In this example, 0 of 14 Contracts Entered is displayed at the top of the screen. As data is entered for each contract, the screen displays the total number of contracts for the component and the number of that total that has been entered.

The middle portion of the screen provides fields for you to enter the number of errors, injuries, and restraint information. This section includes RSS (Residential Support Services), SL (Supervised Living), OTHER (Foster/Companion care and individual living in own home or family home), and TOTAL fields. You will enter the following information:

**Number Of Emergency Restraints Used:**
These fields include the total number of times a restraint was used in each category. You must manually add the numbers and enter the total in the TOTAL fields.

**Number Of Individuals Requiring Emergency Restraint:**
These fields include the total number of individuals who were restrained in each category. You must manually add the numbers and enter the total in the TOTAL fields.

**Number Of Restraint Related Injuries:**
These fields include the total number of injuries that were related to a restraint incident in each category. You must manually add the numbers and enter the total in the TOTAL fields.

See the note and example on the following page.
Critical Incident Data (686): Add – HCS, Continued

<table>
<thead>
<tr>
<th>Step</th>
<th>View</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>3 cont.</td>
<td><strong>Note:</strong> Zeroes must be entered in the fields on this screen when there is no reportable data for that month. <strong>Data must be entered monthly.</strong></td>
<td>When all contracts have been entered, type N in the READY TO ADD? field and press Enter to return to the header screen.</td>
</tr>
</tbody>
</table>

Example screen:

<table>
<thead>
<tr>
<th>Component Code/Name:</th>
<th>686: CRITICAL INCIDENT DATA:ADD</th>
<th>HCSF005E1</th>
</tr>
</thead>
<tbody>
<tr>
<td>Contract Number:</td>
<td>0018067555</td>
<td>0 of 4 contracts entered</td>
</tr>
<tr>
<td>Total number of:</td>
<td>Medication errors: 2</td>
<td>Serious Injuries: 1</td>
</tr>
<tr>
<td>Number of Emergency Restraints Used:</td>
<td>RSS</td>
<td>SL</td>
</tr>
<tr>
<td>Personal Restraints:</td>
<td>4</td>
<td>2</td>
</tr>
<tr>
<td>Mechanical Restraints:</td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td>Psychotropic Medication:</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Number of Individuals requiring Emergency Restraint:</td>
<td>Personal Restraints:</td>
<td>1</td>
</tr>
<tr>
<td>Mechanical Restraints:</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Psychotropic Medication:</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Number of Restraint Related Injuries:</td>
<td>Emergency Personal Restraints:</td>
<td>1</td>
</tr>
<tr>
<td>Emergency Mechanical Restraints:</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Emergency Psychotropic Medication:</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Ready to Add?</td>
<td>Y (VM)</td>
<td></td>
</tr>
</tbody>
</table>

**Example:** The following describes the data displayed on the sample screen on the left side of the page.

**Number of Emergency Restraints** section:
- John is in Residential Support Services and has had four personal restraints in a month. You would type 4 in the PERSONAL RESTRAINTS: RSS field.
- Sally is in Supervised Living and has had two personal restraints in a month. You would type 2 in the PERSONAL RESTRAINTS: SL field, and Type 6 in the TOTAL field.
- Bob is in Residential Support Services and has had two mechanical restraints in a month. You would type 2 in the MECHANICAL RESTRAINTS: RSS field and 2 in the TOTAL field.

**Number of Individuals Requiring Emergency Restraint** section:
- Even though John has had 4 and Sally has had 2 personal restraints, this field is counting individuals, so you would type 1 in the PERSONAL RESTRAINTS: RSS field, 1 in the SL field, and 2 in the TOTAL field. Bob has had two mechanical restraints, but you would type 1 in the MECHANICAL RESTRAINTS: RSS field and 1 in the TOTAL field.

**Number of Restraint Related Injuries** section:
- One of Bob’s restraints resulted in a restraint related injury, so you would type 1 in the MECHANICAL RESTRAINTS: RSS field and 1 in the TOTAL field.

**Important:** Remember that you must type zeroes in all fields that have no critical incident data to be reported.
Critical Incident Data (686): Change – HCS

Procedure

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

<table>
<thead>
<tr>
<th>Step</th>
<th>View</th>
<th>Action</th>
</tr>
</thead>
</table>
| 1    |      | • Type 686 in the ACT: field of any screen.  
      |      | • Press Enter.  
      |      | Result: The 686: Critical Incident Data: Add/Change/Delete header screen is displayed. |
| 2    | A sample 686: Critical Incident Data: Add/Change/Delete header screen is shown below. | Your component code is displayed based on your logon account number.  
      |      | • Type the month and year being reported in the MONTH AND YEAR field. (MMYYYY format)  
      |      | • Type the contract number in the CONTRACT NUMBER field.  
      |      | • Type C (Change) in the TYPE OF ENTRY field.  
      |      | • Press Enter.  
      |      | Result: The 686: Critical Incident Data: Change screen is displayed. |
| 3    | A sample 686: Critical Incident Data: Change screen is shown below. | • Type changes to the critical incident data in the appropriate fields.  
      |      | • Type Y in the READY TO CHANGE? field to submit the data to the system.  
      |      | • Press Enter.  
      |      | Result: The header screen is displayed with the message, “Previous Information Changed.” |
Critical Incident Data (686): Delete – HCS

Procedure

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

<table>
<thead>
<tr>
<th>Step</th>
<th>View</th>
<th>Action</th>
</tr>
</thead>
</table>
| 1    | _ _  | • Type 686 in the ACT: field of any screen.  
|      |      | • Press Enter.  
|      |      | Result: The 686: Critical Incident Data: Add/Change/Delete header screen is displayed. |
| 2    | A sample 686: Critical Incident Data: Add/Change/Delete header screen is shown below.  
|      | Your component code is displayed based on your logon account number.  
|      | • Type the month and year being reported in the MONTH AND YEAR field. (MMYYYY format)  
|      | • Type the contract number in the CONTRACT NUMBER field.  
|      | • Type D (Delete) in the TYPE OF ENTRY field.  
|      | • Press Enter.  
|      | Result: The 686: Critical Incident Data: Delete screen is displayed. |
| 3    | A sample 686: Critical Incident Data: Delete screen is shown below.  
|      | • Type Y in the READY TO DELETE? field to submit the data to the system.  
|      | • Press Enter.  
|      | Result: The header screen is displayed with the message, “Previous Information Deleted.” |
Critical Incident Data: Inquiry (286) – HCS

Introduction

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

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

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

Requesting Reports

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

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

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

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

continued on next page
Critical Incident Data: Inquiry (286) – HCS, Continued

Procedure

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

<table>
<thead>
<tr>
<th>Step</th>
<th>View</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>_ _ _</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Type 286 in the ACT: field of any screen.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Press <strong>Enter</strong>.</td>
</tr>
<tr>
<td></td>
<td></td>
<td><strong>Result:</strong> The <strong>286: Critical Incident Data: Inquiry</strong> header screen is displayed.</td>
</tr>
<tr>
<td>2</td>
<td><a href="#">Image</a></td>
<td>A sample <strong>286: Critical Incident Data: Inquiry</strong> header screen is shown below.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Your component code is displayed based on your logon account number.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Type the month and year in the <strong>MONTH AND YEAR</strong> field. (MMYYYY format)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Type the contract number in the <strong>CONTRACT NUMBER</strong> field, or</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Type an <strong>X</strong> beside the appropriate contract type. (HCS, TxHmL, ICF/MR, or GR)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Type <strong>Y</strong> in the <strong>SUMMARY ONLY</strong> field if you want a summary <strong>only</strong>.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Type <strong>Y</strong> in the <strong>NOT REPORTED ONLY</strong> field if you want a list of contracts for which incidents were not reported <strong>only</strong>.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Press <strong>Enter</strong>.</td>
</tr>
<tr>
<td></td>
<td></td>
<td><strong>Result:</strong> The <strong>286: Critical Incident Data Inquiry</strong> screen is displayed.</td>
</tr>
</tbody>
</table>
3. A sample **286: Critical Incident Data Inquiry** screen is shown below.

The following sample screens display a complete report that includes a summary of total incidents reported, a list of contracts for which no incidents were reported, and a summary for the contract for which data was reported in our example. The system displays data entered for each contract.

<table>
<thead>
<tr>
<th>Step</th>
<th>View</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>3</td>
<td><strong>286: Critical Incident Data Inquiry</strong> screen is shown below.</td>
<td>The screen displays the data that was entered for each contract on the <strong>686: Critical Incident Data</strong> screens.</td>
</tr>
</tbody>
</table>

This screen is accessed when you leave **N (No)** in the **SUMMARY ONLY** and the **NOT REPORTED ONLY** fields on the header screen.
### Critical Incident Data: Inquiry (286) – HCS, Continued

#### Procedure, continued

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

#### Example Screens

**Summary Screen (Including Only Summary):**

```
06-17-09  283:CRITICAL INCIDENT DATA INQUIRY  00026532
COMPONENT CODE/NAME: #1 / EDUCARE COMMUNITY LIVING CORPORATION - TEXAS
INCIDENT MONTH/YEAR: 05/2009  1 out of 5 contracts reported
BEHAVIOR INTERVENTION PLAN AUTHORIZING RESTRAINT: 5
TOTAL NUMBER OF MEDICATION ERRORS: 2
TOTAL NUMBER OF SERIOUS INJURIES: 1
HRS SL DIH TOTAL
MBA, EMER. RESTRAINTS USED:  PERS. RESTRAINTS: 0 0 0 6
MED. RESTRAINTS: 0 0 0 2
PSYCH. RESTRAINTS: 0 0 0 0
MBA, INJ. REQ. EMER. RESTRAINT:  PERS. RESTRAINTS: 0 0 0 7
MED. RESTRAINTS: 0 0 0 1
PSYCH. RESTRAINTS: 0 0 0 0
MBA, SER. INJ. DUE TO:  EMER. PERS. RESTRAINTS: 0 0 0 1
MED. RESTRAINTS: 0 0 0 0
PSYCH. RESTRAINTS: 0 0 0 0
```

**Report Screen (Including Contracts with No Incidents):**

```
06-17-09  283:CRITICAL INCIDENT DATA INQUIRY  00026532
COMPONENT CODE/NAME: #1 / EDUCARE COMMUNITY LIVING CORPORATION - TEXAS
INCIDENT MONTH/YEAR: 05/2009  4 contracts not reported - HCS only
00100702  HCS  EDUCARE COMMUNITY LIVING CORPORATION - TEXAS
001007162  HCS  EDUCARE COMMUNITY LIVING CORPORATION - TEXAS
001007429  HCS  EDUCARE COMMUNITY LIVING CORPORATION - TEXAS
001007859  HCS  EDUCARE COMMUNITY LIVING CORPORATION - TEXAS
TOTAL NUMBER OF CONTRACTS NOT REPORTED: 4
```

The following sample screen displays a report that includes a list of contracts that had no incidents reported. This screen is accessed when you type N (No) in the SUMMARY ONLY field and Y (Yes) in the NOT REPORTED ONLY fields on the header screen.
Critical Incident Data (686) - TXHmL

Introduction

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

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

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

Reportable Data

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

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

continued on next page
### Reportable Data, continued

<table>
<thead>
<tr>
<th>Term</th>
<th>Definition</th>
</tr>
</thead>
</table>
| Behavior Intervention Plan Authorizing Restraint | A behavior intervention plan is reported if it authorizes a personal, mechanical or psychoactive medication, as defined below, for an individual.  
- **Personal restraint** - the application of pressure, except physical guidance or prompting of brief duration that restricts the free movement of part or all of an individual’s body.  
- **Mechanical restraint** - the use of a device that restricts the free movement of part or all of an individual’s body. Such a device includes an anklet, a wristlet, a camisole, a helmet with fasteners, a mitt with fasteners, a posey, a waist strap, a head strap, and a restraining sheet. Such a device does not include one used to provide support for functional body position or proper balance, such as a wheelchair belt, or one used for medical treatment, such as a helmet to prevent injury during a seizure.  
- **Psychoactive medication** - the use of a chemical, including a pharmaceutical, through topical application, oral administration, injection, or other means, to control an individual’s activity and which is not a standard treatment for the individual’s medical or psychiatric condition. |
| Emergency Personal Restraint             | An emergency personal restraint is reported when the Program Provider uses a personal restraint, as defined above, and such restraint is not authorized in a written behavior intervention plan approved by the individual’s IDT.                                                                                                                   |
| Emergency Mechanical Restraint           | An emergency mechanical restraint is reported when the Program Provider uses a mechanical restraint, as defined above, and such restraint is not authorized in a written behavior intervention plan approved by the individual’s IDT.                                                                                                             |
| Emergency Psychoactive Medication        | An emergency psychoactive medication is reported when the Program Provider uses a psychoactive medication, as defined above and such restraint is not authorized in a written behavior intervention plan approved by the individual’s IDT.                                                                                                 |
| Individual Requiring Emergency Restraint | An individual is reported as requiring emergency restraint if the individual is restrained (by either personal or mechanical restraint or psychoactive medication) at least once during a calendar month. If an individual is restrained more than once during a calendar month, the individual is reported only once for that month.                                                                                     |
| Restraint Related Injury                 | A restraint related injury is a serious injury sustained by an individual that is clearly related to the application of a personal restraint, an emergency mechanical restraint, or an emergency psychoactive medication administered to an individual. Reportable injuries in this category are not due to self-injury that occurred prior to the application of restraint. Serious injuries sustained during the application of a restraint that are investigated by DFPS as an allegation of abuse, neglect or exploitation must be included in CIRS reporting for this category. |
Critical Incident Data (686): Add - TXhmL

Procedure

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

<table>
<thead>
<tr>
<th>Step</th>
<th>View</th>
<th>Action</th>
</tr>
</thead>
</table>
| 1    | _ _  | • Type 686 in the ACT: field of any screen.  
     |      | • Press Enter.  
     |      | Result: The **686: Critical Incident Data: Add/Change/Delete** header screen is displayed. |
| 2    | A sample **686: Critical Incident Data: Add/Change/ Delete** header screen is shown below.  
     | ![Image](image) | Your component code is displayed based on your logon account number.  
     |      | • Type the month and year being reported in the **MONTH AND YEAR (MMYYYY)** field.  
     |      | • Type the contract number in the **CONTRACT NUMBER** field.  
     |      | • Type **A** (Add) in the **TYPE OF ENTRY** field.  
     |      | • Press Enter.  
     |      | Result: The **686: Critical Incident Data: Add** screen is displayed. |

continued on next page
Critical Incident Data (686): Add - TXHmL, Continued

Procedure, continued

<table>
<thead>
<tr>
<th>Step</th>
<th>View</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>3A sample 686: Critical Incident Data: Add screen is shown below.</td>
<td>The contract number that was entered on the header screen is displayed but can be changed.</td>
<td></td>
</tr>
<tr>
<td>3.</td>
<td></td>
<td>Type the contract number in the CONTRACT NUMBER field, if the contract for which you are entering data is other than the one entered on the header screen.</td>
</tr>
<tr>
<td>3</td>
<td></td>
<td>Type the number of medication errors during the report month for every person served in your contract in the MEDICATION ERRORS field.</td>
</tr>
<tr>
<td>3</td>
<td></td>
<td>Type the number of serious injuries during the report month for every person served in your contract in the SERIOUS INJURIES field.</td>
</tr>
<tr>
<td>3</td>
<td></td>
<td>Type the number of behavior intervention plans authorizing personal, mechanical, or psychoactive medication restraint during the report month in the BEHAVIOR INTERVENTION PLANS AUTHORIZING RESTRAINT field.</td>
</tr>
<tr>
<td>3</td>
<td></td>
<td>Note: Zeros must be entered in the fields on this screen even if there are no behavior intervention plans or critical incident data to be reported during the report month. Data must be entered monthly. See the example on the following page.</td>
</tr>
</tbody>
</table>
Critical Incident Data (686): Add - TXHmL, Continued

Procedure, continued

<table>
<thead>
<tr>
<th>Step</th>
<th>View</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>3 cont.</td>
<td>Example screen:</td>
<td>Example: The following describes the data displayed on the sample screen on the left side of the page.</td>
</tr>
</tbody>
</table>

**Number of Emergency Restraints** section:
- John has had four personal restraints in a month and Sally has had two personal restraints in a month, so you would type 6 in the **TOTAL** field.
- Bob has had two mechanical restraints in a month, so you would type 2 in the **TOTAL** field.
- There were no psychoactive medication restraints, so you would type 0 in the **TOTAL** field.

**Number of Individuals Requiring Emergency Restraint** section:
- Even though John has had 4 and Sally has had 2 personal restraints, this field is counting individuals, so you would type 2 in the **TOTAL** field. Bob has had two mechanical restraints, but you would type 1 in the **TOTAL** field. There were no psychoactive medication restraints, so you would type 0 in the **TOTAL** field.

**Number of Restraint Related Injuries** section:
- One of Bob’s restraints resulted in a restraint related injury, so you would type 1 in the **TOTAL** field. You would type 0 in the **EMERGENCY MECHANICAL RESTRAINT** and **EMERGENCY PSYCHOACTIVE MEDICATION** **TOTAL** fields.

**Important:** Remember that you must type zeroes in all fields that have no critical incident data to be reported.
### Critical Incident Data (686): Change - TXHmL

**Procedure**

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

<table>
<thead>
<tr>
<th>Step</th>
<th>View</th>
<th>Action</th>
</tr>
</thead>
</table>
| 1    |      | - Type 686 in the ACT: field of any screen.  
   |      | - Press Enter.  
   |      | - **Result:** The 686: Critical Incident Data: Add/Change/Delete header screen is displayed. |
| 2    | A sample 686: Critical Incident Data: Add/Change/Delete header screen is shown below.  
   |      | - Your component code is displayed based on your logon account number.  
   |      | - Type the month and year being reported in the MONTH AND YEAR (MMYYYY) field.  
   |      | - Type the contract number in the CONTRACT NUMBER field.  
   |      | - Type C (Change) in the TYPE OF ENTRY field.  
   |      | - Press Enter.  
   |      | - **Result:** The 686: Critical Incident Data: Change screen is displayed. |
| 3    | A sample 686: Critical Incident Data: Change screen is shown below.  
   |      | - Type changes to the critical incident data in the appropriate fields.  
   |      | - Type Y in the READY TO CHANGE? field to submit the data to the system.  
   |      | - Press Enter.  
   |      | - **Result:** The header screen is displayed with the message, “Previous Information Changed.” |
**Critical Incident Data (686): Delete - TXHmL**

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

<table>
<thead>
<tr>
<th>Step</th>
<th>View</th>
<th>Action</th>
</tr>
</thead>
</table>
| 1 | _ _ | • Type **686** in the ACT: field of any screen.  
• Press **Enter**.  
Result: The 686: Critical Incident Data: Add/Change/Delete header screen is displayed. |
| 2 | A sample **686: Critical Incident Data: Add/Change/Delete** header screen is shown below. | Your component code is displayed based on your logon account number.  
• Type the month and year being reported in the **MONTH AND YEAR (MMYYYY)** field.  
• Type the contract number in the **CONTRACT NUMBER** field.  
• Type **D** (Delete) in the **TYPE OF ENTRY** field.  
• Press **Enter**.  
Result: The 686: Critical Incident Data: Delete screen is displayed. |
| 3 | A sample **686: Critical Incident Data: Delete** screen is shown below. | • Type **Y** in the **READY TO DELETE?** field to submit the data to the system.  
• Press **Enter**.  
Result: The header screen is displayed with the message, “Previous Information Deleted.” |
Introduction

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

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

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

Requesting Reports

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

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

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

- If the contract *reported* incidents for the Component Code and Month and Year:
  - The first screen will display critical incidents for the contract
  - The second screen will display 0 number of contracts did not report
  - The third screen will display the total number of Critical Incidents for that contract
- If the contract *did not report* for the Component Code and Month and Year:
  - The first screen will not be displayed
  - The second screen will display that the contract did not report
  - The third screen will display the 0 totals for Critical Incidents for that contract
Critical Incident Data: Inquiry (286) - TXHmL, Continued

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

<table>
<thead>
<tr>
<th>Step</th>
<th>View</th>
<th>Action</th>
</tr>
</thead>
</table>
| 1    | • Type 286 in the ACT: field of any screen.  
     | • Press Enter.  
     | **Result:** The **286: Critical Incident Data: Inquiry** header screen is displayed. |
| 2    | A sample **286: Critical Incident Data: Inquiry** header screen is shown below.  
     | Your component code is displayed based on your logon account number.  
     | • Type the month and year in the **MONTH AND YEAR** field (MMYYYY format).  
     | • Type the contract number in the **CONTRACT NUMBER** field, or  
     | • Type an X beside the appropriate contract type (HCS, TxHmL, ICF/MR, or GR).  
     | • Type Y in the **SUMMARY ONLY** field if you want a summary only.  
     | • Type Y in the **NOT REPORTED ONLY** field if you want a list of contracts for which incidents were not reported only.  
     | • Press Enter.  
     | **Result:** The **286: Critical Incident Data Inquiry** screen is displayed. |

continued on next page
Procedure, continued

<table>
<thead>
<tr>
<th>Step</th>
<th>View</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>3</td>
<td>A sample <strong>286: Critical Incident Data Inquiry</strong> screen is shown below.</td>
<td>The screen displays the data that was entered for each contract on the <strong>686: Critical Incident Data screens</strong>.</td>
</tr>
</tbody>
</table>

The following sample screens display a complete report that includes a summary of total incidents reported, a list of contracts for which no incidents were reported, and a summary for the contract for which data was reported in our example. The system displays data entered for each contract.

![Sample Screens](image_url)
Procedure, continued

<table>
<thead>
<tr>
<th>Step</th>
<th>View</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>3, cont.</td>
<td>The following sample screen displays a report that includes only the summary.</td>
<td>This screen is accessed when you type <strong>Y</strong> (Yes) in the <strong>SUMMARY ONLY</strong> field and <strong>N</strong> (No) in the <strong>NOT REPORTED ONLY</strong> fields on the header screen.</td>
</tr>
</tbody>
</table>

![Sample Screen 1](image1.png)

This screen is accessed when you type **N** (No) in the **SUMMARY ONLY** field and **Y** (Yes) in the **NOT REPORTED ONLY** fields on the header screen.

![Sample Screen 2](image2.png)
This page was intentionally left blank.
## MRA/MHA Contacts (L28)

| Introduction | The *MRA/MHA Contacts* process allows the Mental Retardation Authority (MRA) to add, change or delete MRA contact information. The process is used to specify contact persons with whom the waiver program providers can communicate and designate a sequence and description regarding those contacts for program issues or questions.  
A program provider can use **C87: MRA Contacts: Inquiry** to view available contact information. |
|---|---|
| Sequencing | When adding or changing MRA contact information, the MRA can assign a sequence number to the contact that is being added or changed.  
The sequence order is designed in a five-number progression so that a particular contact can be placed between the previously assigned contacts. For example, if the progression is 5, 10, and 15, the contact being added or changed can be assigned a sequence number of 8 so that it will fall between the 5 and 10 positions. The system then reorders the numbers to a new five-number progression. |
MRA/MHA Contacts (L28): Add

Procedure

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

<table>
<thead>
<tr>
<th>Step</th>
<th>View</th>
<th>Action</th>
</tr>
</thead>
</table>
| 1    |     | **• Type L28 in the ACT: field of any screen.**  
     |     | **• Press Enter.**  
     |     | **Result: The L28: MRA/MHA Contacts: Add/Change/Delete header screen is displayed.** |
| 2    | A sample L28: MRA/MHA Contacts: Add/Change/Delete header screen is shown below.  
     |     | **• Type the MRA component code in the COMP field.**  
     |     | **• Type MRA in the CONTACT TYPE field.**  
     |     | **• Type A (Add) in the TYPE OF ENTRY field.**  
     |     | **• Press Enter.**  
     |     | **Result: The L28: MRA/MHA Contacts: Add Records screen is displayed.** |
| 3    | A sample L28: MRA/MHA Contacts: Add Records screen is shown below.  
     |     | **• View the sequence/type/contact description information.**  
     |     | **• Type Y (Yes) in the READY TO CONTINUE? field.**  
     |     | **• Press Enter.**  
     |     | **Result: The L28: MRA/MHA Contacts: Add Records (Screen 2) is displayed.** |

continued on next page
## MRA/MHA Contacts (L28): Add, Continued

### Procedure, continued

<table>
<thead>
<tr>
<th>Step</th>
<th>View</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>4</td>
<td>A sample <strong>L28: MRA/MHA Contacts: Add Records</strong> (Screen 2) is shown below.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>CONTACT TYPE: MRA/MHA Contacts: Add Records</th>
</tr>
</thead>
<tbody>
<tr>
<td>CONTACT</td>
</tr>
<tr>
<td>CONTACT SEQUENCE/DESCRIPTION</td>
</tr>
<tr>
<td>CONTACT SEQUENCE</td>
</tr>
<tr>
<td>ADDRESS</td>
</tr>
<tr>
<td>PHONE</td>
</tr>
<tr>
<td>READY TO ADD</td>
</tr>
</tbody>
</table>

- View the contact sequence number displayed, and, if necessary, type the appropriate contact sequence number for the contact you are adding in the CONTACT SEQUENCE field.
- Type the contact description in the DESCRIPTION field.
- Type the contact person’s name information in the Contact fields.
- Type the contact person’s address information in the Address fields.
- Type the contact person’s area code and telephone number in the Phone fields.
- Note: Fax and e-mail address information can also be entered for the contact you are adding.
- Type Y in the READY TO ADD? field.
- Note: You can type N in the READY TO ADD? field to take no action and return to the header screen.
- Press Enter.

