FISCAL YEAR 2015

POLICY
&
PROCEDURE
MANUAL

Epilepsy Program

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TEXAS
Department of
State Health Services

Department of State Health Services
Division for Family and Community Health Services
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Introduction
General Information

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INTRODUCTION

Purpose of Manual

The Department of State Health Services (DSHS) Policy and Procedures Manual for Epilepsy Services is a guide for contractors who deliver epilepsy services using Texas general revenue funds. The policy manual has been structured to provide contractors with information needed to comply with Administrative, Client Services, Community Activities, Reimbursement, Data Collection and Reporting policies.

To provide epilepsy services, contractors are required to be in compliance with specific federal and state laws outlined in the manual. State rules that apply most specifically to epilepsy services in Texas are found in the Texas Administrative Code (TAC).
http://info.sos.state.tx.us/pls/pub/readtac$ext.ViewTAC?tac_view=5&ti=25&pt=1&ch=37&sch=K&rl=Y

Authorization:
Enacting Legislation – HB1685, 67th Session, 1981
Health and Safety Code – Chapter 40
Texas Administrative Code – Chapter 37, Subchapter K §§ 37.211 – 37.222

Purpose – Epilepsy services provide comprehensive outpatient care (diagnostic, treatment and support services) to eligible persons who have epilepsy and/or seizure-like symptoms through subrecipient providers in selected service areas in Texas.

Description – Epilepsy is a medical condition that produces seizures affecting a variety of mental and physical functions; also called a *seizure disorder*. A seizure is caused by a brief, strong surge of electrical activity involving part or all of the brain. When a person has two or more seizures without a clear cause (e.g., alcohol withdrawal), it is considered to be epilepsy.

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DEFINITIONS

Below are some general definitions of terms or phrases that are used throughout this manual.

Applicant – A person who is applying for services.

Caretaker – An adult who is present in the home and supervises and cares for a child.

Child – A person who has not reached his/her 18th birthday and who has not had the classification of minor removed in court or who is not or never has been married or recognized as an adult by the State of Texas.

Client – An individual who has been screened, determined to be eligible for services, and has successfully completed the eligibility process.

Community Assessment – A tool used to identify factors that affect the health of a population and to determine the availability of resources within the community to impact these factors.

Contractor – Any entity that the Department of State Health Services has contracted with to provide services. The contractor is the responsible entity even if there is a subcontractor involved who actually provides the services.

Co-Payments – Monies collected directly from clients for services. The amount collected each month should be deducted from the Monthly Reimbursement Request and is considered program income.

Department of State Health Services (DSHS) – The agency responsible for administering physical and mental health-related prevention, treatment, and regulatory programs for the State of Texas.

Diagnosis – The doctor's main tool in diagnosing epilepsy is a careful medical history with as much information as possible about what the seizures looked like and what happened just before they began. The doctor will also perform a thorough physical exam and may require microscopic (i.e. culture), chemical (i.e. blood tests), EEG and/or radiological examinations (CAT or MRI).

Eligibility Date – Date the applicant submits a completed application to the provider and is deemed eligible.

Federal Poverty Level (FPL) – The set minimum amount of income that a family needs for food, clothing, transportation, shelter and other necessities, as determined by the Department of Health and Human Services. FPL varies according to family size. The number is adjusted for inflation and reported

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annually in the form of poverty guidelines. Public assistance programs, such as Medicaid in the U.S., define eligibility income limits as some percentage of FPL.

Fiscal Year – State fiscal year, September 1 – August 31

Health and Human Services Commission (HHSC) – The state agency that has oversight responsibilities for designated Health and Human Services agencies, including DSHS.
Medicaid – Title XIX of the Social Security Act; reimburses for health care services delivered to low-income clients who meet eligibility guidelines.

Outreach – Activities that are conducted with the purpose of informing and educating the community about services and increasing the number of program participants.

Provider – An individual clinician or group of clinicians who provide services.

Re-certification – The process of re-screening and determining eligibility for the next year.

Service – Any client encounter at a facility that results in the client having a medical or health-related need met.

Treatment – Any specific procedure used for the cure or the improvement of a disease or pathological condition.

Unduplicated Client – An enrolled program participant who is counted only one time during the contract period (fiscal year), regardless of the number of times the person is seen or the number of services the individual receives. One client seen four times is counted as one unduplicated client; a family of three seen once is counted as three unduplicated clients.

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Acronyms*:*

ADA- Americans with Disabilities Act
CHIP- Children's Health Insurance Plan
CDSB- Contract Development and Support Branch
CPU- Claims Processing Unit
CSHCN- Children with Special Health Care Needs
DSHS- Department of State Health Services
EEG- Electroencephalograph
FCHSD- Family and Community Health Services Division
FPL- Federal Poverty Level
FY- State Fiscal Year – September 1 through August 31
HB- House Bill
HHS- Human Service Agencies
HHSC- Health and Human Services Commission
HIPPA- Health Insurance Portability and Accountability Act of 1996
HSC- Health & Safety Code
LEP- Limited English Proficiency
QI- Quality Improvement
QM- Quality Management
QMB- Quality Management Branch
SDO- Standing Delegation Orders
TAC- Texas Administrative Code
TANF- Temporary Assistance for Needy Families

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Section I
Administrative Policies

Purpose: Section I assists the contractor in conducting administrative activities such as assuring client access to services and managing client records.

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CLIENT ACCESS

The contractor must ensure that clients are provided services in a timely and nondiscriminatory manner. Epilepsy clients should be contacted as soon as possible, with a goal of 30 days from initial phone contact for most clients.

The contractor must:

- Have a written policy in place that delineates the timely provision of services.
- Comply with all applicable civil rights laws and regulations including Title VI of the Civil Rights Act of 1964, the Americans with Disabilities Act of 1990, the Age Discrimination Act of 1975, and Section 504 of the Rehabilitation Act of 1973, and ensure services are accessible to persons with limited English proficiency and speech or sensory impairments.
- Have a policy in place that requires qualified staff to assess and prioritize client's needs.
- Provide referral resources for individuals that cannot be served or cannot receive a specific service.
- Follow up to determine if the referral made due to abnormal results was completed and document the results in the patient record.
- Manage funds to ensure that established clients continue to receive services throughout the budget year.

For more information, see Section I, Chapter 3 - Client Rights.

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ABUSE REPORTING

The Department of State Health Services expects contractors to comply with state laws governing the reporting of abuse. Contractors must have an agency policy regarding abuse. While the majority of Epilepsy clients are adults, it is mandatory to be familiar with and comply with adult and child abuse reporting in Texas. To report abuse or neglect, call **1-800-252-5400** or use the secure website: http://www.txabusehotline.org/

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CLIENT RIGHTS

CONFIDENTIALITY

All contracting agencies must be in compliance with the U.S. Health Insurance Portability and Accountability Act of 1996 (HIPAA) established standards for protection of client privacy. Information about HIPAA can be found at: http://www.hhs.gov/ocr/hipaa

Employees and volunteers must be made aware during orientation that violation of the law in regard to confidentiality may result in civil damages and criminal penalties.

The client's preferred method of follow-up (cell phone, email, work phone) must be documented in the client's record. (See Client Health Record Section II Chapter 3.)

Each client must receive verbal assurance of confidentiality and an explanation of what confidentiality means (kept private and not shared without permission) and any applicable exceptions such as abuse reporting (See Section I Chapter 2.)

NON-DISCRIMINATION

DSHS Contractors must comply with state and federal anti-discrimination laws, including without limitation:

(1) Title VI of the Civil Rights Act of 1964 (42 U.S.C. §2000d *et seq.*);
(2) Section 504 of the Rehabilitation Act of 1973 (29 U.S.C. §794);
(3) Americans with Disabilities Act of 1990 (42 U.S.C. §12101 *et seq*.);
(4) Age Discrimination Act of 1975 (42 U.S.C. §§6101-6107);
(5) Title IX of the Education Amendments of 1972 (20 U.S.C. §§1681 *et seq.*);
(6) Food and Nutrition Act of 2008 (7 U.S.C. §2011 *et seq*.); and
(7) Administrative rules for HHS agencies, as set forth in the Texas Administrative Code, to the extent applicable.

To ensure compliance with DSHS non-discrimination laws, regulations, and policies, DSHS Contractors must:

- Sign a written assurance as to compliance with applicable federal and state non-discrimination laws and regulations;
- Have a written policy stating that the agency does not discriminate on the basis of race, color, national origin including limited English proficiency (LEP), gender, age, religion, or sexual orientation;
- Ensure that all contractor staff is trained in the contractor's non-discrimination policies, including LEP policies, and HHS complaint procedures;

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- Notify all clients and applicants of contractor's non-discrimination policies and complaint procedures; and
- Notify the HHSC Civil Rights Office of any discrimination allegation or complaint related to its programs or services no later than ten (10) calendar days after receipt of the allegation or complaint. Send notices to:

  HHSC Civil Rights Office
  701 W. 51st Street, Mail Code W206
  Austin, Texas 78751
  Phone Toll Free: (888) 388-6332
  Phone: (512) 438-4313
  TTY Toll Free: (877) 432-7232
  Fax: (512) 438-5885

More information about non-discrimination laws and regulations can be found in the HHSC Civil Rights Office website at: http://www.hhsc.state.tx.us/about_hhsc/civil-rights/.

LIMITED ENGLISH PROFICIENCY

To ensure compliance with civil rights requirements related to LEP, contractors must:

- Take reasonable steps to ensure that persons with LEP have meaningful access to its programs and services, and not require them to use friends or family members as interpreters. However, a family member or friend may serve as a client's interpreter at the client's request, and the family member or friend does not compromise the effectiveness of the service or violate client confidentiality, and
- Make clients and applicants with language service needs, including persons with LEP and disabilities, aware that the contractor will provide an interpreter free of charge.

CIVIL RIGHTS POSTERS

The Contractor must prominently display the following posters in client common areas, including lobbies and waiting rooms, front reception desks and locations where clients apply for services:

- **"Know Your Rights" [English] [Spanish]**
  Size: 8.5" x 11" (standard size sheet of paper).
  Posting Instructions: Post the English and Spanish versions of this poster next to each other.

  Questions: Contact the HHSC Civil Rights Office.

- **"Need an Interpreter" [Language Translation] [American Sign Language]**

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Size: 8.5" x 11" (standard size sheet of paper).
Posting Instructions: Post the "Language Translation" version and "American Sign Language" version next to each other.

Questions: Contact the HHSC Civil Rights Office.

The posters are located at:
http://www.hhsc.state.tx.us/about_hhsc/civil-rights/brochures-posters.shtml. Questions concerning this section and civil rights matters should be directed to the HHSC Civil Rights Office.

CIVIL RIGHTS SURVEYS

Contractors should conduct a self-assessment concerning civil rights compliance. The Contractor must have completed, signed copies of the following surveys available:

- Non-Discrimination Policies and Procedures Survey,
- ADA/Section 504 Policies and Procedures Survey, and
- Limited English Proficiency (LEP) Policies and Procedures Survey.

