FISCAL YEAR 2017

POLICIES
and
PROCEDURES
MANUAL

for

Title V Maternal & Child Health Fee-for-Service for Child Health, Dental and Prenatal

Department of State Health Services
Division for Family and Community Health Services

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Introduction
General Information

PURPOSE OF MANUAL

The Department of State Health Services (DSHS) Policy and Procedure Manual for Title V Maternal and Child Health (MCH) Fee-for-Service (FFS) for Child Health, Dental and Prenatal is a guide for contractors who deliver prenatal, child health, and dental services using Title V Maternal and Child Health Services (MCH) Title V Block Grant funds in Texas. The policy manual has been structured to provide contractor staff with information needed to comply with Title V MCH Administrative, Client Services and Community Activities, and Reimbursement, Data Collection and Reporting policies.

To provide prenatal, child health, and dental services, contractors are required to be in compliance with specific federal and state laws outlined in the manual.

PROGRAM INFORMATION

General Purpose and Program Goals - The purpose of the Maternal and Child Health Services (MCH) Title V Block Grant is to create Federal/State partnerships to develop service systems to meet MCH challenges for all women and children. Title V funding is used to address the following areas, including, but not limited to: (1) Significantly reducing infant mortality; (2) Providing comprehensive care for women before, during, and after pregnancy and childbirth; (3) Providing preventive and primary care services for infants, children, and adolescents; and (4) Providing comprehensive care for children and adolescents with special health care needs. Systems of care are designed to be family-centered, comprehensive, coordinated and community-based.

Background - Through Title V of the Social Security Act (SSA) of 1935, the federal government pledged to support state efforts to improve the health of all mothers and children. The MCH Block Grant Program under Title V of the SSA was created in 1981 to consolidate multiple programs to support a more comprehensive, coordinated approach to meeting states' individual needs consistent with the applicable health status goals and national health objectives now identified in Healthy People 2010. Subsequent amendments enacted under the Omnibus Budget Reconciliation Act of 1989 (OBRA'89) introduced stricter requirements for the use of funds and for State planning and reporting.

States submit a standardized application for the block grant funds with an annual report by July 15th of each year. As a result of OBRA'89, each state must provide state funds at a level at least equal to the amount that had been dedicated to maternal and child health programs in Federal Fiscal Year 1989 to receive federal funds through the Maternal and Child Health Services (MCH) Title V Block Grant. This is referred to as the state's "maintenance of effort." States are required to use federal funds awarded as follows:

- at least 30% for preventive/primary care services for pregnant women, mothers, infants up to age one and children;
- at least 30% for services for children with special health care needs; and
- no more than 10% on administration.

Legal Authority

Federal: Title V of the Social Security Act (1935)

Within Texas, Title V operates within a framework articulated by the Texas Legislature, the Health and Human Services Commission (HHSC), and the Department of State Health Services (DSHS). The state health department, now known as DSHS, has administered Title V programs since the 1930s.

CHIP Perinatal Program

Senate Bill 1, HHSC Rider 70 (79th Legislature, Regular Session, 2005) authorized the Health and Human Services Commission (HHSC) to expend appropriated funds "to provide unborn children with health benefit coverage under the Texas Title XXI Health Plan." This expanded health insurance coverage for children was established by the State Children's Health Insurance Program (S-CHIP) as part of Title XXI of the Social Security Act.
As a result of this mandate, HHSC created the CHIP Perinatal Program to provide health coverage to unborn children of pregnant women up to 200% Federal Poverty Level who are ineligible for Medicaid due to income or immigration status. Implementation of this program began January 1, 2007. The benefits and eligible services are limited to prenatal and postpartum care (the same as Title V Prenatal Services). The goal of the CHIP Perinatal Program is to provide perinatal services for the unborn child as soon as possible for the best outcome.

For the period of September 1, 2012, through August 31, 2017, the Title V Prenatal and the CHIP Perinatal Program will run concurrently. Title V prenatal contractors may provide prenatal care and bill Title V up to 60 days for prenatal services and up to two case management contacts (for contractors that are approved to provide case management) for women who are in the process of applying for and enrolling in the CHIP Perinatal Program. Title V contractors must inform, encourage and assist pregnant women in the CHIP Perinatal Program application process. See Section III, Chapter 1 – Reimbursement for additional guidance on billing Title V during this transition period.

Title V Prenatal Contractors (or their providers/subcontractors) are expected to be enrolled as CHIP Perinatal providers. Contractors currently not enrolled as a CHIP Perinatal provider, must have a mechanism in place for prenatal care

benefits to be coordinated with existing CHIP Perinatal providers in the areas served.

A Promotor(a) or Community Health Worker (CHW) is a liaison who can assist the pregnant woman with the CHIP Perinatal application process. For information on promotor(a) or community health worker see Appendix E.

TITLE V MCH SERVICES

Contractors and their subcontractors are expected to:

- Identify, define, and prioritize specific interventions addressing the specific health care needs of the community.
- Ensure ongoing community involvement in the planning, implementation, and evaluation of the program.
- Ensure involvement of representatives of the cultural, racial, ethnic, gender, economic, and linguistic diversities within the community.
- Provide adequate automation systems to ensure direct communication with DSHS.
- Show evidence of new hire and annual periodic orientation of all staff to Title V concepts and revisions as applicable to their job descriptions.
- Notify DSHS of any issues, concerns or questions regarding the Program.
- Establish and implement eligibility, clinical, reporting, and billing systems for Title V.
- Work with other local, state, and federal entities in the community to develop a network of complementary services.
- Screen all participants with an approved screening process and refer to other programs/funding sources as appropriate. Failure to adequately screen is deemed as unsatisfactory performance and may result in defunding.
- Develop a referral system with effective follow-up.
- Develop a working relationship with other programs to ease the referral process for clients.
- Comply with eligibility, clinical, reporting, and billing mandates outlined in this handbook.
- Comply with and utilize DSHS web-based application, Integrated Business Information System (IBIS), for client eligibility determination, financial billing and reports.
- Client data, medical and/or dental services are to be entered into IBIS within 30 days of services provided.
- Work in collaboration with the DSHS to improve performance deemed unsatisfactory.

Termination of contract or defunding – Either the contractor or DSHS may give 30 days notice to terminate the contract. DSHS has the right to withhold reimbursement of payment if reports to DSHS are not timely and accurate.

DSHS may either defund with 30 days notice or choose not to award for the next fiscal year if contractor performance is deemed unsatisfactory.

Specific Contract Information – The contract period is September 1 of the current year through August 31 of the following year. Contracts may be amended during the fiscal year to increase or decrease funding and/or make wording changes under most circumstances. Amendments must be signed by both a DSHS representative and the contractor and must be returned to the DSHS Client Services Contracting Unit (CSCU) before they are considered fully executed. No payments may be issued on any contract attachment until it is fully executed.

DEFINITIONS

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

Age – For a child to be counted as part of the household, the child must be under 18 years of age and unmarried. The eligibility worker should terminate the child's eligibility at the end of the month the child becomes 18 unless the child:

- is a full-time student (as defined by the school) in high school, attends an accredited GED class, or regularly attends vocational or technical training as an equivalent to high school attendance, and
- is expected to graduate before or during the month of his/her 19th birthday.
- If the child does not meet the above criteria, he/she will be considered a separate household of one.

Children Health Insurance Program (CHIP) – A child health insurance program for non-Medicaid eligible children with a family income up to 200% Federal Poverty Level (FPL).

CHIP Perinatal Program – HHSC Program that provides medical coverage for perinatal care of unborn children of non-Medicaid eligible women with an income up to 200% FPL.

Children and Adolescents – A person from his/her 1st birthday through the 21st year.

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

Community Assessment – 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 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 implements 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.

Consultation – A type of service provided by a physician with expertise in a medical or surgical specialty and who upon request of another appropriate healthcare provider assists with the evaluation and/or management of a patient.

Dental Services – Diagnostic, preventive, and therapeutic dental services provided to children 0 through the 21st year, pregnant women, and post-partum up to three months post-delivery.

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 recognition of disease status determined by evaluating the history of the client and the disease process, and the signs and symptoms present. Determining the diagnosis may require microscopic (i.e. culture), chemical (i.e. blood tests), and /or radiological examinations (x-rays).

Documented Immigrant – A person who is not a U.S. citizen, and has an immigration document.

Eligibility Date – Date the individual submits a completed application to the provider and is deemed eligible. The eligibility expiration date will be twelve months from the eligibility date.

Family Composition – A person living alone or a group of two or more persons related by birth, marriage (including common law) or adoption, who reside together and who are legally responsible for the support of the other person.

Federal Poverty Level (FPL) – The set minimum amount of income that a family needs for food, clothing, transportation, shelter and other necessities. In the United States, this level is determined by the Department of Health and Human Services. FPL varies according to family size. The number is adjusted for inflation and reported 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 Education – The process of educating or teaching individuals about lifestyles and daily activities that promote physical, mental, and social well being. This process may be provided on an individual, one-to-one basis, or to a group of individuals.

Health and Human Services Commission (HHSC) – State agency that has oversight responsibilities for designated Health and Human Services agencies, including DSHS, and administers certain health and human services programs including the Texas Medicaid Program, Children's Health Insurance Program (CHIP), and Medicaid waste, fraud, and abuse investigations.

Health Service Region (HSR) – For administrative purposes, DSHS has grouped counties within a specified geographic area into 11 Health Service Regions.

Informed Consent – The process by which a health care provider ensures that the benefits and risks of a diagnostic or treatment plan, the benefits and risks of other appropriate options and the benefits and risk of taking no action are explained to a patient in a manner that is understandable to that patient and allows her/him to participate and make sound decisions regarding her/his own medical care.

Integrated Business Information System (IBIS) – An electronic web based application for client eligibility determination and billing.

Laboratory, X-Ray, or other Appropriate Diagnostic Services – Studies or tests ordered by the client's health care practitioner(s) to evaluate an individual's health status for diagnostic purposes.

Medicaid – Title XIX of the Social Security Act; reimburses for health care services delivered to low-income clients who meet eligibility guidelines.

Minor – 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.

Nutritional Services – The provision of services to identify the nutritional status of an individual, and instruction which includes appropriate dietary information based on the client's needs, i.e. age, sex, health status, culture. This may be provided on an individual, one to one basis, or to a group of individuals.

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

Payor Source – Programs, benefits, or insurance that pays for the service provided. Examples of payor sources are listed on page 29.

Prescription Drugs and Devices and Durable Supplies – Medically necessary pharmaceuticals, medical supplies (capable of withstanding wear) which are needed for the treatment of a diagnosed condition.

Presumptive Eligibility – Short-term availability and access to health care services (up to 60 days) when an immediate medical need exists as determined by a medical professional and the client screens potentially eligible for services.

Preventive Health Care Services – The major emphasis is placed on guarding or defending an individual or group against specific illness or injury. Included are immunizations, risk assessments, health histories, and baseline physicals for early detection of disease and restoration to a previous state of health, and prevention of further deterioration and/or disability.

Priority Population – Low income, uninsured or underinsured women and children.

Program Income – Monies collected directly by the contractor/provider for services provided under the grant award.

Promotor(a) or Community Health Worker – A person who, with or without compensation, is a liaison and provides cultural mediation between health care and social services, and the community. A Community Health Worker (CHW) is a trusted member of the community who: has a close understanding of the ethnicity, language, socio-economic status, and life experiences of the community served; assists people gain access to needed services; and increases health knowledge and self-sufficiency through a range of activities such as outreach, patient navigation and follow-up to community health education and information, informal counseling, social support, advocacy, and participation in clinical research. A Certified CHW is an individual with current certification as a community health worker issued by the Department of State Health Services.

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.

Referral – The process of directing or redirecting (as a medical case or a patient) to an appropriate specialist or agency for definitive treatment. To direct to a source for help or information.

Referral Agency – An agency that will provide a service for the Title V client that the Title V contractor does not provide and it is not a reimbursable Title V service.

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

Social Services – The provision of counseling and guidance; assistance to client and family in locating, accessing, and utilizing appropriate community resources.

Subcontractor – An agency who does all or part of the work required in the original contract for the DSHS contractor for the Title V reimbursement rate or agreed amount.

Texas Resident – An individual who resides within the geographic boundaries of the state.

Transportation – Services provided to a client for the purpose of receiving required health care services. Transportation could be provided via private vehicle, public transportation, project site vehicle, or emergency medical vehicle.

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

Undocumented Immigrant – A person who is not a U.S. citizen, and has no immigration document.

Unduplicated Client – Clients are counted only once per category regardless of the number of services they receive; client can be counted once in prenatal, dysplasia, and children/adolescent health as appropriate. One client seen four times in one category is counted as one unduplicated client and a family of three seen once is counted as three unduplicated clients.

ACRONYMS

Acronym	Term
ADA	Americans with Disabilities Act
ADA	American Dental Association
AED	Automated External Defibrillator
BCCS	Breast and Cervical Cancer Services
CAM	Complementary and Alternative Medications
CDSB	Contract Development and Support Branch
CFTR	Cystic Fibrosis Transmembrane Conductance Regulator

CHIP	Children's Health Insurance Program
CHW	Community Health Worker
CIHCP	County Indigent Health Care Program
CLIA	Clinical Laboratory Improvement Amendments
CMB	DSHS Contract Management Branch
CPR	Cardiopulmonary Resuscitation
DES	Diethylstilbestrol
DHHS	U.S. Department of Health and Human Services
DSHS	Texas Department of State Health Services
EMR	Electronic Medical Record
FPL	Federal Poverty Level
FQHC	Federally Qualified Health Center
FSR	Financial Status Report
HIPAA	Health Insurance Portability and Accountability Act of 1996
HHSC	Texas Health and Human Services Commission
HPV	Human Papilloma Virus
HSR	DSHS Health Service Region
IBIS	Integrated Business Information System
IPV	Intimate Partner Violence
IRB	Institutional Review Board
LEP	Limited English Proficiency
MCH	Maternal and Child Health Services
OTC	Over the Counter
PMU	DSHS Performance Management Unit
PPCU	DSHS Preventive and Primary Care Unit
QA	Quality Assurance
QM	Quality Management
QMB	DSHS Quality Management Branch
RFP	Request for Proposal
RSDI	Retirement Survivors Disability Income
SDO	Standing Delegation Orders
SSA	Social Security Administration
SSDI	Social Security Disability Income
SSI	Supplemental Security Income
STI	Sexually Transmitted Infection
STL	South Texas Lab
TAC	Texas Administrative Code
TANF	Temporary Assistance for Needy Families
TMHP	Texas Medicaid Healthcare Partnership
TMPPM	Texas Medicaid Provider Procedures Manual

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.

CLIENT ACCESS

The contractor must ensure that clients are provided services in a timely and nondiscriminatory manner. The contractor must:

- Have a 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 (see http://www.lep.gov/) 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;
- Manage funds to ensure that established clients continue to receive services throughout the budget year; and
- Continue to provide services to establish clients after allocated funds are expended.

ABUSE AND NEGLECT REPORTING

DSHS expects contractors to comply with state laws governing the reporting of abuse and neglect. Contractors must have an agency policy regarding abuse and neglect. It is mandatory for contractors to be familiar with and comply with adult and child abuse and neglect reporting laws in Texas.

To report abuse or neglect, call the Texas Abuse Hotline at **1-800-252-5400** use the secure website, or call local or state law enforcement agency for cases that pose an imminent threat or danger to the client.

DSHS CHILD ABUSE COMPLIANCE AND MONITORING

Chapter 261 of the Texas Family Code requires child abuse reporting. Contractors/providers are required to develop policies and procedures that comply with the child abuse reporting guidelines and requirements set forth in Chapter 261 and the DSHS Child Abuse, Screening, Documenting and Reporting Policy for Contractors/Providers. For the DSHS Child Abuse Reporting Matrix, see Appendix F.

The following outlines the review for contractor compliance.

Policy – Contractors must adopt the DSHS Child Abuse Screening, Documenting and Reporting Policy for Contractors/Providers, develop an internal policy specific to how these reporting requirements will be implemented throughout their agency, how staff will be trained, and how internal monitoring will be done to ensure timely reporting.

Procedures –
During the site monitoring visit reviewers will use the following procedures to evaluate compliance with the DSHS Child Abuse Screening, Documenting and Reporting Policy for Contractors.

1) The contractor's policy and process used to ensure that staff is reporting according to Chapter 261 and the DSHS Child Abuse Screening, Documenting and Reporting Policy for Contractors will be reviewed as part of the Core Tool. To verify compliance with this item, monitors must review the contractor's:

a) Child Abuse Policy should include:
- a statement that the contractor has adopted the DSHS Policy;
- details how the contractor will determine, document, report, and track instances of abuse, sexual or non-sexual for all clients under the age of 17 in compliance with the Texas Family Code, Chapter 261 and the DSHS Policy.

b) client records that meet reporting or the establishment of an affirmative defense re, and supporting documentation, such as:
- a completed DSHS Child Abuse Reporting Form, confirmation fax report, tracking log, etc.; and

- fax and or emails confirmation that a report was made to the appropriate agencies (DFPS and local law enforcement agency) within the required timeframes required by law; and
- training documentation (i.e., training rosters and or employee training files) that staff attended training on child abuse reporting requirements and procedures.

2) All Rider records of clients under 14 years of age who are pregnant or have a confirmed diagnosis of an STD acquired in a manner other than through perinatal transmission or transfusion will be reviewed for appropriate screening and reporting documentation as required in the clinic or site being visited during a site-monitoring visit.

3) Records of clients who are ages 14, 15, or 16 who are sexually active, meet the criteria for an affirmative defense, will be reviewed for appropriate screening and reporting documentation as required in the clinic or site being visited during a site-monitoring visit.

If it is found during routine record review that a report should have been made as evidenced by the age of the client and evidence of sexual activity, the failure to appropriately screen and report will be identified as lack of compliance..

Failure to report will be brought to the attention of the staff person who should have made the report or the appropriate supervisor with a request to report immediately. This failure to report will also be discussed with the agency director and during the exit conference with the contractor.

4) The report sent to the contractor will indicate the number of applicable records reviewed in each clinic and the number of records that were found to be out of compliance. This report will be sent to the contractor approximately 4 weeks from the date of the review, which is the usual process for site monitoring reports.

5) The contractor will have a determined length of time to respond with written corrective actions to all findings. The contractor is required to use the DSHS Corrective Action Template which is found at http://www.dshs.texas.gov/chscontracts/all_forms.shtm#QMB.

If the contractor does not provide corrective actions during the required timeframe, the contractor will be sent a past due letter with a time period of 10 days to submit the corrective actions. If the corrective actions are not submitted during the time period given, failure to submit the corrective action is considered a subsequent finding of noncompliance with Chapter 261and the DSHS Policy.

If the contractor has other findings that warrant technical assistance or accelerated monitoring review (ACM), either regional and/or central office staff will make the necessary contacts. Records and/or policies will again be reviewed to ensure compliance with Chapter 261 and the DSHS Policy requirements. If any subsequent finding of noncompliance is identified during a subsequent monitoring or technical assistance visit, the contractor will be referred for financial sanctioning.

6) If a contractor is found to have minimal findings overall but did have findings of noncompliance with Chapter 261 and the DSHS Policy, an additional accelerated monitoring(ACM) visit solely to review child abuse reporting will not be conducted. For agencies that receive technical assistance visits as the result of a quality assurance review, the agency child abuse reporting processes will be reviewed again for compliance. In all cases, the corrective actions submitted by the contractor will be reviewed to ensure that the issues have been addressed. Agencies who do not receive an accelerated monitoring (ACM) and/or technical assistance visit will be required to complete the DSHS Progress Report, Compliance with Child Abuse Reporting within 3 months after the corrective actions are begun (no later than 6 months from the initial visit). Failure to submit a Progress Report within the required time frame or submission of a report that is not adequate constitutes a subsequent finding of noncompliance with the DSHS Child Abuse Screening, Documenting, and Reporting Policy for Contractors/Providers will result in the contractor being referred for financial sanctions. Information about this topic is available on the internet at: **http://www.dshs.state.tx.us/childabusereporting/default.shtm**.