**Result:** The **L28: MRA/MHA Contacts** header screen is displayed with the message, "Previous Information Added."
## MRA/MHA Contacts (L28): Change

### Procedure

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

<table>
<thead>
<tr>
<th>Step</th>
<th>View</th>
<th>Action</th>
</tr>
</thead>
</table>
| 1    | _ _  | • Type L28 in the ACT: field of any screen.  
     |      | • Press Enter.  
     |      | Result: The **L28: MRA/MHA Contacts: Add/Change/Delete** header screen is displayed. |
| 2    | A sample **L28: MRA/MHA Contacts: Add/Change/Delete** header screen is shown below.  
     | ![Screen](image) | • Type the MRA component code in the **COMP** field.  
     |      | • Type **MRA** in the **CONTACT TYPE** field.  
     |      | • Type **C** (Change) in the **TYPE OF ENTRY** field.  
     |      | • Press Enter.  
     |      | Result: The **L28: MRA/MHA Contacts Change Records** screen is displayed. |
| 3    | A sample **L28: MRA/MHA Contacts Change Records** screen is shown below.  
     | ![Screen](image) | • View the sequence/type/contact description information.  
     |      | • Type **X** in the **SELECT** field next to the record to be changed.  
     |      | • Type **Y** in the **READY TO SELECT?** field.  
     |      | • Press Enter.  
     |      | Result: The **L28: MRA/MHA Contacts Change Records** (Screen 2) is displayed. |

continued on next page
### MRA/MHA Contacts (L28): Change, Continued

#### Procedure, continued

<table>
<thead>
<tr>
<th>Step</th>
<th>View</th>
<th>Action</th>
</tr>
</thead>
</table>
| 4    | A sample **L28: MRA/MHA Contacts Change Records** (Screen 2) is shown below.  

```
AT: 10-40  
L28: MRA/MHA CONTACTS CHANGE RECORDS  
COMP: 088 TEXAS PAROLE AUTHORITY  
CONTACT SEQUENCE/DESCRIPTION  
25 TAHSA  
  
CONTACT  
FIRST NAME: JAMES  
LAST NAME: JAMES  
ADDRESS: 1212 BROADWAY  
CITY: AUSTIN  
STATE: TX  
ZIP CODE: 78704  
PHONE: 555-555555  
FAX: 555-555555  
E-MAIL ADDRESS:  
  
READY TO CHANGE? [Y/N]  
[?/Y] MAIN MENU Q(QUIT)  
```

<p>| | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
</table>
|      | • View the current information on the contact record selected.  
|      | • Type any changes in the appropriate fields.  
|      | • Type Y in the **READY TO CHANGE?** field.  
|      | Note: You can type N in the **READY TO CHANGE?** field to take no action and return to the header screen.  
|      | • Press **Enter**.  
| Result: | The **L28: MRA/MHA Contacts** header screen is displayed with the message, “**Previous Information Changed.**” |
MRA/MHA Contacts (L28): Delete

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

<table>
<thead>
<tr>
<th>Step</th>
<th>View</th>
<th>Action</th>
</tr>
</thead>
</table>
| 1 | _ _ | • Type L28 in the ACT: field of any screen.  
• Press Enter.  
| 2 | A sample L28: MRA/MHA Contacts: Add/Change/Delete header screen is shown below.  

```
02-18-04   L28: MRA/MHA CONTACTS:ADD/CHANGE/DELETE   02/16/04

PLEASE ENTER THE FOLLOWING:

COMP: ___
CONTACT TYPE: ___ (MHA/MRA)
TYPE OF ENTRY: ___ (A/ADD,C/CHANGE,D/DELETE)

*** PRESS ENTER ***

ACT: ___ (A/MAIN MENU, Q/QUIT)```

| | | • Type the MRA component code in the COMP field.  
• Type MRA in the CONTACT TYPE field.  
• Type D (Delete) in the TYPE OF ENTRY field.  
• Press Enter.  
Result: The L28: MRA/MHA Contacts Delete Records screen is displayed. |
| 3 | A sample L28: MRA/MHA Contacts Delete Records screen is shown below.  

```
02-18-04   L28: MRA/MHA CONTACTS DELETE RECORDS   02/16/04
COMP: 020 TEXAS PAYABLE MHA AUTHORITY

SELECT/SEQUENCE/TYPE/CONTACT DESCRIPTION
  5 MRA ISPHA
  10 MHA ISPHA
  15 MRA ISPH/MHS
  20 MRA MHA/MRA

X-SELECT RECORD TO BE DELETED
READY TO SELECT? ___ Y/N

ACT: ___ (A/MAIN MENU, Q/QUIT)```

| | | • View the sequence/type/contact description information.  
• Type X in the SELECT field next to the record to be deleted.  
• Type Y in the READY TO SELECT? field.  
• Press Enter.  
Result: The L28: MRA/MHA Contacts Delete Records (Screen 2) is displayed. |

continued on next page
### Procedure, continued

<table>
<thead>
<tr>
<th>Step</th>
<th>View</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>4</td>
<td>A sample <strong>L28: MRA/MHA Contacts Delete Records</strong> (Screen 2) is shown below.</td>
<td>• View the current information on the contact record selected.</td>
</tr>
<tr>
<td></td>
<td><img src="image-url" alt="Screen Screenshot" /></td>
<td>• Type Y in the READY TO DELETE? field. <strong>Note:</strong> You can type N in the READY TO DELETE? field to take no action and return to the header screen.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Press Enter.</td>
</tr>
<tr>
<td></td>
<td></td>
<td><strong>Result:</strong> The <strong>L28: MRA/MHA Contacts</strong> header screen is displayed with the message, “Previous Information Deleted.”</td>
</tr>
</tbody>
</table>
This page was intentionally left blank.
Introduction

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

The *Permanency Planning Review* process allows an MRA to add, change, or delete an individual’s initial and subsequent permanency plans.
Permanency Planning Review (309): Add

Procedure

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

<table>
<thead>
<tr>
<th>Step</th>
<th>View</th>
<th>Action</th>
</tr>
</thead>
</table>
| 1    | _ _  | • Type 309 in the ACT: field of any screen.  
      |      | • Press Enter.  
| 2    | A sample 309: Permanency Planning Review: Add/Change/Delete header screen is shown below.  
      | ![Screen Screenshot](image.png)  
      | • Type the MRA component code in the COMPONENT CODE field.  
      | | • Type the individual’s local case number in the LOCAL CASE NUMBER field.  
      | | • Type A (Add) in the TYPE OF ENTRY field.  
      | | • Press Enter.  

continued on next page
## Permanency Planning Review (309): Add, Continued

<table>
<thead>
<tr>
<th>Step</th>
<th>View</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>3</td>
<td>A sample <strong>309: Permanency Planning Review: Add</strong> screen is shown below.</td>
<td>- Type the date of the individual’s permanency planning review in the <strong>Review Date</strong> field.</td>
</tr>
<tr>
<td></td>
<td><img src="image" alt="Screen Screenshot" /></td>
<td>- Type the code indicating the permanency plan goal in the <strong>Permanency Plan Goal</strong> field.</td>
</tr>
<tr>
<td></td>
<td><img src="image" alt="Screen Screenshot" /></td>
<td>- Type the code indicating the frequency of parent/guardian contact with the individual during the last six months in the <strong>Contact Freq</strong> field.</td>
</tr>
<tr>
<td></td>
<td><img src="image" alt="Screen Screenshot" /></td>
<td>- Type the number of visits to the facility by the parent/guardian in the <strong># Visit by Fam</strong> field.</td>
</tr>
<tr>
<td></td>
<td><img src="image" alt="Screen Screenshot" /></td>
<td>- Type the number of the resident’s visits to the home in the <strong># Visit to Fam</strong> field.</td>
</tr>
<tr>
<td></td>
<td><img src="image" alt="Screen Screenshot" /></td>
<td>- Type <strong>Y</strong> (Yes) or <strong>N</strong> (No) to indicate whether the person has a history of traumatic brain injury in the <strong>Traumatic Brain Injury</strong> field.</td>
</tr>
<tr>
<td></td>
<td><img src="image" alt="Screen Screenshot" /></td>
<td>- Type <strong>Y</strong> (Yes) or <strong>N</strong> (No) to indicate whether the family/LAR supports the goal in the <strong>Does Family/LAR Support Goal</strong> field.</td>
</tr>
<tr>
<td></td>
<td><img src="image" alt="Screen Screenshot" /></td>
<td>- Type <strong>Y</strong> (Yes), <strong>N</strong> (No), or <strong>NA</strong> (Not Applicable) to indicate whether the family/LAR participated in the initial or annual meeting to discuss the Plan of Care in the <strong>Family Participated/POC</strong> field.</td>
</tr>
<tr>
<td></td>
<td><img src="image" alt="Screen Screenshot" /></td>
<td>- Type <strong>Y</strong> (Yes) or <strong>N</strong> (No) to indicate whether the family/LAR participated in this initial or review of the permanency plan in the <strong>Family Participated/PP</strong> field.</td>
</tr>
<tr>
<td></td>
<td><img src="image" alt="Screen Screenshot" /></td>
<td>- Type <strong>Y</strong> (Yes) or <strong>N</strong> (No) to indicate whether the family could be located when needed within the last six months in the <strong>Located Family</strong> field.</td>
</tr>
<tr>
<td></td>
<td><img src="image" alt="Screen Screenshot" /></td>
<td>- Type <strong>Y</strong> (Yes) or <strong>N</strong> (No) to indicate whether the family/LAR responded to requests to participate in permanency planning meetings within the last six months in the <strong>Family Responded</strong> field.</td>
</tr>
<tr>
<td></td>
<td><img src="image" alt="Screen Screenshot" /></td>
<td>- Type <strong>Y</strong> (Yes) or <strong>N</strong> (No) or <strong>leave blank</strong> for each Family and Community Support.</td>
</tr>
<tr>
<td></td>
<td><img src="image" alt="Screen Screenshot" /></td>
<td><strong>Note:</strong> The <strong>Family and Community Supports to Achieve Goal</strong> section of the screen is not required for individuals 18 to 21 years of age with a Permanency Plan Goal of <strong>4</strong>.</td>
</tr>
<tr>
<td></td>
<td><img src="image" alt="Screen Screenshot" /></td>
<td>- Type the name of the permanency planning staff contact in the <strong>Contact Name</strong> field.</td>
</tr>
<tr>
<td></td>
<td><img src="image" alt="Screen Screenshot" /></td>
<td>- Type the permanency planning staff contact person’s telephone number in the <strong>Contact Phone</strong> field.</td>
</tr>
<tr>
<td></td>
<td><img src="image" alt="Screen Screenshot" /></td>
<td>- Type <strong>Y</strong> (Yes) or <strong>N</strong> (No) to indicate if the individual is enrolled or enrolling in any Medicaid Waiver or is currently living in a nursing home and has access to a Medicaid waiver in the <strong>Enrolled, Is Enrolling, or Is Eligible for MFP in a Medicaid Waiver</strong> field.</td>
</tr>
<tr>
<td></td>
<td><img src="image" alt="Screen Screenshot" /></td>
<td>- Type <strong>Y</strong> in the <strong>Ready to Add?</strong> field.</td>
</tr>
<tr>
<td></td>
<td><img src="image" alt="Screen Screenshot" /></td>
<td><strong>Note:</strong> You can type <strong>N</strong> in the <strong>Ready to Add?</strong> field to take no action and return to the header screen.</td>
</tr>
<tr>
<td></td>
<td><img src="image" alt="Screen Screenshot" /></td>
<td><strong>Press Enter.</strong></td>
</tr>
<tr>
<td></td>
<td><img src="image" alt="Screen Screenshot" /></td>
<td><strong>Result:</strong> The <strong>431: Client Correspondent Update</strong> screen is displayed.</td>
</tr>
</tbody>
</table>
Procedure, continued

<table>
<thead>
<tr>
<th>Step</th>
<th>View</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>4</td>
<td>A sample 431: <strong>Client Correspondent Update</strong> screen is shown below.</td>
<td><strong>Type</strong> primary and secondary correspondent information as appropriate. <strong>Type Y</strong> in the READY TO UPDATE? field. <strong>Note:</strong> You can type N in the READY TO UPDATE? field to take no action and return to the header screen. <strong>Press Enter.</strong> <strong>Result:</strong> The header screen is displayed with the message, “<em>Previous Information Changed.</em>”</td>
</tr>
</tbody>
</table>
Permanency Planning Review (309): Change

Procedure

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

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

<table>
<thead>
<tr>
<th>Step</th>
<th>View</th>
<th>Action</th>
</tr>
</thead>
</table>
| 1 | _ _ | • Type 309 in the ACT: field of any screen.  
• Press Enter.  
| 2 | A sample 309: Permanency Planning Review: Add/Change/Delete header screen is shown below. | • Type the MRA component code in the COMPONENT CODE field.  
• Type the individual’s local case number in the LOCAL CASE NUMBER field.  
• Type C (Change) in the TYPE OF ENTRY field.  
• Press Enter.  
| 3 | A sample 309: Permanency Planning Review: Change screen is shown below. | • Type changes to the permanency plan in the appropriate fields.  
• Type Y in the READY TO CHANGE? field to submit the data to the system.  
Note: You can type N in the READY TO CHANGE? field to take no action and return to the header screen.  
• Press Enter.  
Result: The header screen is displayed with the message, “Previous Information Changed.” |
Permanency Planning Review (309): Delete

Procedure

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

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

<table>
<thead>
<tr>
<th>Step</th>
<th>View</th>
<th>Action</th>
</tr>
</thead>
</table>
| 1 | 309: Permanency Planning Review: Add/Change/Delete | • Type 309 in the ACT: field of any screen.  
• Press Enter.  
| 2 | 309: Permanency Planning Review: Delete | • Type the MRA component code in the COMPONENT CODE field.  
• Type the individual’s local case number in the LOCAL CASE NUMBER field.  
• Type D (Delete) in the TYPE OF ENTRY field.  
• Press Enter.  
Result: The 309: Permanency Planning Review: Delete screen is displayed. |
| 3 | 309: Permanency Planning Review: Delete | • Type Y in the READY TO DELETE? field to submit the data to the system.  
Note: You can type N in the READY TO DELETE? field to take no action and return to the header screen.  
• Press Enter.  
Result: The header screen is displayed with the message, “Previous Information Deleted.” |
Consumer Discharge

Introduction

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

Termination of Waiver Services

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

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

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

<table>
<thead>
<tr>
<th>For Termination of Waiver Services...</th>
<th>Send the...</th>
</tr>
</thead>
<tbody>
<tr>
<td>due to death</td>
<td>Notification of Termination of Waiver Services form. Indicate CLIENT DEATH and the specific circumstances of the death in the Comments section.</td>
</tr>
<tr>
<td>for reasons other than death</td>
<td>• Termination of Waiver Services form,</td>
</tr>
<tr>
<td></td>
<td>• Discharge Staffing Summary, and</td>
</tr>
<tr>
<td></td>
<td>• Freedom of Choice form.</td>
</tr>
</tbody>
</table>

Suspension of Waiver Services

A suspension of waiver services is the temporary suspension of services to the individual by the provider while the individual is unable or unavailable to receive services.

Data entry is only required by the MRA for suspension of waiver services if the individual is self-directing all their services.

An individual who is on temporary discharge can be transferred directly to the new contract. The temporary discharge should not be ended prior to the entry of L06 by the MRA.
# Consumer Discharge (C18)

**Procedure**

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

<table>
<thead>
<tr>
<th>Step</th>
<th>View</th>
<th>Action</th>
</tr>
</thead>
</table>
| 1    | • Type C18 in the ACT: field of any screen.  
|      | • Press Enter.  
|      | Result: The C18: Consumer Discharge header screen is displayed. |

**Step 2**

A sample C18: Consumer Discharge header screen is shown below.

<table>
<thead>
<tr>
<th>View</th>
<th>Action</th>
</tr>
</thead>
</table>
| • Type the requested identifying information in the appropriate fields.  
| Rule: You must enter the Client ID, the local case number, or the Medicaid number.  
| • Type the provider’s component code in the COMPONENT CODE field.  
| • Type P (Permanent) in the TYPE OF DISCHARGE field.  
| • Type A (Add) in the TYPE OF ENTRY field.  
| • Press Enter.  
| Result: The C18: Consumer Discharge screen is displayed. |

**Step 3**

A sample C18: Consumer Discharge: Add screen is shown below.

<table>
<thead>
<tr>
<th>View</th>
<th>Action</th>
</tr>
</thead>
</table>
| • Type the name of the provider representative in the PROVIDER REPRESENTATIVE NAME field.  
| • Type the termination date in the DISCHARGE DATE field.  
| • Type Y (Yes) or N (No) in the DID CONSUMER RECEIVE SERVICES ON DISCHARGE DATE? field.  
| • Type the number representing the termination reason in the TERMINATION REASON field.  
| If the reason of discharge is death:  
| • Type the date of death in the DATE OF DEATH field.  
| • Type the time of death in the TIME OF DEATH field (HH/MM/PP format).  
| • Type Y in the READY TO ADD? field.  
| Note: You can type N in the READY TO UPDATE? field to take no action and return to the header screen.  
| • Press Enter.  
| Result: The C18: Consumer Discharge header screen is displayed with the message, “Previous Information Added.” |
Consumer Discharge (L18)

Procedure

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

<table>
<thead>
<tr>
<th>Step</th>
<th>View</th>
<th>Action</th>
</tr>
</thead>
</table>
| 1 | ![L18: Consumer Discharge screen](image) | • Type L18 in the ACT: field of any screen.  
• Press Enter.  
Result: The L18: Consumer Discharge header screen is displayed. |
| 2 | ![L18: Consumer Discharge screen](image) | • Type the requested identifying information in the appropriate fields.  
Rule: You must enter the Client ID, the local case number, or the Medicaid number.  
• Type the provider’s component code in the COMPONENT CODE field.  
• Press Enter.  
Result: The L18: Consumer Discharge screen is displayed. |
| 3 | ![L18: Consumer Discharge screen](image) | • Type the name of the MRA Representative in the BY: field.  
• Type the date the termination was reviewed in the DATE field.  
• Type Y in the READY TO UPDATE? field.  
Note: You can type N in the READY TO UPDATE? field to take no action and return to the header screen.  
• Press Enter.  
Result: The L18: Consumer Discharge header screen is displayed with the message, “Previous Information Changed.” |

Reminder: After the termination of waiver services staffing occurs and the provider and the MRA have completed the data entry, the Service Coordinator must fax to Program Enrollment a copy of the Notification of Termination of Waiver Services form, and the Discharge Meeting Summary.
## Consumer Discharge (C18): Add (Suspension of Waiver Services)

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

<table>
<thead>
<tr>
<th>Step</th>
<th>View</th>
<th>Action</th>
</tr>
</thead>
</table>
| 1    |     | - Type **C18** in the `ACT:` field of any screen.  
     |     | - Press **Enter**.  
     |     | **Result**: The **C18: Consumer Discharge: Add/Change/Delete** header screen is displayed. |
| 2    | A sample **C18: Consumer Discharge: Add/Change/Delete** header screen is shown below.  
     |     | - Type the requested identifying information in the appropriate fields.  
     |     | **Rule**: You must enter the Client ID, the local case number, or the Medicaid number.  
     |     | **Note**: Your component code is displayed based on your logon account number.  
     |     | - Type **T** (Temporary) in the **TYPE OF DISCHARGE** field.  
     |     | - Type **A** (Add) in the **TYPE OF ENTRY** field.  
     |     | - Press **Enter**.  
     |     | **Result**: The **C18: Consumer Discharge: Add** screen is displayed. |

continued on next page
Consumer Discharge (C18): Add (Suspension of Waiver Services), Continued

Procedure, continued

<table>
<thead>
<tr>
<th>Step</th>
<th>View</th>
</tr>
</thead>
<tbody>
<tr>
<td>3</td>
<td>A sample C18: Consumer Discharge: Add screen is shown below.</td>
</tr>
</tbody>
</table>

- Type the name of the provider representative in the PROVIDER REPRESENTATIVE NAME field.
- Type the suspension of waiver services begin date in the DISCHARGE BEGIN DATE field.
- Type the projected return date in the PROJECTED RETURN DATE field.
- Type Y (Yes) or N (No) in the DID CONSUMER RECEIVE SERVICES ON DISCHARGE BEGIN DATE? field.

Note: 24-hour services cannot be billed on the suspension date.

- Type the reason for suspension of waiver services in the TERMINATION REASON field. The following table lists the reasons and their descriptions.

<table>
<thead>
<tr>
<th>Reason</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Loss of Financial Eligibility</td>
<td>Individual has lost Medicaid eligibility</td>
</tr>
<tr>
<td>2. Hospitalization (Medical)</td>
<td>Individual is in a medical hospital.</td>
</tr>
<tr>
<td>3. Elopement (Unable to Locate)</td>
<td>Individual cannot be found or refuses to cooperate.</td>
</tr>
<tr>
<td>4. Crisis Stabilization</td>
<td>Individual is in a private psychiatric hospital or an acute behavioral treatment center.</td>
</tr>
<tr>
<td>5. Hospitalization (Psychiatric)</td>
<td>Individual is in a State Hospital.</td>
</tr>
<tr>
<td>6. Vacation/Furlough</td>
<td>Individual is on vacation or not receiving waiver services.</td>
</tr>
<tr>
<td>7. Incarceration</td>
<td>Individual is in a city/town, county, state, or federal correction facility.</td>
</tr>
<tr>
<td>8. State School</td>
<td>Individual is in a State Supported Living Center.</td>
</tr>
<tr>
<td>9. Nursing Facility</td>
<td>Individual is in a nursing home or other type of nursing facility.</td>
</tr>
</tbody>
</table>

- Type Y in the READY TO ADD? field.

Note: You can type N in the READY TO ADD? field to take no action and return to the header screen.
- Press Enter.

Result: The C18: Consumer Discharge header screen is displayed with the message, “Previous Information Added.”
Consumer Discharge (C18): Change (Suspension of Waiver Services)

Procedure

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

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

<table>
<thead>
<tr>
<th>Step</th>
<th>View</th>
<th>Action</th>
</tr>
</thead>
</table>
| 1    | _ _ | • Type C18 in the ACT: field of any screen.  
• Press Enter.  
Result: The C18: Consumer Discharge: Add/Change/Delete header screen is displayed. |
| 2    | A sample C18: Consumer Discharge: Add/Change/Delete header screen is shown below.  
• Type the requested identifying information in the appropriate fields.  
Rule: You must enter the Client ID, the local case number, or the Medicaid number.  
Note: Your component code is displayed based on your logon account number.  
• Type T (Temporary) in the TYPE OF DISCHARGE field.  
• Type C (Change) in the TYPE OF ENTRY field  
• Press Enter.  
Result: The C18: Consumer Discharge: Change screen is displayed. |
| 3    | A sample C18: Consumer Discharge: Change screen is shown below.  
• Type changes to the suspension information in the appropriate fields.  
• If the individual is ending his/her suspension of waiver services, type the end date in the END DATE field.  
• Type Y in the READY TO CHANGE? field.  
Note: You can type N in the READY TO CHANGE? field to take no action and return to the header screen.  
• Press Enter.  
Result: The C18: Consumer Discharge header screen is displayed with the message, “Previous Information Changed.” |
## Consumer Discharge (C18): Delete (Suspension of Waiver Services)

### Procedure

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

<table>
<thead>
<tr>
<th>Step</th>
<th>View</th>
<th>Action</th>
</tr>
</thead>
</table>
| 1    | _ _  | • Type **C18** in the ACT: field of any screen.  
      |      | • Press **Enter**.  
      |      | **Result:** The **C18: Consumer Discharge: Add/Change/Delete** header screen is displayed. |
| 2    | A sample **C18: Consumer Discharge: Add/Change/Delete** header screen is shown below.  
      |      | • Type the requested identifying information in the appropriate fields.  
      |      | **Rule:** You must enter the Client ID, the local case number, or the Medicaid number.  
      |      | **Note:** Your component code is displayed based on your logon account number.  
      |      | • Type **T** (Temporary) in the **TYPE OF DISCHARGE** field.  
      |      | • Type **D** (Delete) in the **TYPE OF ENTRY** field  
      |      | • Press **Enter**.  
      |      | **Result:** The **C18: Consumer Discharge: Delete** screen is displayed. |
| 3    | A sample **C18: Consumer Discharge: Delete** screen is shown below.  
      |      | • Type **Y** in the **READY TO DELETE?** field.  
      |      | **Note:** You can type **N** in the **READY TO DELETE?** field to take no action and return to the header screen.  
      |      | • Press **Enter**.  
      |      | **Result:** The **C18: Consumer Discharge** header screen is displayed with the message, “Previous Information Deleted.” |
Inquiry

Introduction

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

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

Inquiry Screens

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

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

continued on next page
### Inquiry Screens, continued

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

**Introduction**

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

**Basic Steps**

The basic steps for accessing and viewing all Inquiry options are:
- Type the Inquiry option action code in the ACT: field of any screen.
- Enter the type fields used to access the information.
- View the online Inquiry information.