These documents and instructions can be downloaded from the Quality Management Branch (QMB) website:
http://www.dshs.state.tx.us/qmb/contractor.shtm

Information concerning the self-assessment and surveys can be directed to the DSHS Quality Management Branch.

TERMINATION OF SERVICES

Contractors have the right to terminate services to a client if the client is disruptive, unruly, threatening, or uncooperative to the extent that the client seriously impairs the Contractor's ability to provide services or if the client's behavior jeopardizes his or her own safety, clinic staff, or other clients.

Any policy related to termination of services must be included in the Contractor's policy and procedures manual.

RESOLUTION OF COMPLAINTS

Contractors must ensure that clients have the opportunity to express concerns about care received and to further ensure that those complaints are handled in a consistent manner. Contractors' policy and procedure manuals must explain the process clients will follow if they are not satisfied with the care received. If an aggrieved client requests a hearing, a Contractor shall not terminate services to the client until a final decision is rendered. Any client grievance must be documented in the client's record.

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RESEARCH (HUMAN SUBJECT CLEARANCE)

Contractors considering clinical or sociological research using EPHC grant funded clients as subjects must obtain prior approval from their own internal Institutional Review Board (IRB) or the Department of State Health Services Institutional Review Board (DSHS-IRB). The IRB is responsible for the review of human subjects' research and the review of requests for release of data, including Protected Health Information.

Contractor agencies that have their own IRB must obtain their approval for any research conducted on these clients. Documentation of approval must be submitted to DSHS prior to implementation of the research project. In such instances, the contractor is not required to seek approval from the DSHS IRB.

Request for Proposals (RFPs) will include a checkbox to indicate if a contractor is performing research on any EPHC grant funded clients. If so, the contractor must submit documentation of IRB approval along with the RFP. DSHS staff will review to ensure that policy requirements are being met and to ensure compliance with any grant restrictions pertaining to research.

The contractor must have a policy in place that indicates that prior approval will be obtained from the IRB prior to instituting any research activities. The contractor must also insure that all staff is made aware of this policy through staff training. Documentation of training on this topic must be maintained. Further information on the IRB may be found at: http://www.dshs.state.tx.us/irb.

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CLIENT RECORDS MANAGEMENT

DSHS contractors must have an organized and secure client record system. The contractor must ensure that the record is organized and readily accessible, available to the client upon request with a signed release of information, and confidential and secure, as follows:

- Safeguarded against loss or use by unauthorized persons;
- Secured by lock when not in use or inaccessible to unauthorized persons;
- Maintained in a secure environment in the facility as well as during transfer between clinics and in between home and office visits.

In addition, a confidentiality assurance statement must appear in the client's record. The written consent of the client is required for the release of personally identifiable information, except as necessary to provide services to the client or as required by law, with appropriate safeguards for confidentiality. HIV information should be handled according to law.

When information is requested, contractors must release only the specific information requested. Information collected for reporting purposes may be disclosed only in summary, statistical, or other form that does not identify particular individuals. Upon request, clients transferring to other providers must be provided with a copy or summary of their record to expedite continuity of care. Electronic records are acceptable as medical records.

Contractors, providers, sub-recipients, and subcontractors must maintain for the time period specified by DSHS all records pertaining to client services, contracts, and payments. Record retention requirements are found in the TAC §354.1004 (relating to Retention of Records).

Contractors must follow contract provisions and the DSHS Retention Schedule for Medical Records. All records relating to services must be accessible for examination at any reasonable time to representatives of DSHS and as required by law. DSHS guidelines for medical record retention are available from the DSHS website at: http://www.dshs.state.tx.us/records/medicalrec.shtm.

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PERSONNEL POLICY AND PROCEDURES

Contractors must develop and maintain personnel policies and procedures to ensure that clinical staff are hired, trained, and evaluated appropriately to their job position. Personnel policies and procedures must include job descriptions, a written orientation plan for new staff and performance evaluation. Job descriptions, including those for contracted personnel, must specify required qualifications and licensure. All staff must be appropriately identified with a name badge.

Contractors must show evidence that employees meet all required qualifications, are provided annual training. Job evaluations should include observation of staff/client interactions during clinical, counseling, and educational services.

Contractors shall establish safeguards to prohibit employees from using their positions for a purpose that constitutes or presents the appearance of personal or organizational conflict of interest or personal gain.

Contractors must provide medical care services under the supervision, direction, and responsibility of a qualified Medical Director.

Contractors must have a documented plan of organized staff development based on an assessment of training needs, quality assurance indicators, and changing regulations/requirements, and must include orientation and in-service training for all personnel, including volunteers. There must be documentation of initial employee orientation and continuing education.

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QUALITY MANAGEMENT

Organizations that embrace Quality Management (QM) concepts and methodologies and integrate them into the structure of the organization and day-to-day operations discover a very powerful management tool. Quality Management programs can vary in structure and organization and will be most effective if they are individualized to meet the needs of a specific agency, services and the populations served.

Contractors are expected to develop quality processes based on the four core Quality Management principles of focusing on: the client, systems and processes, measurement and teamwork. Contractors must have a Quality Management program individualized to their organizational structure and based on the services provided. The goals of the quality program should ensure availability and accessibility of services, and quality and continuity of care.

A Quality Management program must be developed and implemented that provides for ongoing evaluation of services. Contractors should have a comprehensive plan for the internal review, measurement, and evaluation of services, the analysis of monitoring data, and the development of strategies for improvement and sustainability. Contractors who subcontract for the provision of services must also address how quality will be evaluated and how compliance with policies and basic standards will be assessed with the subcontracting entities.

The Quality Management Committee, whose membership consists of key leadership of the organization, including the Executive Director/CEO and the Medical Director, where applicable, annually reviews and approves the quality work plan for the organization.

Committee

The Quality Management Committee must meet at least quarterly to:

- Receive reports of monitoring activities;
- Make decisions based on the analysis of data collected;
- Determine quality improvement actions to be implemented;
- Reassess outcomes and goal achievement.

Minutes of the discussion and actions taken by the committee must be maintained.

Work Plan

The quality management work plan, at a minimum, must:

- Include clinical and administrative standards by which services will be monitored;

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- Include process for credentialing and peer review of clinicians;
- Identify individuals responsible for implementing monitoring, evaluating and reporting;
- Establish timelines for quality monitoring activities;
- Identify tools/forms to be utilized;
- Outline reporting to the Quality Management Committee.

Although each organization's quality program is unique, the following activities must be undertaken by all agencies providing client services:

- On-going eligibility, billing, and clinical record reviews to assure compliance with program requirements and clinical standards of care;
- Tracking and reporting of adverse outcomes;
- Client satisfaction surveys;
- Annual review of facilities to maintain a safe environment, including an emergency safety plan;
- Annual review of policies, clinical protocols and standing delegation orders (SDOs) to ensure they are current.

Data from these activities must be presented to the Quality Management Committee. Plans to improve quality should result from the data analysis and reports considered by the committee and should be documented.

Website

Operating processes of the DSHS Quality Management Branch as well as policies and review tools are available from the QMB website at: http://www.dshs.state.tx.us/qmb/default.shtm.

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SUBCONTRACTING

Contracts with Subrecipient Subcontractors – Contractor may enter into contracts with subrecipient subcontractors unless restricted or otherwise prohibited in a specific Program Attachment(s). Prior to entering into an agreement equaling $25,000 or twenty-five percent (25%) of a Program Attachment amount, whichever is greater, contractor shall obtain written approval from DSHS. Contracts with subcontractors shall be in writing and include the following:

- Name and address of all parties;
- Detailed description of the services to be provided;
- Measurable method and rate of payment and total amount of contract;
- Clearly defined and executable termination clause;
- Beginning and ending dates that coincide with the dates of the applicable Program Attachment(s) or cover a term within the beginning and ending dates of the applicable Program Attachment(s);
- Access to inspect the work and the premises on which any work is performed, in accordance with the Access and Inspection Article in this Contract; and
- Copy of General Provisions and the Statement of Work and any Special Provisions in the Program Attachment(s) applicable to the subcontract.

Contractor is responsible to DSHS for the performance of any subcontractor. Contractor shall monitor both financial and programmatic performance and maintain pertinent records that shall be available for inspection by DSHS. Contractor shall ensure that subcontractors are fully aware of the requirements placed upon them by state/federal statutes and regulations and under this contract. Contractor shall not contract with a subcontractor, at any tier, that is debarred or suspended or excluded from or ineligible for participation in federal assistance programs**.**

Status of Subcontractors - Contractor shall require that all subcontractors certify that they are in good standing with all state and federal funding and regulatory agencies; are not currently debarred, suspended, revoked, or otherwise excluded from participation in federal grant programs; are not delinquent on any repayment agreements; and have not had a contract terminated by DSHS. Contractor shall further require that subcontractors certify that they have not voluntarily surrendered within the past three (3) years any license issued by DSHS.

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Section II
Client Services and Community Activities

Purpose: Section II provides policy requirements for providing client services.

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GENERAL PRINCIPALS

For an individual to receive epilepsy services with DSHS funds, four (4) criteria must be met:

- Diagnosis of epilepsy certified by a licensed physician, or a statement that applicant is suspected of having epilepsy;
- Gross family income is at or below 200% of Federal Poverty Level (FPL); http://www.dshs.state.tx.us/epilepsy/eligibility.shtm
- Applicant is a Texas resident; and
- Applicant is not eligible for other programs or benefits providing the same services, such as Medicaid, Medicare, or Children with Special Health Care Needs (CSHCN). If a child (under 21) is on a waiting list for CSHCN, they can receive epilepsy services until removed from the waiting list.

If an applicant meets all eligibility requirements except for the financial criteria the applicant is eligible only for support services.

Contractor Responsibilities –
The contractor must ensure the eligibility process is complete and includes documentation of the following:

- Individual/family name, present address, date of birth, and whether the individual/family members are currently eligible for Medicaid or other benefits;
- Health insurance policies, if applicable, providing coverage for the individual, spouse, and dependent(s);
- Monthly income of individual and spouse; and
- Other benefits available to the family or individual.

Any specified or supporting documentation necessary for the contractor to determine eligibility. The contractor shall allow the individual an opportunity to resolve any discrepancy by providing documentary evidence or by designating a suitable contact to verify information. If the individual fails or refuses to do so, eligibility can be denied. Document this information on the DSHS Epilepsy Funding Source - Worksheet.

Special circumstances may occur in the disclosure of information, documentation of pertinent facts, or events surrounding the client's application for services that make decisions and judgments by the contractor staff necessary. These circumstances should be documented in the case record on the DSHS Epilepsy Funding Source - Worksheet.

Applicant's Responsibility –

- Complete the DSHS Epilepsy Application Form (Form E100) or request assistance with completion;
- Provide verification requested by the contractor. Failure to provide all required information will result in denial of eligibility. If verification is not

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available or is insufficient to determine eligibility, contractor staff should ask the individual to designate a contact person to provide the information.