HUMAN TRAFFICKING

DSHS mandates that contractors comply with state laws governing the reporting of abuse and neglect. Additionally, as part of the requirement that contractors comply with all applicable federal laws, Title V contractors must comply with the federal anti-trafficking laws, including the Trafficking Victims Protection Act of 2000 (Pub.L.No. 106-386), as amended, and 19 U.S.C. 1591.

Contractors must have a written policy regarding awareness and identification of human trafficking, including annual staff training.

The monitors will verify that staff has attended the annual human trafficking training through agency documentation (i.e., training rosters and or employee training files).

INTIMATE PARTNER VIOLENCE (IPV)

Intimate partner violence (IPV) describes physical, sexual, or psychological harm by a current or former partner or spouse. This type of violence can occur among heterosexual or same-sex couples and does not require sexual intimacy. The goal is to stop IPV before it begins.

Contractors must have a written policy related to assessing for and preventing IPV, including annual staff training.

The monitors will verify that staff has attended the annual human intimate partner violence training through agency documentation (i.e., training rosters and or employee training files).

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.hhsl.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 for clinic services (cell phone, email, work phone) and preferred language 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 Abuse and Neglect Reporting - Section I, Chapter 2).

CIVIIL RIGHTS

DSHS contractors must provide services to clients in a non-discriminatory manner, and comply with state and federal civil rights laws and regulations as amended, including, but not limited to:

- Title VI of the Civil Rights Act of 1964 (42 U.S.C. §2000d *et seq.*);
- Title IX of the Education Amendments of 1972 (20 U.S.C. §§1681 *et seq.*);
- Section 504 of the Rehabilitation Act of 1973 (29 U.S.C. §794);
- Age Discrimination Act of 1975 (42 U.S.C. §§6101-6107);
- Americans with Disabilities Act of 1990 (42 U.S.C. §12101 *et seq*.); and
- Administrative rules for HHS agencies as set forth in the Texas Administrative Code.

More information about civil rights requirements can be found on the HHSC Civil Rights Office website at http://www.hhsc.state.tx.us/about_hhsc/civil-rights/ or contact the Civil Rights Office at HHSCivilRightsOffice@hhsc.state.tx.us or (888) 388-6332.

Contract Terms and Conditions

To ensure compliance with civil rights laws, regulations, and policies, contractors must:

- Sign a written assurance to comply with applicable federal and state civil rights laws and regulations;
- Have a written policy that states the contractor does not discriminate on the basis of race, color, national origin, including limited English proficiency (LEP), sex, age, religion, disability, or in certain programs, sexual orientation;
- Ensure that all contractor staff is trained in the contractor's non-discrimination policies, including policies for serving clients with LEP and HHS complaint procedures;
- Post applicable civil rights posters that include contact information for the HHSC Civil Rights Office in areas open to the public informing clients of their civil rights; and
- Notify the HHSC Civil Rights Office of any discrimination allegation or complaint related to its programs and services no later than ten (10) calendar days after receipt of the allegation or complaint.

  Send notices to:
  Texas Health and Human Services Commission
  Civil Rights Office
  701 W. 51st Street, Mail Code W206
  Austin, Texas 78751
  (888) 388-6332
  (512) 438-4313
  Fax: (512) 438-5885
  HHSCivilRightsOffice@hhsc.state.tx.us

Language Services for People with Limited English Proficiency and Disabilities

DSHS contractors must take reasonable steps to ensure that people with LEP and people with disabilities, including speech and hearing impairments, have meaningful access to its programs and services. Contractors must not require them to bring or use friends or family members to serve as interpreters. However, a family member or friend may serve as a client's interpreter:

- at the client's request, and
- if the family member or friend does not compromise the effectiveness of the service nor violate client confidentiality.

Contractors must not use minor children to serve as interpreters, except in emergencies.

Clients and applicants with language service needs must be informed that the contractor will provide:

- an interpreter free of charge.
- written program materials in their primary language.

Civil Rights Posters

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

Your Rights
- Your Rights - English (PDF)
- Your Rights - Spanish (PDF)

Need an Interpreter?
- Language Translation (PDF)
- American Sign Language (PDF)

Americans With Disabilities Act
- ADA - English (PDF)
- ADA - Spanish (PDF)

Print the posters on 8" x 11" paper, and post the English and Spanish versions next to each other. Post the Need Interpreter? posters next to each other. The posters are located at:
http://www.hhsc.state.tx.us/about_hhsc/civil-rights/brochures-posters.shtml

Questions concerning the civil rights posters can be directed to the HHSC Civil Rights Office at HHSCivilRightsOffice@hhsc.state.tx.us or (888) 388-6332.

Civil Rights Survey

Contractors can use the Civil Rights Self-Assessment tool to conduct a self-assessment on their programs and facilities. Contractors should have copies available of the survey.

The survey can be downloaded from the Quality Management Branch (QMB) website at http://www.dshs.state.tx.us/qmb/contractor.shtm.

Questions concerning the self-assessment can be directed to the DSHS Quality Management Branch or the HHSC Civil Rights Office at HHSCivilRightsOffice@hhsc.state.tx.us or (888) 388-6332.

TERMINATION OF SERVICES

Clients must never be denied services due to an inability to pay.

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 the safety of himself or herself, 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 complaint must be documented in the client's record.

RESEARCH (HUMAN SUBJECT CLEARANCE)

Contractors considering clinical or sociological research using Office of Title V & Family Health Services (OTV&FH) grant funded clients as subjects must obtain prior approval from their own internal Institutional Review Board and the Texas Department of State Health Services Institutional Review Board (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.

Contractors should first contact DSHS Title V MCH FFS Program (TitleV@dshs.state.tx.us) to initiate a research request. Next, contractors should complete the most current version of the DSHS IRB #1 application and submit it to TitleV@dshs.state.tx.us. The DSHS IRB will review the materials and approve or deny the application.

The contractor must have a policy in place that indicates that prior approval will be obtained from the DSHS Title V MCH FFS Program, as well as the DSHS 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**

CLIENT RECORDS MANAGEMENT

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

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

The written consent of the client is required for the release of personally identifiable information, except as may be 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 (see **http://www.dshs.state.tx.us/hivstd/policy/laws.shtm**).

When information is requested, contractors should 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, subrecipients, 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 Title 1, Part 15 TAC §354.1003 (relating to Time Limits for Submitted Claims) and Title 22, Part 9 TAC §165 (relating to Medical 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 at:
http://www.dshs.state.tx.us/records/medicalrec.shtm

PERSONNEL POLICY AND PROCEDURES

Contractors must develop and maintain personnel policies and procedures to ensure that clinical staff are hired, trained, and evaluated appropriately for their job position. Personnel policies and procedures must include:

- Job descriptions;
- A written orientation plan for new staff to include skills evaluation and/or competencies appropriate for the position; and
- Performance evaluation process for all staff.

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 and 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 ensure that all medical services (including screening & eligibility, direct client care, quality management, and oversight of clinical services) are provided under the supervision, direction, and responsibility of a qualified Medical Director. The Title V Medical Director must be a Texas licensed physician.

Contractors must ensure that all dental services are provided under the supervision, direction, and responsibility of a qualified licensed dentist. The Title V Dental Director must be a U.S. licensed dentist.

Contractors must have a documented plan for organized staff development. There must be an assessment of:

- Training needs;
- Quality assurance indicators; and
- Changing regulations/requirements.

Contractors must also include orientation and in-service training for all personnel, including volunteers. Employee orientation and continuing education must be documented in agency personnel files.

FACILITIES AND EQUIPMENT

DSHS contractors are required to maintain a safe environment at all times. Contractors must have written policies and procedures that address the handling of hazardous materials, fire safety, and medical equipment.

Hazardous Materials – Contractors must have written policies and procedures that address:

- The handling, storage, and disposing of hazardous materials and waste according to applicable laws and regulations;
- The handling, storage, and disposing of chemical and infectious waste, including sharps; and
- An orientation and education program for personnel who manage or have contact with hazardous materials and waste.

Fire Safety – Contractors must have a written fire safety policy that includes a schedule for testing and maintenance of fire safety equipment. Evacuation plans for the premises must be clearly posted and visible to all staff and clients.

Medical Equipment – Contractors must have a written policy and maintain documentation of the maintenance, testing, and inspection of medical equipment, including Automated External Defibrillator (AED). Documentation must include:

- Assessments of the clinical and physical risks of equipment through inspection, testing, and maintenance;
- Reports of any equipment management problems, failures, and use errors;
- An orientation and education program for personnel who use medical equipment; and
- Manufacturer recommendations for care and use of medical equipment.

Smoking Ban – Contractors must have written policies that prohibit smoking in any portion of their indoor facilities. If a contractor subcontracts with another entity for the provision of health services, the subcontractor must also comply with this policy.

Disaster Response Plan – Written and oral plans that address how staff is to respond to emergency situations (i.g., fires, flooding, power outage, bomb threats, etc.). A disaster response plan must be in writing, formally communicated to staff, and kept in the workplace available to employees for review. For an employer with 10 or fewer employees the plan may be communicated orally to employees.

For additional resources on facilities and equipment, visit https://www.osha.gov/law-regs.html .

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 size, structure and organization and are most effective if they are individualized to meet the agency's needs, specific services offered, and the populations served.

Contractors are expected to develop quality processes based on the four core Quality Management principles 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 Management 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 quality 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 in the comprehensive plan how the quality of subcontracted services will be evaluated and how compliance with DSHS policies and basic standards will be assessed with the subcontracting entities.

The (QM) Committee, whose membership consists of key leadership within the organization, including the Executive Director/CEO, the Medical/Dental Director, a clinic, director, a nurse, dental hygienist/dental assistant, billing and eligibility staff, a records manager, and any other appropriate staff, where applicable. The QM Committee annually reviews and approves the organization's quality work plan. The Medical Director must be a licensed Texas physician. Dental Director must be a U.S. licensed dentist.

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; and
- reassess outcomes and goal achievement.

Minutes of the discussion, actions taken by the committee and a list of the attendees must be maintained.

The quality work plan at a minimum must

- include clinical and administrative standards by which services will be monitored;
- include process for to verify clinicians and healthcare providers licenses and credentials are current, and ensure that a peer review process for clinicians are in place;
- identify individuals responsible for implementing monitoring, evaluating, and reporting;
- establish timelines for quality monitoring activities;
- identify tools/forms to be utilized;
- Establish and implement a corrective action plan process; and
- outline the process for reporting to the Quality Management Committee.

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

- on-going eligibility, billing, and clinical record reviews, at a minimum, twice yearly, to assure compliance with program requirements and clinical standards of care;
- tracking and reporting of adverse outcomes;
- client satisfaction surveys, at a minimum, annually;
- 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), immunizations status; and
- performance evaluations to include primary license verification, DEA and staff immunization status in compliance with the organization's infection control policy, to ensure they are current.

DSHS 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 including:

- QM process
- License verification (primary source verification at a minimum, annually)
- Clinical record review (at a minimum twice yearly)
- Eligibility and billing review (at a minimum twice yearly)
- Facility on-site review (at a minimum, annually)
- Client satisfaction surveys (at a minimum, annually)
- Training
    - Child Abuse
    - Human Trafficking
    - Intimate Partner Violence

Data from these activities must be presented to the Quality Management Committee. Plans to improve quality should result from data analysis and reports presented to committee for action. These actions and activities should be documented in the QM Committee Minutes.

Information on the operating process of Quality Management Branch, as well as policies and review tools, can be found at: **http://www.dshs.state.tx.us/qmb/default.shtm**

PROGRAMMATIC ELIGIBILITY DESK REVIEWS

Contractor shall provide information and supporting documentation as requested by DSHS to conduct programmatic desk reviews to verify client eligibility for TV MCH. Failure to submit requested information in a timely manner may result in sanctions according to provisions of the contract. If a contractor's desk review results in non-compliance of DSHS TV MCH policy, contractor shall take appropriate corrective action.

Section II
Client Services and Community Activities

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

CLIENT ELIGIBILITY AND ASSESSMENT OF CO-PAY/FEES

For an individual to receive Title V MCH services, three (3) criteria must be met:

- Gross family income at or below 185% of the adopted Federal Poverty Level (FPL);
- Texas resident; and
- Not eligible for other programs/benefits providing the same services.

CONTRACTOR RESPONSIBILITIES

Contractors must develop a policy to determine Title V eligibility. The policy shall be available for Quality Assurance Review visits.

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

- Individual/family members' 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).
- Gross monthly income of individual and spouse;
- Other benefits available to the family or individual; and
- Any specified or other supporting documentation necessary for the contractor to determine eligibility.

The contractor will:

- Ensure the applicant's household income is at or below 185% of the federal poverty level, documented in the client's record and if applicable, in IBIS; Use the DSHS HOUSEHOLD Eligibility Screening Form (Form EF05-14214); and HOUSEHOLD Eligibility Screening Form Worksheet (Form EF05-13227); and verification/documentation procedures established by DSHS or completion of a comparable paper or electronic screening and eligibility tool that has the required DSHS information for determining eligibility. If a comparable eligibility screening tool is being used, it must be reviewed and approved by DSHS staff before use. Contractors must use DSHS eligibility screening forms until approval to use a comparable form/tool is received.;
- Assist the applicant with accurately completing the application for screening and eligibility determination purposes;
- Ensure that the documentation the individual provides is sufficient to make an eligibility decision. Request for Information (Form 104) may be used to assist applicants with requested verification requirements;
- Accept reasonable documentation provided by the individual;
- Document oral designations of any additional contacts;
- Determine eligibility for TV services based on the three (3) eligibility criteria;
- Provide the eligible individual information regarding the services he/she is entitled to receive and his/her rights and responsibilities;

- Advise the client of his/her responsibility to report changes; and
- Determine the effect reported changes have on the client's eligibility by re-screening and completing the eligibility determination process.

The contractor shall allow the individual an opportunity to resolve any discrepancy by providing documentary evidence or designating a suitable contact to verify information. If the individual fails or refuses to do so, eligibility can be denied. Document this information on DSHS HOUSEHOLD Eligibility Screening Form (Form EF05-14214); and HOUSEHOLD Eligibility Screening Form Worksheet (Form EF05-13227).

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 HOUSEHOLD Eligibility Screening Form (Form EF05-14214); and HOUSEHOLD Eligibility Screening Form Worksheet (Form EF05-13227) if applicable, filed in the client record and/or in IBIS in the notes section of the enrollment screen.

DSHS values the efforts of community based organizations that include the promotores or community health workers (CHWs). Promotores or CHWs may assist with access to community resources and with the application process for Medicaid and CHIP. For information on this resource, see Appendix E.

Applicant's Responsibility for Providing Proof –

- Complete the DSHS HOUSEHOLD Eligibility Screening Form (Form EF05-14214) or request assistance for completion;
- Provide documents requested by the contractor. Failure to provide all required information will result in denial of eligibility. If documentation is not available or is insufficient to determine eligibility, contractor staff should ask the individual to designate a contact person to provide the information.

The individual is responsible for completing page one of his/her own DSHS HOUSEHOLD Eligibility Screening Form (Form EF05-14214). If the individual 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 EF05-14214 on the applicant's behalf. This representative must be knowledgeable about the applicant and his household. A copy of this form and instructions can be found in Appendix A. If assistance is needed in completing the form, the contractor shall provide knowledgeable staff to assist. One form must be completed for each family member being screened for eligibility. To expedite the process, 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. Each Title V MCH eligible client, who is a legal

adult, is required to sign and date the form. 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 areas: income, family composition, residence, address, employment, types of medical insurance coverage, and receipt of Medicaid and/or other 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.

Interviews – An appointment with the individual may be scheduled for a face-to-face or telephone interview. The contractor will document information in the case record to support all decisions about eligibility.

SCREENING AND ELIGIBILITY DETERMINATION

To determine if a client is eligible for services, the screening and eligibility process has two steps. Each of the following steps will be discussed further in this section.

- Screening and Eligibility Determination – This step includes the completion of the DSHS HOUSEHOLD Screening and Eligibility Form and HOUSEHOLD Eligibility Screening Form Worksheet (Appendix A); submission of required documentation; determination of eligibility and referral if necessary; and completion of Statement of Applicant's Rights and Responsibilities.
- Annual Re-certification – This step is the annual eligibility review prompted by the anniversary date the client was deemed eligible for Title V MCH. The DSHS HOUSEHOLD Screening and Eligibility Form and HOUSEHOLD Eligibility Screening Form Worksheet is used to determine continued eligibility and/or update eligibility status. For example, if a client was deemed eligible for Title V MCH on August 31, 2005, then the client must be re-certified for eligibility before he/she can access services after August 31, 2006. The annual re-certification can be performed before the anniversary date the client was deemed eligible for Title V MCH or before services are provided on the first visit after the anniversary date.

Individuals must be screened for potential Medicaid, CHIP, or other programs using one of two processes:

- Completion of the DSHS HOUSEHOLD Eligibility Screening Form and HOUSEHOLD Eligibility Screening Form Worksheet or

- Completion of 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 Screening and Eligibility Form must be maintained in the medical record. The comparable paper or electronic screening and eligibility tool must be reviewed and approved by DHSH Office of Title V and Family Health.

For Title V MCH 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. The website offers access to information on HHSC benefits including Medicaid, Supplemental Nutrition Assistance Program (SNAP), Temporary Assistance for Needy Families (TANF), Children's Health Insurance (CHIP), and nursing home care and other services for people who are elderly or have disabilities. The use of this system may replace the HOUSEHOLD Eligibility Screening Form Worksheet (Form EF05-13227), but can not replace the DSHS HOUSEHOLD Eligibility Screening Form (Form EF05-14214). More information about HHSC benefits can also be obtained by calling 2-1-1.

Family Composition – Establishing family size is an important step in the eligibility process. Assessment of income eligibility relies on an accurate count of family members.

A family is defined as a person living alone or a group of two or more persons related by birth, marriage (including common law), or adoption, which reside together and are legally responsible for the support of the other person. Unborn children are also included in family size.

Children and Family Composition – A child must be under 18 years of age to be counted as part of a larger family. Eligibility will end on the last day of the month the child becomes 18 years of age unless the child is:

- A full-time high school student as defined by the school, attends an accredited GED class, or regularly attends vocational or technical training in place of high school and
- Expected to graduate from one of the above before or during the month of his/her 19th birthday.

A child who is 18 years of age or older and resides with his/her parent(s)/guardian(s), but is not currently attending high school is considered a family of one.

Special Family Composition - A child may be considered part of a family when living with relatives other than natural parents if documentation can be provided that verifies the relationship. Acceptable documents include birth certificates or

other legal documents that demonstrate the relationship between the caretaker and the child. If no biological relationship exists between the caretaker or if documentation is not provided to verify biological relationship:

- The child becomes a separate Title V MCH household;
- The situation must be explained on the worksheet; and
- Caretaker may apply for Title V MCH benefits on the child's behalf.

Documentation of Date of Birth – Document proof of client's birth provided by the client on the HOUSEHOLD Eligibility Screening Form Worksheet, if applicable, and in IBIS. For documentation of client's date of birth, one of the following items shall be provided:

- Birth certificate
- Baptismal certificate
- School records
- Other documents or proof of date of birth valid by the contractor

Documentation of Family Composition – If family relationships appear questionable, one of the following items shall be requested:

- Birth certificate
- Baptismal certificate
- School records
- 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 HOUSEHOLD Eligibility Screening Form Worksheet (Form EF05-13227) if applicable, and in IBIS.

Residency – To be eligible for Title V MCH, 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, care taker, or guardian is a resident of Texas.

There is no requirement regarding the amount of time an individual must live in Texas to establish residency for the purposes of Title V MCH eligibility.

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

- Persons who move into the state solely for the purpose of obtaining health care services.
- Student primarily supported by their parents, whose home residence is in another state.

Individuals described below are not eligible to receive Title V MCH services:

- Inmates of correctional facilities;
- Residents of state schools or federal schools; and
- Patients in federal institutions or state psychiatric hospitals.

Documentation of Residency – Document proof of residency provided by the client on the HOUSEHOLD Eligibility Screening Form Worksheet, if applicable, and in IBIS and explain why residency is questionable, if necessary. For documentation of residency, one of the following items shall be provided:

- Valid Texas Driver 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

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

- Observance of personal effects and living arrangement or
- Statements from landlords, neighbors, or 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 a home in Texas and returns to that home 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.