**Procedure**

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

<table>
<thead>
<tr>
<th>Step</th>
<th>View</th>
<th>Action</th>
</tr>
</thead>
</table>
| 1    | _ _  | • Type C61 in the ACT: field of any screen.  
• Press Enter.  
Result: The **C61: Consumer Demographics: Inquiry** header screen is displayed. |
| 2    | A sample **C61: Consumer Demographics: Inquiry** header screen is shown below.  

![Sample Inquiry Screen](image)

• Type the requested identifying information in the appropriate fields.  

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

**Note:** Your component code is displayed based on your logon account number.  
• Press Enter.  

Result: The **C61: Consumer Demographics** screen is displayed. |

continued on next page
## Accessing an Inquiry Screen, Continued

### Procedure, continued

<table>
<thead>
<tr>
<th>Step</th>
<th>View</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>3</td>
<td>A sample <strong>C61: Consumer Demographics</strong> screen is shown below.</td>
<td>View the data. The sample screen displays the following information about the individual:</td>
</tr>
</tbody>
</table>
| | ![Sample C61 Screen](image) | - name  
- Client ID  
- address  
- Medicaid number  
- local case number  
- component/MRA  
- contract number  
- service county  
- packet status  
- birthdate  
- SSN  
- consumer status  
- enrollment letter sent date  
- enrollment date  
- slot and slot number  
- enroll request date  
- location  
- guardian information (if applicable)  
- current IPC begin date, revised date, end date  
- Level of Care/Need, begin date, end date  
- Medicaid program, begin date, end date |
Accessing Reports

Overview

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

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

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

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

To obtain access to the EDTS server:
1. A provider must submit an Electronic Transmission Agreement (ETA) form fax to HHS Enterprise Security Management (ESM), using the fax number provided in the Forward Completed Form To: section of the form. The ETA form is, in part, a request for a user ID and password to have access to retrieve the Waiver reports. The user ID and password created by the ETA form are separate from the CARE user ID and password and the retrieval of the Waiver reports uses a process that is also completely separate from CARE. DO NOT confuse the ETA and CARE user IDs and passwords.

2. While ESM is processing the ETA form, the provider must determine which software to use and download it. Because of HIPAA Privacy rules, providers must use encryption software to retrieve Waiver reports. See the options in the Recommended Client Software section (most options can be downloaded from the Internet).
Overview, Continued

**Obtain Access, continued**

3. After the ETA form is processed, HHS Enterprise Security Management (ESM) will telephone the provider with a user ID and password. This process should take about two weeks.

**Retrieve Reports in a Timely Manner**

It is the provider’s responsibility to retrieve the reports from their respective EDTS server folder. Providers should be aware that their reports are overwritten each time new reports are loaded. Several of these reports are loaded weekly. Therefore, providers must access the EDTS server on a weekly basis to avoid missing reports.

**Backup Files**

Backup files are kept in the event that previous reports must be recovered. These files, however, are not kept indefinitely, and reports can only be recovered for a limited period of time. Reports will be limited only to recovery for the most recent three months including the current month. Reports requested for recovery will be loaded to the provider’s EDTS server folder. They will not be mailed.
# Recommended Client Software

## Introduction

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

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

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

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

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

Introduction
Starting July 1, 2004, DADS HCS/TXHML began compressing or ‘Zipping’ all reports loaded to the EDTS server. Therefore, providers will be required to use zip software to open their report files. This was done to conserve space on the server in anticipation of an increased number of providers needing access to the EDTS server, as well as additional reports becoming available.

Zip Software
DADS HCS/TXHML plans to use the WINZIP software, which does have a minor cost associated with it. Providers may use any ZIP software to Unzip a file, regardless of the software that DADS HCS/TXHML uses to Zip the file. A comprehensive list of ZIP software products can be found at http://www.tucows.com/. A search on this site will identify software that can be downloaded.

Freeware
Some of the ZIP software products available at the above link are available at no cost to the user. They are listed as ‘Freeware.’ It is at the provider’s discretion which ZIP Software is downloaded and used to UnZIP files.

Support
DADS HCS/TXHML will not provide support for any non-DADS HCS/TXHML software downloaded by the provider. It will be the provider’s responsibility to contact the software company or vendor if problems are encountered during downloading or usage of ZIP software.
Access the EDTS Server Connection

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

```
mhmredts.mhmr.state.tx.us
```

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

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

Reports Loaded

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

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

- **HC062460 – MRA Service Utilization Report** * (Portrait) Tuesday after the last Friday of the month/Monthly
  The Texas Home Living Utilization Report.

- **HC062942 – Remittance & Status Report** (Landscape) Friday/Weekly
  The Remittance & Status Report reconciles the warrant (actual paid claims from the Comptroller) to claims submitted, minus any additional credits from the Comptroller.

- **HC062962 – HCS Accumulated Approved to Pay Report** (Landscape) Friday/Weekly
  The Accumulated Approved to Pay report contains information on all claims submitted and sent to the comptroller for payment, but it does not indicate payment from the comptroller.

- **HC062017 – Approved to Pay Report** * (Landscape) Tuesday/Weekly
  Formerly known as the Billing Report. The information on this report now includes ICN & Line numbers. This report has the same information as the Paid Claim File (GC062040), except that it is in a report format.

- **HC062310 – Service Utilization Report** * (Portrait) Tuesday after the last Friday of the month/Monthly
  The Utilization Report has not changed.
Access Server Connection/Load Reports/Retrieve Waiver Reports, Continued

- **HC062015 – Denied Claims Report** * (Landscape) Tuesday/Weekly
  Formerly known as the Exceptions Report. The information on this report now includes ICN & Line numbers.

- **GC062040 – Paid Claim File** * (File, semi-colon delimited) Tuesday/Weekly
  (For formatting instructions see *Paid Claims Files* section)
  The Paid Claims File is new and contains data on claims DADS HCS & TXHML Waiver Programs have sent to the Comptroller to be paid. The data in this file is in semi-colon delimited format, which can be downloaded directly into the provider’s local billing program.

- **HC062020 – Client Profile Report** * (Landscape) Tuesday after the last Friday of the month/Monthly

- **HC062746 – Waiver Local Authority Refinance by MRA Report** * (Landscape) Monday/Weekly
  This report is only distributed to MRAs. Waiver Refinance Status by MRA.

  Contains information that will assist with Annual Cost Reports.

- **GC027877 - HCS Waiting List Report of Contacts by Wait Date** *
  (File, semi-colon delimited) Monday/Weekly
  (For formatting instructions see *Paid Claims Files* section)
  This semi-colon delimited file is only distributed to MRAs.

*All billing reports will be available once Medicaid Administration approves billing.

Note: See *Format Report* for assistance on formatting the reports.
Retrieve Reports

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

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

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

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

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

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

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

<table>
<thead>
<tr>
<th>Format Paid Claim File</th>
<th>Paid Claims files will be available on request for those providers who want to receive a semi-colon delimited file (information that is not in any particular format.)</th>
</tr>
</thead>
</table>
| • **Spreadsheet Software** - Any spreadsheet software capable of importing delimited files can be used.  
  • **Semi-Colon Delimited Files** - Open the file in Excel, then follow the **Text Import Wizard** pop-up screens.  
    - For **Original Data Type** select **Delimited** (instead of **Fixed-width**).  
    - Click on **Next** to go to the next window.  
    - In **Delimiters** check **Semicolon** and uncheck all others.  
    - Click on **Next**.  
  Note: Providers will need to adjust column formats in this third window.  
    - Click on the columns that contain numbers (especially those with large numbers) in **Data Preview**  
    - Select **Text** (instead of **General**) in **Column Data Format**.  
    - Click **Finish**. |
## Passwords/Contacts

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

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

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

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

For questions regarding DADS HCS/TXHML forms, contact:
- HHSC Help Desk, Field Support, 1-512-438-4720 or 1-888-952-4357

For questions regarding software, contact:
- the software vendor.
Screen Fields

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

<table>
<thead>
<tr>
<th>Field</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>AA</td>
<td>Local code for Adaptive Aids. AA is one of the services provided by the HCS and/or TxHmL programs.</td>
</tr>
<tr>
<td>ABL</td>
<td>Code indicating the individual’s adaptive behavior level. 1 = Mild ABL deficit, 2 = Moderate ABL deficit, 3 = Severe ABL deficit, 4 = Profound ABL deficit</td>
</tr>
<tr>
<td>ADAPTIVE AIDS</td>
<td>The amount to be spent on adaptive aids. (Do not use commas - $$$$$ format.)</td>
</tr>
<tr>
<td>ADAPTIVE AIDS ASSESSMENT/BID</td>
<td>An assessment allowing the provider (HCS) or MRA (TxHmL) to seek a bid for the Adaptive Aids.</td>
</tr>
<tr>
<td>ADD TO HCS LIST?</td>
<td>Indicate whether individual is to be added to the Interest List.</td>
</tr>
<tr>
<td>ADDING A PROGRAM PROVIDER OR CDS AGENCY?</td>
<td>When transferring an individual, indicates whether a Program Provider or CDSA will be added when an SDO will be added where it does not exist.</td>
</tr>
<tr>
<td>ADDRESS DATE</td>
<td>Date the individual’s address record is being updated.</td>
</tr>
<tr>
<td>ADDRESS TYPE</td>
<td>Type of address being updated on the Provider/Contract Update screen. 1 = Provider Physical, 2 = Provider Mailing, 3 = Provider Billing, 4 = Contract Physical, 5 = Contract Mailing</td>
</tr>
<tr>
<td>ADMIT FROM</td>
<td>The living arrangement in which the individual is currently residing. 1 = Community, 2 = ICF-MR, 3 = State School, 4 = Refinance, 5 = State Hospital</td>
</tr>
<tr>
<td>AGE OF MAIN CAREGIVER</td>
<td>The age of the person who is the main caregiver of the individual.</td>
</tr>
<tr>
<td>AGGRESSIVE BEHAVIOR</td>
<td>Behavior intended to cause harm or injury to others.</td>
</tr>
<tr>
<td>AMBULATION</td>
<td>An individual’s ability to walk or move about reflecting the amount of assistance required.</td>
</tr>
<tr>
<td>ANNUAL COST</td>
<td>Total annual cost of the IPC.</td>
</tr>
<tr>
<td>Field</td>
<td>Description</td>
</tr>
<tr>
<td>-----------------------------------------------</td>
<td>---------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td><strong>ARE ANY SERVICES STAFFED BY A RELATIVE/GUARDIAN?</strong></td>
<td>On the IPC, indicates whether any services are provided by a relative or guardian.</td>
</tr>
<tr>
<td><strong>ASSIGNMENT BEGIN DATE</strong></td>
<td>The date the IPC begins.</td>
</tr>
<tr>
<td><strong>ASSIGNMENT END DATE</strong></td>
<td>The date the individual is permanently discharged or transferred to a different MRA.</td>
</tr>
<tr>
<td><strong>AUTHORIZATION NUMBER</strong></td>
<td>For <strong>C22: Service Delivery</strong>, the Reimbursement Authorization Tracking Number obtained from the <strong>C77: Reimbursement Authorization Inquiry</strong> screen for Adaptive Aids/Minor Home Modifications/Dental services. Only Reimbursement Authorization Tracking Numbers with approved status can be used in this field.</td>
</tr>
<tr>
<td><strong>AUTHORIZED DESIGNEE</strong></td>
<td>Full name of the person authorized to respond to contract related issues.</td>
</tr>
<tr>
<td><strong>BEG DT</strong></td>
<td>Begin date of the IPC. Note: If this date is incorrect, contact Medicaid Administration.</td>
</tr>
<tr>
<td><strong>BEHAVIOR PROGRAM</strong></td>
<td><strong>Y</strong> (Yes) or <strong>N</strong> (No) to indicate whether or not a behavior program is in place for the person.</td>
</tr>
<tr>
<td><strong>BILLABLE UNITS</strong></td>
<td>Term used by DADS to describe one (1) unit of a HIPAA Standard Procedure Code (e.g., HCPCS, Dental, or CPT code). Depending on the procedure code, one (1) unit may be equal to either 15 minutes or 1 day of service.</td>
</tr>
<tr>
<td><strong>BILLED AMOUNT</strong></td>
<td>For <strong>C22: Service Delivery</strong>, this field allows the provider to indicate the cost of providing the specific service. If left blank, the standard rate is applied.</td>
</tr>
<tr>
<td><strong>BILLING ADDRESS</strong></td>
<td>The billing contact’s billing address.</td>
</tr>
<tr>
<td><strong>BILLING CONTACT LAST NAME</strong></td>
<td>The last name of the billing contact’s name.</td>
</tr>
<tr>
<td><strong>BROAD INDEPENDENCE</strong></td>
<td>A number from the 3rd page of the ICAP Computer Report that reflects an individual’s ability to independently perform activities of daily living</td>
</tr>
<tr>
<td><strong>C.O. AUTHORIZE TRANSFER?</strong></td>
<td>Field for DADS Access &amp; Intake, Program Enrollment to authorize the transfer after the transfer has been accepted by the receiving provider.</td>
</tr>
<tr>
<td><strong>C/O</strong></td>
<td>Field that can be used as an extra address line.</td>
</tr>
<tr>
<td><strong>CALCULATE?</strong></td>
<td>Calculate the total annual cost of the IPC.</td>
</tr>
<tr>
<td><strong>CARE ID</strong></td>
<td><em>Same as Client ID.</em> Individual’s unique statewide identification number generated by the CARE system when each person is registered.</td>
</tr>
<tr>
<td><strong>CASE COORDINATOR</strong></td>
<td>Case coordinator’s name. The signature must be on the IPC in the individual’s chart.</td>
</tr>
<tr>
<td><strong>CASE MANAGER POSITION</strong></td>
<td>A code assigned to an MRA employee, usually an MRA service coordinator.</td>
</tr>
</tbody>
</table>
### Screen Fields, Continued

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

<table>
<thead>
<tr>
<th>Field</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>CONSUMER/LEGAL REPRESENTATIVE</td>
<td>Name of the individual or legal representative. The signature must be on the IPC in the individual’s chart.</td>
</tr>
<tr>
<td>CONSUMER STATUS</td>
<td>Individual’s enrollment status. (Pre-enroll, Active, Enrollment Denied, Enrollment Terminated, Hold, Transferred)</td>
</tr>
</tbody>
</table>
| CONTACT FREQ (Permanency Planning) | Code indicating the frequency of parent/guardian contact with the individual during the last six months.  
  1 = New Admission  
  2 = Daily  
  3 = Weekly  
  4 = Monthly  
  5 = 1-3 Times  
  6 = None |
| CONTACT INFO                 | Y (Yes) or Blank (No) to indicate whether you want to view contact information for Central Office staff who reviewed your Prior Approval packet/4116A. |
| CONTACT NAME (Permanency Planning) | The name of the permanency planning staff contact.                                                                                       |
| CONTACT PHONE (Permanency Planning) | The telephone number of the permanency planning staff contact.                                                                         |
| CONTACT TYPE                 | Indicates MHA (Mental Health Authority) or MRA (Mental Retardation Authority) for adding contact information.                              |
| CONTRACT NAME                | Name of the contract.                                                                                                                     |
| CONTRACT NUMBER              | Nine-digit number that identifies the contract under which an individual is receiving services.                                           |
| CONTRACTED PROVIDER NAME     | Name of the provider representative. The signature must be on the IPC in the individual’s chart and should be the name of the individual who signed the IPC. |
| CORRES. CITY                 | The primary/secondary correspondent’s city of residence.                                                                                  |
| CORRES. NAME                 | The primary/secondary correspondent’s name. The primary correspondent is the first person to contact on behalf of an individual in case of an emergency. The secondary correspondent is the person to contact on behalf of an individual if the primary correspondent cannot be reached. |
### Screen Fields, Continued

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

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

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

<table>
<thead>
<tr>
<th>Field</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>INTERNAL CONTROL NUMBER or ICN</strong></td>
<td>Number used to uniquely identify a single claim. An ICN will be assigned to a claim when at least 1 line item for that claim has passed the Phase 1 edits (i.e., has been accepted into the system).</td>
</tr>
<tr>
<td><strong>INTEREST COUNTY</strong></td>
<td>The county of residence of the individual or LAR.</td>
</tr>
<tr>
<td><strong>IPC BEGIN DATE</strong></td>
<td>Date the Individual Plan of Care (IPC) began.</td>
</tr>
<tr>
<td><strong>IPC END DATE</strong></td>
<td>Date the Individual Plan of Care (IPC) ends.</td>
</tr>
<tr>
<td><strong>IPC NON WAIVER SERVICES</strong></td>
<td>Services that will be provided to the individual that are not HCS or TxHmL waiver services.</td>
</tr>
<tr>
<td><strong>IPC REMAINING - AMTS TO BE PROVIDED</strong></td>
<td>Total dollars for all services minus the amounts the transferring provider will be paid for services provided prior to the transfer effective date.</td>
</tr>
<tr>
<td><strong>IQ</strong></td>
<td>Actual IQ score, if obtainable. IF IQ cannot be ascertained for a person because of the severity of the disability (such as profound mental retardation), 19 should be entered as the score.</td>
</tr>
<tr>
<td><strong>LAST NAME</strong></td>
<td>Last name of the service provider.</td>
</tr>
<tr>
<td><strong>LAST NAME/SUF</strong></td>
<td>Individual’s last name and suffix, if any.</td>
</tr>
<tr>
<td><strong>LAST REVISION DATE</strong></td>
<td>Date of the last revision.</td>
</tr>
<tr>
<td><strong>LEGAL GUARDIANSHIP</strong></td>
<td>Code that represents the individual’s legal guardianship status. 1 = Minor 2 = Minor w/Conservator 3 = Adult w/ Guardian of Estate and Person 4 = Adult w/ Guardian of Estate 5 = Adult w/Guardian of Person 6 = Adult w/Limited Guardian 7 = Adult w/Temporary Guardian 8 = Adult, No Guardian</td>
</tr>
<tr>
<td><strong>LEGAL STATUS</strong></td>
<td>Code to indicate the person’s legal status. 0 = Minor – less than 18 years of age (with parent/guardian) 1 = Minor (ward of the state) 2 = Minor w/conservator 3 = Adult w/guardian of estate and person 4 = Adult w/guardian of estate 5 = Adult w/guardian of person 6 = Adult w/limited guardianship 7 = Adult w/temporary guardian 8 = Adult, no guardian</td>
</tr>
<tr>
<td><strong>LEVEL OF CARE (LOC)</strong></td>
<td>A determination of eligibility of an individual for the HCS and/or TxHmL programs. Assignment of the LOC is based on medical and intellectual diagnosis and professional evaluation of the person’s needs.</td>
</tr>
<tr>
<td>Field</td>
<td>Description</td>
</tr>
<tr>
<td>-------------------------------</td>
<td>------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>LEVEL OF NEED (LON)</td>
<td>An assignment given to an individual enrolled in the HCS and/or TxHmL programs upon which reimbursement for services is based. The Level of Need determines the payment rate for Day Habilitation, Supervised Living, Residential Support Service, and Foster Care.</td>
</tr>
<tr>
<td>LINE ITEM</td>
<td>A single service or item submitted by the provider for payment. The line item contains information such as the billing procedure code, Staff ID, and date of service, or date range (for per diem services only). Claims are made up of one or more line items.</td>
</tr>
<tr>
<td>LINE NUMBER</td>
<td>Number used to uniquely identify a single line item within a claim. It is always used in conjunction with the ICN. Both the ICN and Line Number will be assigned to a line item when at least 1 line item on a claim has passed the Phase 1 edits (i.e., has been accepted into the system).</td>
</tr>
<tr>
<td>LOCAL CASE NUMBER</td>
<td>Number assigned to the individual by the provider. The number can be 1-10 characters with any combination of letters and numbers.</td>
</tr>
<tr>
<td>LOCATED FAMILY</td>
<td>Indicate whether the family could be located when needed within the last six months.</td>
</tr>
<tr>
<td>MAILING ADDRESS</td>
<td>The mailing address of the contract/provider.</td>
</tr>
<tr>
<td>MARITAL STATUS</td>
<td>Code that represents the individual’s marital status.</td>
</tr>
<tr>
<td></td>
<td>1 = Married</td>
</tr>
<tr>
<td></td>
<td>2 = Widowed</td>
</tr>
<tr>
<td></td>
<td>3 = Divorced</td>
</tr>
<tr>
<td></td>
<td>4 = Separated</td>
</tr>
<tr>
<td></td>
<td>5 = Never Married</td>
</tr>
<tr>
<td></td>
<td>6 = Unknown/NA</td>
</tr>
<tr>
<td>MEDICAID NUMBER</td>
<td>The number assigned by HHSC to an individual who receives Medicaid.</td>
</tr>
<tr>
<td></td>
<td>Note: The provider cannot change the Medicaid number of a currently enrolled HCS individual. Call DADS Access &amp; Intake, Program Enrollment if you feel the number is incorrect and needs to be changed.</td>
</tr>
<tr>
<td>MEDICAID RECIPIENT NUMBER</td>
<td>Number that uniquely identifies an individual in the Medicaid Eligibility file.</td>
</tr>
<tr>
<td>MEDICARE NUMBER</td>
<td>The number assigned by the SSA to an individual who receives Medicare.</td>
</tr>
<tr>
<td></td>
<td>Note: The provider cannot change the Medicare number of a currently enrolled HCS individual. Call DADS Access &amp; Intake, Program Enrollment if you feel the number is incorrect and needs to be changed.</td>
</tr>
<tr>
<td>MFP DEMO</td>
<td>Indicate whether the person is participating in the Money Follows the Person Demonstration Grant.</td>
</tr>
<tr>
<td>MHM</td>
<td>Local code for Minor Home Modifications. MHM is one of the services provided by the HCS and/or TxHmL programs.</td>
</tr>
</tbody>
</table>
### Screen Fields, Continued

<table>
<thead>
<tr>
<th>Field</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>MID INIT</td>
<td>Depending on the screen, the middle initial of the individual/CEO contact/program contact/guardian.</td>
</tr>
<tr>
<td>MIDDLE INITIAL</td>
<td>Middle initial of the service provider.</td>
</tr>
<tr>
<td>MIDDLE NAME</td>
<td>Individual’s middle name.</td>
</tr>
<tr>
<td>MINOR HOME MOD</td>
<td>The amount to be spent on minor home modifications. (Do not use commas - $$$$$ format.)</td>
</tr>
<tr>
<td>MINOR HOME MOD ASSESSMENT/BID</td>
<td>An assessment allowing the provider (HCS) or MRA (TxHmL) to seek a bid for the Minor Home Modifications.</td>
</tr>
<tr>
<td>MODIFIER</td>
<td>See Procedure Code Modifier.</td>
</tr>
<tr>
<td>MOVE DATE (MRA Assignment Notification)</td>
<td>The date the individual moves to the new location (address).</td>
</tr>
<tr>
<td>MRA</td>
<td>Mental Retardation Authority.</td>
</tr>
<tr>
<td>NAME</td>
<td>The individual’s name.</td>
</tr>
<tr>
<td>NEW FED ETHNICITY</td>
<td><strong>H</strong> for Hispanic or Latino or <strong>N</strong> for not Hispanic or Latino.</td>
</tr>
<tr>
<td>NEW SDO</td>
<td>The Service Delivery Option for the existing services the receiving or current program provider enters.</td>
</tr>
<tr>
<td>NURSE</td>
<td>Name of the nurse on the interdisciplinary team. The signature must be on the IPC in the individual’s chart.</td>
</tr>
<tr>
<td>ONSET</td>
<td>The month and year that the individual’s condition was diagnosed.</td>
</tr>
<tr>
<td>OPEN DATE</td>
<td>Date the location type opened.</td>
</tr>
<tr>
<td>PACKET STATUS</td>
<td>The latest enrollment/renewal packet status. Enrollment packet = Pre-enroll, In-progress, Complete, Hold Renewal packet = Pre-renew, Complete, Hold</td>
</tr>
</tbody>
</table>
| PERMANENCY PLAN GOAL          | Code indicating the permanency plan goal.  
1 = Return to family  
2 = Move to family-based alternative (e.g., foster, extended family care, open adoption)  
3 = Alternative living arrangement determined by individual and Legally Authorized Representative (LAR) (for individuals 18 through 21 only)  
4 = Remain in current residence as determined by individual and LAR (for individuals 18 through 21 only). |
| PERSON DIRECTED PLANS/SMRF COMMUNITY LIVING PLAN | A Person Directed Plan is completed by the MRA and a SMRF Community Living Plan is completed by the State School. |
| PHONE                         | Depending on the screen, the phone number of the CEO/billing/program contact.                                                               |
### Screen Fields, Continued