The applicant is responsible for completing the DSHS Epilepsy Application Form (Form E100). If the applicant is incompetent, or incapacitated, someone acting responsibly for the client (a representative) may represent the applicant in the application and the review process, including signing and dating the Form # on the applicant's behalf. This representative must be knowledgeable about the applicant and his household. If assistance is needed in completing the form, the contractor shall provide knowledgeable staff to assist. It is acceptable to fill out the form once and photocopy the form for the number of family members needed. The family member name listed under the family composition chart on question 1 can be highlighted or circled to indicate the intended client record in which it shall be filed. If confidentiality of services is a concern, separate forms for spouses may be completed. The signature of anyone assisting in completion of the form is required as well. The form is filed in the client record.

Client's Responsibility for Reporting Changes – A client must report changes in the following area: income, family composition, residence, address, employment, types of medical insurance coverage, and receipt of Medicaid and/or third-party coverage benefits. The client may report changes by mail, telephone, in-person, or through someone acting on the individual's behalf. Changes must be reported no later than 30 days after the client is aware of the change. If changes result in the client no longer meeting eligibility criteria, the individual is denied continued services. By signing the required forms, the individual attests to the truth of the information provided.

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SCREENING & ELIGIBILITY DETERMINATION

Clients Screened Potentially Eligible for Other Benefits – Contractors must work to ensure that individuals seeking Epilepsy covered services use other programs or benefits first. If individuals are determined potentially eligible for other benefits, contractors must refer them to the specific programs and assist them in completing the eligibility determination process.
Individuals must be screened for potential Medicaid, CHIP, or other programs by using the DSHS Epilepsy Application Form (Form E100) or a comparable paper or electronic screening and eligibility tool that has the required DSHS information and applicant's signature for determining eligibility. A copy of the Epilepsy Application Form must be maintained in the medical record.

For Epilepsy purposes, contractors may use the Health and Human Services Commission's (HHSC) Your Texas Benefits website: www.yourtexasbenefits.com to assist in the screening of client eligibility for Medicaid or CHIP. The website offers access to information on HHSC benefits including Medicaid, Supplemental Nutrition Assistance Program (SNAP), Temporary Assistance for Needy Families (TANF), and Children's Health Insurance (CHIP). The use of this system does not replace the contractors' Application Form. More information about HHSC benefits can also be obtained by calling 2-1-1.

FAMILY COMPOSITION/HOUSEHOLD

Establishing family composition/household is an important step in the eligibility process. Assessment of income eligibility relies on an accurate count of family members.

An Epilepsy household is a person living alone or two or more persons living together where legal responsibility for support exists. Legal responsibility for support exists between:

- Persons who are legally married (including common-law marriage),
- A legal parent and a minor child (including unborn children), or
- A managing conservator and a minor child.

Children and Family Composition – A child must be under 18 years of age to be counted as part of an Epilepsy household. The configuration of that household will change on the last day of the month the child becomes 18 years of age. This would be processed as a reported change for the Epilepsy household.

A child who is 18 years of age or older and resides with his/her parent(s)/guardian(s), is considered a family of one.

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Special Family Composition/Household

If the applicant is a relative and the caretaker (not the natural parent) of a child who is living with the applicant, that child may be considered a part of the applicant's Epilepsy household if documentation can be provided that verifies the relationship. Acceptable documents include birth certificates or other legal documents that demonstrate the relationship between the applicant and the child. If no biological relationship exists between the applicant and the child, or if documentation is not provided to verify a biological relationship:

- The child is not included in the applicant's Epilepsy household;
- The situation must be explained on the worksheet; and
- The applicant may apply for Epilepsy benefits on the child's behalf, if applicable.

Verification/Documentation of Family Composition/Household – If family relationships appear questionable, one of the following items may be provided:

- Birth certificate;
- Baptismal certificate;
- School records; or
- Other documents or proof of family relationship determined valid by the contractor to establish the dependency of the family member upon the client or head of household.

Family members who receive other health care benefits are included in the family count. The contractor has discretion to document special circumstances in the calculation of family composition. Additionally, if a separate family group is established within the household based on the documentation gathered, document the basis used for determining separate households on the DSHS Worksheet (Form E101).

RESIDENCY

To be eligible for Epilepsy, an individual must be physically present within the geographic boundaries of Texas and:

- Has the intent to remain within the state, whether permanently or for an indefinite period;
- Does not claim residency in any other state or country; and/or
- Is less than 18 years of age and his/her parent, managing conservator, or guardian is a resident of Texas.

If the applicant is a minor child; or a legal dependent of, and residing with, a resident (such as an adult child or spouse); or a person under a legal guardianship, then the parent(s), resident providing support, or legal guardian of the applicant shall meet all of the residency criteria.

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If the applicant is a parent residing with their adult child who is a resident of Texas, residency may be determined through the adult child. If the applicant is a parent being supported by their adult child, whether or not the child is a resident of Texas, the residency may be determined by the adult child providing the required documents supporting the Texas residency of the parent. These provisions apply even if no legal guardianship has been established.

There is no requirement regarding the amount of time an individual must live in Texas to establish residency for the purpose of Epilepsy eligibility.

Although the following individuals may reside in Texas, they are not considered Texas residents for the purpose of receiving Epilepsy services and are considered ineligible:

- Incarcerated in city, county, state, or federal jail, or prison;
- A ward of the state; or
- A Medicaid-eligible nursing home recipient.

Verification/Documentation of Residency – Verification and documentation of residency must be provided. To verify residency, one of the following items may be provided.

- Valid Texas Driver's License;
- Current voter registration;
- Rent or utility receipts for one month prior to the month of application;
- Motor vehicle registration;
- School records;
- Medical cards or other similar benefit cards;
- Property tax receipt;
- Mail addressed to the applicant, his/her spouse, or children if they live together; or
- Other documents considered valid by the contractor.

If none of the listed items are available, residence may be verified through:

- Observance of personal effects and living arrangement, or
- Statement from landlords, neighbors, other reliable sources.

Temporary Absences from State – Individuals do not lose their residency status because of temporary absences from the state. For example, a migrant or seasonal worker may travel during certain times of the year but maintains an abode in Texas and returns to that abode after these temporary absences. If a family is otherwise eligible, but residence is in question/dispute, the household is entitled to services until factual information regarding residency change proves otherwise.

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INCOME

To be eligible for Epilepsy, clients must have a gross family income at or below 200% FPL. The table below details sources of income that contribute to the calculation of gross family income as well as income that is exempt from being counted.

Types of Income	Countable	Exempt
Adoption Payments		X
Cash Gifts and Contributions*	X	
Child Support Payments*	X	
Child's Earned Income		X
Crime Victim's Compensation *		X
Dividends, Interest, and Royalties*	X	
Educational Assistance		X
Energy Assistance		X
Foster Care Payment		X
In-kind Income		X
Job Training		X
Loans (Non-educational)*	X	X
Lump-Sum Payments*	X	X
Military Pay*	X	
Mineral Rights*	X	
Pensions and Annuities*	X	
Reimbursements*	X	
Social Security Payments (RSDI /SSDI)	X	
Self-Employment Income*	X	
SSI Payments		X
TANF		X
Unemployment Compensation*	X	
Veteran's Administration*	X	X
Wages and Salaries, Commissions*	X	
Worker's Compensation*	X	

Explanation of countable income provided below

Cash Gifts and Contributions – Count unless they are made by a private, non-profit organization on the basis of need; and total $300 or less per household in a federal fiscal quarter. The federal fiscal quarters are January – March, April – June, July – September, and October – December. If these contributions exceed $300 in a quarter, count the excess amount as income in the month received.

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Exempt any cash contribution for common household expenses, such as food, rent, utilities, and items for home maintenance, if it is received from a non-certified household member who:

- Lives in the home with the certified household member,
- Shares household expenses with the certified household member, and
- No landlord/tenant relationship exists.

Child Support Payments – Count income after deducting $75 from the total monthly child support payments the household receives.

Dividends, Interest, and Royalties – Countable. Exception: Exempt dividends from insurance policies as income.

Count royalties, minus any amount deducted for production expenses and severance taxes.

In-Kind Income – Exempt - An in-kind contribution is any gain or benefit to a person that is not in the form of money/check payable directly to the household, such as clothing, public housing, or food.

Loans (Non-educational) – Count as income unless there is an understanding that the money will be repaid and the person can reasonably explain how he/she will repay it.

Lump-Sum Payments – Count as income in the month received if the person receives it or expects to receive it more often than once a year. Exempt lump sums received once a year or less, unless specifically listed as income.

Military Pay – Count military pay and allowances for housing, food, base pay, and flight pay, minus pay withheld to fund education under the G.I. Bill.

Mineral Rights – Countable - A payment received from the excavation of minerals such as oil, natural gas, coal, gold, copper, iron, limestone, gypsum, sand, gravel, etc.

Pensions and Annuities – Countable - A pension is any benefit derived from former employment, such as retirement benefits or disability pensions.

Reimbursements – Countable, minus the actual expenses. Exempt a reimbursement for future expenses only if the household plans to use it as intended.

Self-Employment Income – Count total gross earned income, minus allowable costs of producing the self-employment income.

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Social Security Payments/RSDI/SSDI – Count the Retirement, Survivors, and Disability Insurance (RSDI) or the Social Security Disability Insurance (SSDI) benefit amount, including the deduction for the Medicare premium, minus any amount that is being recouped for a prior RSDI overpayment.

SSI Payments – Exempt Supplemental Security Income (SSI) benefits.

Terminated Employment – Count terminated income in the month received. Use actual income and do not use conversion factors if terminated income is less than a full month's income. Income is terminated if it will not be received in the next usual payment cycle.

Unemployment Compensation Payments – Count the gross benefit less any amount being recouped for a UIB overpayment.

VA Payments – Count the gross Veterans Administration (VA) payment, minus any amount being recouped for a VA overpayment. Exempt VA special needs payments, such as annual clothing allowances or monthly payments for an attendant for disabled veterans.

Wages, Salaries, Tips and Commissions – Count the actual (not taxable) gross amount.

Worker's Compensation – Count the gross payment, minus any amount being recouped for a prior worker's compensation overpayment or paid for attorney's fees. NOTE: The Texas Workforce Commission (TWC) or a court sets the amount of the attorney's fee to be paid.

Verification/Documentation of Income – Verification and documentation of income <u>must</u> be provided to complete the DSHS Epilepsy Worksheet. Declarations of "unknown" will not be accepted as representations of required facts and documentation. Incomplete or inadequately documented eligibility determination will result in limitations in the provision of funded services.

To verify income, one of the following must be provided: 2 pay periods that accurately represent their earnings dated within the 60 days prior to the application processing date or one month's pay (only if paid same gross amount on a monthly basis), unless special circumstances are noted on the DSHS Epilepsy Worksheet. The pay periods must accurately reflect the individual's usual and customary earnings.