Income – To be eligible for Title V MCH, clients must have a gross family income at or below 185% FPL. The table below details sources of earned and unearned 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.

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, minus the allowable costs of producing the self-employment income.

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.

Supplemental Security Income (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.

Documentation of Income – Documentation of income must be provided to complete the DSHS HOUSEHOLD Eligibility Screening Form and HOUSEHOLD Eligibility Screening Form Worksheet if applicable, and in IBIS. 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 document income, the following documentation shall be provided: at least 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 HOUSEHOLD Eligibility Screening Form Worksheet if applicable, and in IBIS. The pay periods must accurately reflect the individual's usual and customary earnings.

Proof may include, but is not limited to:

- Copy(ies) of the most recent paycheck(s)
- Copy(ies) of the most recent paycheck stub/monthly earning statement(s)
- Employer's written verification of gross monthly income or the Employment Verification Form (Form 128)

- Award letters
- Domestic relation printouts 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
- Notes for cash contributions
- Other documents or proof of income determined valid by the contractor

Special Circumstances Regarding 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 FUNDING SOURCE – Worksheet if applicable, and in IBIS.

Income Determination Procedure

- Count income already received and any income the family 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 HOUSEHOLD Eligibility Screening Form Worksheet if applicable, and in IBIS.
- 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.
- When income is received in lump sums or at longer intervals than monthly, at irregular intervals, (i.e. contract labor seasonal employment, lump sums, etc.) the total amount received will be divided over the period of time the income is expected to cover in order to determine a monthly income. For seasonal income, count the total income for the months worked in the overall calculation of income.
- 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
    - 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 of the TV MCH household. This

deduction is allowed even when the child or adult with disabilities is not included in the Title V MCH 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
- $175 per month for each adult with disabilities.

Child support payments made by a member of the 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 above listed 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 al 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 their pay when determining the amount of self-employment income received. Verify one month's pay amount that accurately represent their 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 Title V MCH coverage will not be renewed on subsequent applications without acceptable documentation of self-employment income or expenses. Documentation 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 household income is from conducting a self-employment business in the 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.

Employment Terminated/New Employment – When the individual has been terminated, resigned, or laid off, the income from that job will then be disregarded. 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 FUNDING SOURE – Worksheet if applicable, and in IBIS.

Disability – The individual must submit a statement from his/her physician verifying the approximate length of disability or a letter from the company/program providing eligibility dates.

Statements 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 Drivers License, Social Security card, or a birth certificate of the supporter.

Completed Application Date – The date the DSHS HOUSEHOLD Eligibility Screening Form (Form EF05-14214) if applicable, and in IBIS 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.

Calculation of Applicant's Federal Poverty Level Percentage
Contractor must determine the applicant's actual household Federal Poverty Level (FPL) percentage.
Steps used to determine an applicant's exact household FPL percentage:
● Determine the applicant's **household** size.
● Determine the applicant's **total monthly income** amount.
● Divide the applicant's **total monthly income** amount by the **maximum monthly income** amount at 100% FPL, for the appropriate **household size**.
● Multiply by 100%.

Example:
Applicant has a total monthly income of $2,063 and counts three (3) family members in the household.

Total Monthly Income		Maximum Monthly Income (Household Size 3)		Actual Household FPL%
$2,063	/	$1,650	=	1.25 x 100% = 125%

The maximum monthly income amounts by household size are based on the Department of Health and Human Services federal poverty guidelines at http://www.medicaid.gov/medicaid-chip-program-information/by-topics/eligibility/downloads/2015-federal-poverty-level-charts.pdf. The guidelines are subject to change around the beginning of each calendar year.

If applicable, IBIS will determine the applicant's FPL.

Eligibility Determination
The contractor must consider the information provided by the individual and document the basis for the eligibility decision on the HOUSEHOLD Eligibility Screening Form Worksheet (Form EF05-13227) if applicable, and in IBIS.

If determined eligible, the individual must sign the Statement of Applicants Right's and Responsibilities (Form 101) to complete the eligibility determination.

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 expires; and
  - The services the individual/family 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; and
  - The appropriate referrals to alternative agencies/programs for services, if applicable.

Appeal Eligibility Determination – Individuals and families can appeal to the DSHS Title V contractor regarding the eligibility determination for Title V, if they disagree with the determination that was issued on their case. Applicants may submit additional information to establish eligibility, or repeat the application process.

If the client feels that the repeated eligibility determination is still incorrect, then the individual may appeal to the DSHS Title V Regional Coordinator at the Regional DSHS office.

Date Eligibility Begins – An individual/family is entitled to services beginning with the date the completed application was submitted and deemed eligible This includes the date an applicant is deemed eligible for Presumptive Eligibility.

Presumptive Eligibility – Individuals, who have not had final eligibility for services determined but present with a **medical/dental need**, may receive Title V MCH-funded services on a presumptive eligibility basis during the time that eligibility for services is pending. Presumptive eligibility may be effective for up to 60 days from the date the client is first seen by the medical provider. A client shall be enrolled on a presumptive eligibility basis only once in a 12-month period.

If the individual has not already applied for Title V MCH, an application for services should occur at the time of receiving services. If a medical condition makes eligibility determination impossible, an appointment to complete the process should be made at the first possible opportunity. If the client has applied for another program, the contractor is responsible for updating the individual's eligibility status on a timely basis. Documented proof of eligibility within the other funding sources is required. If services are needed immediately and are not provided by another program, services may be provided during this 60-day period. If the client becomes Medicaid eligible, the services must be billed to Medicaid under the "90-days prior provision."

Title V MCH emphasizes the importance of prevention and early intervention. The goal of Title V MCH is for clients to be part of the health care system and not rely on episodic, acute care. Although Title V MCH is under strict eligibility guidelines, it is encouraged that an applicant's medical needs be met quickly and appropriately using whatever resources are locally available.

A Presumptive Eligibility Form (Appendix C) and Statement of Applicant's Rights and Responsibilities (Appendix B) must be completed when a client is determined presumptively eligible.

Clients Screened Potentially Eligible for Other Benefits – Contractors must work to ensure that individuals seeking Title V MCH-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. It is possible that a family will be referred to several programs as a result of the eligibility determination process. Payor source that must be used first include:

- Private/Employer Insurance
- Medicare
- Medicaid
- TRICARE
- County Indigent Health Care
- Children with Special Health Care Needs

- CHIP (other than family planning services)
- Title XIX (including WHP) and DSHS Family Planning
- Breast and Cervical Cancer Services
- Worker's Compensation
- Veteran's Administration Benefits
- CHIP Perinatal Program

Two exceptions to using other benefits in place of Title V MCH include:

- If the benefits were created by the establishment of a city or county hospital, a joint city-county hospital, a county hospital authority, a hospital district, or by the facilities of a publicly supported medical school. Benefits created by any of these entities would not disqualify individuals from using Title V MCH services.
- Contractors are not expected to refer clients to the County Indigent Health Care Program (CIHCP) if the county of residence does not have state-supported funds to provide CIHCP services or the client does not meet the county's eligibility criteria for the program.

Individuals potentially eligible for Medicaid or CHIP should be referred to http://www.chipmedicaid.org or 1-877 KIDS NOW to request an application. They may also be referred to Your Texas Benefits website http://www.yourtexasbenefits.com) or 2-1-1 for comprehensive Medicaid or CHIP eligibility determination.

Individuals who are determined potentially eligible for another benefit by the DSHS HOUSEHOLD Eligibility Screening Form if applicable, and in IBIS, but fail to fully complete the required application process for the benefit, will not be eligible to receive Title V MCH-funded services beyond those services delivered during the presumptive eligibility period. If a client fails to complete the eligibility determination process for another benefit, the contractor may bill Title V MCH for the services delivered during the presumptive eligibility period only. Contractors should make clients aware that failing or refusing to complete the appropriate eligibility determination processes will result in their determination as self-pay clients. A copy of the DSHS HOUSEHOLD Eligibility Screening Form and HOUSEHOLD Eligibility Screening Form Worksheet, if applicable, must be maintained in the medical record and in IBIS.

CHIP PERINATAL PROGRAM - ELIGIBILITY

HHSC created the CHIP Perinatal Program to provide health benefit coverage to unborn children of pregnant women up to 200% FPL who are ineligible for Medicaid due to income or immigration status. Implementation of this program

began January 1, 2007. The benefits and eligible services are limited to prenatal and postpartum care, similar to Title V Prenatal Services. The goal is to provide perinatal services for the unborn child as soon as possible for the best outcome.

All pregnant women currently served by Title V are eligible for the CHIP Perinatal Program to receive health benefits for the unborn child and newborn. There is a 12-month continuous eligibility period for the unborn child, including pre- and post-delivery. For example: If eligibility is determined when the mother is three months pregnant, the unborn child has six months perinatal care, and six months of coverage after birth under CHIP Perinatal. The mother of the child is eligible to receive two post partum visits maximum within 60 days. More information is available online at the following Internet address: http://www.CHIPmedicaid.org

CHIP Perinatal Program applications are available at HHSC benefits offices, participating community-based organizations, and online at http://www.yourtexasbenefits.com. A supply of applications can be ordered at http://www.chipmedicaid.org/en/CHIP-Perinatal. Clients can also call 1-877-KIDSNOW or 1-877-543-7669 to get an application or apply online at http://wwwCHIPmedicaid.org.

Contractors must assist clients in completing the Children's Health Insurance Program (CHIP), Children's Medicaid, and CHIP Perinatal Application. Income verification is required to be sent in with the application. To document income verification, one of the following items shall be provided:

- One pay stub in the last 60 days,
- Letter from an employer stating monthly income,
- Last income tax return (including schedule C, if filed),
- Cash assistance receipt,
- Most recent social security statement,
- Child support check stub or receipt, or
- Client's Statement of Self-Employment Income Form from the Texas Health and Human Services Commission (Form H1049).

In addition, during the application process, HHSC will ask for identity and citizenship verification (new federal Medicaid requirements) because HHSC checks eligibility for Medicaid first, then CHIP, then CHIP Perinatal. While verification of citizenship is required for Medicaid, it is not required for CHIP Perinatal. Pregnant women determined to be eligible for CHIP Perinatal can self-declare immigration status.

Once the application is completed, the contractor will mail or fax the application for processing using instructions on the application. The contractor should insure that the application is complete and signed. Verification of income should be sent with the application. Contractors should send the application even if the verification of income documentation is not provided by the client. Contractor must document application has been completed and may also have a copy of the

CHIP Perinatal application in the chart. The application will be considered incomplete until the information is provided.

For the CHIP Perinatal Program eligibility process, the client is exempt from the CHIP asset test and all cost sharing.

CHIP Perinatal Program eligibility is determined within 15 business days of receipt of the application. The effective date of coverage is the first day of the month in which the eligibility was determined. For example, if an application is submitted February 23, 2007, and eligibility is determined March 13, 2007, coverage will start March 1, 2007. To expedite the eligibility process, clients will receive a toll-free number to call and choose a health care plan rather than choosing by mail.

ANNUAL RE-CERTIFICATION

The contractor will determine the system used to track clients' status and renewal eligibility. Eligibility determination using the DSHS HOUSEHOLD Eligibility Screening Form and HOUSEHOLD Eligibility Screening Form Worksheet if applicable, and in IBIS is required for all clients. Eligibility services must be re-determined every 12 months.

At least 30 days prior to the anniversary date of their original eligibility date, Title V MCH clients 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 mail out notices, either postcards or letters, requesting that the individual or family representative come to the office for re-certification. A contractor may include a new application in the letter and ask the individual to return with documentation. If an actual interview is chosen, appointment times may be given to prevent long waiting periods.

For each record being renewed, whether in person or by mail, the eligibility provider staff shall complete a new DSHS HOUSEHOLD Eligibility Screening Form (Form EF05-14214) and HOUSEHOLD Eligibility Screening Form Worksheet (Form EF05-13227), Statement of Applicant's Rights and Responsibilities Form, if applicable, and in IBIS using updated information provided by the client. Sending a Notice of Eligibility is required to inform the individual/family of continued eligibility. Sending a Notice of Ineligibility is required to inform the individual/family of ineligibility. The contractor shall assist clients who request help in completing forms or providing documentation.

ASSESSMENT OF CO-PAY/CLIENT FEES

Title V MCH contractors may (but are not required to) assess a co-pay for services from TV MCH clients. Contractors must have a co-pay policy using the following guidelines:

● Co-pay may be assessed for Title V clients whose gross family income exceeds 100% and is below 185% FPL.
● Client co-pay shall not exceed 25% of the total Title V reimbursement amount for the visit.
● Clients who declare an inability to pay a co-pay shall not be denied services, have an account with an outstanding balance turned over to a collection agency, or reported delinquent to a credit reporting agency.
● Co-pay must be reported as program income on the Monthly Reimbursement Request (MRR) and fiscal reporting Form 270, if applicable, and in IBIS.
● Contractor must submit a policy whether they collect copay or not to DSHS, TitleV@dshs.state.tx.us for review and approval prior to implementation of the policy. Policy must be resubmitted for approval when changes are made prior to the revised policy being implemented.

OTHER FEES

Clients shall not be charged administrative fees for items such as processing and/or transfer of medical records, copies of immunization records, etc.

Contractors are allowed to bill clients for services outside the scope of Title V MCH allowable services, if the service is provided at the client's request, and the client is made aware of his/her responsibility for paying for the charges.

Continuation of Services - Contractors who have expended their awarded funds must continue to serve their existing Title V MCH eligible clients per the Title V MCH policy. It is allowable to obtain other funding to pay for these services as well as continue to charge a co-pay per policy. This funding should be recorded as program income for the Title V MCH contract.

Upon award expenditure, contractors are not required to screen new clients for Title V MCH eligibility; however, if screening is completed, the contractor is required to provide services to the Title V MCH eligible clients per Title V MCH policy. No Title V MCH client can be denied services for the inability to pay. For the unscreened clients it is allowable to make these clients self-pay and consider doing a sliding scale fee.

Integrated Business Information System (IBIS)

Before entering a client into the IBIS application system, contractors must determine whether the client has ever received services funded by Title V and has an existing IBIS number (a unique number assigned to each IBIS client that is used to record IBIS services provided) by doing a client search. This process can be completed by entering the last name, first name, date of birth, and social security number

Minimum PC Requirements for IBIS is a broadband connection capable of running the Internet Explorer web browser version 8.0 or higher.

CLINICAL INFORMED CONSENT

GENERAL INFORMED CONSENT

Contractors must obtain the client's written, informed, voluntary general consent to receive services prior to receiving any clinical services. A general informed consent explains the types of services provided and how client information may be shared with other entities for reimbursement or reporting purposes. If there is a period of time of three years or more during which a client does not receive services, a new general consent must be signed prior to reinitiating delivery of services.

All clients who are enrolled in Title V must sign a general informed consent that authorizes the contractor to enter or view protected health information and client data in the statewide database. If this statement is not included in the general consent, an additional consent must be developed for the client to sign and include with the general consent in the patient health record.

CLINICAL INFORMED CONSENT

Consent information must be effectively communicated to every client in a manner that is understandable by that client and allows her to participate and make sound decisions regarding her own medical care. Communication must be in compliance with Limited English Proficiency regulations and addressing any disabilities that impair communication. Only the client may consent. For situations when the client is legally unable to consent (i.e., a minor or an individual with development disability), a parent, legal guardian or caregiver must consent. Consent must never be obtained in a manner that could be perceived as coercive.

INFORMED CONSENT for DENTAL PROCEDURES

Written informed consent for dental procedures must be obtained in compliance with TAC, Title 22 Examining Boards, Part 5 State Board of Dental Examiners, Chapter 108 Professional Conduct, Subchapter A Professional Responsibility, Rule § 108.7 Minimum Standard of Care, General.

DSHS contractors should consult a qualified attorney to determine the appropriateness of the consent forms utilized by their health care agency.

PROCEDURE SPECIFIC INFORMED CONSENT

The contractor is responsible for assuring that informed consent is obtained from the patient for procedures as required by the Texas Medical Disclosure Panel. (See additional information and link below)

Texas Medical Disclosure Panel Consent

The Texas Medical Disclosure Panel (TMDP) was established by the Texas Legislature to determine which risks and hazards related to medical care and surgical procedures must be disclosed by health care providers or physicians to their patients or persons authorized to consent for their patients, and to establish the general form and substance of such disclosure. TMDP has developed a List A (informed consent requiring full and specific disclosure) for certain procedures. More information about the TMDP can be found at: http://www.dshs.state.tx.us/hfp/tmdp.shtm.

List A procedures can be found at the following Texas Administrative Code link: http://texreg.sos.state.tx.us/public/readtac$ext.TacPage?sl=R&app=9&p_dir=&p_rloc=&p_tloc=&p_ploc=&pg=1&p_tac=&ti=25&pt=7&ch=601&rl=2

PARENTAL CONSENT FOR SERVICES TO MINORS

The general rule is that parents must consent for minors (Family Code § 151.001). A minor is defined as a person under 18 years of age who has never been married. However there are certain circumstances under which a minor may consent for her/his own treatment. Requirements for parental consent for provision of family planning services to minors vary according to the funding source subsidizing the services The department and providers may provide family planning services, including prescription drugs, without the consent of the minor's parent, managing conservator, or guardian only as authorized by Chapter 32 of the Texas Family Code or by federal law or regulations.

There are instances in which a minor may consent to his/her own medical, dental, psychological and surgical treatment by a licensed physician or dentist if the minor

- is on active duty with the armed services:
- is at least 16 years old, living apart from a parent or guardian and managing his or her own financial affairs. You do not have to prove the child is emancipated if the minor so declares in writing.
- is consenting to diagnosis and treatment of an infectious, contagious, or communicable disease required to be reported to the local health officer or the Department of State Health Services.
- consents to examination and treatment for drug or chemical addiction, dependency or any other condition directly related to drug or chemical use

- is unmarried and pregnant and seeking treatment related to the pregnancy, unless it's an abortion
- has custody of his/her biological child and also consents to the child's medical, dental, psychological or surgical treatment of the child
- is seeking a diagnosis or treatment for a sexually transmitted disease, including HIV
- is seeking counseling for chemical dependency or addiction, suicide prevention or sexual, physical or emotional abuse

The Texas Family Code, Chapter 32, may be found at the following website: http://www.statutes.legis.state.tx.us/?link=FA.

CONSENT FOR HIV TESTS

Texas Health and Safety Code §81.105 and §81.106:

§ 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.

§ 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.

Texas Health and Safety Code may be found at the following website: http://www.statutes.legis.state.tx.us/?link=HS

PRENATAL CLINICAL GUIDELINES

Prenatal and postpartum services should be provided based on guidelines of The American College of Obstetricians and Gynecologist (ACOG).

COMPONENTS OF INITIAL PRENATAL INTERVENTIONS/SCREENING

COVERED SERVICES

Title V contractors may:

- Bill Title V for allowable services provided in clinical prenatal care visits for women during the CHIP Perinatal Program enrollment process for up to 60 days.
- In addition, contractors which have been approved to provide CPW Case Management may bill Title V for one comprehensive visit (CPT Code G9012-U5) and one follow-up visit which can be either face-to-face (CPT Code G9012-U5-TS) or by telephone (CPT Code G9012-TS (TH). See Section II, Chapter 6

Initial Prenatal Visit – The initial encounter with a pregnant patient includes: complete history, physical examination, assessment, planning, treatment, counseling and education, referral as indicated, and routine prenatal labs and additional lab as indicated by history, physical exam and/or assessment.

The above components included in the initial visit may only be billed once, even if the components are provided at separate visits.

Standard prenatal laboratory services may be submitted to laboratory(ies) of provider's choice.

COMPONENTS OF RETURN ANTEPARTUM INTERVENTIONS/SCREENING

Return Prenatal/Antepartum Visit –– Follow up prenatal visit includes interval **history,** physical examination, risk assessment, medical services, nutritional counseling, psychosocial counseling, family planning counseling, and patient education about maternal and child health topics. Hemoglobin and/or hematocrit as indicated and urinalysis for protein and glucose each visit.

There are no limitations on the number of allowable services reimbursed as long as they are clinically indicated. It is allowable to bill Title V services up to 60 days if it is clinically indicated and client is in the CHIP Perinatal application process.

Multivitamins with folic acid is recommended, however, it is not billable to Title V.