<table>
<thead>
<tr>
<th>Field</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>PHYS EXAM DATE</strong></td>
<td>Date of the individual’s physical examination.</td>
</tr>
<tr>
<td><strong>PHYSICAL ADDRESS</strong></td>
<td>CEO contact’s physical address.</td>
</tr>
</tbody>
</table>
| **PHYSICIANS EVALUATION AND RECOMMENDATION** | Physician’s assessment of the individual.  
  Note: Fields in this section are **not** required for waiver programs.  
  Note: If this screen is used, **all** entries must be completed. |
| **PLACE OF SERVICE or POS**              | One of five code sets providers use in **C22: Service Delivery** to bill for services. POS codes are used to identify the physical location where services were provided. |
| **PRESENTING PROBLEM**                   | Code representing the individual’s presenting problem.  
  1 = MH (Mental Health)  
  2 = MR (Mental Retardation)  
  3 = ECI/DD (Early Childhood Intervention/Developmentally Delayed)  
  4 = SA (Substance Abuse)  
  5 = Related Condition - MR |
| **PREV. RES.**                            | Code to indicate the individual’s previous residence location (program) immediately before the current enrollment.  
  1 = Home (not enrolled in any program)  
  2 = Hospital  
  3 = Another ICF/MR community-based facility  
  4 = HCS provider services  
  5 = State hospital or state school  
  6 = Nursing facility  
  7 = Other  
  8 = Cannot determine |
<p>| <strong>PRIMARY CORRESPONDENT</strong>                | Name of the individual’s primary correspondent. |
| <strong>PRIMARY DIAG</strong>                         | Individual’s current primary diagnosis (not symptoms) as determined by a physician. |
| <strong>PROCEDURE CODE MODIFIER</strong>              | One of five code sets providers use in <strong>C22: Service Delivery</strong> to bill for services. A Procedure Code Modifier is a two-digit code that further defines the services described by a HCPCS, CPT® or Dental procedure code. DADS uses modifiers to distinguish between services that are billed using the same HCPCS or CPT® code (e.g., SL and RSS, OT and PT). |
| <strong>PROCEDURE CODE QUALIFIER</strong>             | One of five code sets providers use in <strong>C22: Service Delivery</strong> to bill for services. Procedure Code Qualifier <strong>HC</strong> indicates that HCPCS or CPT® procedure codes are being used to bill for services. Procedure Code Qualifier <strong>AD</strong> indicates that Dental procedure codes are being used to bill for services. |
| <strong>PROGRAM CONTACT LAST NAME</strong>            | The program contact’s last name. |
| <strong>PROJECTED RETURN DATE</strong>                | Individual’s projected return date. |</p>
<table>
<thead>
<tr>
<th>Field</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>PROVIDER COMMENTS</td>
<td>The MRA may enter comments for DADS review.</td>
</tr>
<tr>
<td>PROVIDER COMPONENT</td>
<td>Component code of the program provider chosen by the individual for <strong>L05: Provider Choice.</strong></td>
</tr>
<tr>
<td>PROVIDER CONTRACT NUMBER</td>
<td>Contract number of the program provider chosen by the individual for <strong>L05: Provider Choice.</strong></td>
</tr>
<tr>
<td>PROVIDER LOCAL CASE NUMBER</td>
<td>Local case number that the program provider assigned the individual for <strong>L05: Provider Choice.</strong></td>
</tr>
<tr>
<td>PROVIDER REPRESENTATIVE NAME</td>
<td>Name of the provider representative.</td>
</tr>
<tr>
<td>PSYCHIATRIC DIAG</td>
<td>Diagnosis of an individual’s current mental disorder(s), if applicable, as defined in the DSM.</td>
</tr>
<tr>
<td>PURPOSE CODE</td>
<td>Code to indicate the purpose of the MR/RC Assessment.</td>
</tr>
<tr>
<td></td>
<td>2 = No Current Assessment</td>
</tr>
<tr>
<td></td>
<td>3 = Continued Stay Assessment</td>
</tr>
<tr>
<td></td>
<td>4 = Change LON on Existing Assessment</td>
</tr>
<tr>
<td></td>
<td>E = Gaps in Assessment</td>
</tr>
<tr>
<td>QUALIFIER</td>
<td>See Procedure Code Qualifier.</td>
</tr>
<tr>
<td>READY TO ADD?</td>
<td>Determine the action you want to take to submit the data to the system or cancel your request to add data.</td>
</tr>
<tr>
<td>READY TO CHANGE?</td>
<td>Determine the action you want to take to submit the data to the system or cancel your request to change data.</td>
</tr>
<tr>
<td>READY TO CORRECT?</td>
<td>Determine the action you want to take to submit the data to the system or cancel your request to correct data.</td>
</tr>
<tr>
<td>READY TO REACTIVATE?</td>
<td>Determine the action you want to take to submit the data to the system or cancel your request to reactivate.</td>
</tr>
<tr>
<td>READY TO RENEW?</td>
<td>Determine the action you want to take to submit the data to the system or cancel your request to renew the IPC.</td>
</tr>
<tr>
<td>READY TO REVISE?</td>
<td>Determine the action you want to take to submit the data to the system or cancel your request to revise data.</td>
</tr>
<tr>
<td>READY TO SEND FOR AUTHORIZATION?</td>
<td>Determine whether you want to submit the MR/RC Assessment to Utilization Review (UR).</td>
</tr>
<tr>
<td>READY TO TRANSFER?</td>
<td>Determine the action you want to take to submit the data to the system or cancel your request to transfer.</td>
</tr>
<tr>
<td>REC. LOC</td>
<td>Code identifying the recommended level of care for the individual.</td>
</tr>
<tr>
<td></td>
<td>0 = Denial of LOC (only entered by DADS)</td>
</tr>
<tr>
<td></td>
<td>1 = Mild to Profoundly Mentally Retarded or Related Conditions with an IQ of 75 or below</td>
</tr>
<tr>
<td></td>
<td>8 = Primary Diagnosis is a Related Condition with an IQ of 76 and above</td>
</tr>
<tr>
<td>REC. LON</td>
<td>Code identifying the recommended level of need for the individual.</td>
</tr>
</tbody>
</table>
### Screen Fields, Continued

<table>
<thead>
<tr>
<th>Field</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>RECEIVING AUTHORITY Accepted By</td>
<td>The name of the receiving MRA contact person.</td>
</tr>
<tr>
<td>(MRA Assignment Notification)</td>
<td></td>
</tr>
<tr>
<td>RECEIVING AUTHORITY DATE (MRA Assignment</td>
<td>The date the MRA entered the data.</td>
</tr>
<tr>
<td>Notification)</td>
<td></td>
</tr>
<tr>
<td>REGISTRATION EFFECTIVE DATE (MMDDYY)</td>
<td>Effective date of the individual’s registration, the formal enrollment into the CARE system</td>
</tr>
<tr>
<td></td>
<td>which establishes that an individual is registered to receive services from the system.</td>
</tr>
<tr>
<td></td>
<td>Registration is done by the MRA only.</td>
</tr>
<tr>
<td>REGISTRATION EFFECTIVE TIME (HHMM A/P)</td>
<td>Effective time of the individual’s registration.</td>
</tr>
<tr>
<td>RESIDENTIAL TYPE (entered on IPC)</td>
<td>Individual’s residence type. 2 = Foster/companion care</td>
</tr>
<tr>
<td></td>
<td>3 = Own home/family home (OHFH)</td>
</tr>
<tr>
<td></td>
<td>4 = Supervised Living</td>
</tr>
<tr>
<td></td>
<td>5 = Residential Support</td>
</tr>
<tr>
<td>REV DT</td>
<td>Effective date of revisions made to the IPC. This field is required if the TYPE OF ENTRY is R</td>
</tr>
<tr>
<td></td>
<td>(Revision).</td>
</tr>
<tr>
<td>REVENUE CODE</td>
<td>One of five code sets providers use in C22: Service Delivery to bill for services. A Revenue</td>
</tr>
<tr>
<td></td>
<td>Code groups services into distinct cost centers. Revenue codes are required on the C22: Service</td>
</tr>
<tr>
<td></td>
<td>Delivery screen when billing for services other than adaptive aids, minor home modifications,</td>
</tr>
<tr>
<td></td>
<td>and dental.</td>
</tr>
<tr>
<td>REVIEW DATE</td>
<td>Date of the permanency planning review.</td>
</tr>
<tr>
<td>REVISION DATE</td>
<td>Effective date of revisions made to the IPC. This field is required if the TYPE OF ENTRY is R</td>
</tr>
<tr>
<td></td>
<td>(Revision).</td>
</tr>
<tr>
<td>SELF-INJURY BEHAVIOR</td>
<td>Behavior which may result in physical injury to one’s self.</td>
</tr>
<tr>
<td>SECONDARY CORRESPONDENT</td>
<td>Name of the individual’s secondary correspondent.</td>
</tr>
<tr>
<td>SENDING AUTHORITY DATE (MRA Assignment</td>
<td>The date the Sending Authority entered the data.</td>
</tr>
<tr>
<td>Notification)</td>
<td></td>
</tr>
<tr>
<td>SENDING AUTHORITY CONTACT NAME</td>
<td>The name of the Sending Authority MRA contact person.</td>
</tr>
<tr>
<td>(MRA Assignment Notification)</td>
<td></td>
</tr>
<tr>
<td>SENDING AUTHORITY PHONE (MRA Assignment</td>
<td>The area code and telephone number of the Sending Authority MRA contact person.</td>
</tr>
<tr>
<td>Notification)</td>
<td></td>
</tr>
<tr>
<td>SERIOUS DISRUP BEH</td>
<td>Behavior that seriously disrupts social activities or results in property damage.</td>
</tr>
<tr>
<td>Field</td>
<td>Description</td>
</tr>
<tr>
<td>-------</td>
<td>-------------</td>
</tr>
<tr>
<td><strong>SERVICE (Waiver MR/RC Assessment)</strong></td>
<td>(Non-Vocational or Vocational) Whether and what kind of day services in which the individual participates.</td>
</tr>
<tr>
<td><strong>SERVICE CATEGORY or SVC CATEGORY or SVC CAT</strong></td>
<td>For C89: Claims Inquiry, this field indicates the formerly used bill code. You may enter this service category code or the HCPCS procedure code and modifier.</td>
</tr>
<tr>
<td><strong>SERVICE CODE</strong></td>
<td>One of five code sets providers use in C22: Service Delivery to bill for services. HCPCS and CPT® procedure codes are used in this field.</td>
</tr>
<tr>
<td><strong>SERVICE COUNTY or SVC CNTY</strong></td>
<td>Code for the county in which an individual is receiving services.</td>
</tr>
<tr>
<td><strong>SERVICE DATE</strong></td>
<td>Date services were provided.</td>
</tr>
<tr>
<td><strong>SERVICE DATE FOR MM-YYYY</strong></td>
<td>The month and year of the requested service date. If you requested a date in the current month, the days of the month are displayed with the cursor in the field for the date specified. You can enter data for days prior to and including the current date. You <strong>cannot</strong> enter data for future dates. If you requested a date in the previous month, the days for the month are displayed with the cursor in the date you specified. You can enter data for any day of the month.</td>
</tr>
<tr>
<td><strong>SERVICE PROVIDER</strong></td>
<td>Code to indicate if nursing services are provided by an LVN or RN.</td>
</tr>
<tr>
<td><strong>SERVICE TYPE</strong></td>
<td>Type of service based on the code entered on the request screen.</td>
</tr>
<tr>
<td><strong>SERVICES BEGIN DATE</strong></td>
<td>The date the waiver services will begin.</td>
</tr>
<tr>
<td><strong>SERVICES PAID</strong></td>
<td>Dollars for all services by service category.</td>
</tr>
<tr>
<td><strong>SEX</strong></td>
<td>Code indicating the individual’s sex. (M = Male, F = Female)</td>
</tr>
<tr>
<td><strong>SEXUAL AGGRESSIVE BEHAVIOR</strong></td>
<td>Trying to impose one’s sexual desires on another individual who is unwilling or unable to consent to such activities</td>
</tr>
<tr>
<td><strong>SLOT TRACKING NUMBER</strong></td>
<td>The number assigned to a specific type of slot. <strong>Note:</strong> the MRA can only enter the Slot Tracking Number or the Slot Type field.</td>
</tr>
<tr>
<td><strong>SLOT TYPE</strong></td>
<td>Refers to HCS waiver category offered to the individual.</td>
</tr>
<tr>
<td><strong>SOCIAL SECURITY NUMBER</strong></td>
<td>Individual’s social security number. (N=None, U=Unknown)</td>
</tr>
<tr>
<td><strong>STAFF BEGIN DATE</strong></td>
<td>Date the staff member began providing services at your program.</td>
</tr>
<tr>
<td><strong>STAFF ID</strong></td>
<td>Staff member’s identification number. <strong>Note:</strong> Providers define their own staff ID numbers. The numbers can be alpha or numeric or alphanumeric and up to five characters in length.</td>
</tr>
</tbody>
</table>
### Screen Fields, Continued

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

<table>
<thead>
<tr>
<th>Field</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>TERMINATION REVIEWED BY:</strong></td>
<td>The name of the MRA Representative who reviewed the termination request and the date the request was reviewed. Note: the date entered should be the same as the <strong>Effective Date of Discharge</strong> located under the signature line.</td>
</tr>
<tr>
<td><strong>DATE:</strong></td>
<td>The registration effective time.</td>
</tr>
<tr>
<td><strong>TIME (HHMM A/P)</strong></td>
<td>The registration effective time.</td>
</tr>
<tr>
<td><strong>TIME OF DEATH</strong></td>
<td>If the <strong>TERMINATION REASON</strong> is <strong>Death</strong>, indicates the time of the death.</td>
</tr>
<tr>
<td><strong>TO BE PROVIDED NOW TO TRANSFER DT</strong></td>
<td>Dollars to be provided between today and the transfer effective date for all services that have not been entered. Note: If no amount is entered, the transferring provider will not be able to enter any additional services for that individual.</td>
</tr>
<tr>
<td><strong>TO USE</strong></td>
<td>The number of units to be used from now to transfer effective date (units that have not been claimed) for the transferring program and/or the transferring CDSA. The entry must be a valid number or “NA.” The field will allow decimal fraction of units up to two decimal places (dollars for CDS services).</td>
</tr>
<tr>
<td><strong>TOTAL ANNUAL COST</strong></td>
<td>Total annual cost of the IPC.</td>
</tr>
<tr>
<td><strong>TRANSFER ACCEPTED?</strong></td>
<td>Indicates whether the provider receiving the individual accepts the transfer. The receiving provider completes this field <strong>after</strong> the transfer IPC has been entered.</td>
</tr>
<tr>
<td><strong>TRANSFER EFFECTIVE DATE</strong></td>
<td>Effective date of the individual’s transfer.</td>
</tr>
<tr>
<td><strong>TRANSFER TO COMPONENT</strong></td>
<td>Three-digit code of the component to which the individual is transferring. Note: The provider transferring the individual completes this field. When the receiving provider accesses this screen, this field is displayed.</td>
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<td><strong>TRANSFER TO CONTRACT NUMBER</strong></td>
<td>Contract number to which the individual is transferring.</td>
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<tr>
<td><strong>TRANSFER TO SERVICE COUNTY</strong></td>
<td>Service county to which the individual is transferring. See the <strong>County Codes</strong> section for a list of county codes and names.</td>
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<td><strong>TRAUMATIC BRAIN INJURY</strong></td>
<td>Indicate whether the person has a history of traumatic brain injury.</td>
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<tr>
<td><strong>TXHML STATUS</strong></td>
<td>The status of the individual’s TxHmL offer.</td>
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<td><strong>TYPE OF DISCHARGE</strong></td>
<td>Type of discharge (P=Permanent, T=Temporary).</td>
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<td>Determine the action you want to take. (A=Add, C=Change/Correct, D=Delete).</td>
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<td><strong>TYPE OF ENTRY</strong> (Individual Plan of Care)</td>
<td>Type of IPC (Individual Plan of Care) being entered.</td>
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<td>(entered on C:24 Location and C25: Location Type Modification screens)</td>
<td>2 = Foster/Companion Care</td>
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<td>3 = 3-bed facility</td>
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<td>4 = 4-bed facility</td>
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<td><strong>UNITS</strong></td>
<td>Units (hours, days, or months) the service was provided.</td>
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<td><strong>UNITS REMAIN IN IPC</strong></td>
<td>The remaining units in the IPC for the type of service requested.</td>
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<td>Indicates whether the units are by hours, days, or months.</td>
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<tr>
<td><strong>VIEW COMMENTS</strong></td>
<td>Y (Yes) or Blank (No) to indicate whether you want to view comments made</td>
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<td>by your reviewer concerning your Prior Approval packet/4116A.</td>
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<td><strong>ZIP CODE</strong></td>
<td>Depending on the screen, the zip code of the individual/primary correspond-</td>
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<td><strong>ZIP CODE/SUFFIX</strong></td>
<td>Individual’s zip code and suffix.</td>
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<td><strong># VISITS BY FAM</strong></td>
<td>Number of visits to the facility by the parent/guardian.</td>
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<td><strong># VISITS TO FAM</strong></td>
<td>Number of the resident’s visits to the home.</td>
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<td>The waiver type in which the individual is to be enrolled.</td>
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<td>Zavala</td>
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# Glossary

## Introduction

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

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

## Adult

A person who is 18 years of age or older.

## Actively involved

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

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

## Allowable Cost

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

## Applicant

Depending on the context, an applicant is:

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

## Assignment (to Location Code)

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

## Authorized Amount

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

## Billable Unit

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

<p>| <strong>Budget</strong> | A written projection of expenditures for each program service delivered through the CDS option. |
| <strong>Budgeted Unit Rate</strong> | The unit rate calculated for employee compensation (wages and benefits) in the budgeting process for services delivered through the CDS option. The rate is calculated after employer support services have been budgeted. |
| <strong>CARE (Client Assignment and REgistration) System</strong> | Centralized, confidential client database, in which service recipients are registered and tracked. |
| <strong>CARE CDS Service Codes</strong> | In the CARE system, all services being self-directed have acronyms that end in “V.” For example, in HCS with Supported Home Living (SHL), this service will appear as “SHLV.” |
| <strong>Case Manager</strong> | A person who provides case management services to an individual. The case manager assists an individual who receives program services in gaining access to needed services, regardless of the funding source for the services, and assists with other duties as required by the individual’s program. In the HCS Program, an individual is assigned a case manager. |
| <strong>CDS Option (Consumer Directed Services)</strong> | A service delivery option that allows individuals or their legally authorized representatives to be the employer of their direct service providers by recruiting, hiring, training, supervising, and terminating their service providers. Services that can be self-directed vary depending on the DADS program. |
| <strong>Certified HCS Provider</strong> | A contracted HCS program provider, serving enrolled individuals, that has received an on-sight survey by DADS and has demonstrated compliance with the HCS Principles. |
| <strong>Certified TxHmL Provider</strong> | A contracted TxHmL program provider, serving enrolled individuals, that has received an on-sight survey by DADS and has demonstrated compliance with TxHmL standards. |
| <strong>Claim</strong> | A service that is submitted by the provider for payment. Each claim must be for one individual, one contract, one service type, one month, one place of service, and one level of need. A single claim may include multiple dates of service within the month. |
| <strong>Client Identification Number (Client ID)</strong> | Unique statewide identifier generated by the CARE system when each person is registered by the Mental Retardation Authority. Also referred to as the CARE ID. |</p>
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<th><strong>Glossary, Continued</strong></th>
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<tr>
<td><strong>Client/Consumer</strong> A person enrolled in the HCS and/or TxHmL program.</td>
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<tr>
<td><strong>Community-Based Services</strong> Services provided within the community by community centers or private providers. Includes the array of services reflected on the IPC.</td>
</tr>
<tr>
<td><strong>Component Code</strong> Three-digit unique code that identifies a state hospital, state school, state center, community center, or private provider. You must provide this three-digit code each time you contact DADS.</td>
</tr>
<tr>
<td><strong>Comptroller Vendor Number</strong> Fourteen-digit number by which the State of Texas Comptroller’s office identifies the provider.</td>
</tr>
<tr>
<td><strong>Consumer Directed Services Agency (CDSA)</strong> An agency that contracts with DADS to provide financial management services (FMS) to individuals who choose to use the consumer directed services option.</td>
</tr>
<tr>
<td><strong>Consumer Enrollment</strong> Process of enrolling an individual into HCS and/or TxHmL in which the local Mental Retardation Authority has the responsibility of completing all steps in the enrollment process, including developing the PDP, MRRC, and IPC, monitoring the financial eligibility determination process, and electronically submitting information to the DADS, Program Enrollment/Utilization Review unit for review. The Program Enrollment unit approves all enrollments into the HCS or TxHmL program.</td>
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<tr>
<td><strong>Consumer Hold</strong> Consumer hold may be temporary hold or permanent hold and results in withholding of payment after claims have been submitted. Reasons for consumer hold are listed on the Consumer Hold Report (HC062270).</td>
</tr>
<tr>
<td><strong>Contract Number</strong> Nine-digit number that identifies the contract under which an individual is receiving services.</td>
</tr>
<tr>
<td><strong>Contractor</strong> A person, such as a licensed or certified therapist, a licensed or registered nurse, or other professional, who has a service agreement with an employer to perform one or more program services as an independent contractor, rather than an employee of the employer or of an entity. A contractor may be a sole proprietor.</td>
</tr>
<tr>
<td><strong>Correspondent</strong> In case of an emergency, the primary correspondent is the first person to contact on behalf of an individual. This person is not necessarily a relative or financially responsible for the care of the individual being served. The secondary correspondent is the person to contact on behalf of an individual if the primary correspondent cannot be reached.</td>
</tr>
</tbody>
</table>
Glossary, Continued

Cost Ceiling  See *Authorized Amount*.

CPT® Code  Current Procedural Terminology (CPT®) is a set of procedure codes providers use to bill for services in **C22: Service Delivery**. CPT® Codes are used in the **SERVICE CODE** field.

DADS  The Department of Aging and Disability Services.

Designated Representative (DR)  An adult who is chosen by the employer (individual or LAR) to assist or to perform employer responsibilities in the CDS option. This individual must be willing to perform these duties on a volunteer basis, must be age 18 years or older, must pass a criminal background check and must not be listed on either the Employee Misconduct Registry or the Nurse Aid Registry.

Discharge  **Permanent Discharge (PD)**: the termination of services to the individual by DADS because the individual has voluntarily left the program or is found to be ineligible for the program.

**Temporary Discharge (TD)**: the suspension of services to the individual by the provider while the individual is unable, ineligible, or unwilling to receive services.

Electronic Transmission Agreement (ETA)  A DADS form that providers use to request access to a secure server. Access may be for the provider, a clearinghouse that the provider has designated to transmit X12 transactions on its behalf, or any provider to retrieve reports from the EDTS server.

Employee  A person employed by an employer through a service agreement to deliver program services and is paid an hourly wage for those services.

Employer  An individual or LAR who chooses to participate in the CDS option, and, therefore, is responsible for hiring and retaining service providers to deliver program services. In the CDS option the employer must be either the individual receiving services (who is at least 18 years of age and does not have a legal guardian), a parent, or legal representative of a minor-aged individual, or the legal guardian, regardless of the age of the individual receiving services.