Proof may include, but is not limited to:

- Copy(ies) of pay periods that accurately represent earnings /monthly earning statement(s);

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- Employer's written verification of gross monthly income or the Employment Verification Form (Form 128);
- Award letters;
- Domestic relation printout of child support payments;
- Statement of support;
- Unemployment benefits statement or letter from the Texas Workforce Commission;
- Award letters, court orders, or public decrees to verify support payments; or
- Notes for cash contributions.

Special Circumstances Regarding Verification/Documentation
If the applicant is unable to provide required documentation for verification purposes due to a potential threat of abuse or if an employer/payer refuses to provide information or threatens continued employment, and no other proof can be found staff may make a determination utilizing the best available information. These types of special circumstances should be appropriately documented on the DSHS Epilepsy Worksheet.

Income Determination Procedure
- Count income already received and any income the household expects to receive. When an individual has not yet received income for new employment, use the best estimate of the amount to be received. If telephone verification regarding new or terminated employment is made, it must be documented by the contractor on the DSHS Epilepsy Worksheet (Form E101).
- Count terminated income in the month received. Use actual income and do not use conversion factors if terminated income is less than a full month's income.
- Use 2 pay periods that accurately represent their earnings dated within the 60 days prior to the application processing date. If the client is paid one time per month and receives the same gross pay each month, then one pay period will suffice.
- If actual or projected income is not received monthly, convert it to a monthly amount using one of the following methods:
- Weekly income x 4.33;
- Every two weeks x 2.17; or
- Twice a month x 2.0.

Income Deductions
Dependent childcare or adult with disabilities care expenses shall be deducted from the total income when determining eligibility, if paying for the care is necessary for the employment of a member in the Epilepsy household. This deduction is allowed even when the child or adult with disabilities is not included in the Epilepsy household. Deduct the actual expenses up to:
- $200 per month for each child under age 2
- $175 per month for each child age 2 or older, and

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- $175 per month for each adult with disabilities.

Child support payments made by a member of the Epilepsy household group shall also be deducted. Payments made weekly, every two weeks or twice a month must be converted to a monthly amount by using one of the conversion factors.

Self-Employment Income – If an applicant earns self-employment income, it must be added to any income received from other sources. Annualize self-employment income that is intended for an individual or family's annual support, regardless of how frequently the income is received.

If the household had self-employment income for the past year, use the income figures from the previous year's U.S. Internal Revenue Service (IRS) tax forms or their business records if the records are anticipated to reflect current self-employment income and expenses. Staff may accept the costs listed on the IRS tax forms associated with producing self-employment income or allow the following deductions when self-employment income is verified with documents other than an IRS tax form:

- Capital asset improvements;
- Capital asset purchases, such as real property, equipment, machinery and other durable goods, i.e., items expected to last at least 12 months;
- Fuel;
- Identifiable costs of seed and fertilizer;
- Insurance premiums;
- Interest from business loans on income-producing property;
- Labor;
- Linen service;
- Payments of the principal of loans for income-producing property;
- Property taxes;
- Raw materials;
- Rent;
- Repairs that maintain income-producing property;
- Sales tax;
- Stock;
- Supplies;
- Transportation costs. The person may choose to use 50.0 cents per mile instead of keeping track of individual transportation expenses. Do not allow travel to and from the place of business, and
- Utilities.

Verify four recent pay amounts that accurately represent the person's pay when determining the amount of self-employment income received. Verify one month's

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pay amount that accurately represents the person's pay for self-employed income received monthly.

Accept the applicant's statement as proof of their income and expenses if there is a reasonable explanation why documentary evidence or a collateral source is not available and the applicant's statement does not contradict other individual statements or other information provided. Inform the applicant that Epilepsy coverage will not be renewed on subsequent applications without acceptable verification and documentation of self-employment income or expenses. Verification may include but is not limited to: Statement of Self-Employment Income Form 149, current IRS tax forms, bookkeeping or business records and receipts, etc.

NOTE: If the applicant conducts a self-employment business in his home, consider the cost of the home (rent, mortgage, utilities) as shelter costs, not business expenses, unless these costs can be identified as necessary for the business separately.

- If the self-employment income is only intended to support the individual or family for part of the year, average the income over the number of months it is intended to cover.
- If the individual has had self-employment income for the past year, use the income figures from the previous year's business records or tax forms.
- If current income is substantially different from income the previous year, use more current information, such as updated business ledgers or daybooks. Remember to deduct predictable business expenses.
- If the individual or family has not had self-employment income for the past year, average the income over the period of time the business has been in operation and project the income for one year.
- If the business is newly established and there is insufficient information to make a reasonable projection, calculate the income based on the best available estimate and follow-up at a later date.

Seasonal Employment – Include the total income for the months worked in the overall calculation of income. The total gross income for the year can be verified by a letter from the individual's employer, if possible.

Statement of Support – Unless the person providing the support to the individual is present during the interview and has acceptable documentation of identity, a statement of support will be required. The Statement of Support is used to document income when no supporting documentation is available or when income is irregular. If questionable, the contractor may document proof of identification such as a Texas Driver's License, Social Security card, or a birth certificate of the supporter.

CASE PROCESSING

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Steps for Processing the DSHS Epilepsy Application Form (Form)

- Accept the DSHS Epilepsy Application Form (Form E100).
- Conduct an interview, if needed.
- Request supporting documentation/verification and if necessary, pend the case.
- Check that all information is complete, consistent, and sufficient to make an eligibility determination.
- Determine eligibility.
- Issue the appropriate forms.
- Document on the DSHS Epilepsy Worksheet (Form E101) the information to support the determination.

Completed Application Date – The date the DSHS Epilepsy Application Form (Form) is completely filled out and all supporting information necessary to make an eligibility determination is received by the contractor.

Decision Pended - If eligibility cannot be determined because components that pertain to the eligibility criteria are missing, the contractor should issue Form 104, Request for Information. The contractor should ensure that all information that needs to be provided by the applicant is listed, as well as the due date by which the information should be submitted. If the requested information is not provided by the due date, issue Form 117, Notice of Ineligibility. When the requested information is the result of a referral to another program and is dependent on other programs making an eligibility determination, the due date should be a best estimate. Inform the applicant of their responsibility to contact the contractor by this date to provide the status of their application for the other benefits. If the requested information is provided by the due date, proceed with processing the application.

Eligibility Determination – The contractor must consider the information provided by the client and document the basis for the eligibility decision on the DSHS Epilepsy Worksheet (Form E101).

After an eligibility determination is made, the contractor must inform the individual of the following:

- If eligible
  - Complete and issue Notice of Eligibility (Form 103)
  - The date eligibility begins; and
  - The services the individual is entitled to receive.
- If ineligible
  - Complete and issue the Notice of Ineligibility (Form 117);
  - The reason the application was denied;
  - The effective date of denial;
  - The individual's right to appeal.

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Issue the appropriate referrals to alternative agencies/programs for services, if applicable.

Date Eligibility Begins – An individual/household is entitled to services beginning with the date the completed application was submitted and deemed eligible.

Appeal of Eligibility Determination – Applicant/Recipient can request an appeal to DSHS regarding the eligibility determination for epilepsy if they disagree with the determination that was issued on their case. The contractor will assist the Applicant/Recipient with submitting their notification requesting an appeal to DSHS.

ANNUAL RE-CERTIFICATION

The contractor will determine the system used to track clients' status and renewal eligibility for their annual re-certification. Eligibility determination using the DSHS Epilepsy Application Form (Form E100) form is required for all clients. Eligibility services must be re-determined for each individual/household every 12 months.

At least 30 days prior to the anniversary date of their original eligibility date, client should be notified that they must renew eligibility by the anniversary date or lose their benefits until they are re-certified by the program. If renewal has not been completed by the anniversary date, the individual/family record should be removed from active status and placed in the inactive files. The individual family should be notified of the status change.

Contractors should send notifications requesting that the individual or family representative come to the office for re-certification. A contractor may include a new application with the notification and ask the individual to return with documentation.

ASSESSMENT OF CO-PAYMENTS/FEES

Epilepsy clients may be charged a co-payment (co-pay) fee for services according to the determinations of the contracting agency.

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INFORMED CONSENT FOR SERVICES AND PROCEDURES

General Informed Consent

Consent information must be effectively communicated to every client, including those who have language barriers (in compliance with Limited English Proficiency regulations) or who have disabilities that impair communication. If the client does not understand the language of the consent form, the form must be interpreted.

Contractor must obtain the client's written, informed, voluntary general consent to receive services prior to the client receiving any clinical services. If there is a period of time of two years or more during which a client does not receive services, the general consent must be signed again prior to delivery of services.

Contractor must obtain parental consent for minors to receive health services in accordance with Chapter 32, Family Code (may be linked at the following website: http://www.statutes.legis.state.tx.us/Docs/FA/htm/FA.32.htm and with guidance of the contractor's own legal counsel.

Consent for HIV Tests

Vernon's Texas Code Annotated, Health and Safety Code (HSC) §§81.105 and 81.106 is as follows:

§ 81.105. INFORMED CONSENT. (a) Except as otherwise provided by law, a person may not perform a test designed to identify HIV or its antigen or antibody without first obtaining the informed consent of the person to be tested. (b) Consent need not be written if there is documentation in the medical record that the test has been explained and the consent has been obtained.

Added by Acts 1991, 72nd Leg., ch. 14, § 26, eff. Sept. 1, 1991.

§ 81.106. GENERAL CONSENT. (a) A person who has signed a general consent form for the performance of medical tests or procedures is not required to also sign or be presented with a specific consent form relating to medical tests or procedures to determine HIV infection, antibodies to HIV, or infection with any other probable causative agent of AIDS that will be performed on the person during the time in which the general consent form is in effect. (b) Except as otherwise provided by this chapter, the result of a test or procedure to determine HIV infection, antibodies to HIV, or infection with any probable causative agent of AIDS performed under the authorization of a general consent form in accordance with this section may be used only for diagnostic or other purposes directly related to medical treatment.

Added by Acts 1991, 72nd Leg., ch. 14, § 27, eff. Sept. 1, 1991.

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CLINICAL GUIDELINES

Clinical Guidelines are intended to establish minimal expectations of contractor agencies that receive funds to support epilepsy services. In general, specific decisions about tests for diagnostic evaluation, treatment modalities, and ongoing follow-up are to be based on the discretion of the clinician in consultation with the client and/or the client's family, with the understanding that these decisions will be in line with nationally recognized standards of credible organizations.

Client Health Record (Medical Record) – Contractor must ensure that a client health record (medical record) is established for every client who obtains clinical services. These records must be maintained according to accepted medical standards and state laws, including those governing record retention.

All client records must be:

- Complete, legible, and accurate, documenting all clinical encounters, including those by telephone, in ink without erasures or deletions;
- Signed by the provider making the entry, including name of provider, provider title and date for each entry;
- Readily accessible to assure continuity of care and availability to client;
- Systematically organized to allow easy documentation and prompt retrieval of information;
- Maintained to safeguard against loss or unauthorized access and to assure confidentiality (complying with HIPAA* regulations); and
- Secured by lock when not in use.