Cystic Fibrosis – Screening for cystic fibrosis is a complex process. Although there is a frequent common mutation, there are a large number of mutations identified in the cystic fibrosis transmembrane conductance regulator (CFTR) gene whose frequency varies between ethnic backgrounds. There is also variability of clinical expression of some of these mutations. In addition, counseling patients about testing involves complex concepts of risk and genetics, made more complex by the racial diversity of the Texas population. For example, risk of carrier status varies markedly by race and has not yet been identified in populations with mixed race. Although Texas now screens newborns for cystic fibrosis in the newborn screening program, preconception and prenatal carrier screening should still be offered to all woman of child bearing age.

Cystic Fibrosis carrier screening is not available through Title V Fee for Service Genetic providers nor billable to Title V.

COMPONENTS OF POSTPARTUM INTERVENTIONS/SCREENING

Postpartum Visit – Two postpartum visits per patient per pregnancy are reimbursable and include interval history, physical examination, assessment, family planning, counseling and education, and referral as indicated.

PATIENT HEALTH RECORD (MEDICAL RECORD)

(Please note that the Patient Health Medical Record information applies to Child Health as well.)

Contractors must ensure that a patient health record (medical record) is established for every client who obtains clinical services. These records must be maintained according to accepted medical standards and in compliance with applicable federal and state laws, including those governing record retention.

All patient health records must be:

- Complete, legible, and accurate, documenting all clinical encounters, including those by telephone, email or text message;
- Written in ink without erasures or deletions; or documented by electronic medical record (EMR)/ electronic health record (EHR);
  - Scanned original signed DSHS HOUSEHOLD Eligibility Screening Form is allowable.
- Signed by the provider making the entry, including that individual's name, title and credentials, and date for each entry;
  - Electronic signatures are allowable to document provider review of care. However, stamped signatures are **not** allowable.

- Readily accessible to appropriate clinic staff and health care providers to assure continuity of care and availability to clients;
- 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 Health Insurance Portability and Accountability Act of 1996 (HIPAA) regulations); and
- Secured by lock when not in use.

The patient health record must include:

- Client identification and personal data
- Completed DSHS HOUSEHOLD Eligibility Screening For and HOUSEHOLD Eligibility Screening Form Worksheet or comparable form/tool
- Completed Statement of Applicant's Rights and Responsibilities signed by the client or responsible party
- Copies of acceptable documentation establishing income, residency, and family composition
- Copy of Medicaid and/or CHIP denial letter, if applicable
- Preferred language/method of communication
- Patient contact information with the best way to reach patient in such a manner that facilitates continuity of care, assures confidentiality, and adheres to HIPAA* regulations
- Medical history, (in Medical History and Risk Assessment
- Physical examination (in Physical Assessment)
- Laboratory and other diagnostic tests orders, results and follow-up
- Assessment or clinical impression
- Plan of care, including education/counseling, treatment, special instructions, scheduled revisits and referrals
- Documentation regarding follow-up of missed appointments
- Informed consent documentation
- Refusal of services documentation – when applicable
- Medication and other allergic reactions recorded prominently in specific location
- Problem list
- Client education

MEDICAL HISTORY AND RISK ASSESSMENT

At the initial comprehensive clinical visit, a complete medical history must be documented on all patients. Any pertinent history must be updated at each subsequent clinical visit.

Initial Prenatal Visit

The comprehensive medical history documented at the initial prenatal visit must at least address the following:

- Current health status, including symptoms of pregnancy, acute and chronic medical conditions
- Significant past illness, 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 medications (CAM)
- Allergies, sensitivities or reactions to medicines or other substance(s) (i.e., latex)
- Immunization status/assessment, including Rubella status
- Mental Health Assessment (current/past mental health conditions)
- Pertinent history of immediate family, including genetic conditions
- Pertinent partner history, (including injectable drug use, number of partners, STI and HIV history and risk factors, gender of sexual partners)
- Reproductive health history must include:
  - Menstrual history, including last normal menstrual period
  - Sexual behavior history, including family planning practices (i.e., contraceptive use-past and current), number of partners, gender of sexual partners, and sexual abuse, as indicated
  - Detailed obstetrical history
  - Gynecological and urologic conditions
  - STIs, (including hepatitis B and C) and HIV risks and exposure
  - Cervical cancer screening history (date and results of last Pap test or other cervical cancer screening test, note of any abnormal results and treatment)
- Social History/Health Risk Assessment:
  - Home environment, to include living arrangements
  - Family dynamics with assessment for family violence (including safety assessment, when indicated)**(Mandated by Texas Family Code, Chapter 261 and Rider 19);**
  - Human Trafficking
  - Tobacco/alcohol/medications/recreational drug use/abuse and/or exposure; drug dependency (including type, duration, frequency, route);
  - Nutritional history
  - Occupational hazards or environmental toxin exposure
  - Ability to perform activities of daily living (AADL)
  - Risk assessment including but not limited to:
    - Diabetes
    - Heart disease
    - Intimate Partner Violence
    - Injury

- Malignancy

Review of systems with pertinent positives and negatives documented in health record

Return Prenatal visits:

- Interval history, includes:
  - symptoms of infections
  - symptoms of preterm labor
  - headaches or visual changes
  - fetal movement (>18 weeks)
  - family violence screening (>28 weeks)
  - Intimate Partner Violence assessment at least once each trimester

Postpartum Visits

- Interval history, includes:
  - labor and delivery history, noting maternal and neonatal complications
  - infant bonding
  - breast feeding/infant feeding issues
  - symptoms of infections
  - symptoms of excessive/abnormal vaginal bleeding
  - assessment for postpartum depression
  - Intimate Partner Violence assessment
  - Family planning/contraception (current method and/or future plans)

PHYSICAL ASSESSMENT

All initial and routine prenatal visits must include an appropriate physical exam according to the purpose of visit and week of gestation. For any portion of the examination that is deferred, the reason(s) for deferral must be documented in the patient health record.

Initial Prenatal Visit

- Height measurement
- Weight measurement, with documentation of pre-pregnancy weight and assessment for underweight, overweight and/obesity
- Blood pressure evaluation
- Cardiovascular assessment
- Clinical breast exam
- Visual inspection of external genitalia and rectum
- Pelvic exam, including estimate of uterine size (by bimanual exam for gestational age less than or equal to 14 weeks or by fundal height for gestational age equal to or more than 14 weeks)
- Fetal heart rate for gestational age > 12 weeks

- Other systems as indicated by history and health risk assessment (e.g., evaluation of thyroid, lungs, abdomen).

Return Prenatal Visits:
- Weight measurement
- Blood pressure evaluation
- Uterine size/Fundal height
- Fetal heart rate (> 12 weeks)
- Fetal lie/position (> 30 weeks)
- Other systems as indicated by history or other findings

Postpartum Visits:
- Weight
- Blood pressure evaluation
- Breast/axillae
- Abdomen
- Pelvic exam, including uterine size
- Systems as indicated by history/risk profile/other findings

LABORATORY AND OTHER DIAGNOSTIC TESTS

All initial and return prenatal visits must include appropriate laboratory and diagnostic tests as indicated by weeks of gestation and clinical assessment. Contractors must have written plans to address laboratory and other diagnostic test orders, results and follow-up to include:
- Tracking and documentation of tests ordered and performed for each patient
- Tracking of test results and documentation in patient records
- Mechanism to address abnormal results, facilitate continuity of care and assure confidentiality, adhering to HIPAA regulations (i.e., making results and interventions accessible to the delivering hospital, facility or provider).

Initial Prenatal Visit Laboratory and Diagnostic Tests
- Blood type, Rh and antibody screen
- Sexually transmitted infection testing as indicated by risk assessment, history, and physical exam, and the following:
  - Chlamydia
  - Gonorrhea when indicated
  - Hepatitis B Antigen (HbsAg) **(Mandated by Health and Safety Code 81.090)**
  - HIV, unless declined by patient, who must then be referred to anonymous testing **(Mandated by Health and Safety Code 81.090)**
    - CDC's revised recommendations for HIV testing for adults, adolescents, and pregnant women in health care settings can be

found at:
http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5514a1.htm

- Syphilis serology **(Mandated by Health and Safety Code 81.090)**

- Hemoglobin and/or hematocrit
- Rubella serology, or immunization documented in chart
- Cervical cancer screening test (e.g., Pap test)

ACOG/ACS/ASCCP/ASCP Cervical Cancer Screening Guidelines:

- Cervical cancer screening begins at age 21 years;
- Cervical cytology (Pap smear) alone screening every three (3) years for women between the ages of 21 and 29 years;
- Cervical cytology (Pap smear) alone every three (3) years **or c**ervical cytology and HPV co-testing every five (5) years for women between the ages of 30 and 65 years.
- Continue screening women who had a hysterectomy for CIN disease for 20 years, even if this extends screening past age 65 years
- Continue screening women who have had cervical cancer indefinitely as long as they are in reasonable health
- Both liquid-based and conventional methods of cervical cytology are acceptable for screening.

Women with special circumstances, who are considered high-risk (e.g. HIV+, immunosuppressed or were exposed to Diethylstilbestrol (DES) in utero) may be screened annually or more frequently as determined by the clinician.

Clients already following a plan of care/algorithm may continue with that plan of care/algorithm until completed and they return to routine screening. Once the client returns to routine screening follow the guidelines above.

- Hemoglobinopathy screening, as indicated
- Urine screen or culture
- TB skin test as indicated by risk assessment, history, or physical exam (see algorithm for pregnant patients at: http://www.heartlandntbc.org/assets/products/evaluation_of_pregnant_patient_at_risk_for_tb.pdf .
- Ultrasound, only as clinically indicated
- Other laboratory and diagnostic as indicated by risk assessment, history and physical exam

Return Prenatal Visits Laboratory and Diagnostic Tests

- Quadruple testing for antenatal screening offered to patients presenting between 15 – 20 weeks
    - Alpha-Fetoprotein Test (AFP)
    - Human Chorionic Gonadotropin (hCG)

    - Estriol (uE3)
    - Inhibin-A
- Prenatal fetal screening/diagnosis should be discussed and offered to all pregnant patients onsite or by referral
- Diabetes screen (24 – 28 weeks)
- Glucose Tolerance test (GTT) for abnormal diabetic screen
- Antibody screen for RH negative patients, not previously known to be sensitized, between 24 – 28 weeks (to assess need for Anti-D immune globulin to be given at ~ 28 weeks)
- Hemoglobin and/or hematocrit (recommended recheck between 32 – 36 weeks)
- Group B Streptococcus screen, between 35 – 37 weeks if using "screened-base approach (see the Centers for Disease Control and Prevention (CDC) revised 2002 recommendations to prevent perinatal transmission of Group B Streptococcus (GBS) infection to the neonate on the CDC web site at *http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5111a1.htm*.)
- Women at high risk for HIV, including injection drug users and women with multiple sex partners during their pregnancy, should be tested again in their third trimester. (American College of Obstetricians and Gynecologists [ACOG])
- Ultrasound, only as clinically indicated
- Non-Stress Test (NST) to assess fetal well-being, as clinically indicated
- Biophysical Profile (BPP)/Fetal Biophysical Profile (FBPP) to assess fetal well-being, as clinically indicated
- Other laboratory and diagnostic as indicated by risk assessment, history and physical exam

Postpartum Visits Laboratory and Diagnostic Tests

- Lab as indicated by history, risk assessment and physical exam
    - Hemoglobin and/or hematocrit (if indicated)
    - Rubella serology or immunization if not previously documented in the patient health record.

DIAGNOSTIC TESTS AND INTERVENTION

Ultrasounds

Obstetrical ultrasounds will be reimbursed when clinically indicated, such as:

- estimation of gestational age for women with uncertain clinical dates, or verification of dates for women who had a previous cesarean delivery
- vaginal bleeding of undetermined origin
- suspected multiple gestation
- significant uterine size/clinical dates discrepancy

- pelvic mass
- suspected ectopic pregnancy
- suspected fetal death
- suspected uterine abnormality
- intrauterine contraceptive device localization
- abnormal alpha-fetoprotein value
- follow-up observation of identified fetal anomaly
- follow-up evaluation of placental location for identified placenta previa
- history of previous congenital anomaly
- serial evaluation of fetal growth in multifetal gestation
- evaluation of fetal condition in late registrants for prenatal care

Complete ultrasound – A complete evaluation of the pregnant uterus, to include fetal number, viability, presentation, dating measurements, complete anatomical survey; placental localization characterizations, and amniotic fluid assessment.

Complete ultrasound for confirmed multiple gestation – A complete evaluation of the pregnant uterus that includes viability, presentation, dating measurements, complete anatomical survey, placental localization characterizations, and amniotic fluid assessment.

Follow-up or limited ultrasound – A brief, more limited evaluation of the pregnant uterus that may follow a previous complete exam, be it an initial exam prior to 12 weeks, or be it an initial exam 12 weeks which is limited in scope. Includes fetal number, viability, presentation, dating measurements, limited anatomic assessment; placental localization and characterization; and amniotic fluid assessment.

Repeat D-antibody Test – For all unsensitized D-negative women at 24-28 weeks of gestation followed by the administration of a full dose of D immunoglobulin if they are antibody negative, unless the father is known to be D-negative.

Special Procedures

Non-Stress Test (NST) fetal well-being assessment to be performed in the presence of identified risk factors, as indicated, once a viable gestational age has been reached. ***May be billed as often as the provider deems the procedure to be medially necessary.***

Biophysical Profile (BPP)/Fetal Biophysical Profile (FBPP)– fetal well-being assessment to be performed in the presence of identified risk factors, as

indicated, once a viable gestational age has been reached. May be billed as often as the provider deems the procedure to be medically necessary.

EDUCATION AND COUNSELING SERVICES

Contractors must have written plans for **patient education** that ensure consistency and accuracy of information provided, and that identify mechanisms used to ensure patient understanding of the information.

Patient education and counseling must be:

- Documented in the patient health record
- Appropriate to patient's age, level of knowledge and socio-cultural background
- Presented in an unbiased manner

Patient education and counseling during the initial prenatal visit, based on health history, risk assessment and physical exam, must cover the following:

- Nutrition and weight gain counseling
- Intimate Partner Violence/abuse
- Human Trafficking
- Physical activity and exercise
- Sexual activity
- Environmental or work hazards
- Travel
- Tobacco cessation
- Alcohol use
- Substance abuse
- Breastfeeding
- When and where to obtain emergency care
- Risk factors identified during visit
- Anticipated course of prenatal care
- HIV and other prenatal test
- Injury prevention, including seat belt use
- Cocooning infants/children against pertussis (immunization of family members and potential caregivers of infant)
- Toxoplasmosis precautions
- Referral to WIC
- Use of medications (including prescription, over the counter (OTC), and complementary/alternative medicines (CAM)

- Information on parenting and postpartum counseling **(Mandated by Chapter 161, Health and Safety Code, Subchapter T)**
- Other education and counseling as indicated by risk assessment, history and physical exam

Patient education and counseling during the return prenatal visits, should be appropriate to weeks gestation and be based on health history, risk assessment and physical exam, including, but not limited to:

- Signs and symptoms of preterm labor beginning in 2nd trimester
- Warning signs and symptoms of pregnancy induced hypertension (PIH)
- Selecting provider for infant
- Postpartum family planning

Tobacco Assessment and Quit Line Referral - All women receiving prenatal services should be assessed for tobacco use. Women who use tobacco should be referred to tobacco quit lines. The Texas American Cancer Society Quit Line is 1-877-YES-QUIT or 1-866-228-4327 (Hearing Impaired). The assessment and referral should be performed by agency staff and documented in the clinical record.

Nutrition Counseling – Conducted by a licensed dietitian, comprehensive nutritional assessment and counseling for patients with a high risk condition, e.g., gestational diabetes, inappropriate weight gain, hyperemesis. *Nutritional counseling by a licensed dietitian is not billable by Title V. Refer to WIC for nutritional counseling.*

Information for Parents of Newborns Requirement: Chapter 161, Health and Safety Code, Subchapter T requires hospitals, birthing centers, physicians, nurse-midwives, and midwives who provide prenatal care to pregnant women during gestation or at delivery to provide the woman and the father of the infant or other adult caregiver for the infant with a resource pamphlet that includes information on postpartum depression, shaken baby syndrome, immunizations, newborn screening, pertussis and sudden infant death syndrome. In addition, it must be documented in the patient's chart that she received this information and the documentation must be retained for a minimum of five years. It is recommended that the information be given twice, once at the first prenatal visit and again after delivery.

Relevant Literature/Inventory Number: *Information for Parents of Newborns 1-316 (Spanish 1-316A)*
For more information, http://www.dshs.state.tx.us/mch/Parents_of_newborn.shtm

Information for Parents of Children: Chapter 161, Health and Safety Code, Subchapter T also requires hospitals, birthing centers, physicians, nurse-midwives, and midwives who provide prenatal care during gestation or at delivery to pregnant women on Medicaid to provide the woman and the father of the infant or other adult caregiver for the infant with a resource guide that includes information relating to the development, health, and safety of a child from birth until age five. The resource guide must provide information about medical home, dental care, effective parenting, child safety, importance of reading to a child, expected developmental milestones, health care, selecting appropriate child care and other resources available in the state.

Relevant Literature/Inventory Number: A Parent's Guide to Raising Healthy, Happy Children. – available through Texans Care for Children, www.texanscareforchildren.org

Provision of Information about Umbilical Cord Blood Donation
Requirement: Chapter 162, Health and Safety Code, Subtitle H requires that a physician or other person permitted by law to attend a pregnant woman during gestation or at delivery of an infant shall provide the woman with an informational brochure, before the third trimester of the woman's pregnancy or as soon as reasonably feasible, that includes information about the uses, risks and benefits of cord blood stem cells for a potential recipient, options for future use or storage of cord blood, the medical process used to collect cord blood, any costs that may be incurred by a pregnant woman who chooses to donate or store cord blood after delivery, and average cost of public and private storage**.** The brochure is available on the DSHS website or can be ordered from the DSHS literature warehouse.

Relevant Literature/Inventory Number: *Information on Umbilical Cord Blood Banking and Donation Stock #6-73 (Spanish 6-73A)*
For more information, see: http://www.dshs.state.tx.us/mch/#Umbilical

All documents(unless otherwise noted) may be ordered or downloaded from our web site Literature Ordering Link and Online Catalog at: http://hhsc.pinnaclecart.com/. For questions related to *Information for Parents of Newborns* or A Parent's Guide to Raising Healthy, Happy Children, call 512-776-7373 or email titlev@dshs.state.tx.us.

For questions related to *Information on Umbilical Cord Blood Donation,* call 512-776-7373 or email titlev@dshs.state.tx.us.

Someday Starts Now - Someday Starts now offers tools that healthcare providers can use to help their patients make healthy decisions today so they can be ready for a baby in the future. Providers can download Birth Plan and Life Plan templates, patient worksheets and more. There are videos that highlight the

important messages providers can pass on, discuss or share in their waiting rooms. The tools are located at https://www.somedaystartsnow.com

There are a number of other available tools that are available at no charge the agency can have on hand to hand out during visits. Check out the helpful tools and order at http://hhsc.pinnaclecart.com/healthy-texas-babies/

Patient education and counseling during postpartum visits should include but not be limited to:

- Physiologic changes
- Signs and symptoms of common complications
- Care of the breast,
- Care of perineum and abdominal incision, if indicated
- Physical activity and exercise
- Breastfeeding/Infant feeding
- Resumption of sexual activity
- Family planning/contraception
- Preconception counseling
- Depression/post partum depression

REFERRAL AND FOLLOW-UP

Agencies 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 patients' 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 which are beyond the scope of the agency, patients must be referred to other providers for care. (Whenever possible, patients should be given a choice of providers from which to select.) When a patient is referred to another provider or for emergency clinical care, the agency must:

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

INFANT/CHILD/ADOLESCENT HEALTH CLINICAL GUIDELINES

WELL CHILD/ADOLESCENT

Title V contractors are expected to provide infant/child/adolescent health services based on recommendations of the American Academy of Pediatrics (AAP), in accordance with the current periodicity schedule of Texas Health Steps, and as indicated by the health and social history, risk assessments, and/or physical exams. For further information please review the Texas Health Steps periodicity schedule at http://www.dshs.state.tx.us/thsteps/providers.shtm.