Employer-Agent  The Internal Revenue Service (IRS) designation of a CDSA as the entity responsible for specific activities and responsibilities required by the IRS on behalf of an employer in the CDS option.
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<td><strong>HCPCS</strong></td>
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<td><strong>Home and Community-Based Services (HCS) Waiver Program</strong></td>
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<td><strong>ICAP Service Level</strong></td>
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<td><strong>ICF/MR</strong></td>
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### Glossary, Continued

| **Individual** | A person enrolled in a program. |
| **Individual Plan of Care (IPC)** | A format for documentation of services needed by a person receiving services in the HCS or TxHmL program. The IPC is based on an assessment of the individual’s needs and personal goals and is developed by qualified individuals. The IPC contains the specific types of services required to support an individual in the community, the units of services, and the estimated annual cost. |
| **Individual Service Plan (ISP)** | A written plan developed by the Interdisciplinary Team that describes the individual’s characteristics, desires, needs, and personal outcomes, the waiver and non-waiver services necessary to achieve the individual’s outcomes, the objectives and methodologies related to each service, and the justification for each service. The ISP must be reviewed and updated at least annually and as the individual’s circumstances change. The ISP describes the services to be included in the IPC. |
| **Interdisciplinary Team (IDT)** | A planning team constituted by the provider consisting of the individual and Legally Authorized Representative (LAR), a case manager, a nurse, other persons chosen by the individual/LAR, and professional or direct care staff necessary to address the needs and desires of the individual. |
| **Internal Control Number or ICN** | An ICN is used to uniquely identify a single claim. An ICN will be assigned to a claim when at least 1 line item for that claim has passed the Phase 1 edits (i.e., has been accepted into the system). |
| **Inventory for Client and Agency Planning (ICAP)** | A validated, standardized assessment that measures the level of assistance and supervision an individual requires and, thus, the amount and intensity of services and supports an individual needs. |
| **Legally Authorized Representative (LAR)** | A person authorized or required by law to act on behalf of an individual with regard to a matter described in this chapter, including a parent, guardian, managing conservator of a minor, or the guardian of an adult. |
| **Level of Care (LOC)** | A determination of eligibility of an individual for the ICF/MR, HCS, or TxHmL programs. Assignment of the LOC is based on medical and intellectual diagnosis and professional evaluation of the person’s needs. |
| **Level of Need (LON)** | An assignment given to an individual enrolled in the ICF/MR, HCS, or TxHmL programs upon which reimbursement for services is based. The Level of Need determines the payment rate for Day Habilitation, Supervised Living, Residential Support Service, and Foster Care in HCS and the daily rate in community ICF/MRs. |
| **Line Item** | The part of the claim that specifies the date of service. Multiple line items can be included as part of one claim. |
| **Line Number** | Number used to uniquely identify a single line item within a claim. It is always used in conjunction with the ICN. Both the ICN and Line Number will be assigned to a line item when at least 1 line item on a claim has passed the Phase 1 edits (i.e., has been accepted into the system). |
| **Local Case Number** | Number assigned to the individual by the provider. The local case number can be 1-10 characters with any combination of letters and numbers. When an individual moves from one provider to another, the new provider must assign a local case number. |
| **Location Code** | Code used to identify a home in which residential services are provided. The Location Code can be 1-4 characters with any combination of letters and numbers. |
| **Logon Account Number (User ID Number)** | Number assigned to each user by DADS that identifies the user and allows that user to access the network. |
| **Mental Retardation Authority (MRA)** | An entity to which the Texas Health and Human Services Commission’s authority and responsibility described in THSC, §531.002(11) has been delegated. |
| **Minor** | A person who is 17 years of age or younger. |
| **Minor Home Modification/Adaptive Aids/Dental Summary Sheet (4116A)** | A form that is used to request Reimbursement Authorization for adaptive aids, minor home modifications, or dental services. |
| **Modifier** | See Procedure Code Modifier. |
| **MR/RC Assessment** | A form utilized by DADS for eligibility determination, LOC determination, and LON assignment. Refer to the MR/RC Assessment instructions at http://www.dads.state.tx.us/handbooks/instr/8000/F8578-HCS/ for definitions of the terms used on the MR/RC. |
| **Non-Program Resource** | A resource other than an individual’s program that provides one or more support services or items. |
| **Parent** | A natural, legal, foster, or adoptive parent of a minor. |
| **Permanency Planning** | A philosophy and planning process that focuses on the outcome of family support for an individual under 22 years of age by facilitating a permanent living arrangement in which the primary feature is an enduring and nurturing parental relationship. |
| **Person-Directed Plan (PDP)** | The service plan for individuals in the TxHmL program that describes the supports and services necessary to achieve the desired outcomes identified by the individual, or the LAR on behalf of the individual. This document identifies the program services to be provided to the individual, the number of units of each service to be provided, and the projected cost of each service. |
| **Place of Service or POS** | One of five code sets providers use in C22: Service Delivery to bill for services. POS codes are used to identify the physical location where services were provided. |
| **Prior Approval** | Approval for those adaptive aids (AA) and minor home modifications (MHM) that have not been purchased. Providers may obtain prior approval to determine how much DADS will pay for a particular AA or MHM. Providers submit the AA/MHM Request for Prior Approval form to DADS, Provider Services, Billing and Payment unit to request approval of an AA or MHM prior to its purchase. Submitted requests will be assigned a Prior Approval (PA) Tracking Number. Providers are responsible for accessing C75: Prior Approval Inquiry to look up the PA Tracking Number and status for a submitted request. |
| **Prior Authorization** | A general term used in the healthcare industry to describe a process in which providers are responsible for getting services authorized, usually before the services have been provided, but in some cases afterward. Both Prior Approval and Reimbursement Authorization are types of prior authorization. |
| **Procedure Code Modifier** | One of five code sets providers use in C22: Service Delivery to bill for services. A Procedure Code Modifier is a two-digit code that further defines the services described by a HCPCS, CPT®, or Dental procedure code. DADS uses modifiers to distinguish between services that are billed using the same HCPCS or CPT® code (e.g., SL and RSS, OT and PT). |
| **Procedure Code Qualifier** | One of five code sets providers use in C22: Service Delivery to bill for services. Procedure Code Qualifier HC indicates that HCPCS or CPT® procedure codes are being used to bill for services. Procedure Code Qualifier AD indicates that Dental procedure codes are being used to bill for services. |
### Glossary, Continued

<table>
<thead>
<tr>
<th>Term</th>
<th>Definition</th>
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<tbody>
<tr>
<td><strong>Program</strong></td>
<td>A community services program administered by DADS.</td>
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<tr>
<td><strong>Program Unit</strong></td>
<td>A term used by DADS to describe one (1) unit of service as it appears on the IPC. Depending on the service type, one (1) unit may be equal to 1 hour, 1 day, or 1 month of service.</td>
</tr>
<tr>
<td><strong>Provider</strong></td>
<td>A service provider with whom the department contracts for the delivery of community-based mental retardation services in a specified local service area (contract area) of the state.</td>
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<td><strong>Program Provider (PRGP)</strong></td>
<td>In the CDS option, this term refers to the individual’s comprehensive program provider agency.</td>
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<td><strong>Provisionally Certified HCS Provider</strong></td>
<td>A legal entity that has completed the application process to become an HCS program provider, including submission of required contract information and an HCS Self-Assessment, attendance at the Pre-Application Orientation and New Provider Orientation, and demonstration of an HCS Self-Assessment that is in 100% compliance with the HCS Principles. Provisional certification must be obtained prior to the legal entity contracting with DADS as an HCS program provider.</td>
</tr>
<tr>
<td><strong>Provisionally Certified TxHmL Provider</strong></td>
<td>A legal entity that has completed the application process to become a TxHmL program provider. Provisional certification must be obtained prior to the legal entity contracting with DADS as a TxHmL program provider.</td>
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<tr>
<td><strong>Qualifier</strong></td>
<td>See Procedure Code Qualifier.</td>
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<tr>
<td><strong>Registration</strong></td>
<td>Formal enrollment into the CARE system which establishes that an individual is registered to receive services. Registration is done by the MRA only.</td>
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<tr>
<td><strong>Reimbursement Authorization</strong></td>
<td>Authorization that providers request from DADS to bill for adaptive aids (AA), minor home modifications (MHM), or dental (DE) services that have already been purchased and which may or may not have gone through the Prior Approval process. When providers submit a Minor Home Modification/Adaptive Aids/Dental Summary Sheet (4116A) with receipts and any other needed information, they are requesting Reimbursement Authorization (i.e., authorization for payment). Once Reimbursement Authorization has been given an “approved” status in C77: Reimbursement Authorization Inquiry, providers may bill for the AA, MHM, or DE service using C22: Service Delivery. The Reimbursement Authorization (RA) Tracking Number obtained from C77 should be used as the authorization number in C22. Providers are responsible for reviewing C77 to obtain the RA Tracking Number and status for a submitted request.</td>
</tr>
</tbody>
</table>
Related Condition  A severe, chronic disability that meets all of the following conditions:  
(A) a condition attributable to:  
   (i) cerebral palsy or epilepsy; or  
   (ii) any other condition including autism, but excluding mental illness, found to be closely related to mental retardation because this condition results in impairment of general intellectual functioning or adaptive behavior similar to that of persons with mental retardation and requires treatment or services similar to those required for these persons;  
(B) a condition manifested before the person reaches age 22 years;  
(C) a condition likely to continue indefinitely; and  
(D) a condition that results in substantial functional limitations in three or more of the following areas of major life activity:  
   (i) self-care;  
   (ii) understanding and use of language;  
   (iii) learning;  
   (iv) mobility;  
   (v) self-direction; and  
   (vi) capacity for independent living.

Residential Type  Code for the type of residential services the individual is receiving.  
(for IPC entry)  See the Screen Fields section of this User Guide for the complete list of Residential Type codes.

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

SDO  See Service Delivery Option

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

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

Service Back-Up Plan  A documented plan to ensure that critical program services delivered through the CDS option are provided to an individual when normal service delivery is interrupted or there is an emergency.
### Glossary, Continued

<table>
<thead>
<tr>
<th><strong>Service Code</strong></th>
<th>One of five code sets providers use in C22: Service Delivery to bill for services. HCPCS and CPT® procedure codes are used in the Service Code field.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Service Coordinator</strong></td>
<td>An employee of a mental retardation authority who is responsible for assisting an applicant, individual, or LAR to access needed medical, social, educational, and other appropriate services, including DADS program services. A service coordinator provides case management services to an individual in the TxHmL program.</td>
</tr>
<tr>
<td><strong>Service County</strong></td>
<td>County in which an individual is receiving services.</td>
</tr>
<tr>
<td><strong>Service Delivery Option (SDO)</strong></td>
<td>The manner in which individuals choose to receive their program services. In HCS, an individual can choose to self-direct supported home living and respite while having the remainder of their services provided by their program provider. An individual may also choose to have all of their services delivered by their program provider with the agency option. In TxHmL, an individual may choose to use CDS with ALL of their services. An individual may also choose to have a program provider agency provide all of their services, or may choose to self-direct some services while having a program provider deliver others.</td>
</tr>
<tr>
<td><strong>Service Plan</strong></td>
<td>A document developed in accordance with rules governing an individual’s program that identifies the program services to be provided to the individual, the number of units of each service to be provided, and the projected cost of each service.</td>
</tr>
<tr>
<td><strong>Service Planning Team</strong></td>
<td>A group of people convened to plan services and supports with an individual receiving services, determined based on the requirements of an individual's program. Some DADS programs refer to the service planning team as an interdisciplinary team.</td>
</tr>
<tr>
<td><strong>Service Provider</strong></td>
<td>An employee, contractor, or vendor.</td>
</tr>
<tr>
<td><strong>Service Type (for Waiting List entry)</strong></td>
<td>Code for the type of service the individual is waiting to receive.</td>
</tr>
</tbody>
</table>
**Slot Tracking Number**
When an individual is enrolled in the waiver program, a Slot Tracking Number is assigned to the individual if the slot is classified as new allocation. When an individual is permanently discharged from the waiver program, the status of the Slot Tracking Number is automatically changed to unavailable. When a slot is released for use, the slot is assigned to a particular slot type and the status is changed to available. When an MRA enters the L01 screen and the individual has an assigned Slot Tracking Number, the slot type is omitted and the Slot Tracking Number is entered.

**Slot Type**
The slot type is determined by the specific funding allocation from the Texas Legislature.

**Support Advisor**
A person who provides support consultation to an employer, or a DR, or an individual receiving services through the CDS option. This person must have been certified through DADS to provide the service.

**Support Consultation**
An optional service that is provided by a support advisor and provides a level of assistance and training beyond that provided by the CDSA through FMS. Support consultation helps an employer to meet the required employer responsibilities of the CDS option and to successfully deliver program services.

**Texas Home Living (TxHmL) Waiver Program**
A Medicaid waiver program which provides community-based services and supports to eligible individuals who live in their own homes or in their family homes.

**Transfer**
The movement of an individual from one provider to a different provider or from one contract to another contract. All transfers must be approved by Program Enrollment staff of DADS, Access and Intake, Mental Retardation Authorities.

**Vendor**
A person selected by an employer or DR to deliver services, goods, or items, other than a direct service to an individual. Examples of vendors include a building contractor, electrician, durable medical equipment provider, pharmacy, or a medical supply company.

**Vendor Hold**
Temporary suspension of payment from department to a program provider.

**Working Day**
Any day except Saturday, Sunday, a state holiday, or a federal holiday.

**4116A Form**
See *Minor Home Modification/Adaptive Aids/Dental Summary Sheet*.
**Introduction**

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

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<td>Client Name Update (L11): Delete</td>
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Add Case to ID/Demographic Update (410)

Step 1 – Access the Add Case to ID/Demographic Update option.
- Type 410 in the ACT: field of any screen.
- Press Enter.

Step 2 – Identify the individual and indicate the type of entry.
On the 410: Add Case to ID/Demographic Update header screen:
- Type the Client ID in the CLIENT ID field.
- Type the MRA component code in the COMPONENT CODE field.
- Type A (Add Case) in the TYPE OF ENTRY field.
- Press Enter.

Step 3 – Add a local case number for the MRA component.
On the 410: Add Case to ID/Demographic Update screen:
- Type the local case number for the MRA in the LOCAL CASE NUMBER field.
- Type Y in the READY TO UPDATE? field to submit the data to the system.
- Press Enter.
Client Address Update (L12)

Step 1 – Access the Client Address Update option.
- Type L12 in the ACT: field of any screen.
- Press Enter.

Step 2 – Identify the individual.
On the L12: Client Address Update header screen:
- Type the requested identifying information in the appropriate fields.
  Rule: You must enter the Client ID or the local case number.
- Type the component code of the individual’s current component in the COMPONENT CODE field.
- Press Enter.

Step 3 – Update an individual’s address information.
On the L12: Client Address Update screen:
- Type update information (street address, city, state, zip code) in the appropriate CLIENT’S CURRENT ADDRESS fields.
- Type the date the individual’s address record is being updated in the ADDRESS DATE field.
- Type Y in the READY TO UPDATE? field to submit the data to the system.
- Press Enter.
Client Assignments (L26): Add

Step 1 – Access the Client Assignments option.
- Type L26 in the ACT: field of any screen.
- Press Enter.

Step 2 – Identify the individual and indicate the type of entry.
On the L26: Client Assignments: Add/Correct/Delete header screen:
- Type the requested identifying information in the appropriate fields.
  Rule: You must enter the Client ID, the local case number, or the Medicaid Number.
- Type the provider’s component code in the COMPONENT CODE field.
- Type A (Add) in the TYPE OF ENTRY field.
- Press Enter.

Step 3 – Add a new client assignment record for a TxHmL individual if the individual moves to a different county.
On the L26: Client Assignments: Add screen:
- Type the effective date of the new assignment in the EFFECTIVE DATE field.
- Type OHFH (Own Home/Family Home) in the LOCATION CODE field.
- Type the county code of the new assignment in the COUNTY field.
- Type Y in the READY TO ADD? field.
- Press Enter.
Client Assignments (L26): Correct

Step 1 – Access the Client Assignments option.
- Type L26 in the ACT: field of any screen.
- Press Enter.

Step 2 – Identify the individual and indicate the type of entry.
On the **L26: Client Assignments: Add/Correct/Delete** header screen:
- Type the requested identifying information in the appropriate fields.
  
  **Rule:** You must enter the Client ID, the local case number, or the Medicaid Number.
- Type the provider’s component code in the COMPONENT CODE field.
- Type C (Correct) in the TYPE OF ENTRY field.
- Press Enter.

Step 3 – Correct errors on existing TxHmL assignments (incorrect assignment date, location code, or county).
On the **L26: Client Assignments: Correct** screen:
- Type corrections to errors in the current assignment in the appropriate fields.
- Type Y in the READY TO CHANGE? field.
- Press Enter.
Client Assignments (L26): Delete

Step 1 – Access the Client Assignments option.
- Type L26 in the ACT: field of any screen.
- Press Enter.

Step 2 – Identify the individual and indicate the type of entry.
On the L26: Client Assignments: Add/Correct/Delete header screen:
- Type the requested identifying information in the appropriate fields.
  Rule: You must enter the Client ID, the local case number, or the Medicaid Number.
- Type the provider’s component code in the COMPONENT CODE field.
- Type D (Delete) in the TYPE OF ENTRY field.
- Press Enter.

Step 3 – Add a new client assignment record for a TxHmL individual if the individual moves to a different county.
On the L26: Client Assignments: Delete screen:
- Type Y in the READY TO DELETE? field.
- Press Enter.
Client Correspondent Update (L10)

Step 1 – Access the Client Correspondent Update option.
- Type L10 in the ACT: field of any screen.
- Press Enter.

Step 2 – Identify the individual.
On the L10: Client Correspondent Update header screen:
- Type the requested identifying information in the appropriate fields.
  **Rule:** You must enter the Client ID or the local case number.
- Type the component code of the individual’s current component in the COMPONENT CODE field.
- Press Enter.

Step 3 – Update an individual’s correspondent information.
On the L10: Client Correspondent Update screen:
- Type Primary Correspondent and/or Secondary Correspondent information (name, relationship, street, telephone, city, state, zip code) in the appropriate **Primary Correspondent** and/or **Secondary Correspondent** fields.
  **Note:** If you type a name in the CORRES. NAME field, you must type a code for the correspondent’s relationship in the CORRES. RELATIONSHIP field.
- Type Y in the READY TO UPDATE? field to submit the data to the system.
- Press Enter.
Client Name Update (L11): Add

Step 1 – Access the Client Name Update option.
- Type L11 in the ACT: field of any screen.
- Press Enter.

Step 2 – Identify the individual and indicate the type of entry.
On the L11: Client Name Update header screen:
- Type the requested identifying information in the appropriate fields.
  Rule: You must enter the Client ID or the local case number.
- Type the component code of the individual’s current component in the COMPONENT CODE field.
- Type A (Add) in the TYPE OF ENTRY field.
- Press Enter.

Step 3 – Add information to an individual’s name record.
On the L11: Client Name Update screen:
- Type update information (last name/suffix, first name, middle name) in the appropriate Add Client Name fields.
- Type Y in the READY TO ADD? field to submit the data to the system.
- Press Enter.
Client Name Update (L11): Change

Step 1 – Access the Client Name Update option.
- Type **L11** in the ACT: field of any screen.
- Press **Enter**.

Step 2 – Identify the individual and indicate the type of entry.
On the **L11: Client Name Update** header screen:
- Type the requested identifying information in the appropriate fields.
  **Rule**: You must enter the Client ID or the local case number.
- Type the component code of the individual’s current component in the **COMPONENT CODE** field.
- Type **C** (Change) in the **TYPE OF ENTRY** field.
- Press **Enter**.

Step 3 – Change name information that was entered incorrectly by your MRA.
On the **L11: Client Name Update** screen:
- Type update information (last name/suffix, first name, middle name) in the appropriate **Change Client Name** fields.
- Type **Y** in the **READY TO CHANGE?** field to submit the data to the system.
- Press **Enter**.
Client Name Update (L11): Delete

Step 1 – Access the Client Name Update option.
• Type L11 in the ACT: field of any screen.
• Press Enter.

Step 2 – Identify the individual and indicate the type of entry.
On the L11: Client Name Update header screen:
• Type the requested identifying information in the appropriate fields.
  Rule: You must enter the Client ID or the local case number.
• Type the component code of the individual’s current component in the COMPONENT CODE field.
• Type D (Delete) in the TYPE OF ENTRY field.
• Press Enter.

Step 3 – Delete a name update that was entered in error by your MRA.
  Note: If there is more than one name update record, the system displays the most recent name update record.
On the L11: Client Name Update screen:
• Type Y in the READY TO DELETE? field to submit the data to the system.
• Press Enter.
  Result: If there is more than one record, the next record is displayed with the message, “Previous Information Deleted.”
• Repeat the action to delete the record displayed or
• Type N in the READY TO DELETE? field to take no action and return to the header screen.
• Press Enter.
Consumer Discharge (L18)

The Consumer Discharge process allows the MRA to review the provider’s permanent discharge of an individual from the HCS or TxHmL waiver program. For termination of waiver services, the provider must complete the C18: Consumer Discharge screen and the MRA must complete the L18: Consumer Discharge screen after C18 is completed by the provider. If there is no program provider, the MRA must complete both the C18: Consumer Discharge and L18: Consumer Discharge screens.

Step 1 – Access the Consumer Discharge option.
- Type L18 in the ACT: field of any screen.
- Press Enter.

Step 2 – Identify the individual.
On the L18: Consumer Discharge header screen:
- Type the requested identifying information in the appropriate fields.
  Rule: You must enter the Client ID, the local case number, or the Medicaid number.
- Type the provider’s component code in the COMPONENT CODE field.
- Press Enter.

Step 3 – Review an individual’s permanent discharge from the TxHmL waiver program.
On the L18: Consumer Discharge screen:
- Type the name of the MRA Representative in the BY: field.
- Type the date the termination was reviewed in the DATE field.
- Type Y in the READY TO UPDATE? field.
- Press Enter.
Consumer Discharge – Permanent (C18/L18) (No Program Provider)

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

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

**Step 1 – Access the Consumer Discharge option.**
- Type C18 in the ACT: field of any screen.
- Press Enter.

**Step 2 – Identify the individual.**
On the C18: Consumer Discharge header screen:
- Type the requested identifying information in the appropriate fields.
  - **Rule**: You must enter the Client ID, the local case number, or the Medicaid number.
- Type the provider’s component code in the COMPONENT CODE field.
- Type P in the TYPE OF DISCHARGE field.
- Type A in the TYPE OF ENTRY field.
- Press Enter.

**Step 3 – Discharge the individual**
On the C18: Consumer Discharge screen:
- Type the name of the provider representative in the PROVIDER REPRESENTATIVE NAME field.
- Type the discharge date in the DISCHARGE DATE field.
- Type Y (Yes) or N (No) in the DID CONSUMER RECEIVE SERVICES ON DISCHARGE DATE? field.
- Type the number representing the termination reason in the TERMINATION REASON field.

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

**Step 4 – Access the Consumer Discharge option.**
- Type L18 in the ACT: field of any screen.
- Press Enter.

**Step 5 – Identify the individual.**
On the L18: Consumer Discharge header screen:
- Type the requested identifying information in the appropriate fields.
  - **Rule**: You must enter the Client ID, the local case number, or the Medicaid number.
- Type the provider’s component code in the COMPONENT CODE field.
- Press Enter.

**Step 6 – Review an individual’s permanent discharge from the TxHmL waiver program.**
On the L18: Consumer Discharge screen:
- Type the name of the MRA Representative in the BY: field.
- Type the date the termination was reviewed in the DATE field.
- Type Y in the READY TO UPDATE? field.
- Press Enter.
Consumer Discharge – Temporary (C18) (Consumer is Self-Directing Services)

Step 1 – Access the Consumer Discharge option.
- Type C18 in the ACT: field of any screen.
- Press Enter.

Step 2 – Identify the individual.
On the C18: Consumer Discharge header screen:
- Type the requested identifying information in the appropriate fields.
  Rule: You must enter the Client ID, the local case number, or the Medicaid number.
- Type T in the TYPE OF DISCHARGE field.
- Type A in the TYPE OF ENTRY field.
- Press Enter.

Step 3 – Suspend the individual’s waiver services
On the C18: Consumer Discharge screen:
- Type the name of the provider representative in the PROVIDER REPRESENTATIVE NAME field.
- Type the discharge date in the DISCHARGE DATE field.
- Type Y (Yes) or N (No) in the DID CONSUMER RECEIVE SERVICES ON DISCHARGE DATE? field.
- Type the number representing the termination reason in the TERMINATION REASON field.
- Type Y in the READY TO ADD? field.
- Press Enter.
Consumer Discharge (C18): Change (Temporary) (Consumer is Self-Directing Services)

Step 1 – Access the Consumer Discharge option.
- Type C18 in the ACT: field of any screen.
- Press Enter.

Step 2 – Identify the individual.
On the C18: Consumer Discharge header screen:
- Type the requested identifying information in the appropriate fields.
  **Rule:** You must enter the Client ID, the local case number, or the Medicaid number.
- Type T in the TYPE OF DISCHARGE field.
- Type C in the TYPE OF ENTRY field.
- Press Enter.

Step 3 – Change the suspension of waiver services.
On the C18: Consumer Discharge screen:
- Type the changes to the discharge information in the appropriate fields.
- If the individual is ending his/her temporary discharge, type the end date in the END DATE field.
- Type Y in the READY TO CHANGE? field.
- Press Enter.
Consumer Discharge (C18): Delete (Temporary) (Consumer is Self-Directing Services)

Step 1 – Access the Consumer Discharge option.
- Type C18 in the ACT: field of any screen.
- Press Enter.

Step 2 – Identify the individual.
On the C18: Consumer Discharge header screen:
- Type the requested identifying information in the appropriate fields.
  Rule: You must enter the Client ID, the local case number, or the Medicaid number.
- Type T in the TYPE OF DISCHARGE field.
- Type D in the TYPE OF ENTRY field.
- Press Enter.

Step 3 – Delete the suspension of waiver services.
On the C18: Consumer Discharge screen:
- Type Y in the READY TO DELETE? field.
- Press Enter.
**Consumer Enrollment (L01)**

**Step 1 – Access the Consumer Enrollment option.**
- Type **L01** in the **ACT**: field of any screen.
- Press **Enter**.

**Step 2 – Identify the individual and indicate the type of entry.**
On the **L01: Consumer Enrollment: Add/Change/Delete** header screen:
- Type the requested identifying information in the appropriate fields.
  
  **Rule:** You must enter the Client ID *or* the local case number.
- Type the MRA component code in the **COMPONENT CODE** field.
- Type **A** (Add) in the **TYPE OF ENTRY** field.
- Press **Enter**.