The client's record must include:

- Client identification and personal data;
- Preferred language/method of communication;
- Where and how to contact the client (to facilitate continuity of care and assure confidentiality, adhering to HIPAA regulations);
- Medical history;
- Physical examination;
- Laboratory and other diagnostic tests orders, results and follow-up;
- Assessment or clinical impression;
- Plan of care, including education/counseling, treatment, special instructions and referrals;
- Scheduled revisits;
- Informed consent documentation;
- Refusal of services documentation;
- Allergies and untoward reactions to drugs recorded prominently in specific location; and
- Problem list to provide a consistent mechanism to document and track health and social problems/issues and to promote continuity of care.

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Medical History and Risk Assessment – At the initial comprehensive clinical visit, a complete medical history must be obtained on all clients. Any pertinent history must be updated at each subsequent clinical visit. The comprehensive medical history must at least address the following:

- Reason for visit;
- Current health status, including acute and chronic medical conditions, to include a detailed description of seizures and possible precipitating factors as reported by the client and significant observers;
- Significant past illness or injury, including hospitalizations;
- Previous surgery and biopsies;
- Blood transfusions and other exposure to blood products;
- Current medications, including prescription, over the counter (OTC) as well as complementary and alternative medicines (CAM);
- Allergies, sensitivities, or reactions to medicines or other substance(s);
- Use of tobacco/alcohol/illicit drugs (including type, duration, frequency, route);
- Immunization status/assessment;
- Review of systems (with pertinent positives and negatives clearly noted);
- Pertinent history of immediate family, with a particular focus on seizures or other neurological disorders; and
- Assessment for family violence (including safety assessment, if indicated).

Health Screening – All clients must be provided an appropriate physical assessment as indicated by client history. The following are the required components of initial exams:

- Height measurement;
- Weight measurement;
- Blood pressure evaluation;
- Cardiovascular assessment;
- Neurological assessment;
- Evaluation of thyroid, lungs, and abdomen; and
- Other systems as indicated by history.

Client Education – All clients must be provided counseling and health education by a person who:

- Is knowledgeable, objective, non-judgmental, and sensitive to the rights and differences of individual clients;
- Provides accurate, current information;
- Documents session in the client record;
- Provides information appropriate to client's age, level of knowledge and socio-cultural background; and
- Presents information in an unbiased manner.

Educational counseling session should provide the following minimum content:

- Types of seizure disorders;

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- Possible symptoms;
- Common first aid procedures;
- Emergency contact numbers;
- Presence and absence of auras;
- Medication, dosages, side effects and interactions;
- Drug level monitoring;
- Signs of toxicity;
- Diagnostic tests;
- Treatment options;
- Frequency of follow-up visits; and
- After-hour assistance.

Other topics as appropriate:

Epilepsy and women's health
- Pre-conception counseling;
- Birth control and anti-epileptic drugs (AED's);
- Pregnancy and AED's;
- Bone health; and
- Menopause.

Epilepsy and men's health
- Self-image;
- Mental health.

General issues
- Employment;
- Driving restrictions;
- Safety (school, sports, jobs);
- Financial assistance;
- Community resources, support group, legal aid and social services;
- Sexuality;
- Mental health; and
- Personal violence.

Referral and Follow-up – Contractor should assist clients to meet all identified health care needs either directly or by referral. Contractor must have written policies and procedures for follow-up on referrals that are made as a result of abnormal physical examination or laboratory test findings. These policies must be sensitive to clients' concerns for confidentiality and privacy and must be in compliance with state or federal requirements for transfer of health information. For services determined to be necessary, but are not provided by the contractor, clients must be referred to other resources for care. Whenever possible, clients should be given a choice of referral resources from which to select.

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When a client is referred to another resource or for emergency clinical care, the contractor must:

- Make arrangements for the provision of pertinent client information to the referral resource (obtaining required client consent with appropriate safeguards to ensure confidentiality – i.e., adhering to HIPAA regulations);
- Advise client about his/her responsibility in complying with the referral;
- Counsel client on the importance of the referral and follow-up method.

Laboratory Tests and Diagnostic Evaluation – All initial and routine follow-up clients must be provided appropriate laboratory and diagnostic tests or interventions as indicated by contractor policy or procedure or clinician judgment.

Tests may include:

- Routine blood tests such as complete blood count, glucose, serum electrolytes, calcium, magnesium, blood urea nitrogen (BUN), creatinine, liver function tests;
- Toxicology screening of blood/urine;
- Serum drug concentrations;
- Lumbar puncture and cerebrospinal fluid analysis;
- Electroencephalogram (EEG);
- Magnetic resonance imaging (MRI);
- Positron emission tomography (PET);
- TB skin test as indicated by risk assessment, history, or physical, either on-site or by referral; and
- Other lab as indicated by risk assessment, history, and physical, either on-site or by referral.

Agencies must have written plans to address laboratory and other diagnostic tests orders, results and follow-up to include:

- Tracking and documentation of tests ordered and performed for each client
- Tracking test results and documentation in client's records
- Mechanism to notify clients of results in a manner to ensure confidentiality, privacy and prompt, appropriate follow-up

Treatment – Treatment decisions must be made individually for each client. Before initiating anti-epileptic drugs (AEDs) as therapy, factors to discuss with the client/family are the likelihood of further seizures without drug treatment, the efficacy of the drug, adverse effects, and client/family preferences. Non-AED treatment may include implantation of a vagus nerve stimulator (VNS) or surgical intervention in selected clients.

Protocols, Standing Delegation Orders, and Procedures

Contractors that provide clinical services must develop and maintain written clinical protocols and standing delegation orders (SDOs) in compliance with

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statutes and rules governing medical and nursing practice. The written clinical protocols and/or SDOs must be signed by the Medical Director or supervising physician on an annual basis or more often if changes are made. Requirements addressing scope of practice and delegation of medical and nursing acts can be accessed at the following websites: http://www.tmb.state.tx.us/ (Texas Medical Board) and http://www.bne.state.tx.us/ (Board of Nurse Examiners for the State of Texas). Rules that are most pertinent to this topic are: Texas Administrative Code, Title 22, Part 9, Chapter 193, Texas Administrative Code, and Title 22, Part 11, Chapters 221 and 224

Contractors that employ Advanced Practice Nurses or Physician Assistants must have written protocols to delegate authorization to initiate medical aspects of client care. The protocols must be agreed upon and signed by the supervising physician and the physician assistant and/or advanced practice nurse, reviewed and signed at least annually, and maintained on site. They also must contain a list of the types or categories of dangerous drugs and controlled substances available for prescription, limitations on the number of dosage units and refills permitted, and instructions to be given to the patient for follow-up monitoring or contain a list of the types or categories of dangerous drugs and controlled substances that may not be prescribed. The protocols need not describe the exact steps that an advanced practice nurse or a physician assistant must take with respect to each specific condition, disease, or symptom.

Contractors that employ unlicensed and licensed personnel, other than advanced practice nurses or physician assistants, whose duties include actions or procedures for a client population with specific diseases, disorders, health problems or sets of symptoms must have written SDOs in place. SDOs are instructions, orders, rules, regulations or procedures that delineate under what set of conditions and circumstances actions should be instituted. They are intended for use with clients presenting themselves prior to being examined or evaluated by a physician and are distinct from specific orders written for a particular patient. The SDOs must be dated and signed by the physician who is responsible for the delivery of medical care covered by the orders and must be reviewed at least annually. Examples of actions addressed by SDOs are the taking of a personal and medical history, the performance of appropriate physical examination elements and the recording of physical findings, the ordering of tests appropriate to the services provided, and administration of immunization vaccines.

In addition to the above, contractor must have written plans for client education that include goals and content outlines to ensure consistency and accuracy of information provided. The Medical Director must sign client education plans.

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COMMUNITY EDUCATION, OUTREACH AND PARTICIPATION

Epilepsy contractor must develop and implement an annual plan to provide community education to inform the public of its purpose and services, to disseminate knowledge of epilepsy, to enlist community support, and to educate potential clients. The plan should be based on an assessment of the needs of the community and contain an evaluation strategy. Promotional activities should be reviewed annually.

Informational Brochure – Contractor shall have an informational brochure with the following minimum content:

- Mission statement
- Hours of operation
- Location
- Services offered
- Eligibility requirements
- Phone number of each community clinic site
- Toll free number or web address

Duplication of Services – In order to prevent the duplication of services, contractor shall coordinate activities with but not limited to the following types of related agencies, organizations, and health and social service agencies in the area:

- Area hospital physicians
- School personnel
- Local Epilepsy Association and support groups

Professional Education – Contractor shall provide the opportunity for community-wide professional education events for primary care providers, nurses, emergency workers and social workers, etc.

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Section III
Reimbursement, Data Collection & Reporting

Purpose: Section III provides policy requirements for submitting reimbursement, data collection, and required reports.

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VOUCHER & REPORT SUBMISSION INFORMATION

PROGRAM INFORMATION:
Program Name: Epilepsy Services
Contract Type: Categorical
Contract Term: September 1--August 31

VOUCHER: Voucher 1
Voucher Name: State of Texas Purchase Voucher-Form B-13
Submission Date: By the last business day of the following month. **Final due within 45 days after end of contract term**.
Submit Copy to:

Name of Unit/Branch	Original Required Yes	Original Required No	Accepted Method of Submission	# Copies
Contract Development & Support Branch (CDSB)		X	Email (preferred), or Fax	1
Accounting Section/Claims Processing Unit (CPU)		X	Fax or Email	1

Instructions: Submit one B-13 with expense documents attached to CDSB.
Submit one B-13 only to CPU.

NOTE: Vouchers must be submitted each month even if there are zero expenditures. Vouchers must still be submitted each month for actual expenditures of the program even if the contract limit has been reached.

VOUCHER: Report 1--Supporting
Report Name: Expense Documents
Submission Date: Within 30 days following the end of the month. **Final due within 45 days after end of contract term.**
Submit Copy to:

Name of Unit/Branch	Original Required Yes	Original Required No	Accepted Method of Submission	# Copies
Contract Development & Support Branch (CDSB)		X	Email (preferred), or Fax	1

Instructions: Attach expense documents to B-13 for CDSB only.

REPORT: Report 1
Report Name: Epilepsy Program Quarterly Report
Submission Date: Quarterly reports are due by the 10th business day of the first month following the quarter for which the contractor is reporting. 1st quarter (Sept, Oct, Nov) due Dec 12, 2014; 2nd quarter (Dec, Jan, Feb) due March 13, 2015; 3rd quarter (Mar, Apr, May) due June 12, 2015; 4th quarter (June, July, Aug) due Sept 14, 2015.

Submit Copy to:

Name of Unit/Branch	Original Required Yes	Original Required No	Accepted Method of Submission	# Copies
Preventive and Primary Care Unit (PPCU)		X	Email (preferred), or Fax	1

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Instructions: Short turn around on these reports requires contractors to submit timely, no exceptions.