Components of a Well Child/Adolescent Visit

Well Child/Adolescent Visit – A preventive encounter includes a comprehensive health history, comprehensive unclothed physical examination to include length/height, weight, fronto-occipital head circumference (age 2 years and younger), BMI (age 2 years and older), blood pressure (age 3 years and older), oral health screening, developmental screening, mental health screening, nutritional screening, TB screening, sensory screening for vision and hearing, counseling/education, age appropriate anticipatory guidance, age appropriate immunizations, age and risk appropriate laboratory tests and referrals as indicated.

Children ages 6 months through 35 months may receive intermediate oral evaluation with fluoride varnish application using CPT code 99429-U5. Preventive services provided include:

- Intermediate oral evaluation include:
  - Inspection of teeth for signs of early childhood caries, and other caries
  - Inspection for bleeding, swelling, or infection, and indications of lack of cleaning of the mouth
  - Inspection of the oral soft tissues for any abnormalities by a physician, advanced practice registered nurse, or Physician Assistant. All other components may be delegated.
- Fluoride varnish application
- Anticipatory dental guidance to include:
  - The need for thorough daily oral hygiene practices
  - Education in potential gingival manifestations for patients with diabetes and patients under long-term medication therapy
  - Diet, nutrition and food choices
  - Fluoride needs
  - Injury prevention
  - Antimicrobials, medications, and oral health
- Referral to a dental home

If the child has no erupted teeth, additional dental anticipatory guidance is expected.

The intermediate oral evaluation with fluoride varnish application must be billed on the same date of services as a medical checkup visit by the same provider and is limited to 6 services per lifetime by any provider. CPT code 99429-U5 must be billed with one of the following medical checkup codes: 99381, 99382, 99391, or 99392.

Providers (physicians, physician assistants, and advanced practice registered nurses) must complete the Oral Evaluation and Fluoride Varnish component in the Medical Home training and be certified by DSHS Oral Health Program to be reimbursed for CPT code 99429-U5.

Laboratory screening/testing is required per the Texas Health Steps periodicity schedule. Title V providers will continue to submit only the Newborn Hereditary/Metabolic Testing (NBS) to the Austin DSHS Laboratory. All other specimens will be submitted to laboratory of provider's choice.

PATIENT HEALTH RECORD (MEDICAL RECORD)

For Patient Health Medical Record, please see Chapter 3, for medical record guidelines.

Contractors must ensure that a patient health record (medical record) is established for every client who obtains child health services (infant, child, and adolescent care). These records must be maintained according to accepted medical standards and State laws, including those governing record retention. The website for the Medical checkup forms (birth to 20 years), Tuberculosis screening questionnaires, and Lead poisoning screening questionnaires, is as follows: http://www.dshs.state.tx.us/thsteps/forms.shtm.

MEDICAL HISTORY AND RISK ASSESSMENT

At the initial well-child/adolescent clinical visit, a comprehensive health history must be documented on all patients. Any pertinent history must be updated at each subsequent well child/adolescent visit.

Initial Well Child/Adolescent Visit – The comprehensive health history documented at the initial well child/adolescent visit must at least address the following:

- Reason for visit

- Current health status, including family medical history, neonatal history for 5 years and younger, physical and mental health history, developmental history, immunization history, and nutrition/feeding history
- Significant past illness, including hospitalizations
- Previous surgery and biopsies
- Blood transfusions and other exposure to blood products
- Current medications, including prescriptions, over the counter (OTC) as well as complementary and alternative medicines (CAM)
- Allergies, sensitivities or reactions to medicines or other substance(s) (i.g., latex)
- Exposure or use of tobacco/alcohol/illicit drugs (including type, duration, frequency and route)
- Immunization status
  - Title V MCH contractors are recommended to become a Texas Vaccines for Children (TVFC) provider.
  - TVFC improves vaccine availability by providing vaccines free of charge to eligible children through public and private providers statewide.
  - Additional information on provider enrollment can be found at http://www.dshs.state.tx.us/immunize/tvfc/default.shtm
  - or by calling 1-800-252-9152.
- Review of systems (with pertinent positives and negatives clearly noted)
- Assessment for family violence (including a safety assessment when indicated) **(Mandated by Texas Family Code, Chapter 261 and Rider 19)**
- Reproductive health history when appropriate must include:
  - Secondary sex characteristics
  - Menstrual history, including last normal menstrual period
  - Sexual behavior history, including family planning practices (i.e., contraceptive use-past and current), number of partners, gender of sexual partner, and sexual abuse
  - Gynecological and urologic conditions
  - STDs and HIV risks and exposure
  - Cervical cancer screening should begin at 21 years of age

Return Well Child/Adolescent Visits – Interval history, including:

- Reason for visit
- Any changes in self/family medical history
- Any changes in physical and mental health history
- Any changes in review of systems
- Hospitalizations
- Any surgeries

PHYSICAL ASSESSMENT

All initial and routine well child/adolescent visits must include an appropriate unclothed physical exam according to the purpose of visit. For any portion of the examination that is deferred, the reason(s) for deferral must be documented in the patient health record.

Initial/Return Well Child/Adolescent Visit

- Length/height measurement
- Weight measurement
- Fronto-occipital head circumference 2 years of age and under
- BMI ages 2 through 20
- Blood pressure evaluation ages 3 and older
- General head-to-toe exam
- Oral health assessment and dental referral beginning at 6 months of age (or earlier if childhood caries are identified) and every 6 months thereafter until it has been confirmed that a dental home has been established.
    - Intermediate oral evaluation with fluoride varnish application may be provided to children ages 6 months through 35 months if providers have completed the Oral Evaluation and Fluoride Varnish component in the Medical Home training and been certified by DSHS Oral Health Program
- Developmental screening using a standardized tool at specific ages and developmental surveillance at other checkups birth through 6 years of age
    - Standardized assessment tools that are required by Texas Health Steps and Title V effective September 1, 2011 are:
        - Ages and Stages Questionnaire (ASQ) – 9, 18, and 24 months, 3 years, and 4 years or
        - Ages and Stages Questionnaire Social-Emotional (ASQ:SE) at ages 3 and 4 years, or
        - Parents' Evaluation of Developmental Status (PEDS) – 9,18,24 months, 3 years, and 4 years
        - Modified Checklist for Autism in Toddlers (M-CHAT) – 18 months and 24 months (M-CHAT RF form is allowable in place of the M-CHAT form)
- Mental health screening
- Nutritional screening
    - Nutritional screening or counseling by licensed dietitian is completed for children with a high-risk condition, such as but not limited to, failure-to-thrive < 2yrs of age, feeding delays, short stature, chronic anemia due to a disease process, and for children 3 years of age and older with an abnormal Body Mass Index (BMI). Nutritional screening must be performed at every visit.

- Risk screening (including family violence, lead, TB, adolescent lifestyle)

- Sensory Screening: Documented results in the prior 12 months are acceptable
- Vision screening (vision acuity) at 3-6 years, 8, 10, 12, 15, and 18 years of age.
  - Hearing screening (audiometric screening) at Birth, 4-6 years, 8, 10 and 15 years of age
- Age appropriate immunizations
  - Immunization schedule is found at http://www.dshs.state.tx.us/immunize/Schedule/schedule_child.shtm
- Age appropriate laboratory tests to include:
  - Newborn Hereditary Metabolic testing (Newborn Screening)
  - Anemia
  - Lead
  - Risk based tests for STD, HIV, Hyperlipidemia, Type 2 diabetes

Follow-Up Visit – To compete necessary procedures related to the Well Child check-up (e.g., reading of TST (Tuberculin skin test), administering immunizations if not provided at the initial visit, repeating lab work).

LABORATORY AND OTHER DIAGNOSTIC TESTS

All initial and return well child/adolescent visits must include appropriate laboratory and diagnostic tests in accordance with the current periodicity schedule of Texas Health Steps and clinical assessment. Contractors must have written plans to address laboratory and other diagnostic test orders, results and follow-up to include:

- Tracking and documentation of tests ordered and performed for each patient
- Tracking of test results and documentation in patients records
- Mechanism to address abnormal results, facilitate continuity of care and assure confidentiality, adhering to HIPAA regulations.

Documented laboratory results within the prior month are acceptable for use for children 2 and younger and up to 90 days for those 3 years and older.

Laboratory and Diagnostic Tests for Well Child/Adolescent Visit:

- Newborn Screening Testing (NBS) up to 12 months of age (child may be older than 12 months if in foster care/adopted and no previous newborn screen can be located).
  - All Texas newborns get two blood spot tests that screen for 29 rare congenital disorders, and two point-of-service screenings for hearing and critical congenital heart

disease. Combined, these are identified as "core" conditions
- In mid-2015, DSHS began blood spot testing for 24 "secondary" conditions
- A listing of disorders screened for, frequently asked questions and more information on newborn screening can be found at www.dshs.state.tx.us/newborn/default.shtm

- Hemoglobin and/or hematocrit
- Urinalysis as indicated
- Lead blood testing at 12 and 24 months and up to 6 years of age if not previously tested.
  - Screening and testing guidelines at http://www.dshs.state.tx.us/lead
- Hepatitis C testing for newborns born to mothers with Hepatitis C
- Cholesterol screening is risked based beginning at 24 months but no later than age 10
- Dyslipidemia screening:
  - Once between 9 - 11 years and again once between 18 - 20 years of age regardless of risk
  - Risk based for 2-20 years
- Sexually transmitted disease testing as indicated by risk assessment, history, and physical exam, and the following:
  - Chlamydia and gonorrhea testing should be done on all sexually active females age 25 or younger, even if symptoms are not present
  - Hepatitis B Antigen (HbsAg)
  - HIV testing:
    - Required once between ages 16 and 18,
    - Indicated by risk assessment, history, and physical exam for all other ages.
  - Syphilis serology

  Cervical cancer screening should begin at age 21 years.
  - Both liquid-based and conventional methods of cervical cytology are acceptable of screening

Tuberculin Skin Test (TST) - Administer the TB Questionnaire beginning at 12 months of age and thereafter annually at other checkups. The TB Questionnaire can be located at http://www.dshs.state.tx.us/thsteps/forms.shtm. A newly positive response to one of the questions about risk would indicate the administration of a tuberculin skin test. Refer to "Standing Delegation Orders and Procedures for TB Skin Testing" at www.dshs.state.tx.us/idcu/disease/tb/policies/ for guidance on the administration and interpretation of a tuberculin skin test.

Other laboratory and diagnostic as indicated by risk assessment, history, and physical exam.

EDUCATION AND COUNSELING SERVICES

Contractors must have written plans for **patient education** that ensures consistency and accuracy of information provided, and that identify mechanisms used to ensure that patient/care taker understanding of the information. Patient education must be face to face. Use of the information included in the Bright Futures literature is preferred. This may be found at http://brightfutures.aap.org/

Patient education and counseling must be:

- Documented in the patient record
- Appropriate to patient's age and at the parent/guardian level of knowledge and socio-cultural background
- Presented in an unbiased manner

Patient education and counseling during the initial/return well child/adolescent visit, based on health history, risk assessment and physical exam, must cover the following:

- Age appropriate anticipatory guidance including injury prevention, behavior, health promotion, and nutrition
- Child development
- Immunizations
- When and where to obtain emergency care
- Risk factors identified during visit
- Referral to WIC
- Information on parenting and postpartum counseling **(Mandated by Chapter 161, Healthy and Safety Code, Subchapter R)**
- Other education and counseling as indicated by risk assessment, history and physical exam

REFERRAL AND FOLLOW-UP

Agencies must have written policies and procedures for follow-up with referring providers and agencies. These policies must be sensitive to patient, parent and/or guardian 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 which are beyond the scope of the agency, patient, parent, and/or guardian must be referred to other providers for care. Whenever, possible, patient, parent, and/or guardian should be given a choice of providers from which to select. When a patient is referred to another provider or for emergency clinical care, the agency must:

- Make arrangements for the provision of pertinent patient information to the referral provider (obtaining required patient consent with appropriate safeguards to ensure confidentiality – i.e., adhering to HIPAA regulations);
- Advise patient, parent, and/or guardian about his/her responsibility in complying with the referral; and
- Counsel patient, parent and/or guardian of the importance of the referral and follow-up method.
- Assure the information from the referral source is obtained and included in the patient's medical record at the PCP office.

SICK CHILDREN

Title V emphasizes prevention, therefore well child visits are a priority. It is important, however to establish a medical home and thus, provide comprehensive health care when needed. Therefore, provisions have been made to assist with minor acute episodes of illness.

DSHS requires that all children receiving services must be current on well child/preventive health care according to the current Texas Health Steps periodicity schedule. The contractor is encouraged to have a system in place that emphasizes an appointment system with reminder for periodic, follow-up, and lapsed appointments.

Contractors needing additional funds for sick child care should explore other resources. This is especially true in the area of providing care for chronic health problems.

Sick Child Visit – An encounter that occurs for the purpose of diagnosing and treating or managing a medical or developmental problem. Other sources of funding should be used to provide medications for the treatment of acute and minor illness at little or no cost to the patient. Sick child visit includes problem-oriented history, physical exam and lab tests as indicated by condition.

CHILD/ADOLESCENT DENTAL SERVICES

Dental services are provided to children from birth through 21 years of age. These include diagnostic services including comprehensive and periodic oral evaluations and radiographs; preventive services including fluoride treatment and placement of dental sealants to any tooth at risk of dental decay; and therapeutic services including restorative treatment.

Children ages 6 through 35 months may receive preventive dental services through the First Dental Home program (FDH). FDH (CDT code D0145) visits include a comprehensive oral evaluation, caries risk assessment, toothbrush prophylaxis, fluoride varnish application, oral hygiene instructions and anticipatory guidance with the parent or guardian. The child may be seen as frequently as every 3 months dependent upon the caries risk assessment. There is a limit of 10 FDH visits per child's lifetime. Dentists must be trained either online or in person and certified by the Department of State Health Services Oral Health Program in order to bill D0145 and be reimbursed. Information on First Dental Home training can be found at:
http://www.dshs.state.tx.us/dental/firstdentalhomeTraining.shtm.
The First Dental Home online provider training education module can be found at: http://www.txhealthsteps.com/cms/

Providers are encouraged to periodically go back and retake the online module to ensure they have the most up to date information.

Limited restorative treatment can be provided. These procedures must be documented as medically necessary and appropriate.
For children under 6 months of age, medically necessary dental services may be provided due to oral trauma and/or early childhood caries.

CLIENT HEALTH RECORD (DENTAL RECORD)

Contractors must ensure that a client health record (dental record) is established for every client who obtains dental services. These records must be maintained according to accepted dental 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,
- Written in ink without erasures or deletions; or by Electronic Medical Record (EMR)
  - Scanned original signed DSHS HOUSEHOLD Eligibility Screening Form is allowable.

- Signed by the provider making the entry, including name of provider, provider title and date for each entry
  - Electronic signatures are allowable to document provider review of care. However, stamped signatures are not allowable.
- Readily accessible to ensure 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 ensure confidentiality (complying with HIPAA regulations)
- Secured by lock when not in use or by password/encryption for EHRs

The client's health record must include:

- Client identification and personal data
- Where and how to contact the client (to facilitate continuity of care and ensure confidentiality, adhering to HIPAA regulations)
- Medical history (which may include a mental health risk assessment)
- Dental history
- Oral Examination
- Radiographs and/or photographs, if taken
- Assessment or clinical impression (including assessment for abuse and neglect)
- Plan of care, including education/counseling, treatment, special instructions and referrals
- Return visits
- Documentation on follow-up of missed appointments
- Informed consent documentation, including parental/guardian consent for use of restraints
- Refusal of services documentation
- Allergies and untoward reactions to drugs recorded prominently in a specific location
- Problem list to provide a consistent mechanism to document and track health and social problems/issues and to promote continuity of care

INITIAL/RETURN DENTAL VISIT

At the initial dental visit, a medical/dental history must be documented. Any pertinent history, including the reason for the visit must be updated at each subsequent visit.

A medical/dental history must include:

- Reason for visit
- History of the present problem

- Relevant past medical history:
    - Allergies, sensitivities or reactions to medicines or other substances (i.e. latex)
    - Current medications, including prescription, over the counter (OTC), and complementary and alternative medicines (CAM)
    - Medical illnesses (i.e. HIV +)
    - Pertinent previous surgery or biopsies

- Other:
    - Use of tobacco/alcohol including type, duration, frequency and route
    - Reproductive health history including pregnancy status

EXAMINATION

All dental visits must include an oral examination.

Initial/return dental visit must include:

- Limited head and neck examination for the initial visit and as indicated for return visits
- Assessment and reporting for abuse and neglect **(Mandated by Texas Family Code, Chapter 261 and outlined by the ADA's Code of Professional Conduct concerning abuse and neglect at http://www.ada.org/1381.aspx)**
- Blood pressure and pulse as indicated
- Radiographs / photographs as indicated
- Prescription(s) if indicated
- Treatment plan of care
- Procedure(s)/treatment provided

EDUCATION AND COUNSELING

Contractors must have written plans for client education that ensure consistency and accuracy of information provided, and that identify mechanisms used to ensure the client's understanding of the information.

Client education and counseling tailored to meet the clients needs based on:

- Documentation in the client's health record
- Appropriate to client and parent/guardian age, level of knowledge and socio-cultural background

Client education and counseling as indicated by:

- Medical/dental history
- Oral Examination
- Radiographs / photographs, if taken
- Procedure(s)/treatment

Dental nutritional education/counseling is provided by dentists and/or dental hygienists as it relates to prevention of dental disease and achieving oral health. Therefore, a registered dietician is not eligible to perform these services.

REFERRAL AND FOLLOW-UP

Agencies must have written policies and procedures for follow-up with referring providers and agencies. These policies must be sensitive to the client's 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 medically necessary, but which are beyond the scope of the agency, clients must be referred to other contractors for care. Whenever possible, clients, parents, and/or guardians should be given a choice of provider from which to select. When a client is referred to another provider, the agency must:

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

X-RAY EQUIPMENT QUALITY ASSURANCE

All dental facilities providing services for Title V dental must:

- Possess a current Certificate of Registration from the Texas Department of State Health Services, Radiation Control Program
- Have operating and safety procedures as required by Title 25 Texas Administrative Code Chapter 289, Texas Regulations for Control of Radiation.
- Post NOTICE TO EMPLOYEES, Texas Regulations for Control of Radiation

Information on dental x-ray machine registration by the Texas Department of State Health Services, Radiation control Program is found at http://www.dshs.state.tx.us/radiation/dental.shtm.

PRENATAL/POST-PARTUM DENTAL SERVICES

Prenatal/Post-partum dental services are provided to pregnant women up to three months post-partum. These include comprehensive and periodic oral evaluations; radiographs; and preventive and therapeutic dental services.

Providing dental services to pregnant women:

- Encourages perinatal dental care and emphasize the importance of maternal oral health for the health of the baby,
- Allows for adequate prenatal and post-partum nutritional intake to support healthy development of the fetus and infant,
- Reduces the potential for transmission of decay causing bacteria from the mother to the infant, and
- Decreases the inflammatory mediators that are associated with gum disease (periodontitis) and that impact the ability to effectively treat and control conditions such as diabetes, cardiovascular disease, and arthritis during pregnancy and post-partum.

PRENATAL/POST-PARTUM HEALTH RECORD (DENTAL RECORD)

Contractors must ensure that a client health record (dental record) is established for every client who obtains dental services. These records must be maintained according to accepted dental 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,
- Written in ink without erasures or deletions; or by Electronic Medical Record (EMR)
  - Scanned original signed DSHS HOUSEHOLD Eligibility Screening Form is allowable.
- Signed by the provider making the entry, including name of provider, provider title and date for each entry
  - Electronic signatures are allowable to document provider review of care. However, stamped signatures are not allowable.
- Readily accessible to ensure 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 ensure confidentiality (complying with HIPAA regulations)
- Secured by lock when not in use

The client's health record must include:

- Client identification and personal data
- Where and how to contact the client (to facilitate continuity of care and ensure confidentiality, adhering to HIPAA regulations)
- Medical history (which may include a mental health risk assessment)
- Dental history
- Oral Examination
- Radiographs and/or photographs, if taken
- Assessment or clinical impression (including assessment for abuse and neglect)
- Plan of care, including education/counseling, treatment, special instructions and referrals
- Return visits
- Documentation on follow-up of missed appointments
- Informed consent documentation
- Refusal of services documentation
- Allergies and untoward reactions to drugs recorded prominently in a specific location
- Problem list to provide a consistent mechanism to document and track health and social problems/issues and to promote continuity of care

INITIAL/RETURN DENTAL VISIT

At the initial dental visit, a medical/dental history must be documented. Any pertinent history, including the reason for the visit must be updated at each subsequent visit.