**Step 3 – Establish a waiver program enrollment for an individual.**
On the **L01: Consumer Enrollment: Add** screen:
- Type the code for the waiver type in which the applicant is to be enrolled in the **WAIVER TYPE** field.
- Type **Y** (Yes) or **N** (No) in the **PRIOR DISCHARGE FROM A MEDICAID CERTIFIED NF OR ICF-MR?** field.
- Type the code for where the person was living prior to entering the waiver program in the **ADMIT FROM** field.
- Type *either* the Slot Type (for new allocation slots) in the **SLOT TYPE** field *or* the Slot Tracking Number (for recycled slots) in the **SLOT TRACKING NUMBER** field.
- Type **Y** (Yes) or **N** (No) to indicate whether the person is participating in the Money Follows the Person Demonstration Project in the **MFP DEMO?** field.
- Type the county code of the county in which the individual will receive services in the **COUNTY OF SERVICE** field.
- Type **Y** in the **READY TO ADD?** field.
- Press **Enter**.
No services are or will be self-directed. If more than one MRA is involved in the transfer, the transferring MRA is responsible for completing all of the data entry screens.

Step 1 – Access the Consumer Hold Inquiry screen.
- Type C88 in the ACT: field of any screen.
- Press Enter.

Step 2 – Identify the individual.
On the C88: Consumer Hold Inquiry header screen:
- Type the requested identifying information in the appropriate fields.
- Type the associated component code in the COMPONENT CODE field.
- Leave the OVERRIDES field blank.
- Press Enter.

Step 3 – View the Hold information.
- If no hold records are found, proceed with the transfer.
- If the individual has been placed on Hold, correct the error and repeat Steps 1 and 2 before you proceed with the transfer.

Step 4 – Assign a Local Case Number.
- Type L09 in the ACT: field of any screen.
- Press Enter.

Step 5 – Identify the individual.
On the L09: Register Client Update screen:
- Type the Client ID in the CLIENT ID field.
- Type the Component Code of the receiving Program Provider in the COMPONENT CODE field.
- Press Enter.

Step 6 – Assign the Local Case Number.
On the L09: Register Client Update screen:
- Type the individual’s local case number obtained from the receiving Program Provider in the LOCAL CASE NUMBER field.
Note: The LOCAL CASE NUMBER field cannot be blank.
- Type updated information in the appropriate fields, if necessary.
- Type Y in the READY TO UPDATE? field to submit the data to the system.
- Press Enter.

Step 7 – Access the Transfer Option.
On the L09: Register Client Update header screen:
- Type L06 in the ACT: field.
- Press Enter.

Step 8 – Identify the Transferring Component and the Individual.
On the L06: Consumer Transfer: Contract Services: A/C/D header screen:
- Type the requested identifying information in the appropriate fields.

Step 8, continued
Rule: You must enter the Client ID, the local case number, or the Medicaid Number.
- Type the Component Code of the transferring (current) Program Provider in the COMPONENT CODE field.
- Type the contract number in the CONTRACT field.
- Type the transfer effective date in the TRANSFER EFFECTIVE DATE field.
- Type A (Add) in the TYPE OF ENTRY field.
- Type Y (Yes) as the answer to question 1. CHANGING A PROGRAM PROVIDER OR CDS AGENCY?
- Type N (No) as the answer to question 2. ADDING A PROGRAM PROVIDER OR CDS AGENCY?
- Type N (No) as the answer to question 3. CHANGING SERVICE DELIVERY OPTIONS?
- Press Enter.

Step 9 – Indicate Units/Dollars to be Reserved for Services to be Provided Prior to the Transfer Effective Date.
On the L06: Consumer Transfer: Contract/Services: Add screen:
- Type the units/dollars to be reserved in the appropriate field for each service under the TO USE column.
- Type Y in the READY TO ADD? field.
- Press Enter.

Step 10 – Add the Transfer.
On the L06: Consumer Transfer: Add screen:
- Type the new service county code in the SERVICE COUNTY field.
- Type the location code in the LOCATION CODE field.
- Type the residential type in the RESIDENTIAL TYPE field, if necessary.

Complete the following fields as they apply to the receiving provider.
- Type the component code of the new Program Provider in the COMP field.
- Type the local case number in the LCN field.
- Type the contract number of the new Program Provider in the CONTRACT NUMBER field.
- Type Y in the READY TO ADD? field.
- Press Enter.

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

Step 11 – Access the IPC.
On the L06: Consumer Transfer header screen:
- Type L02 in the ACT: field.
- Press Enter.
Step 12 – Identify the Receiving Provider and the Individual.
On the L06: Consumer Transfer header screen:
• Type the requested identifying information in the appropriate fields.
Rule: You must enter the Client ID, the local case number, or the Medicaid Number.
• Type the Component Code of the receiving provider in the COMPONENT CODE field.
• Type T (Transfer) in the TYPE OF ENTRY field.
• Press Enter.

Step 13 – Make Adjustments to the IPC.
On the L02: Individual Plan of Care Entry: Transfer screen:
• Use this screen to make the adjustments to the IPC that were agreed upon in the Transfer IPC meeting.
Note: You cannot reduce services below what has already been claimed.
• Type Y in the READY TO CONTINUE? field.
• Press Enter.
On the L02: Individual Plan of Care Entry: Transfer screen (screen 2):
• Type Y in the READY TO CONTINUE? field.
• Press Enter.
On the L02: Individual Plan of Care Entry: Transfer screen (screen 3):
• Type Y (Yes) or N (No) to indicate whether any services are staffed by a relative or guardian.
• You must change the date in the DATE fields. The dates must be after the previous REVISE DATE and on or before the current TRANSFER date.
• Change the names if necessary.
• Type Y in the READY TO TRANSFER? field to submit the data to the system.
• Press Enter.
Result: You are informed that the transfer IPC has been entered and that you must return to the L06 screen to complete the transfer.
• Press Enter.

Step 14 – Access the L06 Transfer Screen.
On the L02: Individual Plan of Care header screen:
• Type L06 in the ACT: field.
• Press Enter.

Step 15 – Identify the Component and Individual.
On the L06: Consumer Transfer header screen:
• Type the requested identifying information in the appropriate fields.
Rule: You must enter the Client ID, the local case number, or the Medicaid Number.
• Type the Component Code of the receiving provider in the COMPONENT CODE field.
• Type the contract number in the CONTRACT field.
• Type the transfer effective date in the TRANSFER EFFECTIVE DATE field.
• Type C (Change) in the TYPE OF ENTRY field.
Note: DO NOT attempt to answer the three questions on the header screen for this action. Leave the fields blank.
• Press Enter.

Step 16 – Accept the Transfer Data Entry.
On the L06: Consumer Transfer: Change screen:
• Type Y in the TRANSFER ACCEPTED field.
• Type the name of the person accepting the transfer data entry in the BY field.
• If the:
  - Transfer will occur in the future, type the date of data entry in the DATE field.
  - Transfer occurred in the past, type the date of the transfer in the Date field.
• Type Y in the READY TO CHANGE? field.
• Press Enter.
Result: A screen containing the transfer effective date is displayed. If the date is incorrect, the entire transfer record must be deleted and the transfer must be re-entered.
• Press Enter.

Reminder: A transfer is not complete until authorized by Program Enrollment.
After all of the data entry is complete, the MRA must send the signed Form 3617 Request for Transfer of Waiver Program Services and the receiving provider’s transfer IPC to Program Enrollment for authorization. Do not send any documentation until all of the data entry is complete.
Service claims cannot be entered by the receiving program provider until the transfer has been authorized and the individual is listed as active on the receiving program provider’s Consumer Roster (C67/L67).

Use the A63 screen to view the status of the transfer.
Consumer Transfer – Transfers Involving a CDSA (L06)

At least one service is or will be self-directed. If more than one MRA is involved in the transfer, the transferring MRA is responsible for completing all of the data entry screens.

Step 1 – Access the Consumer Hold Inquiry screen.
- Type C88 in the ACT: field of any screen.
- Press Enter.

Step 2 – Identify the individual.
On the C88: Consumer Hold Inquiry header screen:
- Type the requested identifying information in the appropriate fields.
- Type the transferring provider’s component code in the COMPONENT CODE field.
- Type T in the HOLD TYPE field.
- Type O in the HOLD STATUS field.
- Leave the OVERRIDES field blank.
- Press Enter.

Step 3 – View the Hold information.
- If no hold records are found, proceed with the transfer.
- If the individual has been placed on Hold, correct the error and repeat Steps 1 and 2 before you proceed with the transfer.

Step 4 – Assign a Local Case Number.
- Type L09 in the ACT: field of any screen.
- Press Enter.

Step 5 – Identify the individual.
On the L09: Register Client Update screen:
- Type the Client ID in the CLIENT ID field.
- Type the Component Code of the receiving provider in the COMPONENT CODE field.
- Press Enter.

Step 6 – Assign the Local Case Number.
On the L09: Register Client Update screen:
- Type the individual’s local case number obtained from the receiving provider and/or CDSA in the LOCAL CASE NUMBER field.
Note: The LOCAL CASE NUMBER field cannot be blank.
- Type updated information in the appropriate fields, if necessary.
- Type Y in the READY TO UPDATE? field to submit the data to the system.
- Press Enter.

Step 7 – Access the Transfer Option.
On the L09: Register Client Update header screen:
- Type L06 in the ACT: field.
- Press Enter.

Step 8 – Identify the Transferring Component and the Individual.
On the L06: Consumer Transfer: Contract Services: A/C/D header screen:
- Type the requested identifying information in the appropriate fields.

Step 8, continued
Rule: You must enter the Client ID, the local case number, or the Medicaid Number.
- Type the Component Code of the transferring (current) Program Provider or CDSA in the COMPONENT CODE field.
- Type the contract number in the CONTRACT field.
- Type the transfer effective date in the TRANSFER EFFECTIVE DATE field.
- Type A (Add) in the TYPE OF ENTRY field.
- Type Y (Yes) or N (No) to answer each of the following three questions, as appropriate:
  1. CHANGING PROGRAM PROVIDER OR CDSA AGENCY?
  2. ADDING A PROGRAM PROVIDER OR CDSA AGENCY?
  3. CHANGING SERVICE DELIVERY OPTIONS?
Refer to the charts provided in the Transfer section of the User Guide for help in answering the questions correctly.
- Press Enter.

Step 9 – Answer follow up questions.
On the screen containing the follow up questions:
- Answer Y or N to each question and press Enter after each question.
Refer to the charts in provided in the Transfer section of the User Guide for help in answering the questions correctly.
- Verify that the last statement is correct.

<table>
<thead>
<tr>
<th>If the statement is…</th>
<th>Then…</th>
</tr>
</thead>
</table>
| Correct              | • Type Y.  
                        | • Press Enter.  
| Incorrect            | • Type N.  
                        | • Press Enter.  
                        | Result: The header screen is displayed with the information you just entered.  
                        | • Check the information and make any necessary changes.  
                        | • Press Enter.  
                        | • Repeat this step. |

Step 10 – Indicate Units/Dollars to be Reserved for Services to be Provided Prior to the Transfer Effective Date.
On the L06: Consumer Transfer: Contract/Services: Add screen:
Note: The transferring program provider and/or CDSA calculates the amount of units/dollars to be reserved for services that will be provided by them prior to the transfer effective date and/or have been provided by them but not yet claimed and indicates those units/dollars on Form 3617.
Consumer Transfer – Transfers Involving a CDSA (L06), Continued

Step 10, continued
- Type the units/dollars to be reserved in the appropriate field for each service under the To Use column. Enter NA if the service is not impacted by the transfer.

Note 1: If no units/dollars are entered in the fields of the TO USE column, the transferring Program Provider and/or CDSA will be prevented from entering any additional service claims for the individual.

Note 2: If no unit/dollars need to be reserved, enter zeroes in the fields of the TO USE column.

Step 11 – Add the Transfer.
On the L06: Consumer Transfer: Add screen:
- Type the new service county code in the SERVICE COUNTY field.
- Type the location code in the LOCATION CODE field.
- Type the residential type in the RESIDENTIAL TYPE field, if necessary.

Complete the following fields as they apply to the receiving provider.
- Type the component code of the new Program Provider in the Comp field.
- Type the local case number in the LCN field.
- Type the contract number of the new Program Provider in the CONTRACT NUMBER field.

If the individual is transferring to a different CDSA or adding a CDSA:
- Type the component code of the new CDSA in the Comp field.
- Type the local case number in the LCN field.
- Type the contract number of the new CDSA in the CONTRACT NUMBER field.
- Type Y in the READY TO ADD? field.
- Press Enter.

Step 11, continued
Result: A screen containing the transfer effective date is displayed. If the date is incorrect, do not proceed. You must delete the transfer record and begin again.
- Press Enter.

Step 12 – Access the IPC screen.
On the L06: Consumer Transfer header screen:
- Type L02 in the ACT: field.
- Press Enter.

Step 13 – Identify the individual.
On the L02: Individual Plan of Care header screen:
- Type the requested identifying information in the appropriate fields.
- Type the Component Code of the receiving provider in the COMPONENT CODE field.
- Type T (Transfer) in the TYPE OF ENTRY field.
- Press Enter.

Step 14 – Make adjustments to the IPC.
Use this screen to make the adjustments to the IPC that were agreed upon in the Transfer IPC meeting.
Note: You cannot reduce services below what has already been claimed.
- Type Y in the READY TO CONTINUE? field.
- Press Enter.

On the L02: Individual Plan of Care Entry: Transfer screen (screen 2):
Services currently being self-directed and new services added to the plan which are eligible to be self-directed are displayed on this screen.
- Type N in the CALCULATE? field.
- Type Y in the READY TO CONTINUE? field.
- Press Enter.

On the L02: Individual Plan of Care Entry: Transfer screen (screen 3):
Note: Services not being self-directed are displayed and cannot be changed.
- Type Y in the READY TO CONTINUE? field.
- Press Enter.

On the L02: Individual Plan of Care Entry: Transfer screen (screen 4):
- Type Y (Yes) or N (No) to indicate whether any services are staffed by a relative or guardian.
- You must change the date in the DATE fields. The dates must be after the previous Revise Date and on or before the current Transfer date.
- Change the names if necessary.
- Type Y in the READY TO TRANSFER? field to submit the data to the system.
- Press Enter.

Result: You are informed that the transfer IPC has been entered and that you must return to the L06 screen to complete the transfer.
- Press Enter.
Consumer Transfer – Transfers Involving a CDSA (L06), Continued

Step 15 – Complete the Transfer.
On the **L02: Individual Plan of Care** header screen:
- Type **L06** in the Act: field.
- Press **Enter**.

Step 16 – Identify the Individual.
On the **L06: Consumer Transfer** header screen:
- Type the requested identifying information in the appropriate fields.
- Type the Component Code of the **receiving** provider in the **COMPONENT CODE** field.
- Type the contract number in the **CONTRACT** field.
- Type the transfer effective date in the **TRANSFER EFFECTIVE DATE** field.
- Type **C** (Change) in the **TYPE OF ENTRY** field.

**Note:** **DO NOT** attempt to answer the three questions on the header screen for this action. **Leave the fields blank.**
- Press **Enter**.

On the **L06: Consumer Transfer: Change** screen:
- Type **Y** in the **TRANSFER ACCEPTED** field.
- Type the name of the person accepting the transfer data entry in the **BY** field.
- If the:
  - Transfer will occur in the future, type the date of data entry in the **DATE** field.
  - Transfer occurred in the past, type the date of the transfer in the **DATE** field.
- Type **Y** in the **READY TO CHANGE?** field.
- Press **Enter**.

**Result:** A screen containing the transfer effective date is displayed. If the date is incorrect, the entire transfer record must be deleted and the transfer must be re-entered.
- Press **Enter**.

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

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

Use the **A63** screen to view the status of the transfer.
Critical Incident Data (686): Add - HCS

Step 1 – Access the Critical Incident Data option.
- Type 686 in the ACT: field of any screen.
- Press Enter.

Step 2 – Identify the report month, contract number, and type of entry.
On the 686: Critical Incident Data: Add/ Change/ Delete header screen:
- Type the month and year being reported in the MONTH AND YEAR (MMYYYY) field.
- Type the contract number in the CONTRACT NUMBER field.
- Type A (Add) in the TYPE OF ENTRY field.
- Press Enter.

Step 3 – Enter critical incident data for a specified reporting month.
On the 686: Critical Incident Data: Add screen:
- Type the contract number in the CONTRACT NUMBER field, if the contract for which you are entering data is other than the one entered on the header screen.
- Type the number of medication errors during the report month for every person served in your contract in the MEDICATION ERRORS field.
- Type the number of serious injuries during the report month for every person served in your contract in the SERIOUS INJURIES field.
- Type the number of behavior intervention plans authorizing personal, mechanical, or psychoactive medication restraint during the report month in the BEHAVIOR INTERVENTION PLANS AUTHORIZING RESTRAINT field.

Number Of Restraint Related Injuries
- Type the number of restraint related injuries during the report month in the EMERGENCY PERSONAL RESTRAINTS, EMERGENCY MECHANICAL RESTRAINTS, and EMERGENCY PSYCHOACTIVE MEDICATION fields.
- Type the total number of restraint related injuries in the TOTAL field.
- Type Y in the READY TO ADD? field.
- Press Enter.

Result: The screen is redisplayed with cleared fields to allow for the entry of data for additional contracts, and the message, “Previous Information Added” is displayed.
- Repeat this step for all contracts.

When all contracts have been entered, type N in the READY TO ADD? field and press Enter to return to the header screen.

Number Of Emergency Restraints Used
- Type the number of emergency restraints used by category during the report month in the PERSONAL RESTRAINTS, MECHANICAL RESTRAINTS, and PSYCHOACTIVE MEDICATION fields.
- Type the total number of emergency restraints used in the TOTAL field.

Number Of Individuals Requiring Emergency Restraint
- Type the number of individuals requiring emergency restraint during the report month in the PERSONAL RESTRAINTS, MECHANICAL RESTRAINTS, and PSYCHOACTIVE MEDICATION fields.
- Type the total number of individuals requiring emergency restraints in the TOTAL field.
Critical Incident Data (686): Change - HCS

Step 1 – Access the Critical Incident Data option.
- Type 686 in the ACT: field of any screen.
- Press Enter.

Step 2 – Identify the report month and type of entry.
On the 686: Critical Incident Data: Add/ Change/ Delete header screen:
- Type the month and year being reported in the MONTH AND YEAR (MMYYYY) field.
- Type the contract number in the CONTRACT NUMBER field.
- Type C (Change) in the TYPE OF ENTRY field.
- Press Enter.

Step 3 – Change critical incident data that has been entered incorrectly.
On the 686: Critical Incident Data: Change screen:
- Type changes to the critical incident data in the appropriate fields.
- Type Y in the READY TO CHANGE? field.
- Press Enter.
Step 1 – Access the Critical Incident Data option.
- Type 686 in the ACT: field of any screen.
- Press Enter.

Step 2 – Identify the report month and type of entry.
On the 686: Critical Incident Data: Add/ Change/ Delete header screen:
- Type the month and year being reported in the MONTH AND YEAR (MMYYYY) field.
- Type the contract number in the CONTRACT NUMBER field.
- Type D (Delete) in the TYPE OF ENTRY field.
- Press Enter.

Step 3 – Delete critical incident data that has been entered in error.
On the 686: Critical Incident Data: Delete screen:
- Type Y in the READY TO DELETE? field.
- Press Enter.
Critical Incident Data (686): Add - TxHmL

Step 1 – Access the Critical Incident Data option.
- Type 686 in the ACT: field of any screen.
- Press Enter.

Step 2 – Identify the report month and type of entry.
On the 686: Critical Incident Data: Add/Change/Delete header screen:
- Type the month and year being reported in the MONTH AND YEAR (MMDYYYY) field.
- Type the contract number in the CONTRACT NUMBER field.
- Type A (Add) in the TYPE OF ENTRY field.
- Press Enter.

Step 3 – Enter critical incident data for a specified reporting month.
On the 686: Critical Incident Data: Add screen:
- Type the contract number in the CONTRACT NUMBER field, if the contract for which you are entering data is other than the one entered on the header screen.
- Type the number of medication errors during the report month for every person served in your contract in the MEDICATION ERRORS field.
- Type the number of serious injuries during the report month for every person served in your contract in the SERIOUS INJURIES field.
- Type the number of behavior intervention plans authorizing personal, mechanical, or psychoactive medication restraint during the report month in the BEHAVIOR INTERVENTION PLANS AUTHORIZING RESTRAINT field.

Number Of Restraint Related Injuries
- Type the total number of restraint related injuries during the report month in the EMERGENCY PERSONAL RESTRAINTS, EMERGENCY MECHANICAL RESTRAINTS, and EMERGENCY PSYCHOACTIVE MEDICATION TOTAL fields.
- Type Y in the READY TO ADD? field.
- Press Enter.

Result: The screen is redisplayed with cleared fields to allow for the entry of data for additional contracts, and the message, “Previous Information Added” is displayed.
- Repeat this step for all contracts.
- When all contracts have been entered, type N in the READY TO ADD? field and press Enter to return to the header screen.

Number Of Emergency Restraints Used
- Type the total number of emergency restraints used by category during the report month in the PERSONAL RESTRAINTS, MECHANICAL RESTRAINTS, and PSYCHOACTIVE MEDICATION TOTAL fields.

Number Of Individuals Requiring Emergency Restraint
- Type the total number of individuals requiring emergency restraint during the report month in the PERSONAL RESTRAINTS, MECHANICAL RESTRAINTS, and PSYCHOACTIVE MEDICATION TOTAL fields.
Critical Incident Data (686): Change - TxHmL

Step 1 – Access the Critical Incident Data option.
- Type 686 in the ACT: field of any screen.
- Press Enter.

Step 2 – Identify the report month and type of entry.
On the 686: Critical Incident Data: Add/ Change/ Delete header screen:
- Type the month and year being reported in the MONTH AND YEAR (MMYYYY) field.
- Type the contract number in the CONTRACT NUMBER field.
- Type C (Change) in the TYPE OF ENTRY field.
- Press Enter.

Step 3 – Change critical incident data that has been entered incorrectly.
On the 686: Critical Incident Data: Change screen:
- Type changes to the critical incident data in the appropriate fields.
- Type Y in the READY TO CHANGE? field.
- Press Enter.
Critical Incident Data (686): Delete - TxHmL

Step 1 – Access the Critical Incident Data option.
- Type 686 in the ACT: field of any screen.
- Press Enter.

Step 2 – Identify the report month and type of entry.
On the 686: Critical Incident Data: Add/ Change/ Delete header screen:
- Type the month and year being reported in the MONTH AND YEAR (MMYYYY) field.
- Type the contract number in the CONTRACT NUMBER field.
- Type D (Delete) in the TYPE OF ENTRY field.
- Press Enter.

Step 3 – Delete critical incident data that has been entered in error.
On the 686: Critical Incident Data: Delete screen:
- Type Y in the READY TO DELETE? field.
- Press Enter.
DHS Medicaid Eligibility Search (C63)

Step 1 – Access the DHS Medicaid Eligibility Search option.
- Type C63 in the ACT: field of any screen.
- Press Enter.

Step 2 – Identify the individual and indicate the type of entry.
On the C63: DHS Medicaid Eligibility Search header screen:
- Type the Client ID in the CLIENT ID field to scan the Medicaid eligibility file for matches to the demographic fields entered in CARE, or
- Type the Medicaid Number in the MEDICAID RECIP NO field to search the Medicaid file directly, or
- Type at least two of Name, SSN, and Birthdate.
- Press Enter.

Step 3 – View the Medicaid file information.
On the C63: Medicaid Recipient Information screen:
- View the information from the Medicaid file.
- For further information, type a line number in the ENTER A LINE NUMBER field.
- Press Enter.

Note: If multiple names are displayed on this screen, contact the Program Enrollment section of DADS.

Step 4 – View the DHS Demographics.
On the Medicaid Eligibility Information screen:
- View the DHS demographics, including the Medicaid Certification date.
- Press Enter.

Step 5 – View the Medicaid eligibility information.
On the Medicaid Eligibility Information (screen 2):
- View the Medicaid eligibility information for the selected DHS recipient number, including the program type and begin date.
- Press Enter to display the C63: Medicaid Recipient Information screen.
- Press Enter.
Enrollment Packet Checklist (L03)

Step 1 – Access the Enrollment Packet Checklist option.
- Type L03 in the ACT: field of any screen.
- Press Enter.

Step 2 – Identify the individual and indicate the type of entry.
On the L03: Enrollment Packet Checklist: Add/Change/Delete header screen:
- Type the Client ID in the CLIENT ID field.
- Type the MRA component code in the COMPONENT CODE field.
- Type A (Add) in the TYPE OF ENTRY field.
- Press Enter.

Step 3 – Enter the enrollment packet checklist.
On the L03: Enrollment Packet Checklist: Add screen:
- Type the date waiver services will begin in the SERVICES BEGIN DATE field.
- Type the date the Freedom of Choice form was signed by the individual/legal representative in the FREEDOM OF CHOICE FORM field.
- Type the date of the adaptive aids bid or, if unavailable, the date of the assessment in the ADAPTIVE AIDS ASSESSMENT/BID field.
- Type the date of the minor home modification bid or, if unavailable, the date of the assessment in the MINOR HOME MODS ASSESSMENT/BID fields.

Note: This date is necessary only if the amount of adaptive aids on the IPC exceeds what is approved in the billing guidelines.
- Type the date the Person Directed Plan/SMRF Community Living Plan was completed in the PERSON DIRECTED PLAN/SMRF COMMUNITY LIVING PLAN field.
- Type Y in the READY TO ADD? field.
- Press Enter.
Step 1 – Access the Guardian Information Update option.
- Type L20 in the ACT: field of any screen.
- Press Enter.