REPORT: Report 2
Report Name: Financial Status Report 269A

Submission Date: Quarterly, Sep 1-Nov 30, Dec 1-Feb 28, Mar 1-May 31, and Jun 1-Aug 31. Submit by the last business day of the next month following the quarter for which the contractor is reporting. The 4th quarter is the final report and due within 45 days after the end of the contract term. The 4th quarter report includes all final charges and expenses associated with the program contract. Mark the 4th quarter report as "Final".
Submit Copy to:

Name of Unit/Branch	Original Required Yes	Original Required No	Accepted Method of Submission	# Copies
Contract Development & Support Branch (CDSB)	X		Email (preferred), or Fax	1
Accounting Section/Claims Processing Unit (CPU)	X		Email scanned signed document, fax, or mail	1

Instructions: Financial Status Report 269A must have original signature (scanned or fax accepted).

Email Addresses:	CDSB	cdsb@dshs.state.tx.us
	CPU	invoices@dshs.state.tx.us
	PPCU	Epilepsy@dshs.state.tx.us
Fax Numbers:	CDSB	(512) 776-7521
	CPU	(512) 776-7442
	PPCU	(512) 776-7203
Mail Codes:		Please use mail codes on all mail coming into DSHS to ensure accurate delivery.
	CDSB	Mail code 1914
	CPU	Mail code 1940
	PPCU	Mail code 1923
Mailing Address for CPU:		Claims Processing Unit, Mail Code 1940 Department of State Health Services P.O. Box 149347 Austin, TX 78714-9347

Last Updated/Reviewed:
7/14/14

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DATA COLLECTING AND REPORTING

Contractor shall submit quarterly progress reports on or before the 10th business day of December, March, June, and September. Report includes unduplicated client count, diagnostic and support services performed and client demographics. A copy of the Quarterly Report Form and instructions for it can be found at: http://www.dshs.state.tx.us/chscontracts/all_forms.shtm

Quarterly Progress Report Instructions

I. Client Count

A. Total number of unduplicated DSHS clients determined eligible and provided an epilepsy service* during quarter.

B. Total number of clients from all other funding sources provided an epilepsy service during quarter.

II. ALL CLIENT SERVICES PROVIDED (including DSHS clients)

A. Number of clinic visits (all clients) - The total number of clinic visits by all epilepsy clients during the reported quarter.

B. Number of diagnostics (all clients) (AED, EEG, CAT, other labs) – The total number of diagnostics (AED, EEG, CAT, other labs) provided for all epilepsy clients during the reported quarter.

C. Number of phone encounters (all clients) - The total number of phone encounters provided for all epilepsy clients during the reported quarter.

D. Number of case management services (including counseling, referrals, and medication management) - (all clients) – The total number of case management services provided (including counseling, referrals, and medication management) for all epilepsy clients during the reported quarter.

E. Total number of all encounters (includes non-clinic encounters) -This is the total number of clients seen during the reported quarter (total of rows A, B, C and D).

III. Community Education/Outreach

A. Education/Outreach Sessions - Total number of Education/Outreach Sessions held during the reporting quarter (does not include clinic visits).

B. Number of Persons Attending - Total number of persons attending community/group presentations during the reporting quarter.

IV. NARRATIVE

Include a narrative (maximum three pages) that provides an update on program work plan, including, but not limited to, updates on the following:

- Services provided, locations, clients from outside of service area served,
- Changes in workforce, infrastructure, and/or policies,
- Staff trainings attended,
- Changes in data collection or reporting,

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- Description of networking with other Health and Human Service providers, and
- QA/QI activities

REPORTING

Due to a legislative requirement, quarterly reports for the Epilepsy program must be received by the 10th business day of the month following the quarter for which the contractor is reporting. Failure to submit the report as required will result in contact by the assigned Contract Manager and further action as necessary.

ADDITIONAL INFORMATION – WEB-LINKS

Additional information is available at the following web-links:

Texas Administrative Code
http://info.sos.state.tx.us/pls/pub/readtac$ext.ViewTAC?tac_view=5&ti=25&pt=1&ch=37&sch=K&rl=Y
Quarterly Report Form
http://www.dshs.state.tx.us/chscontracts/all_forms.shtm#epi
General Provisions
http://www.dshs.state.tx.us/grants/gen-prov.shtm

Texas Benefits Website
http://www.yourtexasbenefits.com

Texas Abuse Hotline
http://www.txabusehotline.org/

2-1-1 Texas Hotline
http://www.211texas.org/

Epilepsy Driving Restrictions – Texas Department of Public Safety
http://www.txdps.state.tx.us/DriverLicense/MedicalRevocation.htm

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FORMS

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FISCAL YEAR 2015
DEPARTMENT OF STATE HEALTH SERVICES
PREVENTIVE & PRIMARY CARE UNIT
EPILEPSY PROGRAM QUARTERLY REPORT

CONTRACTOR NAME:

Phone Number:

Report or Amended Report for (Quarter):

Reports are due by the 10th day of the first month following the quarter for which the contractor is reporting.

CLIENT COUNT	Quarter 1 Sep-Nov Due 12/12	Quarter 2 Dec-Feb Due 3/13	Quarter 3 Mar-May Due 6/12	Quarter 4 June-Aug Due 9/14	YTD Total FY 2014 Due 9/14
Total number of unduplicated DSHS clients determined eligible and provided an epilepsy service* during quarter					
Total number of clients from all other funding sources provided an epilepsy service during quarter					
ALL CLIENT SERVICES PROVIDED (including DSHS clients)					
Number of clinic visits (all clients)					
Number of diagnostics (all clients) (AED, EEG, CAT, other labs)					
Number of phone encounters (all clients)					
Number of case management services (including counseling, referrals, and medication management) - (all clients)					
Total number of all encounters (includes non-clinic encounters)	0	0	0	0	0
Community Education / Outreach					
Education/Outreach Sessions					
Number of Persons Attending					

_____ _____

Name of Person Submitting Report Date

*Definition of epilepsy services: 1) diagnosis and treatment of epilepsy; 2) management of continuity of care; and 3) integration of the personal, social, and vocational support services into the treatment plan. (Title 25 TAC § 37.216)

ATTACH NARRATIVE REPORT

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Quarterly Progress Report Instructions

I. Client Count –

A. Total number of unduplicated DSHS clients determined eligible and provided an epilepsy service* during quarter

B. Total number of clients from all other funding sources provided an epilepsy service during quarter

II. ALL CLIENT SERVICES PROVIDED (including DSHS clients)

A. Number of clinic visits (all clients) - The total number of clinic visits by all epilepsy clients during the reported quarter.

B. Number of diagnostics (all clients) (AED, EEG, CAT, other labs) – The total number of diagnostics (AED, EEG, CAT, other labs) provided for all epilepsy clients during the reported quarter.

C. Number of phone encounters (all clients) - The total number of phone encounters provided for all epilepsy clients during the reported quarter.

D. Number of case management services (including counseling, referrals, and medication management) - (all clients) – The total number of case management services provided (including counseling, referrals, and medication management) for all epilepsy clients during the reported quarter.

E. Total number of all encounters (includes non-clinic encounters) -This is the total number of clients seen during the reported quarter (total of rows A, B, C and D).

IV. Community Education/Outreach

A. Education/Outreach Sessions - Total number of Education/Outreach Sessions held during the reporting quarter (does not include clinic visits).

C. Number of Persons Attending - Total number of persons attending community/group presentations during the reporting quarter.

IV. NARRATIVE

Include a narrative (maximum three pages) that provides an update on program work plan, including, but not limited to, updates on the following:

Services provided, locations, clients from outside of service area served,
Changes in workforce, infrastructure, and/or policies,
Staff trainings attended,
Changes in data collection or reporting,
Description of networking with other Health and Human Service providers,
QA/QI activities.

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DSHS EPILEPSY PROGRAM – Application For Health Care Assistance (Page 1 of 2 / September 2013)

Applicant Information/Información del solicitante

Name (Last, First, Middle)/Nombre (Apellido, primer nombre, segundo nombre)	**Home Telephone Number/**Teléfono en casa	**Email Address/**Correo electrónico

Texas Residence Address (Street or P.O. Box)/Domicilio de residencia en Texas (Calle o apartado postal)	**City/**Ciudad	**County/**Condado	**State/**Estado	**ZIP/**Código postal

Household Information/Información del hogar

Fill in the first line with information about yourself. Fill in the remaining lines for everyone who lives in the house with you for which you are legally responsible. /Rellene la primera línea con su propia información. Rellene las líneas restantes con la información de todas las personas que viven en su casa de las que usted es legalmente responsable.

Name (Last, First, Middle) Nombre (Apellido, primer nombre, segundo nombre)	**SSN (optional)** Número del Seguro Social (opcional)	**Date of Birth** Fecha de nacimiento	**Age** Edad	**Sex** Sexo	**Race** Raza	**What Relation to you?** ¿Cuál es su relación con la persona?	**U.S. Citizen** Ciudadano de EE. UU. **Yes or**/Sí o **No**
						Self/El solicitante	

List all of your household's income below. Be sure to include the following: Government checks; money from work; money you collect from charging room and board; cash gifts, loans, or contributions from parents, relatives, friends, and others; sponsor's income; school grants or loans; child support; and unemployment./Ponga todos los ingresos del hogar a continuación. Asegúrese de incluir lo siguiente: los cheques del gobierno, el dinero que obtiene del trabajo, el dinero que obtiene por pensiones completas, los regalos en efectivo, los préstamos y las aportaciones de sus padres, sus familiares, sus amigos y otras personas, los ingresos provenientes de un patrocinador, las becas y los préstamos escolares, la manutención de menores y los pagos por desempleo.

Name of person receiving money Nombre de la persona que recibe el dinero	**Name of agency, person, or employer who provides the money** Nombre de la agencia, la persona o el empleador que provee el dinero	**Amount received** Cantidad recibida	**How often received? (daily, weekly, every two weeks, twice a month, monthly?)** ¿Con qué frecuencia lo recibe (a diario, cada semana, cada dos semanas, dos veces al mes, una vez al mes)?

Do you plan to remain in Texas? ¿Piensa permanecer en Texas?	☐ **Yes/**Sí ☐ **No**
Do you – does any one in your household – have health care coverage (Medicaid, Medicare, CHIP, health insurance, V.A., Tricare, etc.)? ¿Tiene usted, o alguna otra persona en el hogar, cobertura médica (Medicaid, Medicare, CHIP, seguro médico, V.A., Tricare, etc.)? **If yes, who**? Si contestó que sí, ¿quién?	☐ **Yes/**Sí ☐ **No**

I acknowledge that by signing this form I give my informed and voluntary general consent to receive services. The statement I have made, including my answers to all questions, are true and correct to the best of my knowledge and belief. I agree to give eligibility staff any information necessary to prove statements about my eligibility. I understand that giving false information could result in disqualification and repayment.
Reconozco que al firmar este formulario doy mi consentimiento general informado y voluntario para recibir servicios. Esta declaración que he hecho, incluidas las respuestas a todas las preguntas, es verídica y correcta, a mi leal saber y entender. Acepto darle al personal que determina el derecho a la participación en el programa la información necesaria que sustente las declaraciones respecto a mi derecho a participar. Entiendo que el que dé información falsa podría ocasionar que me descalifiquen y tenga que devolver el dinero al programa.