A medical/dental history must include:

- Reason for visit
- History of the present problem
- Relevant past medical history:
  - Allergies, sensitivities or reactions to medicines or other substances (i.e. latex)
  - Current medications, including prescription, over the counter (OTC), and complementary and alternative medicines (CAM)
  - Medical illnesses (i.e. HIV +)
  - Pertinent previous surgery or biopsies

- Other:
  - Use of tobacco/alcohol including type, duration, frequency and route
  - Reproductive health history including pregnancy status

EXAMINATION

All dental visits must include an oral examination.

Initial/return dental visit must include:

- Limited head and neck examination for the initial visit and as indicated for return visits
- Assessment and reporting for family violence **(Mandated by Texas Family Code, Chapter 261 and as outlined in the ADA's Code of Professional Conduct concerning abuse and neglect at** http://www.ada.org/1381.aspx)
- Blood pressure and pulse as indicated
- Radiographs / photographs as indicated
- Prescription(s) if indicated
- Treatment plan of care
- Procedure(s)/treatment provided

EDUCATION AND COUNSELING

Contractors must have written plans for client education that ensure consistency and accuracy of information provided, and that identify mechanisms used to ensure the client's understanding of the information.

Client education and counseling tailored to meet the client's needs based on:

- Documentation in the client's health record
- Appropriate to client level of knowledge and socio-cultural background

Client education and counseling as indicated by:

- Medical/dental history
- Oral Examination
- Radiographs / photographs, if taken
- Procedure(s)/treatment

Dental nutritional education/counseling is not provided by a registered dietician because the teaching coordinates with dental disease and dental services provided. Therefore, a registered dietician is not eligible to perform these services.

Client education and counseling during a dental service appointment should include:

- Developing and/or reinforcing positive oral health behaviors
- How positive oral health behaviors can impact the women's pregnancy and unborn child
- Educate on proper oral health care for infant/children

REFERRAL AND FOLLOW-UP

Agencies must have written policies and procedures for follow-up with referring providers and agencies. These policies must be sensitive to the client's 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 medically necessary, but which are beyond the scope of the agency, clients must be referred to other contractors for care. Whenever possible, clients should be given a choice of provider from which to select. When a client is referred to another provider, the agency must:

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

X-RAY EQUIPMENT QUALITY ASSURANCE

All dental facilities providing services for Title V dental must:

- Possess a current Certificate of Registration from the Texas Department of State Health Services, Radiation Control Program
- Have operating and safety procedures as required by Title 25 Texas Administrative Code Chapter 289, Texas Regulations for Control of Radiation.
- Post NOTICE TO EMPLOYEES, Texas Regulations for Control of Radiation

Information on dental x-ray machine registration by the Texas Department of State Health Services, Radiation control Program is found at http://www.dshs.state.tx.us/radiation/dental.shtm.

CASE MANAGEMENT

Case Management for Children and Pregnant Women is for high risk pregnant women and children up to one year of age with a health condition or health risk who have a need for health related services.

This case management includes the case management policies and the application process, Guidance is provided on subcontracting case management services, eligibility criteria for case managers, client eligibility, and implementation of case management services, documentation, billing, technical assistance and quality assurance that are found at the bottom of the page at http://www.dshs.state.tx.us/caseman/rulepolicy.shtm . The policy numbers are NO: 001 – 0023.

Title V Case management contractors must apply and be approved through the DSHS Case Management and Health Screening Unit prior to being allowed to bill for Title V case management services for the following fiscal year. Applications will only be accepted during the Title V RFP and annual renewal process. Title V case management contractors will not be allowed to bill until their contract for the fiscal year is awarded by Title V.

DSHS LABORATORY SERVICES

Effective September 1, 2013, Title V MCH Fee-for-Service (FFS) contractor will submit all Title V MCH laboratory testing, with the exception of Newborn Hereditary/Metabolic (NBS) testing, to the laboratory of their choice.

The TV MCH contractors submitting non-NBS, Title V-covered laboratory testing to the DSHS Laboratory will be charged at the DSHS Laboratory's published fee schedule rate found at: http://www.dshs.state.tx.us/lab/default.shtmand will be responsible for payment in full.

All prenatal and well child Title V MCH clients must be provided appropriate laboratory and diagnostic tests **as indicated** by history, physical examination and clinical assessment, including specific laboratory or diagnostic tests required for the provision of services.

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 patients' records;
• Mechanism to notify patients of results in a manner to ensure confidentiality; privacy and prompt, appropriate follow-up;
Contractors 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 or clinical assessment;
• Before a patient can consider a patient as 'lost to follow-up," the contractor must have at least three documented separate attempts to contact the patient; and
• Provider must comply with state and local STI/STD reporting requirements.

Newborn Hereditary/Metabolic Testing (NBS)
The Newborn Hereditary/Metabolic Testing (NBS) will be the only test required to be sent to the DSHS Austin Laboratory. Title V Contractors will continue to order NBS testing kits at no charge by requesting the NBS3 Test Kit (Medicaid/Charity Care/CHIP). There will be no charge for to the Title V Contractor for NBS testing submitted using the NBS3 Test Kit.

NBS Testing provided to individuals with third part coverage or an ability to pay should be submitted using the NBS4 Test Kit. The NBS4 Test Kit is purchased by providers at the published fee schedule rate. The DSHS Laboratory's published fee schedule rate is found at: http://www.dshs.state.tx.us/lab/default.shtm.

Contractors/subcontractors are required to have a DSHS laboratory submitter number if they submit specimens to any of the DSHS labs. A laboratory submitter number is assigned by the laboratory staff upon request and is used

only to identify the entity ordering the laboratory test/service. The laboratory submitter number will not be used to bill services to third party payors.

To apply for the DSHS **Austin Laboratory** submitter number, call Tiffunee Odoms at 512-776-6275 or email at: tiffunee.odoms@dshs.state.tx.us

Newborn Screening (NBS) Supplies (Test Kit Form NBS3, Test Kit Form NBS4, mailing envelopes, and address labels) can be ordered via fax or mail from the DSHS Austin Laboratory. Print the Order Form for Newborn Screening Supplies (Form Number G-6D) from the DSHS laboratory website at the following address:
http://www.dshs.state.tx.us/lab/MRS_forms.shtm

Submit the completed form by fax to (512) 776-7672, or by mail to:

Mailing Address:

Texas Department of State Health Services
Laboratory – MC 1947
Attn. Container Preparation Group
P.O. Box 149347
Austin, Texas 78714-9347

Mailing Addresses for Specimen Submission:

Newborn Screening (NBS) Specimens may be sent through the U.S. Postal Service. Send to:

Texas Department of State Health Services
DSHS Laboratory Services Section
P.O. Box 149341
Austin, TX 78714-9341

Email Contact Information:

For questions concerning DSHS Austin Laboratory testing, submitters may contact the following DSHS staff:

- Customer Service: Susan.Hoffpauir@dshs.state.tx.us
- NBS Specimen Logistics: Brendan.Reilly@dshs.state.tx.us
- NBS kit supplies: Dorothy.Breeden@dshs.state.tx.us

Laboratory Reporting

A computer-generated result report is mailed or faxed to the submitting Title V contractor. Additionally, a statistical report card is mailed quarterly to the Title V contractor summarizing their total number of submissions by diagnosis and adequacy.

The DSHS laboratory also offers web-based services (i.e., remote order entry and result reporting). For more information call 1-888-963-7111, Ext. 6030 for assistance.

DSHS Austin Lab
Phone: (512) 776-2468
Fax: (512) 776-7294
Grace Kubin, PH.D, Director, Laboratory Services Section
E-Mail: grace.kubin@dshs.state.tx.us
Physical Address: 1100 W. 49th St.
Austin, Texas 78756
Mailing address: P.O.Box 149347, Mail Code 1947
Austin, Texas 78714
For specimen mailing/shipping information, contact lab.

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 statutes and rules governing medical and nursing practice and consistent with national evidence-based clinical guidelines. The written clinical protocols and/or SDOs must be signed by the Medical Director/Dental Director or supervising physician/dentist on an annual basis or more often if changes are required. When DSHS revises a policy, contractors need to incorporate the revised policy into their written protocols, SDOs, and procedures.

Protocols

Contractors that employ Advanced Practice Nurses or Physician Assistants must have written protocols to delegate authorization to initiate medical aspects of patient care. The protocols must be agreed upon and signed by the medical director, other supervising physician(s) and the physician assistant and/or advanced practice nurse. Once established protocols must be maintained on site and reviewed, revised as indicated, and signed at least annually. 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.

Standing Delegation Orders

Contractors that employ unlicensed and licensed personnel, other than advanced practice nurses or physician assistants, whose duties include actions or procedures for a patient population with specific diseases, disorders, health and oral problems or sets of symptoms, must have written SDOs in place. SDOs are instructions, orders, rules, regulations or procedures that specify under what set of conditions and circumstances actions should be instituted. The SDOs delineate under what set of conditions and circumstances an RN, LVN, dental hyygienist, dental assistant or non-licensed healthcare provider (NLHP), promotor(a) or community health worker actions or tasks may be initiated in the clinical setting, and provide authority for use with patients when a physician, dentist or advance practice provider is not on the premises, and/or prior to being examined or evaluated by a physician, dentist or advance practice provider. Example: SDO for assessment of Blood Pressure/Blood Sugar which includes an RN, LVN or dental hygienist, dental assistant, NLHP that will perform the task, the steps to complete the task, the normal/abnormal range, and the process of reporting abnormal values. Other applicable SDOs when a physician or dentist is not present on-site may include, but are not limited to:

- obtaining a personal and medical history;
- performing an appropriate physical exam and the recording of physical findings;
- initiating/performing laboratory procedures;

- administering or providing drugs ordered by voice communication with the authorizing physician;
- providing pre-signed prescriptions for :
    - oral contraceptives;
    - diaphragms;
    - contraceptive creams and jellies;
    - topical anti-infectives for vaginal use;
    - oral anti-parasitic drugs for treatment of pinworms;
    - topical anti-parasitic drugs; or
    - antibiotic drugs for treatment of venereal disease.
- handling medical emergencies - to include on-site management as well as possible transfer of client;
- giving immunizations; or
- performing pregnancy testing.

SDOs 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. The SDOs must be reviewed and signed at least annually.

DENTAL DELEGATION

Contractors must abide by delegation rules set forth by the Dental Practice Act. A licensed dentist may delegate orally or in writing a service, task, or procedure to a dental hygienist who is under the supervision and responsibility of the dentist as specified by the Dental Practice Act. A dentist is not required to be on the premises when the dental hygienist performs a delegated act. A licensed dentist may delegate to a qualified and trained dental assistant acting under the dentist's general or direct supervision any dental act that reasonable and prudent dentist would find is within the scope of sound dental judgment to delegate as specified by the Dental Practice Act. Physical presence does not require that the supervising dentist be in the treatment room when the dental assistant performs the service as long as the dentist is in the dental office/clinic. A delegating dentist is responsible for a dental act performed by the person to whom the dentist delegates the act.

Patient Education

In addition to the above, contractors must have written plans for patient education that include goals and content outlines to ensure consistency and accuracy of information provided. Plans for patient education must be reviewed and signed by the Medical/Dental Director.

Resources
Medical
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, Title 22, Part 11, Chapters 221 and 224; and
Texas Administrative Code, Title 22, Part 9, Chapter 185 (Physician Assistant Scope of Practice).

Dental
Requirements addressing scope of practice and delegation of dental acts can be accessed at the following websites:
http://www.tsbde.state.tx.us (Texas State Board of Dental Examiners)
Rules that are most pertinent to this topic are:
Texas Administrative Code, Title 22, Part 5, Chapter 114 and 115

EMERGENCY RESPONSIVENESS

Contractors must be adequately prepared to handle clinical emergency situations, as follows:

- There must be a written plan for the management of on-site medical emergencies, emergencies requiring ambulance services and hospital admission, and emergencies requiring evacuation of the premises.
- Each site where sterilization procedures are performed must have an arrangement with a licensed facility for emergency treatment of any surgical complication. If sterilization procedures are performed in a freestanding surgical care center or on an inpatient basis in a hospital, Medicare standards applicable to the facility and staff must be met.
- Each site must have staff trained in basic cardiopulmonary resuscitation (CPR) and emergency medical action. Staff trained in basic CPR must be present during all hours of clinic operation.
- There must be written protocols to address vaso-vagal reactions, anaphylaxis, syncope, cardiac arrest, shock, hemorrhage, and respiratory difficulties.
- Each site must maintain emergency resuscitative drugs, supplies, and equipment appropriate to the services provided at that site and appropriately trained staff when patients are present.
- Documentation must be maintained in personnel files that staff has been trained regarding these written plans or protocols.

DENTAL EMERGENCIES RESPONSIVENESS

Each dentist licensed by the State Board of Dental Examiners and practicing in Texas shall for emergencies in the office/clinic:

- Maintain a positive pressure breathing apparatus including oxygen.
- Maintain other emergency equipment and/or currently dated drugs.
- Provide training to dental office personnel in emergency procedures which shall include, but not necessarily limited to, basic cardiac life support, inspection and utilization of emergency equipment in the dental office/clinic.
- Adhere to generally accepted protocols and/or standards for management of complications and emergencies.

It is recommended that the dental office/clinic have a written emergency plan that all staff are familiar with and should include: medical emergency prevention, development of an action plan, recognizing a patient's distress and management of medical emergencies, and emergency drugs and equipment. The plan should also document all training and review sessions.

Resources
Requirements addressing emergencies can be accessed at the following website:
http://www.tsbde.state.tx.us (Texas State Board of Dental Examiners)
Rules that are most pertinent to this topic are:
Texas Administrative Code, Title 22, Part 5, Chapter 108, Subchapter A; Rule §108.7 (Minimum Standard of Care, General)

Section III
Reimbursement, Data Collection and Reporting

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

BILLING AND REIMBURSEMENT

PROGRAM INFORMATION:

Program Name: Title V Maternal and Child Health (Child Health/Dental & Prenatal Medical/Dental)

Contract Type: Fee-for-Service

Contract Term: September 1--August 31

VOUCHER: Voucher 1 (Use Excel form that matches type of service provided)

Voucher Name: Monthly Reimbursement Request (MRR) EF21-12005 and Purchase Voucher Form 4116

Submission Date: By the last business day of the following month. Final voucher due within 45 days after end of the contract term.

Submit Copy to:

Name of Unit/Branch	Original Required		Accepts Email Only	# Copies
	Yes	No		
Health & Developmental Services (H&DS)		X	Email	1

Instructions: H&DS requires one submission for Voucher 1, Report 1, Report 2, and Report 3**.**

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 (Use Excel form that matches the type of service provided)

Report Name: Title V Maternal-Child Services Report **-** 185 EF21-12005

Submission Date: By the last business day of the following month. Final voucher due within 45 days after end of the contract term.

Name of Unit/Branch	Original Required		Accepts Email Only	# Copies
	Yes	No		
Health & Developmental Services (H&DS)		**X**	Email	1

Instructions: Submit 185 Services Report with the MRR voucher to H&DS.

VOUCHER: Report 2—Supporting (Use Excel form that matches the type of service provided)

Report Name: Title V Maternal-Child Services Report **-** 186 EF21-12005

Submission Date: By the last business day of the following month. Final voucher due within 45 days after end of the contract term.

Submit Copy to:

Name of Unit/Branch	Original Required		Accepts Email Only	# Copies
	Yes	No		
Health & Developmental Services (H&DS)		X	Email	1

Instructions: Submit Services Report with the MRR voucher to H&DS.

Cash Advances – Advances are not provided on fee-for-service (FFS) contract attachments.

Title V Reimbursement – Contractors may bill and receive reimbursement for the provision of services, with the exception of multivitamins and other medications, to Title V eligible clients. Although the scopes of care given to an individual Title V eligible client may encompass more than Title V can fund, contractors may only bill for prenatal, infant/child and adolescent health, and dental services for children as outlined in this section per their contract. Reimbursement is, however, allowable only when these services are delivered as defined and in accordance with nationally recognized guidelines of care.

CHIP PERINATAL PROGRAM BILLING

For the period of September 1, 2016 through August 31, 2017, the following table should be used to determine the appropriate funding source for prenatal services

Scenario	Payer of Services
Title V Contractor is a CHIP Perinatal Program Provider and Client is NOT enrolled in CHIP Perinatal Program.	Contractors can bill Title V program for allowable services provided at clinical prenatal care visits for up to 60 days for women during the CHIP Perinatal Program enrollment process. In addition, contractors which have been approved to provide CPW case management may bill Title V for one comprehensive visit (CPT Code G9012-U5-U2, and one follow-up visit which can be either face-to-face (CPT Code G9012-U5-TS) or telephone (CPT Code G9012-TS (TH). See Section II, Chapter 6. At first contact, Contractor informs client of the CHIP Perinatal Program benefits and assists the client with the CHIP Perinatal Program application.
Title V Contractor is NOT a CHIP Perinatal Program Provider and Client is enrolled in CHIP Perinatal Program.	Title V Contractor must refer the client to the designated CHIP Perinatal Program Provider for services. Title V funds cannot be used for women who are eligible for CHIP Perinatal and who are enrolled in CHIP Perinatal health

	plans.
Title V Contractor is a CHIP Perinatal Program Provider and Client is enrolled in CHIP Perinatal Program.	Title V Contractor bills CHIP Perinatal Program for services.
Title V Contractor is NOT a CHIP Perinatal Program Provider and Client is NOT enrolled in CHIP Perinatal Program.	Contractors can bill Title V program for allowable services provided at clinical prenatal care visits for up to 60 days for women during the CHIP Perinatal Program enrollment process. In addition, contractors which have been approved to provide CPW case management may bill Title V for one comprehensive visit (CPT Code G9012-U5-U2, and one follow-up visit which can be either face-to-face (CPT Code G9012-U5-TS) or telephone (CPT Code G9012-TS (TH). See Section II, Chapter 6. . Contractor educates client on the CHIP Perinatal Program benefits and assists the client with the CHIP Perinatal Program enrollment application. Title V Contractor must refer the client to the designated CHIP Perinatal Program Provider for services.

Well Visit – The Title V contractor may not submit a claim for a Texas Health Steps medical check-up until all required components are completed. If the child is brought back to complete components omitted based on unknown Medicaid status during the initial check-up visit, then the contractor may only bill for a Texas Health Steps medical check-up when those components are completed. In addition, the contractor may not bill a follow-up visit for components omitted by provider's choice due to unknown Medicaid status at the initial visit.

Lead – Providers conducting follow-up on children with elevated lead levels may bill Title V for either a follow-up visit or a sick child visit. However, if the visit is for the sole purpose of drawing a specimen (example: for venous confirmation of capillary specimen), the provider may bill a follow up. If the visit includes further assessment and/or treatment of the child, the provider may bill the visit as a sick

child visit. Title V will not pay for medications, hospital services, and laboratory specimens submitted to outside laboratories or environmental services.

A follow-up visit may not be billed on the same day as a well child/adolescent or sick child visit.

BILLING INSTRUCTIONS

An electronic workbook is provided for the Title V Child Health and Dental Services. A separate electronic workbook is provided for the Title V Prenatal Medical and Dental Services. The instruction below is appropriate for both services. If a contractor provides both services, both Excel forms must be submitted along with the appropriate Purchase Voucher Form 4116.

Request for Reimbursement of the cost of providing allowable child health, dental, and prenatal services will be submitted monthly on the appropriate Purchase Voucher Form 4116 which coincides with the appropriate Title V Maternal Child Health Monthly Reimbursement Request (MRR). Each request will cover services provided or expenses incurred in a preceding month as applicable to the contract attachment. Requests should be submitted within 30 days of the end of the preceding month.

Appropriate financial records must be maintained for review by HHSC through the quality assurance review process and/or fiscal monitoring.