Step 2 – Identify the individual.
On the L20: Guardian Information Update header screen:
- Type the requested identifying information in the appropriate fields.
  Rule: You must enter the Client ID, the local case number, or the Medicaid number.
- Type the component code of the individual’s current component in the COMPONENT CODE field.
- Press Enter.

Step 3 – Update information about an individual’s guardian.
On the L20: Guardian Information Update screen:
In the Guardian’s Name section:
- The system displays the guardian’s name if the individual has a guardian. Update the guardian’s name in the name fields, if appropriate.
- The system displays *SELF* in the LAST NAME field if the individual does not have a guardian.
  Rule: If *SELF* is displayed, the individual must have an address on file in the system. Use L12: Client Address Update to verify the individual’s address.
- Type the guardian code in the TYPE field.
  If the guardian is someone other than the individual:
    - Type the guardian’s name in the LAST NAME, LAST NAME SUFFIX, FIRST NAME, and MIDDLE INITIAL fields.
    - Type the guardian’s current address in the STREET ADDRESS, CITY, STATE, and ZIP CODE fields.
    - Type the guardian’s telephone number in the PHONE field.
    - Type Y in the READY TO UPDATE? field to submit the data to the system.
- Press Enter.
Individual Plan of Care (L02): Initial – HCS

Step 1 – Access the Individual Plan of Care option.
- Type L02 in the ACT: field of any screen.
- Press Enter.

Step 2 – Identify the individual and indicate the type of entry.
- On the L02: Individual Plan of Care header screen:
  - Type the requested identifying information in the appropriate fields.
  - Rule: You must enter the Client ID, the local case number, or the Medicaid number.
  - Type the MRA component code in the Component Code field.
  - Type I (Initial) in the Type of Entry field.
  - Type the date the provider began or will begin providing services in the Begin Date field.
  - Note: The IPC Begin Date cannot be prior to the enrollment request date reflected on screen L01.
- Press Enter.

Step 3 – Begin the entry of the initial IPC.
- On the L02: Individual Plan of Care Entry: Initial entry screen (screen 1):
  - Type the number of units of each service category in the appropriate fields and the dollar amounts in the Adaptive Aids, Minor Home Mod, and Dental fields (from pages 1 and 2 of the IPC).
  - Type Y (Yes) or N (No) in the ANY SERVICES SELF DIRECTED? field to indicate whether any of the services will be self-directed.
  - Note 1: If Y (Yes) is entered and services are to be self-directed, the FMS MONTHLY FEE is required. You must enter one unit per month of the IPC in the FMS MONTHLY FEE field.
  - Note 2: If you enter any units in the Support Consultation field, you must answer Y (Yes).
  - Note 3: Only Supported Home Living and Respite can be self-directed in HCS.
  - Type the individual’s residence type in the Residential Type field. (2=Foster/Companion Care, 3=Own Home/Family Home, 4=Supervised Living, 5=Residential Support)
  - Note: For CDS you must select 3 (Own Home/Family Home).
  - Type Y in the READY TO CONTINUE? field.
  - Press Enter.

Step 4 – Continue with the IPC – Consumer Directed Services.
- On the L02: Individual Plan of Care Entry: Initial screen (screen 2):
  - Note: This screen displays the CDS portion of the IPC. The units for services eligible to be self-directed are displayed and cannot be changed.
  - Note: All services that are self-directed contain a V at the end of the service abbreviation on this screen. For example, the service abbreviation for Respite is REHV.
  - Type N in the CALCULATE? field.
  - Type Y in the READY TO CONTINUE? field.
  - Press Enter.

Step 5 – Continue with the private provider portion of the IPC on the third screen.
- The L02: Individual Plan of Care Entry: Initial screen (screen 3):
  - This screen displays the program provider portion of the IPC. Services not being self-directed are displayed and cannot be changed.
  - Type Y in the READY TO CONTINUE? field.
  - Press Enter.

Step 6 – Complete the initial IPC entry.
- On the L02: Individual Plan of Care Entry: Initial screen (screen 4):
  - Type Y (Yes) or N (No) to indicate whether any services are staffed by a relative or guardian.
  - Type the name of the provider representative (individual’s name) in the Provider Representative field and the date the provider representative signed the IPC in the Date field.
  - Type the Service Coordinator’s name in the Service Coordinator field and the date the Service Coordinator signed the IPC in the Date field.
  - The name of the individual or legal representative is pre-filled based on whether or not a guardian has been identified (screen L20) in the Consumer/Legal Representative field. Type the date the individual or legal representative signed the IPC in the Date field.
  - Note: Before you enter names in the fields on this screen, signatures must be on the IPC in the individual’s chart. All data entered into the CARE system should be entered from a paper copy (a hard copy) and match exactly.
  - Type Y in the READY TO ADD? field to submit the data to the system.
  - Press Enter.
Individual Plan of Care (L02): Initial – TxHmL

Step 1 – Access the Individual Plan of Care option.
- Type L02 in the ACT: field of any screen.
- Press Enter.

Step 2 – Identify the individual and indicate the type of entry.
- On the L02: Individual Plan of Care header screen:
  - Type the requested identifying information in the appropriate fields.
- Rule: You must enter the Client ID, the local case number, or the Medicaid Number.
- Type the MRA component code in the COMPONENT CODE field.
- Type I (Initial) in the TYPE OF ENTRY field.
- Type the date the provider began or will begin providing services in the BEGIN DATE field.
- Note: The IPC Begin Date cannot be prior to the enrollment request date reflected on screen L01.
- Press Enter.

Step 3 – Begin the entry of the initial IPC.
- On the L02: Individual Plan of Care Entry: Initial entry screen (screen 1):
  - Type the number of units of the service in the appropriate fields.
  - If you enter any units in the ADAPTIVE AIDS, MINOR HOME MOD, and DENTAL fields, you must answer Y (Yes).
  - The IPC must be self-directed to be on the IPC in the FMS MONTHLY FEE field.
  - Note 2: If you enter any units in the SUPPORT CONSULTATION or FINANCIAL MANAGEMENT fields, you must answer Y (Yes).
  - If Y (Yes) is entered and services are to be self-directed, the FMS MONTHLY FEE field must be zero.
  - Note 3: If units have been entered for Adaptive Aids or Minor Home Modifications, no service fee is allowed when self-directing.
  - Type 3 (Own Home/Family Home) in the RESIDENTIAL TYPE field.
  - Type Y in the READY TO CONTINUE? field.
  - Press Enter.

Step 4 – Continue with the IPC – Consumer Directed Services.
- On the L02: Individual Plan of Care Entry: Initial screen (screen 2):
  - Note 1: Support Consultation and Financial Management Service fee units cannot be changed on this screen.
  - Note 2: All services that are self-directed contain a V at the end of the service abbreviation on this screen. For example, the service abbreviation for Respite is REH. If that service is self-directed, the abbreviation becomes REHV.

<table>
<thead>
<tr>
<th>If you...</th>
<th>Then...</th>
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<tbody>
<tr>
<td>want to continue to the Program</td>
<td>• Type N in the CALCULATE? field.</td>
</tr>
<tr>
<td>Provider screen (screen 3) after</td>
<td>• Type Y in the READY TO CALCULATE? field.</td>
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<tr>
<td>calculating</td>
<td>• Press Enter.</td>
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<td></td>
<td>• Continue with Step 5.</td>
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<tr>
<td>want to indicate that some of</td>
<td>• Replace the displayed units of service</td>
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<td>the services are not to be</td>
<td>with 0 (zero) for each service that is to</td>
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<td>self-directed, but will be</td>
<td>be provided by the Program Provider.</td>
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<td>provided by the Program Provider</td>
<td>• Press Enter.</td>
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<tr>
<td></td>
<td>• Type N in the CALCULATE? field.</td>
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<td></td>
<td>• Type Y in the READY TO CALCULATE? field.</td>
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<td></td>
<td>• Press Enter.</td>
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<td></td>
<td>• Continue with Step 5.</td>
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Step 5 – Continue with the IPC - Program Provider.
- The L02: Individual Plan of Care Entry: Initial screen (screen 3)
  - This screen displays the Program Provider portion of the IPC. Services not being self-directed are displayed and cannot be changed.
  - Type Y in the READY TO CONTINUE? field.
  - Press Enter.

Step 6 – Complete the initial IPC entry.
- On the L02: Individual Plan of Care Entry: Initial screen (screen 4):
  - Type Y (Yes) or N (No) to indicate whether any services are staffed by a relative or guardian.
  - If the date the provider representative signed the IPC in the DATE field.
  - Type the Service Coordinator’s name in the SERVICE COORDINATOR field and the date the Service Coordinator signed the IPC in the DATE field.
  - The name of the individual or legal representative is pre-filled based on whether or not a guardian has been identified (screen L20) in the CONSUMER/LEGAL REPRESENTATIVE field. Type the date the individual or legal representative signed the IPC in the DATE field.
  - Note: Before you enter names in the fields on this screen, signatures must be on the IPC in the individual’s chart. All data entered into the CARE system should be entered from a paper copy (a hard copy) and match exactly.
    - Type Y in the READY TO ADD? field to submit the data to the system.
    - Press Enter.
Individual Plan of Care (L02): Revision

Step 1 – Access the Individual Plan of Care option.
- Type L02 in the ACT: field of any screen.
- Press Enter.

Step 2 – Identify the individual and indicate the type of entry.
- On the L02: Individual Plan of Care header screen:
  - Type the requested identifying information in the appropriate fields.
  - Rule: You must enter the Client ID, the local case number, or the Medicaid Number.
  - Type the component code of the individual’s current component in the COMPONENT CODE field.
  - Type R (Revision) in the TYPE OF ENTRY field.
  - Type the revision date in the REVISE field.
  - Press Enter.

Step 3 – Enter a revision to a TxHmL individual’s existing IPC.
- On the L02: Individual Plan of Care Entry: Revise screen:
  - Note: The provider will modify the total plan with the required revisions to service units. You cannot reduce the units where it would leave a current provider without any service authorizations for their service delivery option.
  - Type the number of units of each service type in the appropriate fields and the dollar amounts in the ADAPTIVE AIDS, MINOR HOME MOD, and DENTAL fields.
  - Type or verify Y in the ANY SERVICES SELF DIRECTED? field.
  - Type 3 (OHHF) in the RESIDENTIAL TYPE field.
  - Type Y in the READY TO CONTINUE? field.
  - Press Enter.

Step 4 – Continue the IPC revision – Consumer Directed Services
- On the L02: Individual Plan of Care Entry: Revise screen (screen 2):
  - Note 1: The units for services currently being self-directed are displayed and cannot be changed.
  - Note 2: All services that are self-directed contain a V at the end of the service abbreviation on this screen. For example, the service abbreviation for Respite is REH. If that service is self-directed, the abbreviation becomes REHV.
  - Make any necessary changes.
  - Press Enter to calculate.
  - Result: The system calculates and displays the total annual cost for the IPC, and the message, “Please verify the new plan cost” is displayed.
  - Once the system has calculated the IPC:
    - Type N in the CALCULATE? field.
    - Type Y in the READY TO CONTINUE? field.
    - Press Enter.

Step 5 – Continue the IPC revision – Program Provider
- On the L02: Individual Plan of Care Entry: Revise screen (screen 3):
  - Services not being self-directed are displayed on this screen and cannot be changed.
  - Type Y in the READY TO CONTINUE? field.
  - Press Enter.

Step 6 – Complete the IPC revision
- On the L02: Individual Plan of Care Entry: Revise screen (screen 4):
  - Type Y (Yes) or N (No) to indicate whether any services are staffed by a relative or guardian.
  - Type or verify the name of the provider representative (individual’s name) in the PROVIDER REPRESENTATIVE field and the date the provider representative signed the IPC in the DATE field.
  - Type or verify the Service Coordinator’s name in the SERVICE COORDINATOR field and the date the Service Coordinator signed the IPC in the DATE field.
  - The name of the individual or legal representative is pre-filled based on whether or not a guardian has been identified (screen L20) in the CONSUMER/LEGAL REPRESENTATIVE field. Type the date the individual or legal representative signed the IPC in the DATE field.
  - Note: Before you enter names in the fields on this screen, signatures must be on the IPC in the individual’s chart. All data entered into the CARE system should be entered from a paper copy (a hard copy) and match exactly.
  - Type Y in the READY TO REVISE? field to submit the data to the system.
  - Press Enter.
Individual Plan of Care (L02): Renewal

**Step 1** – Access the Individual Plan of Care option:
- Type L02 in the ACT: field of any screen.
- Press Enter.

**Step 2** – Identify the individual and indicate the type of entry.
On the L02: Individual Plan of Care header screen:
- Type the requested identifying information in the appropriate fields.
**Rule:** You must enter the Client ID, the local case number, or the Medicaid Number.
- Type the component code of the individual’s current component in the COMPONENT CODE field.
- Type N (Renewal) in the TYPE OF ENTRY field.
- Press Enter.

**Step 3** – Renew an IPC for a TxHmL individual.
On the L02: Individual Plan of Care Entry: Renewal screen:
- Type the number of units of each service category in the appropriate fields and the dollar amounts in the ADAPTIVE AIDS, MINOR HOME MOD, and DENTAL fields.
- Type or verify Y in the ANY SERVICES SELF DIRECTED? field.

**Note 1:** If you enter units in the SUPPORT CONSULTATION or FINANCIAL MANAGEMENT fields, you **must** answer Y (Yes).
**Note 2:** If Y (Yes) is entered and services are to be self-directed, the FMS MONTHLY FEE is required. You must then enter one unit per month of the IPC in the FMS MONTHLY FEE field.
- Type 3 (Own Home/Family Home) in the RESIDENTIAL TYPE field.
- Type Y in the READY TO CONTINUE? field.
- Press Enter.

**Step 4** – Continue the IPC renewal – Consumer Directed Services
On the L02: Individual Plan of Care Entry: Renewal screen (screen 2):
Services currently being self-directed and new services added to the plan which are eligible to be self-directed are displayed on this screen. The units of new services added to the plan must be changed to zero if they are not being self-directed.

**Note 1:** Support Consultation and Financial Management Service fee units **cannot** be changed on this screen.
**Note 2:** All services that are self-directed contain a V at the end of the service abbreviation on this screen. For example, the service abbreviation for Respite is REH. If that service is self-directed, the abbreviation becomes REHV.

**Step 4 , continued**

<table>
<thead>
<tr>
<th>If you …</th>
<th>Then…</th>
</tr>
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</table>
| want to continue to the Program Provider screen (screen 3) | • Type N in the CALCULATE? field.  
• Type Y in the READY TO CONTINUE? field.  
• Press Enter.  
• Continue with Step 5. |

**Step 5** – Continue the IPC renewal – Program Provider
On the L02: Individual Plan of Care Entry: Renewal screen (screen 3):
This screen displays the Program Provider portion of the IPC. Services not being self-directed are displayed and cannot be changed.
- Type Y in the READY TO CONTINUE? field.
- Press Enter.

**Step 6** – Complete the IPC renewal
On the L02: Individual Plan of Care Entry: Renewal screen (screen 3):
- Type Y (Yes) or N (No) to indicate whether any services are staffed by a relative or guardian.
- Type the name of the provider representative (individual’s name) in the PROVIDER REPRESENTATIVE field and the date the provider representative signed the IPC in the DATE field.
- Type or verify the Service Coordinator’s name in the SERVICE COORDINATOR field and the date the Service Coordinator signed the IPC in the DATE field.
- The name of the individual or legal representative is pre-filled based on whether or not a guardian has been identified (screen L20) in the CONSUMER/LEGAL REPRESENTATIVE field. Type the date the individual or legal representative signed the IPC in the DATE field.

**Note:** Before you enter names in the fields on this screen, signatures **must** be on the IPC in the individual’s chart. **All data entered into the CARE system should be entered from a paper copy (a hard copy) and match exactly.**
- Type Y in the READY TO RENEW? field to submit the data to the system.
- Press Enter.
### Individual Plan of Care (L02): Error Correction

**Step 1 – Access the Individual Plan of Care option.**
- Type L02 in the ACT: field of any screen.
- Press Enter.

**Step 2 – Identify the individual and indicate the type of entry.**
On the L02: Individual Plan of Care header screen:
- Type the requested identifying information in the appropriate fields.
*Rule: You must enter the Client ID, the local case number, or the Medicaid Number.*
- Type the component code of the individual’s current component in the COMPONENT CODE field.
- Type E (Error Correction) in the TYPE OF ENTRY field.
- Type the effective date if error correcting a revision to the IPC in the REVISE DATE field.
- Press Enter.

**Step 3 – Correct data entry errors on a previously entered IPC for a TxHmL individual.**
On the L02: Individual Plan of Care Entry: Correct screen:
- Enter the number of units of each service type in the appropriate fields and the dollar amounts in the ADAPTIVE AIDS, MINOR HOME MOD, and DENTAL fields.
- Type or verify Y in the ANY SERVICES SELF DIRECTED? field, if services are to be self-directed.
*Note 1: If you enter units in the SUPPORT CONSULTATION or FINANCIAL MANAGEMENT fields, you must answer Y (Yes).*
*Note 2: If Y (Yes) is entered and services are to be self-directed, the FMS MONTHLY FEE is required.*
- You must then enter one unit per month of the IPC in the FMS MONTHLY Fee field.
- Type or verify 3 (Own Home/Family Home) in the RESIDENTIAL TYPE field.
- Type Y in the READY TO CONTINUE? field.
- Press Enter.

**Step 4 – Continue with the IPC corrections – Consumer Directed Services**
On the L02: Individual Plan of Care Entry: Correct screen (screen 2):
- Services currently being self-directed and new services added to the plan which are eligible to be self-directed are displayed on this screen. The units of new services added to the plan must be changed to zero if they are not being self-directed.
*Note 1: Support Consultation and Financial Management Service fee units cannot be changed on this screen.*
*Note 2: All services that are self-directed contain a V at the end of the service abbreviation on this*

**Step 4, continued**
- On the L02: Individual Plan of Care Entry: Correct screen. For example, the service abbreviation for Respite is REH. If that service is self-directed, the abbreviation becomes REHV.
- Type Y in the CALCULATE? field.
- Press Enter.

<table>
<thead>
<tr>
<th>If you …</th>
<th>Then…</th>
</tr>
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<tbody>
<tr>
<td>want to continue to the Program Provider screen (screen 3)</td>
<td>Type N in the CALCULATE? field.</td>
</tr>
<tr>
<td>want to indicate that some of the services are not to be self-directed, but will be provided by the Program Provider</td>
<td>Type Y in the READY TO CONTINUE? field.</td>
</tr>
</tbody>
</table>

**Step 5 – Continue with the IPC corrections – Program Provider**
On the L02: Individual Plan of Care Entry: Correct screen (screen 3):
- This screen displays the program provider portion of the IPC. Services not being self-directed are displayed and cannot be changed.
  - Type Y in the READY TO CONTINUE? field.
  - Press Enter.

**Step 6 – Complete the IPC corrections**
On the L02: Individual Plan of Care Entry: Correct screen (screen 4):
- Type Y (Yes) or N (No) to indicate whether any services are staffed by a relative or guardian.
- Type the name of the provider representative (individual’s name) in the PROVIDER REPRESENTATIVE field and the date the provider representative signed the IPC in the DATE field.
- Type or verify the Service Coordinator’s name in the SERVICE COORDINATOR field and the date the Service Coordinator signed the IPC in the DATE field.
- The name of the individual or legal representative is pre-filled based on whether or not a guardian has been identified (screen L20) in the CONSUMER/LEGAL REPRESENTATIVE field. Type the date the individual or legal representative signed the IPC in the DATE field.
*Note: Before you enter names in the fields on this screen, signatures must be on the IPC in the individual’s chart. All data entered into the CARE system should be entered from a paper copy (a hard copy) and match exactly.*
- Type Y in the READY TO CORRECT? field to submit the data to the system.
- Press Enter.
Individual Plan of Care (L02): Delete

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

**Step 1 – Access the Individual Plan of Care option.**
- Type **L02** in the ACT: field of any screen.
- Press **Enter**.

**Step 2 – Identify the individual and indicate the type of entry.**
On the **L02: Individual Plan of Care** header screen:
- Type the requested identifying information in the appropriate fields.
- **Rule:** You must enter the Client ID, the local case number, or the Medicaid Number.
- Type the component code of the individual’s current component in the COMPONENT CODE field.
- Type **D** (Delete) in the TYPE OF ENTRY field.
- Press **Enter**.

**Step 3 – Delete an IPC.**
On the **L02: Individual Plan of Care Entry: Delete** screen:
- Type **Y** in the READY TO DELETE? field.
- Press **Enter**.
Interest List - Services (W21)

*If the person has accepted the waiver slot they were offered, no action is taken on the W21 screens.*

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

**TxHmL Enrollment:**
The MRA will use **W21: Interest List - Services** to change the TxHmL Status field to 2 (Declined) *only if the individual declines enrollment in TxHmL*. No other action on Interest List is required for TxHmL individuals. The following steps will be taken when changing the interest list status to 2 (Declined).

**Step 1 – Access W26: Interest List – Services Inquiry by Person** to determine whether the person is currently on the Waiting List.

**Step 2 – Access the Waiting List - Services option.**
- Type **W21** in the ACT: field of any screen.
- Press **Enter**.

**Step 2 – Identify the individual and indicate the type of entry.**
On the **W21: Waiting List – Services: Add/Change/Delete** header screen:
- Type the requested identifying information in the appropriate fields.
- Type the MRA component code in the **COMPONENT CODE** field.
- Type **C** (Change) in the **TYPE OF ENTRY** field.
- Type **Y** (Yes) or **N** (No) in the **ADD TO HCS LIST** field to indicate whether individual is to be added to the HCS Interest List.
- Press **Enter**.

**Step 3 – Change the status to Declined.**
On the **W21: Waiting List - Services: Change** screen:
- Type **2** (Declined) in the **TXHML STATUS** field.
- Type **Y** in the **READY TO CHANGE?** field.
- Press **Enter**.
Step 1 – Access the MR/RC Assessments - Summary option.

- Type C68 in the ACT: field of any screen.
- Press Enter.

Step 2 – Identify the individual.

On the C68: MR/RC Assessments-Summary header screen:

- Type the requested identifying information in the appropriate fields.
  
  **Rule:** You must enter the Client ID or the local case number.

- Type the MRA component code in the COMPONENT CODE field.
- Press Enter.

Step 3 – Verify that an individual has a current MR/RC Assessment with an existing LOC/LON.

If the C68: MR/RC Assessments-Summary screen displays an existing Level of Care in the individual’s record that will not expire for 60 days from the enrollment date, and the record is correct, no MR/RC Assessment is required at this time.

**Note:** If there is not an existing LOC in the individual’s record:

- The C68: MR/RC Assessments-Summary screen is displayed with the message, “No Records Found.”
- See the Waiver MR/RC Assessment procedure to complete the MR/RC Assessment. An MR/RC Assessment must be authorized by State Office before the entry of L02: Individual Plan of Care.

**Note:** If an existing Level of Care/Level of Need is not accurate the MRA must enter the correct information. See Waiver MR/RC Assessment procedures.
MRA Assignment Notification (L30)
Sending MRA

The sending MRA will use these steps to initiate the MRA assignment notification process.

Step 1 – Access the MRA Assignment Notification option.
- Type L30 in the ACT: field of any screen.
- Press Enter.

Step 2 – Identify the individual and indicate the type of entry.
On the L30: MRA Assignment Notification: Add/Change/Delete header screen:
- Type the requested identifying information in the appropriate fields.
Rule: You must enter the Client ID, the local case number, or the Medicaid number.
- Type the provider’s component code in the COMPONENT CODE field.
- Type the sending MRA’s code in the MRA field.
- Type A (Add) in the TYPE OF ENTRY field.
- Press Enter.

Step 3 – Initiate the MRA assignment notification process.
On the L30: MRA Assignment Notification: Add screen:
- Type the location code in the MOVE TO LOCATION field.
- Type the county code of the new location in the COUNTY field.
Note: For TxHmL, the Move to Location must be OHFH and the MOVE TO LOCATION and COUNTY code fields are required.
- Type the date of the move in the MOVE DATE field.
In the Sending Authority section of the screen:
- Type the name of the MRA contact person in the CONTACT NAME field.
- Type the contact person’s area code and telephone number in the PHONE fields.
- Type the date the data is entered in the DATE field.
- Type Y in the READY TO ADD? field.
- Press Enter.
The receiving MRA will use these steps to continue and complete the MRA assignment notification process.

**Step 1 – Access the MRA Assignment Notification option.**
- Type **L30** in the ACT: field of any screen.
- Press **Enter**.

**Step 2 – Identify the individual and indicate the type of entry.**
On the **L30: MRA Assignment Notification: Add/Change/Delete** header screen:
- Type the requested identifying information in the appropriate fields.
  
  **Rule:** You must enter the Client ID, the local case number, or the Medicaid number.
- Type the provider’s component code in the **COMPONENT CODE** field.
- Type the **receiving** MRA’s code in the **MRA** field.
- Type **C** (Change) in the **TYPE OF ENTRY** field.
- Press **Enter**.