Signature – Applicant/Firma del solicitante	**Date/**Fecha	**Signature – Spouse (if applicable)/**Firma del o la cónyuge (de ser aplicable)	**Date/**Fecha

Signature – Person Who Helped Complete this Application/ Firma de la persona que le ayudó a completar esta solicitud	**Relationship to Client/**Relación con el cliente	**Date/**Fecha

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APPLICATION FOR HEALTH CARE ASSISTANCE

1. Complete your name and address;
2. Sign and date the application; and
3. Answer as many questions as you can on this application

Turn in or mail back your application today even if you cannot answer all the questions.

YOUR RESPONSIBILITIES

Applicants are responsible for completing page one of the application form for medical services assistance.

Applicants are responsible for providing documents requested by the contractor. Examples of some of the items you may be asked to prove and documents you can use for proof are:

Where You Live and Plan to Continue Living

- Possible Proof: Valid Texas Drivers License
- Current voter registration
- Rent or utility receipts for one month prior to the month of application
- Motor vehicle registration
- School records
- Medical cards or other similar benefit cards
- Property tax receipt
- Mail addressed to the applicant, his/her spouse, or children if they live together
- Other documents considered valid by the contractor

Your Income

- Possible Proof: Pay check stubs
- Pay checks
- W-2 tax forms or income tax returns
- Sales records
- Statements from employers
- Award letters
- Legal documents
- Statements from persons giving you money

Other Health Care Coverage

- Possible Proof: Award or claim letters
- Insurance policies
- Court documents
- Other legal papers

Information on social security numbers should be given if this information is available. Information on sex (Male/Female) is voluntary. These types of information will not affect your eligibility.

You must give information about health care insurance and any other third party financially liable for health care services.

SOLICITUD DE ASISTENCIA MÉDICA

1. Ponga su nombre y domicilio.
2. Firme y feche la solicitud.
3. Responda el mayor número de preguntas que pueda en esta solicitud.

Entregue su solicitud o mándela por correo postal hoy mismo aunque no pueda responder todas las preguntas.

SUS RESPONSABILIDADES

El solicitante es responsable de la primera página del formulario de solicitud de asistencia de servicios médicos.

El solicitante es responsable de proveer los documentos que el contratista solicite. Los siguientes son algunos ejemplos de las cosas que podrían pedirle que compruebe y los documentos que puede usar como comprobantes:

Dónde vive y dónde piensa seguir viviendo

- Posible comprobante: licencia de conducir de Texas válida
- Registro actual de votante
- Recibos de renta o servicios públicos del mes anterior al mes de solicitud
- Registro de automóvil
- Registros escolares
- Tarjetas médicas o cualquier otro tipo de tarjeta de prestaciones similar
- Recibos de impuestos sobre la propiedad inmobiliaria
- Correspondencia dirigida al solicitante, a su cónyuge o a sus hijos, si ellos viven con el solicitante
- Otros documentos que el contratista considere que son válidos

Sus ingresos

- Posible comprobante: talones de cheque de paga
- Cheques de paga
- Formularios de impuestos W-2 o declaraciones de impuestos sobre la renta
- Registros de ventas
- Declaraciones de los empleadores
- Cartas de adjudicación
- Documentos jurídicos
- Declaraciones de las personas que le dan dinero a usted

Otro tipo de cobertura médica

- Posible comprobante: cartas de adjudicación o reclamación
- Pólizas de seguro
- Documentos judiciales
- Otro tipo de documentación jurídica

Debe dar la información respecto a los números del Seguro Social si tiene dicha información disponible. La información respecto al sexo (si es hombre o mujer) es voluntaria. Estos tipos de información no afectan su derecho a participar.

Usted debe dar la información sobre el seguro médico y cualquier tercera persona que sea financieramente responsable de los servicios de atención de salud

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DSHS FUNDING SOURCE - Worksheet

Today's Date	Client/Case #	Type of Determination New ☐ Re-certification ☐
Applicant Name	Case Record Action Approved ☐ Supplemental ☐ Denied ☐	Eligibility Effective Date (MM-DD-YYYY)

Eligibility Items	Documentation (if applicable)
Family Composition – Legal Responsibility 1.	
2.	
3.	
4.	
5.	
Residency – Must be physically present within the geographic boundaries of Texas.	Documentation of Residency (if applicable)

Type of Income	Name of Member w/Income		Documentation of Income (if applicable)
Gross Earned Income			
Cash Gifts/Contributions			
Child Support Payments			
Dividends/Interest/Royalties			
Loans (Non-educational)			
Lawsuit/Lump-sum Pymts.			
Mineral Rights			
Pensions/Annuities			
Reimbursements			
Social Security Payments			
Unemployment Payments			
VA Payments			
Worker's Compensation			
Total Countable Income			
Minus Allowable Deductions	-	-	FPL Used: ☐ 100% > ☐ 133% ☐ 150%
Net Countable Income			☐ 185% ☐ 200% ☐ 250%

Other Benefits – Such as Medicaid, Medicare, CHIP, CIHCP, private health insurance, V.A., Tricare, etc.

Special Circumstances – Document any special circumstances as needed and applicable to this application

Co-Pay Fees – DOCUMENT CO-PAY BELOW:

Eligible Household Member(s):

1.	2.	3.
EPILEPSY OTHER	EPILEPSY OTHER	EPILEPSY OTHER
4.	5.	6.
EPILEPSY OTHER	EPILEPSY OTHER	EPILEPSY OTHER

Provider-Staff Signature: Date:

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FORM 103

TEXAS Department of State Health Services

Notice of Eligibility/Aviso de derecho a participar

Epilepsy Program

Date/Fecha	**Case No./**N.o del caso	**Expiration Date/**Fecha de vencimiento

Office Address/Domicilio de la oficina	**Office Telephone/**Teléfono de la oficina

Provider Staff Name/Nombre del miembro del personal del proveedor

1. **Your individual / household application for the Epilepsy Program is APPROVED.**

   Su solicitud individual o familiar del Programa de Epilepsia ha sido **APROBADA**.

2. **The following services will be provided beginning _____.**
   (MM/DD/YYYY)

   Proveeremos los siguientes servicios a partir del _____.
   (DD/MM/AAAA)

Name/Nombre	**Date of Birth/** Fecha de nacimiento	**Services/**Servicios
a.		
b.		
c.		
d.		
e.		

3. **Your co-pay is $_____ for services and $_____ for prescriptions.**

   Su copago es de $_____ dólares por los servicios y $_____ dólares por las medicinas recetadas.

4. **You must notify this office as soon as possible of any changes in your situation such as changes in income, health insurance, family members or address.** Usted debe notificarnos lo antes posible si su situación cambia, por ejemplo, si cambian sus ingresos, su seguro médico, la situación de sus familiares o su domicilio.

5. **If a change occurs that makes you ineligible, and you fail to report the change as required, you may be responsible for payment of any medical services you receive after you become ineligible, or you may be subject to prosecution under the Texas Penal Code.** Si ocurre un cambio y el cambio causa que usted pierda su derecho a participar y no nos informa de dicho cambio según requerimos, usted podría ser responsable de pagar cualquier servicio médico que reciba después de perder el derecho a participar o podría ser procesado bajo el Código Penal de Texas.

6. **You are responsible for renewing your eligibility prior to your certification expiration date. A DSHS Epilepsy Program Application for Health Care Assistance Form must be completed and submitted within thirty (30)-days of your anniversary eligibility date. Assistance will be provided if needed.** Usted es responsable de renovar su solicitud para tener derecho a participar antes de la fecha de vencimiento de su certificación. Debe llenar y presentar el Formulario de solicitud de asistencia médica del Programa de Epilepsia del DSHS en los treinta (30) días anteriores al aniversario de la fecha en que obtuvo el derecho a participar. Le proveeremos asistencia, de ser necesario.

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EPILEPSY PROGRAM
REQUEST FOR INFORMATION
PROGRAMA DE EPILEPSIA
SOLICITUD DE INFORMACIÓN

FORM 104

Date/Fecha	**Case Record No.**/N.o de registro del caso
Office Address and Telephone No./Domicilio y teléfono de la oficina	

Your application for assistance is not complete. To determine your eligibility, we need the following additional information. Su solicitud de asistencia no está completa. Para poder determinar si tiene derecho a participar, necesitamos la siguiente información adicional.

ONLY THE CHECKED BOXES APPLY TO YOU./SÓLO LAS CASILLAS MARCADAS SE APLICAN A USTED.

- ☐ **Mail Addressed to You or Another Household Member**
  Correspondencia dirigida a usted o a algún otro miembro del hogar
- ☐ **Texas Driver's License or Other Official Identification**
  Licencia de conducir de Texas o algún otro tipo de identificación oficial
- ☐ **Voter Registration Card**
  Tarjeta de registro de votante
- ☐ **Notice of TANF, SNAP/ Food Stamps, or Medicaid Benefits**
  Aviso de prestaciones de la TANF, del SNAP (vales de comida) o del Medicaid
- ☐ **Paychecks or Paycheck Stubs**
  Cheques de paga o talones de cheque de paga
- ☐ **Earnings Statement from Employer**
  Declaración de ganancias de su empleador
- ☐ **Worker's Compensation Award Letter or Check**
  Carta de adjudicación o cheque de indemnización a trabajadores
- ☐ **Federal Income Tax Return**
  Declaración de impuestos sobre la renta federal
- ☐ **Self-Employment Bookkeeping, Sales, Expenditure Records**
  Registros de contabilidad, ventas y gastos respecto al autoempleo
- ☐ **Social Security Award Letter, Check, or Denial Notice**
  Carta de adjudicación, cheque o aviso de denegación del Seguro Social
- ☐ **Disability Insurance Award Letter or Check**
  Carta de adjudicación o cheque del seguro de discapacidad
- ☐ **Unemployment Compensation Award Letter or Check**
  Carta de adjudicación o cheque de compensación por desempleo
- ☐ **Veterans Administration Award Letter or Check**
  Carta de adjudicación o cheque de la Administración de Veteranos
- ☐ **Other Items**
  Otro tipo de información

_____

_____

PLEASE RETURN THE ITEMS CHECKED ABOVE BY:
POR FAVOR ENVÍENOS LA INFORMACIÓN DE ARRIBA QUE ESTÁ MARCADA A MÁS TARDAR EL:

If our office does not receive the requested information, it may result in denial of program assistance. Please contact our office if you are unable to meet the above deadline or if you have any questions./Si no recibimos la información solicitada, se le podría denegar la asistencia del programa. Comuníquese con nuestra oficina si no puede enviarnos la información solicitada para la fecha límite que aparece arriba o si tiene alguna pregunta.