MRRs need only the agency name and month of service at the top and the attached CPT code forms and client count form. Voucher form 4116 needs the vendor identification number (14 digits), purchase order number, payee name and address, reimbursement amount (from the MRR), month of service, program name, contract term, and agency contact name and phone number. No signature is required on either form. Forms submitted with incorrect or missing information may be returned, or central office staff will contact the contractor to remedy the problem.

Non-Reimbursable Expenditures – Title V will not reimburse services for individuals potentially eligible for another funding source who do not complete the respective eligibility process. Clients (or their parents, legal guardians, etc.) that do not fully comply with all requirements to apply for Medicaid, CHIP, or CHIP Perinatal services are not eligible for Title V services. Contractors will not be reimbursed for services provided to clients who do not access these alternative assistance programs.

Services are often provided to clients whose screening results indicate they are potentially Medicaid, CHIP, or CHIP Perinatal eligible, but the client has not yet completed or received notification of acceptance or rejection of an application.

For Medicaid, Title V may cover services delivered on the initial date of contact after the eligibility determination is complete and Medicaid denies eligibility. Such a denial of eligibility must be documented in the client's file for the contractor to bill the initial day's services. Once the client's denial letter is received, the services provided on the initial day of service may be billed to Title V for reimbursement.

Title V will only reimburse for services listed on the respective Monthly Maternal-Child Services (185-186) Report.

Deadlines for Submitting Claims – Monthly claims for reimbursement for services delivered must be submitted on the appropriate Purchase Voucher Form 4116 and MRR within 30 days of the end of the preceding month.

Submission of Final Claim – Contractors may have claims after the submission of their August billing. You may claim any additional services on the MRR and 185/186 report on or prior to October 15th. Please mark this as FINAL.

All claims for reimbursement for services delivered must be submitted within 45 days of the end of the contract term as HHSC Title V contracts require closure of the contract attachment within 45 days of the end of the contract term. Reimbursement requests submitted more than 45 days following the end of the Contract Attachment term will not be paid. A Financial Reconciliation Report (FRR) must be filed with the Health & Developmental Services (H&DS), no later than 60 days after the contract term. The Financial Reconciliation Report (FRR) must include all reimbursements and adjustments in payment for the contract term.

Errors – Errors can occur that result in a contractor receiving payment for more services than delivered in a service month or under-billing for services provided.

Errors that result in over-billing can be corrected by subtracting the over-billing from the next month; adjusting all information. Services not yet billed to Title V can also be added to the next month.

Contractors must maintain records that document the necessary information for services provided and billed for reimbursement. Documentation will be audited during HHSC on-site quality assurance reviews and fiscal monitoring reviews.

Altering of Forms – None of the billing or the reporting forms may be altered in any manner. Please use at least 8 pt sized font, 10 pt is preferred, when entering data; any information which is unreadable may be returned of central office staff will contact the contractor to remedy the problem.

Contractors are REQUIRED to use the Excel format for ease of processing. Contractors only need to complete the appropriate Forms 185,186 and Monthly Aggregate Activity Report. The total amount to be reimbursed automatically transfers to the Monthly Reimbursement Request Form. The total amount to be reimbursed on the Monthly Reimbursement Request should match the amount on Form 4116, square #23 entitled Amount. If other non-HHSC funding is being deducted, contractors will need to complete this section as well. Any cost over the contract ceiling should be reflected in non-HHSC funding. Reimbursement requested amount will also be calculated. Cells that include any formula should not be changed.

BILLING PROCEDURES FOR IBIS

Title V client data shall be entered into IBIS no later than 30 days after provision of each service. Requests for reimbursement will be generated periodically as one of the automated functions of IBIS. Title V services and procedures that have met business rules will be marked approved to pay and submitted electronically to HHSC for processing through the State Comptroller. Paid claims will be deposited into the contractor's direct deposit account. Contractors may only be reimbursed for services listed in the Title V Reimbursement Rates and Billing Guidelines (Monthly Voucher) in Appendices H and I.

DATA COLLECTION AND REPORTING

VOUCHER: Report 3 **(Use Excel form that matches the type of services provided)**				
Report Name: Monthly Aggregate Activity Report (MAR) EF21-12005-Monthly Activity				
Submission Date: By the last business day of the following month. Final voucher due within 45 days after end of the contract term.				
Submit Copy to:				
Name of Unit/Branch	**Original Required**		**Accepts Email**	**# Copies**
	Yes	**No**		
Health & Developmental Services (H&DS)		X	Email	1
Instructions: Submit Monthly Aggregate Activity Report with the MRR voucher to H&DS.				
REPORT: Report 4 - Annual				
Report Name: Financial Reconciliation Report (FRR)				
Submission Date: No later than (60) days after the end of the contract term				
Submit Copy to:				
Name of Unit/Branch	**Original Required**		**Accepts Email**	**# Copies**
	Yes	**No**		
Health & Developmental Services (H&DS)	X		Email	1
Instructions: FRR does require a signature (scanned copy by email is preferred). Send to H&DS.				
Email Addresses:	H&DS		WHSFinance@hhsc.state.tx.us	
Fax Numbers:	H&DS		(512) 776-7521	

MONTHLY AGGREGATE ACTIVITY REPORT

Each Monthly Reimbursement Request (MRR) must be accompanied by a Title V MCH Monthly Aggregate Activity Report that justifies the total claim for reimbursement. The "Report Month" space on the activity report form refers to the month the billed services were provided or services are billed to Title V.

The Monthly Activity Report details the unduplicated number of clients receiving billable services by age, race, and ethnicity and the number of visits.

The count for unduplicated clients includes the client's first visit for a medical service provided for each category: prenatal, dental, and child/adolescent.

Each client is counted once at the beginning of the fiscal year (each September) and is not to be counted in that category again.

This definition allows an individual client to be counted up to three times within a given fiscal year as they receive different types of services. A visit is defined as a single, complete clinical encounter of a client with a provider.

Contractors must maintain a monthly Title V billing log (automated or manual) to support their monthly Title V Aggregate Activity Reports. The log should contain at least the clients name, date of service, and procedure code for each service billed. These logs will be audited during HHSC on-site quality assurance reviews and/or fiscal compliance monitoring reviews.

FISCAL REPORTS

Financial Reconciliation Report (FRR) is to be submitted within 60 days of the completion of the contract year to the Health & Developmental Services (H&DS) Please see the CHS forms web page to download a copy of this required form: http://www.dshs.texas.gov/chscontracts/all_forms.shtm

Annual Financial Report	September 1 – August 31 Due: October 31

Billing for Direct Health Care – Title V services contract amounts are ceilings against which contractors may bill for the provision of allowable Title V services to Title V eligible clients. Once this dollar ceiling has been reached, no further funds will be available for reimbursement. However monthly billing should continue and any cost over the contract amount should be included in the non-HHSC funding. Contractors may only bill for services provided to clients who

have been screened for potential Medicaid, CHIP, X eligibility and been deemed as full-service, or presumptive eligible. Although a wide array of services may be provided to Title V eligible clients, only those listed on the Title V Maternal-Child Services (185/186) Report will be reimbursed by Title V.

Section IV
Appendices

DSHS Family & Community Health Services Division
HOUSEHOLD Eligibility Form

Use with HOUSEHOLD Worksheet (Form EF05-13227)

APPENDIX A1

PART I - APPLICANT INFORMATION

Name (Last, First, Middle)	Telephone Number		Email Address	
Texas Residence Address (Street or P.O. Box)	City	County	State	ZIP

a) Please contact me by: (check all that apply) ☐ Mail ☐ Phone ☐ Email

b) Do you – or anyone in your household – have comprehensive health care coverage (Medicaid, Medicare, CHIP, health insurance, VA, TRICARE, etc.)? ☐ Yes ☐ No

**If yes, DSHS' authorized representative will submit a claim for reimbursement from your insurer for any benefit, service or assistance that anyone in your household has received.*

c) Which benefits or health care coverage do you receive? (check all that apply)

☐ CHIP Perinatal ☐ SNAP ☐ WIC

☐ Medicaid for Pregnant Women ☐ TWHP ☐ None

PART II - HOUSEHOLD INFORMATION

Fill in the first line with your information. Fill in the other lines for everyone who lives with you for whom you are legally responsible.

Name (Last, First, Middle)	SSN (optional)	Date of Birth	Sex	Race	Ethnicity	Relationship
1.						
2.						
3.						
4.						
5.						
6.						

PART III - INCOME INFORMATION

List all of your household's income below. 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 benefits.

Name of person receiving money	Name of agency, person, or employer who provides the money	Amount received per month

PART IV - APPLICANT AGREEMENT

I have read the **Rights and Responsibilities** statements in the *instructions* section of this form. ☐ Yes ☐ No

The information that I have provided, including my answers to all questions, is 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.

I authorize release of all information, including income and medical information, by and to the Texas Department of State Health Services (DSHS) and Provider in order to determine eligibility, to bill, or to render services to my household or me.

Signature – Applicant _____ Date _____

Signature – Person who helped complete this application _____ Relationship to Applicant _____ Date _____

SAMPLE

DSHS Family & Community Health Services Division
HOUSEHOLD Eligibility Form Instructions

Use with HOUSEHOLD Worksheet (Form EF05-13227)

PART I - APPLICANT INFORMATION

Fill in the boxes with your information.

a) Check all the boxes that apply.

b) Check *yes* or *no*.

c) Check all the boxes that apply:

- *CHIP (Children's Health Insurance Program) Perinatal*
- *Medicaid for Pregnant Women*
- *SNAP (Supplemental Nutrition Assistance Program)*
- *TWHP (Texas Women's Health Program)*
- *WIC (Special Supplemental Nutrition Program for Women Infants and Children)*
- *None*

If you selected one of these benefit or health care coverage programs and you are able to provide proof of current enrollment, you may be adjunctively (automatically) eligible for a DSHS Family & Community Health Services Division program and able to skip Part II and III on this application, if your agency does not collect a co-pay. **(Exception -- Adjunctive eligibility does not apply to applicants seeking Title V services)**

PART II – HOUSEHOLD INFORMATION

Fill in the first line with your information. Fill in the other lines for everyone who lives with you for whom you are legally responsible.

How to determine your household:

- If you are married (including common-law marriage), include yourself, your spouse, and any mutual or non-mutual children (including unborn children).
- If you are not married, include yourself and your children, if any (including unborn children).
- If you are not married and you live with a partner with whom you have mutual children, count yourself, your partner, your children, and any mutual children (including unborn children).

Applicants 18 years and older are adults. Do not include any children age 18 and older, or other adults living in the house, as part of the household. Minors should include parent(s)/legal guardian(s) living in the house.

PART III - INCOME INFORMATION

List all of your household's income in the table. 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 benefits.

Fill in the table with the following information:

1st column: The name of the person receiving the money.

2nd column: The name of the agency, person, or employer who provides the money.

3rd column: The amount of money received per month.

PART IV - APPLICANT AGREEMENT

Read the **Rights and Responsibilities** above. Check *yes* or *no*.
Sign and date on the lines. If a person helped you complete the application, he/she should sign, state the relationship to you, and date on the lines.

Rights and Responsibilities:

If the applicant omits information, fails or refuses to give information, or gives false or misleading information about these matters, he/she may be required to reimburse the State for the services rendered if the applicant is found to be ineligible for services. The applicant will report changes in his/her household/family situation that affect eligibility during the certification period (changes in income, household/family members, and residency). *(MBCC clients are not required to report changes in income, household, and residency)*

The applicant understands that, to maintain program eligibility, he/she will be required to reapply for assistance at least every twelve months *(not applicable to MBCC)*.

The applicant understands he/she has the right to file a complaint regarding the handling of his/her application or any action taken by the program with the HHSC Civil Rights Office at 1-888-388-6332.

The applicant understands that criteria for participation in the program are the same for everyone regardless of sex, age, disability, race, or national origin.

With few exceptions, the applicant has the right to request and be informed about information that the State of Texas collects about him/her. The applicant is entitled to receive and review the information upon request. The applicant also has the right to ask the state agency to correct any information that is determined to be incorrect. See http://www.dshs.state.tx.us for more information on Privacy Notification. (Reference: Government Code, Section 552.021, 522.023 and 559.004)

SAMPLE

División de Servicios de Salud Familiar y Comunitaria del Departamento Estatal de Servicios de Salud (DSHS)
Formulario para la participación FAMILIAR **Appendix A2**

Use with HOUSEHOLD Worksheet (Form EF05-13227)

PARTE I - INFORMACIÓN DEL SOLICITANTE

Nombre (apellido, primer nombre, segundo nombre)	Número telefónico		Correo electrónico	
Domicilio en Texas (nombre de la calle o número de apartado postal)	Ciudad	Condado	Estado	Código postal

a) Por favor contáctenme por: (marque todo lo que corresponda) ☐Correo postal ☐ Teléfono ☐ Correo electrónico

b) ¿Tiene usted o alguien de su familia cobertura médica integral (Medicaid, Medicare, CHIP, seguro médico, VA, TRICARE, etc.)? ☐ Sí ☐ No

**Si contestó que sí, el representante autorizado del DSHS presentará una reclamación de reembolso ante su compañía de seguro médico por las prestaciones, los servicios o la asistencia que cualquier persona en su hogar haya recibido.*

c) ¿Qué tipo de prestaciones o de cobertura médica tiene? (marque todo lo que corresponda)

☐ CHIP Perinatal ☐ SNAP ☐ WIC

☐Medicaid para mujeres embarazadas ☐ TWHP ☐ Ninguno

PARTE II - INFORMACIÓN DE LA FAMILIA

Llene la primera línea con su información personal. Llene las demás líneas con los datos de cada persona que vive con usted y de quien usted sea legalmente responsable.

Nombre (apellido, primer nombre, segundo nombre)	Número de Seguro Social (SSN) (opcional)	Fecha de nacimiento	Sexo	Raza	Origen étnico	Relación
1.						
2.						
3.						
4.						
5.						
6.						

PARTE III - INFORMACIÓN SOBRE LOS INGRESOS

Enumere abajo todos los ingresos de la familia. Incluya los siguientes: cheques del gobierno; dinero del trabajo; dinero que obtiene por el cargo de alojamiento y comida; regalos en efectivo, préstamos o contribuciones de los padres, familiares, amigos y otros; ingresos que recibe de un patrocinador; becas o préstamos escolares; manutención de menores e ingresos por desempleo.

Nombre de la persona que recibe el dinero	Nombre de la agencia, la persona o el empleador que provee el dinero	Cantidad recibida al mes

PARTE IV - ACUERDO DEL SOLICITANTE

He leído las declaraciones de **Derechos y Responsabilidades** en la sección de *Instrucciones* de este formulario. ☐ Sí ☐ No

La información que aquí proporciono, incluidas mis respuestas a todas las preguntas, es verídica y correcta, según mi leal saber y entender. Acepto darle al personal que determina el derecho a la participación cualquier información que sea necesaria para comprobar mis declaraciones respecto a mi derecho a la participación. Entiendo que dar información falsa podría dar por resultado la descalificación y el reembolso.

Autorizo al Departamento Estatal de Servicios de Salud de Texas (DSHS) y al Proveedor a que dispongan libremente de toda la información que proporciono, incluida la información sobre los ingresos y la médica, con el fin de que determinen mi derecho a la participación y a que paguen o presten servicios a mi familia o a mí.

Firma del solicitante _____ Fecha _____

Firma de la persona que ayudó a completar esta solicitud _____ Relación con el solicitante _____ Fecha _____

SAMPLE

División de Servicios de Salud Familiar y Comunitaria del Departamento Estatal de Servicios de Salud (DSHS)
Instrucciones para llenar el formulario para la participación FAMILIAR

Use with HOUSEHOLD Worksheet (Form EF05-13227)

PARTE I - INFORMACIÓN DEL SOLICITANTE

Llene las casillas con su información personal.

a) Marque todas las casillas que correspondan.

b) Marque *"sí"* o *"no"*.

c) Marque todas las casillas que correspondan:

- *CHIP (Programa de Seguro Médico Infantil) Perinatal*
- *Medicaid para mujeres embarazadas*
- *SNAP (Programa de Asistencia de Nutrición Suplemental)*
- *TWH (El Progama de Salud para la Mujer de Texas)*
- *WIC (Programa de Nutrición Suplemental Especial para Mujeres, Niños y Bebés)*
- *Ninguno*

Si usted seleccionó uno de estos programas de prestaciones o de cobertura médica y puede proporcionar un comprobante de inscripción actualizado, usted podría de manera adjunta (automáticamente) tener derecho a la participación de un programa de la División de Servicios de Salud Familiar y Comunitaria del DSHS y saltar a las Partes II y III de esta solicitud, si su agencia no cobra un copago. (Excepción: elegibilidád adjunto no se aplica a los solicitantes de los servicios del Título V.)

PARTE II - INFORMACIÓN DE LA FAMILIA

Llene la primera línea con su información personal. Llene las demás líneas con los datos de cada persona que vive con usted y de quien usted sea legalmente responsable.

Cómo determinar qué personas componen su familia:

- Si usted es casado (incluso en matrimonio de hecho), inclúyase a usted mismo e incluya a su cónyuge y a todos los hijos, tanto los habidos en común como los no habidos en común (incluidos los no nacidos).
- Si usted no es casado, inclúyase a usted mismo e incluya a sus hijos, de tenerlos (incluidos los no nacidos).
- Si usted no es casado y vive con su pareja con la cual tiene hijos en común, inclúyase a usted mismo e incluya a su pareja, a sus hijos y a los hijos que hayan tenido en común (incluidos los no nacidos).

Los solicitantes de 18 años de edad o más se consideran adultos. No incluya a ningún hijo de 18 años de edad o más ni a ningún otro adulto que viva en su casa como parte de la familia. Los menores de edad deben incluir al padre, a la madre o al tutor legal que vivan en la casa.

PARTE III - INFORMACIÓN SOBRE LOS INGRESOS

Enumere en la tabla todos y cada uno de los ingresos de la familia. Incluya los siguientes: cheques del gobierno; dinero del trabajo; dinero que obtiene por el cargo de alojamiento y comida; regalos en efectivo, préstamos o contribuciones de los padres, familiares, amigos y otros; ingresos que recibe de un patrocinador; becas o préstamos escolares; manutención de menores e ingresos por desempleo.

Llene la tabla con la siguiente información personal:

1.ª columna: El nombre de la persona que recibe el dinero.

2.ª columna: El nombre de la agencia, la persona o el empleador que provee el dinero.

3.ª columna: La cantidad de dinero recibida al mes.

PARTE IV - ACUERDO DEL SOLICITANTE

Lea los **Derechos y Responsabilidades** siguientes. Marque *"sí"* o *"no"*.
Firme y escriba la fecha en las líneas correspondientes. Si alguna persona le ayudó a usted a llenar la solicitud, también debe firmar, declarar cuál es su relación con usted y escribir la fecha en las líneas correspondientes.

Derechos y Responsabilidades:

Si el solicitante omite información, no la proporciona o se niega a proporcionarla, o da información falsa o engañosa sobre estas cuestiones, podría pedírsele que reembolse al Estado el importe de los servicios recibidos si se encontró que el solicitante no cumple con los requisitos para recibir los servicios. El solicitante deberá informar de cualquier cambio en la situación de su hogar o familia que afecte el derecho a la participación durante el periodo de certificación (cambios en los ingresos, en los miembros del hogar o la familia y el lugar de residencia). *(Las clientes de MBCC no tienen que informar de cambios en los ingresos ni en el hogar o el lugar de residencia)*

El solicitante entiende que, para mantener el derecho a participar del programa, se le pedirá que vuelva a solicitar la ayuda al menos cada doce meses *(no aplicable para clientes de MBCC)*.

El solicitante entiende que tiene el derecho a presentar una queja con respecto al manejo de su solicitud o a cualquier acción llevada a cabo por el programa, ante la Oficina de Derechos Civiles de la HHSC, al teléfono 1-888-388-6332.

El solicitante entiende que los criterios para la participación en el programa son iguales para todos sin importar el sexo, la edad, la discapacidad, la raza o el lugar de nacimiento.