**Step 3 – Initiate the MRA assignment notification process.**
On the **L30: MRA Assignment Notification: Change** screen:

In the **Receiving Authority** section of the screen:
- Type the name of the MRA contact person in the **ACCEPTED BY** field.
- Type the date the data is entered in the **DATE** field.
- Type **Y** in the **READY TO CHANGE?** field.
- Press **Enter**.

If the date of the move is **today’s date or in the past**, the **L26: Client Assignments: Add** screen is displayed.

- or -

If the date of the move is **in the future**, a message screen is displayed stating that because the movement date is in the future you will not be able to enter the client movement until that date.

**Step 4 – Receiving MRA adds the client assignment.**
On the **L26: Client Assignments: Add** screen:
- Type **Y** in the **READY TO ADD?** field to add the client assignment.
- Press **Enter**.
MRA/MHA Contacts (L28): Add

Step 1 – Access the MRA/MHA Contacts option.
- Type L28 in the ACT: field of any screen.
- Press Enter.

Step 2 – Identify the component and contact type, and indicate the type of entry.
On the L28: MRA/MHA Contacts: Add/Change/Delete header screen:
- Type the MRA component code in the COMP field.
- Type MRA in the CONTACT TYPE field.
- Type A (Add) in the TYPE OF ENTRY field.
- Press Enter.

Step 3 – View the sequence/type/contact description information.
On the L28: MRA/MHA Contacts: Add Records screen:
- Type Y in the READY TO CONTINUE? field.
- Press Enter.

Step 4 – Add MRA contact information.
- View the contact sequence number displayed and, if necessary, type the appropriate contact sequence number for the contact you are adding in the CONTACT SEQUENCE field.
- Type the contact description in the DESCRIPTION field.
- Type the contact person’s name information in the CONTACT fields.
- Type the contact person’s address information in the ADDRESS fields.
- Type the contact person’s area code and telephone number in the PHONE fields.
- Type Y in the READY TO ADD? field.
- Press Enter.
MRA/MHA Contacts (L28): Change

Step 1 – Access the MRA/MHA Contacts option.
- Type L28 in the ACT: field of any screen.
- Press Enter.

Step 2 – Identify the component and contact type, and indicate the type of entry.
On the L28: MRA/MHA Contacts: Add/Change/Delete header screen:
- Type the MRA component code in the COMP field.
- Type MRA in the CONTACT TYPE field.
- Type C (Change) in the TYPE OF ENTRY field.
- Press Enter.

Step 3 – Select the record to be changed.
On the L28: MRA/MHA Contacts Change Records screen:
- View the sequence/type/contact description information.
- Type X in the SELECT field next to the record to be changed.
- Type Y in the READY TO SELECT? Field.
- Press Enter.

Step 4 – Change MRA contact information.
- View the current information on the contact record selected.
- Type any changes in the appropriate fields.
- Type Y in the READY TO CHANGE? field.
- Press Enter.
MRA/MHA Contacts (L28): Delete

Step 1 – Access the MRA/MHA Contacts option.
- Type **L28** in the **ACT:** field of any screen.
- Press **Enter**.

Step 2 – Identify the component and contact type, and indicate the type of entry.
On the **L28: MRA/MHA Contacts: Add/Change/Delete** header screen:
- Type the MRA component code in the **COMP** field.
- Type **MRA** in the **CONTACT TYPE** field.
- Type **D** (Delete) in the **TYPE OF ENTRY** field.
- Press **Enter**.

Step 3 – Select the record to be deleted.
On the **L28: MRA/MHA Contacts Delete Records** screen:
- View the sequence/type/contact description information.
- Type **X** in the **SELECT** field next to the record to be deleted.
- Type **Y** in the **READY TO SELECT?** Field.
- Press **Enter**.

Step 4 – Delete MRA contact information.
On the **L28: MRA/MHA Contacts Delete Records** screen (screen 2):
- View the current information on the contact record selected.
- Type **Y** in the **READY TO DELETE?** field.
- Press **Enter**.
Permanency Planning Review (309): Add

Step 1 – Access the Permanency Planning Review option.
- Type 309 in the ACT: field of any screen.
- Press Enter.

Step 2 – Identify the individual and indicate the type of entry.
On the 309: Permanency Planning Review: Add/Change/Delete header screen:
- Type the MRA component code in the COMPONENT CODE field.
- Type the individual’s local case number in the LOCAL CASE NUMBER field.
- Type A (Add) in the TYPE OF ENTRY field.
- Press Enter.

Step 3 – Add a permanency plan for an HCS individual.
On the 309: Permanency Planning Review: Add screen:
- Type the date of the individual’s permanency planning review in the REVIEW DATE field.
- Type the code indicating the permanency plan goal in the PERMANENCY PLAN GOAL field.
- Type the code indicating the frequency of parent/guardian contact with the individual during the last six months in the CONTACT FREQ field.
- Type the number of visits to the facility by the parent/guardian in the # VISIT BY FAM field.
- Type the number of the resident’s visits to the home in the # VISIT TO FAM field.
- Type Y (Yes) or N (No) to indicate whether the person has a history of traumatic brain injury in the TRAUMATIC BRAIN INJURY field.
- Type Y (Yes) or N (No) to indicate whether the family/LAR supports the goal in the DOES FAMILY/LAR SUPPORT GOAL field.
- Type Y (Yes), N (No), or NA (Not Applicable) to indicate whether the family/LAR participated in the initial or annual meeting to discuss the Plan of Care in the FAMILY PARTICIPATED/POC field.
- Type Y (Yes) or N (No) to indicate whether the family/LAR participated in this initial or review of the permanency plan in the FAMILY PARTICIPATED/PP field.
- Type Y (Yes) or N (No) to indicate whether the family could be located when needed within the last six months in the LOCATED FAMILY field.
- Type Y (Yes) or N (No) to indicate whether the family/LAR responded to requests to participate in permanency planning meetings within the last six months in the FAMILY RESPONDED field.
- Type Y (Yes) or N (No) or leave blank for each Family and Community Support.

Note: The Family and Community Supports to Achieve Goal section of the screen is not required for individuals 18 to 21 years of age with a Permanency Plan Goal of 4.
- Type the name of the permanency planning staff contact in the CONTACT NAME field.
- Type the permanency planning staff contact person’s telephone number in the CONTACT PHONE field.
- Type Y (Yes) or N (No) to indicate if the individual is enrolled or enrolling in any Medicaid Waiver or is currently living in a nursing home and has access to a Medicaid Waiver in the ENROLLED, IS ENROLLING, OR IS ELIGIBLE FOR MFP IN A MEDICAID WAIVER field.
- Type Y in the READY TO ADD? field.
- Press Enter.

Step 4 – Update client correspondent information.
On the 431: Client Correspondent Update screen:
- Type primary and secondary correspondent information as appropriate.
- Type Y in the READY TO UPDATE? field.
- Press Enter.
Permanency Planning Review (309): Change

Step 1 – Access the Permanency Planning Review option.
- Type 309 in the ACT: field of any screen.
- Press Enter.

Step 2 – Identify the individual and indicate the type of entry.
On the 309: Permanency Planning Review: Add/Change/Delete header screen:
- Type the MRA component code in the COMPONENT CODE field.
- Type the individual’s local case number in the LOCAL CASE NUMBER field.
- Type C (Change) in the TYPE OF ENTRY field.
- Press Enter.

Step 3 – Change an HCS individual’s permanency plan.
On the 309: Permanency Planning Review: Change screen:
- Type changes to the permanency plan in the appropriate fields.
- Type Y in the READY TO CHANGE? field.
- Press Enter.
Permanency Planning Review (309): Delete

Step 1 – Access the Permanency Planning Review option.
- Type 309 in the ACT: field of any screen.
- Press Enter.

Step 2 – Identify the individual and indicate the type of entry.
On the 309: Permanency Planning Review: Add/Change/Delete header screen:
- Type the MRA component code in the COMPONENT CODE field.
- Type the individual’s local case number in the LOCAL CASE NUMBER field.
- Type D (Delete) in the TYPE OF ENTRY field.
- Press Enter.

Step 3 – Delete an HCS individual’s permanency plan.
On the 309: Permanency Planning Review: Delete screen:
- Type Y in the READY TO DELETE? field.
- Press Enter.
Provider Choice (L05)

Step 1 – Access the Provider Choice option.
- Type L05 in the ACT: field of any screen.
- Press Enter.

Step 2 – Identify the individual and indicate the type of entry.
On the L05: Provider Choice: Add/Delete header screen:
- Type the Client ID in the CLIENT ID field.
- Type the MRA component code in the COMPONENT CODE field.
- Type A (Add) in the TYPE OF ENTRY field.
- Press Enter.

Step 3 – Enter provider choice.
On the L05: Provider Choice: Add screen:
Program Provider (PRGP)
- Type the component code of the program provider chosen by the individual in the PROVIDER COMPONENT field.
- Type the local case number that the program provider assigned the individual in the PROVIDER LOCAL CASE NUMBER field.
- Type the contract number of the program provider chosen by the individual in the PROVIDER CONTRACT NUMBER field.
- For TxHmL individuals, type OHFH (Own Home/Family Home) in the LOCATION CODE field. For HCS individuals, type the location code provided by the program provider in the LOCATION CODE field.
  Note: In HCS, when choosing a CDSA, the location code must be OHFH.
Consumer Directed Service Agency (CDSA):
- Type the component code of the CDS Agency in the COMPONENT field.
- Type the local case number assigned the individual by the CDS Agency in the LOCAL CASE NUMBER field.
- Type the contract number of the CDS Agency in the CONTRACT NUMBER field.
- Type Y in the READY TO ADD? field.
- Press Enter.
Register Client Update (L09) – CDSA

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

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

Step 1 – Access the Register Client Update option.

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

Step 2 – Identify the individual.

On the L09: Register Client Update header screen:

• Type the Client ID in the CLIENT ID field.
• Type the CDSA’s component code in the COMPONENT CODE field.
• Press Enter.

Note: Once an individual has been assigned a local case number by a CDSA, it is not necessary to assign them another local case number.

Step 3 – Assign the selected program provider’s local case number for the new enrollment.

On the L09: Register Client Update screen:

• Type the Local Case Number assigned to the individual by the CDSA in the LOCAL CASE NUMBER field.
• Review all fields on the screen for accuracy and correct, if necessary.

Note: Do not change the Registration Effective Date.

• Type Y in the READY TO UPDATE? field.
• Press Enter.

Note: You don’t have to change a local case number if an individual changes programs and leaves the provider, then later returns to the provider.
Register Client Update (L09) – Program Provider

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

Step 1 – Access the Register Client Update option.
- Type L09 in the ACT: field of any screen.
- Press Enter.

Step 2 – Identify the individual.
On the L09: Register Client Update header screen:
- Type the Client ID in the CLIENT ID field.
- Type the program provider’s component code in the COMPONENT CODE field.
- Press Enter.
Note: Once an individual has been assigned a local case number by a provider, it is not necessary to assign them another local case number.

Step 3 – Assign the selected program provider’s local case number for the new enrollment.
On the L09: Register Client Update screen:
- Type the Local Case Number assigned to the individual by the program provider in the LOCAL CASE NUMBER field.
- Review all fields on the screen for accuracy and correctness, if necessary.
Note: Do not change the Registration Effective Date.
- Type Y in the READY TO UPDATE? field.
- Press Enter.
Note: You don’t have to change a local case number if an individual changes programs and leaves the provider, then later returns to the provider.
Service Coordination Assignment (490): Add

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

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

**Step 1 – Access the Service Coordination Assignment option.**
- Type **490** in the ACT: field of any screen.
- Press **Enter**.

**Step 2 – Identify the individual and indicate the type of entry.**
On the **490: Svc Coordination Assignment: Add/Change/Delete** header screen:
- Type the requested identifying information in the appropriate fields.
**Rule:** You must enter the Client ID or the local case number.
- Type the MRA component code in the **COMPONENT CODE** field.
- Type **A** (Add) in the **TYPE OF ENTRY** field.
- Press **Enter**.

**Step 3 – Add a Service Coordinator assignment for a TxHmL individual.**
On the **490: Svc Coordination Assignment: Add** screen:
- Type the date the assignment begins in the **ASSIGNMENT BEGIN DATE** field.
- Type the code for the Service Coordinator position in the **CASE MANAGER POSITION** field.
- Type the Case Management unit code in the **CASE MANAGEMENT UNIT** field.
- Type **Y** in the **READY TO ADD?** field.
- Press **Enter**.
Service Coordination Assignment (490): Change

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

Step 1 – Access the Service Coordination Assignment option.
- Type 490 in the ACT: field of any screen.
- Press Enter.

Step 2 – Identify the individual and indicate the type of entry.
On the 490: Svc Coordination Assignment: Add/Change/Delete header screen:
- Type the requested identifying information in the appropriate fields.
Rule: You must enter the Client ID or the local case number.
- Type the MRA component code in the COMPONENT CODE field.
- Type C (Change) in the TYPE OF ENTRY field.
- Press Enter.

Step 3 – Change a TxHmL individual’s Service Coordinator assignment record.
On the 490: Svc Coordination Assignment: Change screen:
- Type changes to the Service Coordination assignment in the appropriate fields.
- Type Y in the READY TO CHANGE? field.
- Press Enter.
Step 1 – Access the Service Coordination Assignment option.
• Type 490 in the ACT: field of any screen.
• Press Enter.

Step 2 – Identify the individual and indicate the type of entry.
On the 490: Svc Coordination Assignment: Add/Change/Delete header screen:
• Type the requested identifying information in the appropriate fields.
  Rule: You must enter the Client ID or the local case number.
• Type the MRA component code in the COMPONENT CODE field.
• Type D (Delete) in the TYPE OF ENTRY field.
• Press Enter.

Step 3 – Delete a TxHmL individual’s Service Coordinator assignment record.
On the 490: Svc Coordination Assignment: Delete screen:
• Type Y in the READY TO DELETE? field.
• Press Enter.
Waiver MR/RC Assessment Purpose Code 2 (L23)

Step 1 – Access the Waiver MR/RC Assessment option.
   • Type L23 in the ACT: field of any screen.
   • Press Enter.

Step 2 – Identify the individual and indicate the purpose code, type of entry, and requested begin date.
   On the L23: Waiver MR/RC Assessment: Add/Chg/Del header screen:
   • Type the requested identifying information in the appropriate fields.
   Rule: You must enter the Client ID, the local case number, or the Medicaid Number.
   • Type the MRA component code in the COMPONENT CODE field.
   • Type 2 (No Current Assessment) in the PURPOSE CODE field.
   • Type A (Add) in the TYPE OF ENTRY field.
   • Type the MR/RC Assessment begin date in the REQUESTED BEGIN DATE field.
   Note: The Purpose Code 2 MR/RC Assessment must begin on or before the enrollment date. If an MRA fails to enter a Purpose Code 2 by this date, they must enter a comment in the PROVIDER COMMENTS field requesting DADS Program Enrollment staff to backdate the MR/RC to the date of enrollment.
   • Press Enter.

Step 3 – Enter an MR/RC Assessment.
   On the L23: Waiver MR/RC Assessment Purpose Code 2: Add screen:
   • Type the date the MR/RC Assessment was completed in the COMPLETED DATE field.
   • Type the person’s legal status in the LEGAL STATUS field.
   • Type the person’s previous residence location before the current enrollment in the PREV. RES. field.
   • Type the recommended Level of Care in the REC. LOC field.
   • Type the recommended Level of Need in the REC. LON field.
   • Type the person’s current primary diagnosis as determined by a physician in the PRIMARY DIAG field.
   • Type the month and year that the person’s disabling condition was originally diagnosed in the ONSET field.
   • Press Enter.

Step 4 – View client and MR/RC information.
   • View the client and MR/RC record information.
   • Press Enter.

Step 5 – Add the cognitive functioning, ICAP data, behavioral status, and nursing information.
   • Type information in the appropriate fields.
   Note: All of the fields on this screen are required.
   • Press Enter.

Step 6 – Add the day services and functional assessment information.
   • Type information in the appropriate fields.
   Note: All of the fields on this screen are required.
   • Press Enter.

Step 7 – Add the physician’s evaluation and recommendation information, if appropriate.
   • The Physician’s Evaluation and Recommendation fields are not required for waiver programs.
   Note: If the physician has signed the form, you must complete all fields on the screen. If the physician has not signed the form, do not any enter data on this screen.
   • Press Enter to continue.

Step 8 – Add the provider certification and provider comments.
   • Type information in the appropriate fields.
   • Type Y (Yes) or N (No) in the READY TO SEND FOR AUTHORIZATION? field to indicate whether or not you are ready to send the MR/RC Assessment to Program Enrollment (PE) at State Office.
   • Type Y (Yes) or N (No) in the READY TO ADD? field to indicate whether or not you are ready to add the record. You may want to add the record pending further modifications even if you are not ready to send it for authorization by PE. If you add the record, the system saves the data and you won’t have to reenter the information, but you will have to add needed information and send for review prior to proceeding further with the enrollment.
   • Press Enter.
Waiver MR/RC Assessment Purpose Code 3 (L23): Add

Step 1 – Access the Waiver MR/RC Assessment option.
- Type L23 in the ACT: field of any screen.
- Press Enter.

Step 2 – Identify the individual and indicate the purpose code and type of entry.
On the L23: Waiver MR/RC Assessment: Add/Change/Delete header screen:
- Type the requested identifying information in the appropriate fields.
- Type the MRA component code in the COMPONENT CODE field.
- Type the contract number under which services are provided to this individual in the CONTRACT NO field.
- Type 3 (Continued Stay Assessment) in the PURPOSE CODE field.
- Type A (Add) in the TYPE OF ENTRY field.
- Type the requested begin date in the REQUESTED BEGIN DATE field. (Within 45 days prior to the current expiration date, the begin date can be the day after the expiration date. Other than during this 45-day window, the begin date must be the date of data entry.)
- Press Enter.

Step 3 – Add an MR/RC continued stay assessment (Purpose Code 3) for a TxHmL individual.
On the L23: Waiver MR/RC Assessment Purpose Code 3: Add screen:
- Type the date the MR/RC Assessment was completed in COMPLETED DATE field.
- Type in the latest physical examination date in the PHYS EXAM DATE field.
- Type additional information in the appropriate fields.

Note 1: All data entered into the CARE system should be entered from a paper copy (a hard copy) and match exactly.
Note 2: The LEGAL STATUS and PREV. RES. fields are required.
- Press Enter.

Step 4 – View client and MR/RC record information.
- View and verify the client and MR/RC record information.
- Press Enter.

Step 5 – Continue the MR/RC Assessment entry.
- Type information in the appropriate fields.

Note: For the 32. GEN. MALADAPTIVE field, if the number is negative, you must use the – (minus) sign just above the alpha section of the keyboard, not the – sign on the 10-key pad.
- Press Enter.

Step 6 – Continue the MR/RC Assessment entry.
- Type information in the appropriate fields.

Note: All of the fields on this screen are required.
- Press Enter.

Step 7 – Continue the MR/RC Assessment entry.
- Type information in the appropriate fields.
- If any data is entered or shown on this screen, all fields must be correctly entered (not required for waiver programs).

Note: The fields (48-55) on this screen are not required to be completed. If you choose to enter information in the fields, they must be completed completely and accurately.
- Press Enter.

Step 8 – Complete the MR/RC Assessment entry.
- Type information in the appropriate fields.

Note: The title of the person listed on the FULL NAME OF field (field 57) must be on the list displayed on this screen.
- Type Y (Yes) or N (No) in the READY TO SEND FOR AUTHORIZATION? field to indicate whether or not you are ready to send the MR/RC Assessment to DADS Access & Intake, Program Enrollment (PE).
- Type Y (Yes) or N (No) in the READY TO ADD? field to indicate whether or not you are ready to add the record. You may want to add the record pending further modifications even if you are not ready to send it for authorization by UR.
- Press Enter.
Waiver MR/RC Assessment Purpose Code 4 (L23): Add

Step 1 – Access the Waiver MR/RC Assessment option.
- Type L23 in the ACT: field of any screen.
- Press Enter.

Step 2 – Identify the individual and indicate the purpose code and type of entry.
On the L23: Waiver MR/RC Assessment: Add/Change/Delete header screen:
- Type the requested identifying information in the appropriate fields.
  Rule: You must enter the Client ID, the local case number, or the Medicaid Number.
- Type the contract number under which services are provided to this individual in the CONTRACT NO field.
- Type 4 (Change LON on Existing Assessment) in the PURPOSE CODE field.
- Type A (Add) in the TYPE OF ENTRY field.
- Type the requested begin date in the REQUESTED BEGIN DATE field.
  Note: For a Purpose Code 4, the begin date must equal the date of data entry. The end date will be the date that the current LOC/LON expires.
- Press Enter.

Step 3 – Add a change LON on an existing MR/RC assessment (Purpose Code 4) for a TxHmL individual.
On the L23: Waiver MR/RC Assessment Purpose Code 4: Add screen:
- Type the date the MR/RC Assessment was completed in the COMPLETED DATE field.
- Type the recommended Level of Need in the REC. LON field.
- Type additional information in the appropriate fields.
  Note: All data entered into the CARE system should be entered from a paper copy (a hard copy) and match exactly.
- Press Enter.

Step 4 – View client and MR/RC record information.
- View the client and MR/RC record information.
- Press Enter.

Step 5 – Continue the MR/RC Assessment entry.
- Type information in the appropriate fields.
- Press Enter.

Step 6 – Continue the MR/RC Assessment entry.
- Type information in the appropriate fields.
- Press Enter.

Step 7 – Continue the MR/RC Assessment entry.
- Type information in the appropriate fields.
  Note: The fields (48-55) on this screen are not required to be completed. If you choose to enter information in the fields, they must be completed completely and accurately.
- Press Enter.

Step 8 – Complete the MR/RC Assessment entry.
- Type or verify correctness of information in the appropriate fields.
  Note: The title of the person listed on the FULL NAME OF field (field 57) must be on the list displayed on this screen.
- Type Y (Yes) or N (No) in the READY TO SEND FOR AUTHORIZATION? field to indicate whether or not you are ready to send the MR/RC Assessment to DADS Access & Intake, Program Enrollment (PE).
- Type Y (Yes) or N (No) in the READY TO ADD? field to indicate whether or not you are ready to add the record. You may want to add the record pending further modifications even if you are not ready to send it for authorization by PE.
- Press Enter.
Waiver MR/RC Assessment Purpose Code E (L23): Add

Important: The begin date of the gap is the day after the previous LOC/LON expired, and the end date is the day before the current LOC/LON begins.

Step 1 – Access the MR/RC Assessment Summary

- Type C68 in the ACT: field of any screen.
- Press Enter.

Step 2 – Identify the gap dates

- Review information from the two most recent MR/RC Assessments to determine the gap dates.

Step 3 – Access the Waiver MR/RC Assessment option.

- Type L23 in the ACT: field of any screen.
- Press Enter.

Step 4 – Identify the individual and indicate the purpose code and type of entry.

On the L23: Waiver MR/RC Assessment: Add/Change/Delete header screen:

- Type the requested identifying information in the appropriate fields.
- Type E (Gaps in Assessment) in the PURPOSE CODE field.
- Type A (Add) in the TYPE OF ENTRY field.
- Type the requested begin date in the REQUESTED BEGIN DATE field.
- Type the requested end date in the REQUESTED END DATE field.

Note: For Purpose Code E, REQUESTED BEGIN DATE and REQUESTED END DATE are required fields.

- Press Enter.

Step 5 – Add an MR/RC gaps in assessment (Purpose Code E) for a TxHmL individual.

On the L23: Waiver MR/RC Assessment Purpose Code E: Add screen:

- Type the date the MR/RC Assessment was completed in COMPLETED DATE field.

Note: The date must be on or after the gap end date.

- Type additional information in the appropriate fields.
- Press Enter to continue.

Note: An LON increase cannot be authorized on a Purpose Code E.

Step 6 – View the client and MR/RC record information.


- Press Enter.

Step 7 – Continue the MR/RC Assessment entry.


- Type information in the appropriate fields.
- Press Enter.

Step 8 – Continue the MR/RC Assessment entry.


- Type information in the appropriate fields.
- Press Enter.

Step 9 – Continue the MR/RC Assessment entry.


- Type information in the appropriate fields.

Note: The fields (48-55) on this screen are not required to be completed. If you choose to enter information in the fields, they must be completed completely and accurately.

- Press Enter.

Step 10 – Continue the MR/RC Assessment entry.


- Type information in the appropriate fields.

Note 1: The title of the person listed in the FULL NAME OF field (field 57) must be on the list displayed on this screen.

Note 2: The signature date must be on or after the gap end date.

- Type Y (Yes) or N (No) in the READY TO SEND FOR AUTHORIZATION? field to indicate whether or not you are ready to send the MR/RC Assessment to DADS Access & Intake, Program Enrollment (PE).
- Type Y (Yes) or N (No) in the READY TO ADD? field to indicate whether or not you are ready to add the record. You may want to add the record pending further modifications even if you are not ready to send it for authorization by PE.

- Press Enter.
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