Signature/Firma:

I do want to appeal this decision./Quiero apelar esta decisión.

_____ _____

Signature/Firma **Date**/Fecha

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EPILEPSY PROGRAM
EMPLOYMENT VERIFICATION **FORM 128**

Date/Fecha	**Case Record No.**/Núm de Caso
Office Address and Telephone No./Oficina y Teléfono Fax:	

Employee	**Social Security Number**

This individual is a member of a household applying for health care assistance from the Epilepsy Program. To determine this household's eligibility, it is necessary to verify all earnings. Since this individual is/was/will be your employee, your help is needed.

Please completely and accurately provide the information requested on the back of this letter. If a question does not apply, mark it N/A. After you complete this form you may, give it to your employee, mail it in the envelope provided, or fax it to the number listed above.

This information is needed not later than this date: _____.

Thank you for your assistance. If you have any questions, please feel free to contact our office.

I give my permission to release the information requested on this form.

Yo doy mi permiso para que mi empleador dé la información que se pide en esta forma.

_____ _____
Signature / Firma **Date** / Fecha

Comments: _____

_____

_____

_____

_____

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EMPLOYMENT VERIFICATION

FORM 128

Employee Name (as shown on your records)

Employee Address – Street, City, State, ZIP (as shown on your records)

Is/was/will this person (be) employed by you?

☐ Yes ☐ No If yes → ☐ Permanent ☐ Temporary

Is FICA or FIT withheld?

☐ Yes ☐ No

Rate of Pay	**Average Hours per Pay Period**	**How often is employee paid?**
$ ☐ Per Hour ☐ Per Day ☐ Per Week ☐ Per Month ☐ Per Job		

On the chart below, list all wages received by this employee during the months of: _____

Date Pay Period Ended	Date Employee Received Paycheck	Actual Hours	Gross Pay	**Other Pay *** (Bonuses, Commissions, Overtime, Pension Plan, Profit Sharing, Tips)

*** In Comments Section below, please explain when and how Other Pay is received.**

Date Hired	**Date First Paycheck Received**	**If employee is/was on Leave Without Pay**
		Start Date: End Date:

If this person is no longer in your employ

Date Final Paycheck Received: Gross Amount of Final Paycheck: $

Is health insurance available?

☐ Yes ☐ No If Yes, employee is → ☐ Not Enrolled ☐ Enrolled for Self Only ☐ Enrolled with Family Members

Comments: _____

..... **Signature and Title of Person Verifying This Information**

..... **Date**

Company or Employer	**Address (Street, City, State, ZIP)**	**Telephone Number (Include area code.)**

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STATEMENT OF SELF-EMPLOYMENT INCOME
DECLARACIÓN DE INGRESOS DEL NEGOCIO PROPIO **FORM 149**
See Instructions on Page 2./Vea las Instrucciones en la página 2.

Case Record Name	Case Record Number

1. **Name of Person Having Self-Employment Income**/Nombre de la persona que tiene ingresos de negocio propio.

_____

2. **Give the number of months covered by this income statement.**
Dé el número de meses que cubre esta declaración de ingresos. ..... [ ]

3. **Describe what you did to earn this money.**/Describa lo que hizo para ganarse este dinero.

_____

_____

4. **List your business expenses and income. IMPORTANTE: Attach receipts, invoices, or other verifying papers.**
Anote los gastos y ingresos de su negocio. IMPORTANTE: Adjunte recibos, facturas, u otros comprobantes.

Date Fecha	**EXPENSES** GASTOS	**Amount** Cantidad
		$
	Total Expenses Total de Gastos	$

Date Fecha	**INCOME** INGRESOS	**Amount** Cantidad
		$
	SUBTOTAL	$
	Enter expenses here and subtract. Anote el total de gastos y reste.	—
	NET SELF-EMPLOYMENT INCOME INGRESOS NETOS DEL NEGOCIO PROPIO	$

The above information is true, correct, and complete to the best of my knowledge. I understand that giving false information to the provider could result in my being disqualified for fraud./Según mi leal saber y entender, toda esta información es cierta, correcta y completa. Comprendo que si doy información falsa al proveedo puedo ser descalificado por fraude.

Signature of anyone helping you to prepare this form / Date Firma de la persona que le ayudó a llenar la forma / Fecha	**Signature / Firma**	**Date / Fecha**

DRAFT

If you or any member of your household has any kind of self-employment income, fill out this form and attach it to your application. You may attach a copy of the latest income tax forms in place of this form. If your accounting system is not the same as this form, you may substitute a copy of your accounting statement. You must answer all questions and sign and date at the bottom. Use additional sheets of paper if you need to. Sign and date each sheet. Remember, this is your sworn statement. You will need to bring with you to the interview: bills, receipts, checks or stubs, and any other business records you have. Your worker will need to see them. Your records will be returned to you.

Self-employment Income. This is any money you earn working for yourself. It is not money you earn working for someone else. If you are in doubt, ask your caseworker.

Questions 1, 2, and 3. These questions are self-explanatory.

Question 4. List your business income and expenses. In the boxes on the left side of the form, list your business expenses (see the information below). Write in the dates you paid the expenses and the amount of each expense. Add the amounts, and enter your total in the box "total self-employment expenses." In the boxes on the right side of the form, list your income (see the information below). List the dates you received the income, your sources of income, and the amounts. Add the amounts, and enter your total in the box "total self-employment income." Subtract your expenses from your total self-employment income, and enter your "net self-employment income."

<u>Expenses</u> are your costs of doing business. Examples of expenses are supplies, repairs, rent, utilities, seed, feed, business insurance, licenses, fees, payments on principal of loans for income-producing property, capital asset purchases (such as real property, equipment, machinery, and other durable goods and capital asset improvements), your social security contribution for people who worked for you, and labor (not salaries you pay yourself). If you claim labor costs, list each person and the amount you paid them. If you have any other kinds of business expenses, be sure to list them and the date they were paid.

You may not claim:

- **Rent, mortgage, taxes, or utilities on your business if it operates out of your home (unless these costs are separate from the costs of your home);**
- **Cost of goods you buy for the business but use yourself;**
- **Net business loss from a prior period and**
- **Depreciation.**

If you are in doubt, bring proof of the expense and ask your worker.

<u>Income</u> includes money from sales, cash receipts, crops, commissions, leases, fees, or whatever you do or sell for money. If you have any other kind of income from your business, be sure to list it. Be sure to list the dates income was received.

Who must sign. The form must be signed by the applicant, spouse, or authorized representative. Anyone may help you complete the form, but that person must also sign and date the form. Ask your worker if anyone else needs to sign the form.

Si usted u otra persona de su casa tiene algún tipo de ingresos de negocio propio, llene esta forma y adjúntela a su solicitud. En lugar de esta forma, puede adjuntar una copia de la declaración de impuestos sobre ingresos más reciente. Si el sistema de contabilidad que usa no es igual al de esta forma, puede substituir la forma con una copia de su registro de contabilidad. Tiene que contestar todas las preguntas y firmar y fechar la forma al final. Use hojas adicionales si las necesita. Firme y feche cada hoja. Recuerde que ésta es una declaración jurada. Tiene que llevar a la entrevista: cuentas, recibos, cheques o talones de cheques y cualquier otra documentación que tenga del negocio. El trabajador tendrá que verlos. Estos documentos le serán devueltos.

Ingresos del Negocio Propio. Este término se refiere al dinero que gana cuando trabaja por su propia cuenta. No es el dinero que recibe cuando trabaja para otra persona. Si tiene alguna duda, consulte con su trabajador de casos.

Preguntas 1, 2, y 3. Estas preguntas no necesitan más explicación.

Pregunta 4. Apunte los ingresos y gastos de su negocio. En las cajas del lado izquierdo de la forma, enumere los gastos de su negocio (vea la información abajo). Ponga la fecha en que pagó los gastos y la cantidad de cada gasto. Sume las cantidades y ponga el total en la caja que dice "total de gastos del negocio propio". En las cajas a la derecha de la forma, enumere los ingresos (vea la información abajo). Ponga la fecha en que recibió cada ingreso, la fuente del ingreso y la cantidad. Sume las cantidades y ponga el total en la caja que dice "total de ingresos del negocio propio". Reste los gastos del total de ingresos del negocio propio y anote sus "ingresos netos del negocio propio".

<u>Los gastos</u> son los costos de un negocio. Algunos ejemplos de posibles gastos son: provisiones, reparaciones, renta, servicios públicos, semilla, forraje, seguro del negocio, licencias, cuotas, pagos del capital de préstamos para propiedades que generan ingresos, compras de bienes de capital (como bienes raíces, equipo, maquinaria y otros bienes duraderos y mejoras de bienes de capital), su aportación al seguro social de las personas que trabajan para usted y sueldos (pero no los que se paga a sí mismo). Si declara el costo de sueldos, ponga el nombre de cada persona y la cantidad que le pagó a cada quien. Si tiene cualquier otro tipo de gastos del negocio, asegúrese de anotarlos y poner la fecha en que los pagó.

No puede declarar:

- **El pago de la renta, la hipoteca, los impuestos o los servicios públicos del negocio si lo opera de su casa (a no ser que estos costos son aparte de los costos de la casa);**
- **El costo de artículos que compra para el negocio pero que usa personalmente;**
- **La pérdida neta del negocio de un periodo anterior; and**
- **La depreciación.**

Si tiene alguna duda, lleve comprobantes del gasto y consulte con el trabajador.

<u>Los ingresos</u> son, entre otros, el dinero de ventas, el ingreso de caja, las cosechas, las comisiones, las rentas, las cuotas o cualquier cosa que hace o que vende por dinero. Si usted tiene cualquier otro tipo de ingresos del negocio, asegúrese de anotarlo. No olvide poner las fechas en que recibió el ingreso.

Quién debe firmar. El solicitante, su cónyuge o su representante autorizado para firmar la forma. Cualquier persona puede ayudarle a llenar la forma, pero esa persona también tiene que firmar y poner le fecha en la forma. Consulte con el trabajador para saber si alguien más tiene que firmar.

With a few exceptions, you have the right to request and be informed about the information that the county obtains about you. You are entitled to receive and review the information upon request. You also have the right to ask the county to correct information that is determined to be incorrect (Government Code, Sections 552.021, 552.023, 559.004). To find out about your information and your right to request correction, please contact your local county office. / Con algunas excepciones, usted tiene el derecho de saber qué información obtiene sobre usted el condado de pedir dicha información. Si desea recibir y estudiar la información, tiene el derecho de solicitarla. También tiene el derecho de pedir que el condad corrija cualquier información incorrecta (Código Gubernamental, Secciones 552.021, 552.023, 559.004). Para enterarse sobre la información y el derecho de pedir que la corrijan, favor de ponerse en contacto con la oficina local del condado.

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