Con unas cuantas excepciones, el solicitante tiene derecho a pedir y a ser notificado sobre la información que el estado de Texas reúne sobre él. El solicitante tiene derecho a recibir y revisar la información al así pedirlo. El solicitante también tiene derecho a pedirle a la agencia estatal que corrija cualquier información que se determine que es incorrecta. Consulte http://www.dshs.state.tx.us para obtener más información sobre la Notificación de privacidad. (Fuente: Código Gubernamental, secciones 552.021, 522.023 y 559.004)

SAMPLE

DSHS Family & Community Health Services Division
HOUSEHOLD Eligibility Worksheet Appendix A3

TEXAS Department of State Health Services

PART I – APPLICANT INFORMATION

Name (Last, First, Middle)	Today's Date (MM-DD-YYYY)	Eligibility Effective Date (MM-DD-YYYY)
Case Record Action ☐ Adjunctive ☐ Presumptive ☐ Supplemental ☐ Approved ☐ Denied	Client/Case #	Type of Determination ☐ New ☐Re-certification
Texas resident ☐ Yes ☐ No		
Other benefits or health care coverage (Medicaid, Medicare, CHIP, private health insurance, VA, TRICARE, etc.)		
Special circumstances		

PART II – HOUSEHOLD INFORMATION

	Notes
1.	
2.	
3.	
4.	
5.	
6.	

PART III – INCOME INFORMATION

Income Type	Name(s) of household member(s) with income		Documentation of income *(if applicable)*
Gross earned income			
Cash gifts/contributions			
Child support income			
Dividends/interest/royalties			
Loans (non-educational)			
Lawsuit/lump-sum payments			
Mineral rights			
Pensions/annuities			
Reimbursements			
Social security payments			
Unemployment payments			
VA payments			
Worker's compensation			
Total countable income			
Deductions	-	-	
Net countable income			Household FPL %

PART IV– PROGRAM ELIGIBILITY

1. ☐ BCCS ☐ EPHC ☐ DSHS FP ☐ PHC ☐ Title V/MCH	**2.** ☐ BCCS ☐ EPHC ☐ DSHS FP ☐ PHC ☐ Title V/MCH	**3.** ☐ BCCS ☐ EPHC ☐ DSHS FP ☐ PHC ☐ Title V/MCH
4. ☐ BCCS ☐ EPHC ☐ DSHS FP ☐ PHC ☐ Title V/MCH	**5.** ☐ BCCS ☐ EPHC ☐ DSHS FP ☐ PHC ☐ Title V/MCH	**6.** ☐ BCCS ☐ EPHC ☐ DSHS FP ☐ PHC ☐ Title V/MCH
Co-Pay/Fees		

Name of Agency _____ Signature – Agency / Staff Member _____ Date _____

SAMPLE

DSHS Family & Community Health Services Division
HOUSEHOLD Eligibility Worksheet Instructions

PART I - APPLICANT INFORMATION

Fill in the boxes with the applicant's information. Check the appropriate boxes.

Other benefits or health care coverage: Document other benefits received/denied. (An applicant or family member eligible for Medicare Part A/B must be referred to the Medicare Prescription Drug Plan (Part D) for prescription drug benefits.)

Special circumstances: Document any special circumstances.

PART II – HOUSEHOLD INFORMATION

Fill in the boxes with members of the household.

This number will include 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 legal guardian and a minor child.

(Title V contractors may add whether household members are US citizens, eligible immigrants, or non- US citizens.)

Program Eligibility by 2016 Federal Poverty Level (FPL)

Effective March 1, 2016

Family Size	Title V - MCH	PHC EPHC BCCS	FP
	185% FPL	200% FPL	250% FPL
1	$1,832	$1,980	$2,475
2	2,470	2,670	3,338
3	3,108	3,360	4,200
4	3,747	4,050	5,063
5	4,385	4,740	5,925
6	5,023	5,430	6,788
7	5,663	6,122	7,653
8	6,304	6,815	8,519
9	6,946	7,509	9,386
10	7,587	8,202	10,253
11	8,228	8,895	11,119
12	8,870	9,589	11,986
13	9,511	10,282	12,853
14	10,152	10,975	13,719
15	10,794	11,669	14,586

PART III - INCOME INFORMATION

Income may be either earned or unearned. If actual or projected income is not received monthly, convert it to a monthly amount using one of the following methods:

- weekly income is multiplied by 4.33;
- income received every two weeks is multiplied by 2.17;
- income received twice a month is multiplied by 2.

Fill in the *Income Type* table with name(s) of household member(s) and income amounts.

Calculate the *Total countable income*.

Calculate the *Deductions*:

- child support payments;
- dependent childcare;
  - up to $200 per child per month for children under age 2;
  - up to $175 per child per month for children age 2 and older;
- adults with disabilities;
  - up to $175 per adult per month.

Total the *Net countable income*.

Calculate the household FPL using the applicable DSHS program policy and fill in the *Household FPL* box.

Use the *Documentation of income* box for notes (if applicable).

PART IV – PROGRAM ELIGIBILITY

Determine program eligibility for each household member using the corresponding numbers from the household information section.

Document applicable copayments and fees by program in the *Co-Pay/Fees* box.

Fill in the *Name of Agency*, sign, and date.

SAMPLE

Family & Community Health Services Request for Information

Solicitud de Información

This form is optional.

Appendix A4

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

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 determinar su elegibilidad, necesitamos la siguiente información.

ONLY THE CHECKED BOXES APPLY TO YOU./SOLAMENTE LAS CASILLAS MARCADAS SE APLICAN A SU CASO.

- ☐ **Mail Addressed to You or Another Household Member**
  Correo Dirigido a Usted o a Otra Persona de su Casa
- ☐ **Texas Driver's License or Other Official Identification**
  Licencia de Manejar de Texas u Otra Identificación Oficial
- ☐ **Voter Registration Card**
  Certificado de Registro Electoral
- ☐ **Notice of TANF, SNAP/ Food Stamps, or Medicaid Benefits**
  Aviso de Beneficios de TANF,Estampillas para Comida o Medicaid
- ☐ **Paychecks or Paycheck Stubs**
  Cheques de Paga o Talones de Cheques de Paga
- ☐ **Earnings Statement from Employer**
  Verificación de Sueldo Preparada por el Empleador
- ☐ **Worker's Compensation Award Letter or Check**
  Cheque del Seguro Obrero o Carta Diciendo que Van a Dárselo
- ☐ **Federal Income Tax Return**
  Declaración de los Impuestos Federales Sobre los Ingresos
- ☐ **Self-Employment Bookkeeping, Sales, Expenditure Records**
  Comprobantes de Cuentas, Ventas, Gastos de Trabajo Independiente
- ☐ **Social Security Award Letter, Check, or Denial Notice**
  Cheque de Seguro Socil o Carta Diciendo si se lo Van a Dar o No
- ☐ **Disability Insurance Award Letter or Check**
  Cheque de Seguro por Incapacidad or Carta Diciendo que Van a Dárselo
- ☐ **Unemployment Compensation Award Letter or Check**
  Cheque de Compensación de Desempleo o Carta Diciendo que Van a Dárselo
- ☐ **Veterans Administration Award Letter or Check**
  Cheque de la Administración de Veteranos o Carta Diciendo que Van a Dárselo
- ☐ **Other Items**
  Otra

_____

_____

_____

_____

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: _____

SAMPLE

STATEMENT OF SELF-EMPLOYMENT INCOME

DECLARACIÓN DE INGRESOS DEL NEGOCIO PROPIO

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 county 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 condado 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**

SAMPLE

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."

Expenses 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.

Income 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".

Los gastos 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.

Los ingresos 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.

Family & Community Health Services Division Employment Verification

This form is optional.

APPENDIX A6

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. 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, give it to your employee, mail it in the envelope provided, or fax it to the number listed above.

This information is needed by this date: _____. If you could send it before this date, it would be most appreciated.

Thank you for helping. If you have questions, please feel free to call.

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: _____

_____

_____

_____

_____

SAMPLE

Family & Community Health Services Division Employment Verification

This form is optional.

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.)**

SAMPLE

STATEMENT OF APPLICANT'S RIGHTS AND RESPONSIBILITIES
DECLARACIÓN DE LOS DERECHOS Y DEBERES DEL SOLICITANTE

By signing this application for assistance, I affirm the following:	Al firmar esta solicitud para recibir asistencia, yo afirmo lo siguiente:
The information on the application and its attachments is true and correct. This application is a legal document. Deliberately omitting information or giving false information may cause the Provider to terminate services to a member of my household/family or me.	La información escrita en la solicitud y en sus anexos es verdadera y correcta. Esta solicitud es un documento legal. El deliberadamente omitir información o el proporcionar información falsa podría dar lugar a que el Proveedor cancele los servicios a uno de los miembros de mi hogar, de mi familia o los míos propios.
If I omit information, fail or refuse to give information, or give false or misleading information about these matters, I may be required to reimburse the State for the services rendered if I am found to be ineligible for services. I will report changes in my household/family situation that affect eligibility during the certification period (changes in income, household/family members, and residency).	Si yo omito información, dejo de proporcionar o me niego a proporcionar información o; proporciono información falsa o engañosa acerca de estos asuntos, podría requerírseme que reembolse al Estado el costo de los servicios recibidos, si acaso se determina que no califico para los servicios. Yo reportaré los cambios en la situación de mi hogar, de mi familia, que afecten la elegibilidad durante el período de certificación (cambios en el ingreso, en los miembros del hogar, en la familia y, cambios de residencia.)
I authorize release of all information, including but not limited to, income and medical information, by and to the Texas Department of State Health Services (DSHS) and Provider in order to determine eligibility, to bill, or to render services to my household/family or me.	Yo autorizo la divulgación de toda la información, incluyendo pero no limitada a, el ingreso y a la información médica, de parte de y para, el *Texas Department of State Health Services* (DSHS) *[Departamento Estatal de Servicios de Salud de Texas*] y, al Proveedor para poder determinar la elegibilidad, para poder cobrar o, proporcionar servicios en mi hogar, a mi familia o, a mí personalmente.
I understand I may be asked by Provider to provide proof of any of the information provided in this application.	Entiendo y acepto que podría pedirme el Proveedor que proporcione comprobantes de cualquiera de la información proporcionada en esta solicitud.
Health insurance coverage, including but not limited to individual or group health insurance, health maintenance organization membership, Medicaid, Medicare, Veterans Administration benefits, TRICARE, and Worker's Compensation benefits, must be reported to Provider. Benefits from health insurance may be considered the primary source of payment for health care received. I hereby assign to Provider any such benefits. I also assign payment for benefits and services received from and through Provider directly to the service providers.	La cobertura de seguro de salud, incluyendo pero no limitada a seguro para un individuo o seguro de salud para un grupo de personas; los de membresía proporcionados por organizaciones para el mantenimiento de la salud [como HMO], *Medicaid*, *Medicare*; beneficios de la *Veterans Administration;* de la TRICARE y *Worker's Compensation* [beneficios de Compensación Laboral], deben ser reportados al Proveedor. Los beneficios provenientes de esos seguros de salud pudieran ser considerados como la fuente principal de pago de la atención de salud recibida. Por este medio yo, asigno al Proveedor cualquiera de dichos beneficios. También asigno el pago de los beneficios y servicios recibidos de parte de y, a través del Proveedor, directamente a los proveedores de servicios.
I understand that, to maintain program eligibility, I will be required to reapply for assistance at least every twelve months.	Yo entiendo y acepto que, para mantener la elegibilidad para el programa, se me va a requerir que vuelva a solicitar para recibir asistencia, por lo menos cada doce meses.
I am a bona fide resident of Texas or a dependent. I physically live in Texas, maintain living quarters in Texas, and do not claim to be a resident of another state or country, or am a dependent of a bona fide Texas resident.	Soy residente legítimo de Texas o bien, dependiente del territorio. Yo vivo físicamente en Texas, mantengo residencia en Texas y, no afirmo ser residente de otro estado o país o bien, soy un dependiente de un residente legítimo de Texas.
Some programs provide care through program-approved providers. I understand that, to receive benefits from such programs, treatment must be received through those program-approved providers.	Algunos programas proporcionan atención a través de proveedores aprobados por los programas. Yo entiendo y acepto que, para recibir beneficios de dichos programas, el tratamiento debe ser recibido a través de esos proveedores aprobados por el programa.
I understand that criteria for participation in the program are the same for everyone regardless of sex, age, disability, race, or national origin.	Yo entiendo y acepto que el criterio para la participación en el programa es el mismo para todos sin importar sexo, edad, discapacidad, raza o bien, origen de nacionalidad.
I understand I have the right to file a complaint regarding the handling of my application or any action taken by the program with the HHSC Civil Rights Office at 1-888-388-6332.	Yo entiendo y acepto que tengo el derecho de registrar una queja con relación al manejo de mi solicitud o con relación a cualquier acción tomada por el programa con HHSC Civil Rights Office de 1-888-388-6332.
I understand that I will receive written documentation concerning the services for which my household/family or I is eligible or potentially eligible.	Yo entiendo y acepto que recibiré documentación por escrito concerniente a los servicios para los cuales mi hogar, mi familia o yo calificamos o, potencialmente lleguemos a calificar.
With few exceptions, you have the right to request and be informed about information that the State of Texas collects about you. You are entitled to receive and review the information upon request. You also have the right to ask the state agency to correct any information that is determined to be incorrect. See http://www.dshs.state.tx.us **for more information on Privacy Notification. (Reference: Government Code, Section 552.021, 522.023 and 559.004)**	Tan solo por unas cuantas excepciones, usted tiene el derecho de solicitar y de ser informado sobre la información que el Estado de Texas reúne sobre usted. A usted se le debe conceder el derecho de recibir y revisar la información al requerirla. Usted también tiene el derecho de pedir que la agencia estatal corrija cualquier información que se ha determinado sea incorrecta. Diríjase a http://www.dshs.state.tx.us para más información sobre la Notificación sobre privacidad. (Referencia: *Government Code*, sección 552.021, 522.023 y 559.004)
I understand and agree that the program does not provide payment for inpatient care. I understand that I must make my own arrangement for hospital care and that I am responsible for the cost of the care.	Entiendo y acepto que el programa no proporciona pago por la atención de pacientes internos. Entiendo y acepto que yo debo hacer mis propios arreglos de atención en el hospital y que yo soy responsable por el costo de la atención.
Signature – Applicant / Firma – Solicitante **Date** / Fecha	**Provider Staff Signature** **Date**

SAMPLE

Presumptive Eligibility Form
Instructions

PURPOSE

1. If applicant cannot fulfill application procedures **AND** applicant is in need of immediate medical services, the Presumptive Eligibility Form is to be completed. Additionally, a Statement of Applicant's Rights and Responsibilities must be completed.
2. To establish if applicant appears to be eligible for Title V, Primary Health Care (PCH) and Expanded Primary Health Care (EPCH).

PROCEDURE

When to Prepare

Complete for persons in medical need who appear to be eligible for Title V, Primary Health Care and Expanded Primary Health Care but time or lack of materials prevent screening and eligibility determination.

Number of Copies

Complete an original and one copy.

Transmittal

Give a copy of the form to the applicant with an appointment time for application process. File original.

Form Retention

Keep the case record copy for three state fiscal years after services rendered.

DETAILED INSTRUCTIONS

Complete the date, name of applicant, name of legally responsible adult if applicant is a minor, address and phone number where applicant (legally responsible adult) can be reached. Agency staff is responsible for ensuring appropriate completion of the Presumptive Eligibility Form and a Statement of Applicant's Rights and Responsibilities.

1. Verify the residency of applicant and mark yes or no. Refer to the policy manual for definition of residency.
2. Enter the number of members in the immediate family. Refer to the policy manual for definition of family.
3. Enter the gross monthly income of the immediate family. Refer to the policy manual for definition of income if applicant falls within Program guidelines.

The applicant appears to be potentially eligible for services on a Presumptive Eligibility basis if the applicant:

1. is a Texas resident, and
2. gross monthly family income (based on family size) falls at or below income guidelines.

NOTE:

If the contractor renders services and the above two criteria were not met, Title V, PHC and/or EPHC will not reimburse. If applicant does not meet these two criteria it is up to the Contractor to determine where and when services will be provided. Although Title V, PCH and EPHC are under strict eligibility guidelines, it is encouraged that an applicant's medical needs be met quickly and appropriately using whatever resources are locally available.

SAMPLE

TEXAS Department of State Health Services

Appendix C2
Form 102

Notice of Presumptive Eligibility
Family & Community Health Services

Date/Fecha	**Case No./** Número de caso	**Expiration Date/** Fecha de vencimiento

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

Provider Staff Name/Nombre del trabajador

Name/Nombre	**Contact Telephone No./**Teléfono de la casa

Mailing Address (Street or P.O. Box)/Dirección Postal (Calle o Apdo.)	**City/**Ciudad	**State**/Estado	**ZIP/**Zona Postal

Home Address, if different from above. Domicillio particular, si es diferente a la dirección de arriba.

Your individual / household application for Title V / Primary Health Care / Expanded Primary Health Care is APPROVED.

Su solicitud individual o familiar del programa Título V, el Programa Atención Primaria de Salud, el programa Atención Primaria de Salud Ampliado ha sido APROBADA.

The Title V / Primary Health Care / Expanded Primary Health Care services will be provided beginning _____.
(MM/DD/YYYY)

Se proveerán los servicios del programa Título V, el programa Atención Primaria de Salud o el programa Atención Primaria de Salud Ampliado a partir del _____.
(mes/día/año)

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

Due to my need of immediate medical care, I was not able to complete the eligibility determination process for the Program. I understand that I must return with the requested documentation/verification within 90 days (60 days for Title V) of today's date. My appointment to complete the program's eligibility process is scheduled for:

A causa de mi necesidad de recibir atención médica inmediata, no pude completar el proceso de determinación del derecho a participar en el programa. Entiendo que, en los 90 días **(60 dias Titulo V)** siguientes a la prestación de los servicios que reciba hoy, regresaré con la documentación o la verificación solicitada para completar el proceso de determinación del derecho a participar. Mi cita para volver es:

Date and Time/ Hora y Fecha	**Location and Phone/** Lugar y teléfono

SAMPLE

Notice of Eligibility Form
Instructions

PURPOSE

1. To notify Title V, Primary Health Care, or Expanded Primary Health Care applicants that they are either eligible or not eligible for assistance.
2. To notify Title V, Primary Health Care, or Expanded Primary Health Care clients of their responsibilities to report changes in their situation and their liability if they fail to report changes.

PROCEDURE

When to Prepare

Complete form for individuals applying for Title V, Primary Health Care, or Expanded Primary Health Care.

Number of Copies

Complete an original and one copy.

Transmittal

Face-to-face or mail form to the individual applying for assistance. File copy in the case record.

Form Retention

Keep the case record copy for three state fiscal years after eligibility begins. However, eligibility is valid for a maximum of twelve months.

DETAILED INSTRUCTIONS

Complete the information listed on the form.

SAMPLE

Family & Community Health Services Division Notice of Eligibility

Aviso de derecho a participar

This form is required.

Appendix D2

Date/Fecha	**Case No./**No. 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 is APPROVED.**

   Su solicitud individual o familiar del programa Título V, el programa Atención Primaria de Salud y el programa Atención Primaria de Salud Ampliado ha sido **APROBADA**.

☐ **EPHC program** EPHC programa	☐ **Epilepsy program** Epilepsia programa
☐ **PHC program** PHC programa	☐ **Title V program** Título V programa

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. **You must notify this office as soon as possible of any changes in your situation such as changes in income, property, 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.

4. **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.

5. **You are responsible for renewing your eligibility prior to your certification expiration date. A DSHS Funding Source – Screening and Eligibility Form (Form EF05-13229) 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 revisión del derecho a participar según las fuentes de financiación 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.

SAMPLE

Family & Community Health Services Division Notice of Ineligibility

Aviso de Inhabilitacion del Derecho a Participar

This form is required.

Appendix D3

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

On the basis of information received by this office, the following action is being taken regarding the:

Sobre la base de la información recibida por esta oficina, se adoptarán las medidas siguientes con respecto a la:

☐ **EPHC program** ☐ **Epilepsy program**

☐ **PHC program** ☐ **Title V program**

☐ EPHC programa ☐ Epilepsia programa

☐ PHC programa ☐ Título V programa

☐ **Your application for benefits has been denied because:**

_____

_____

Su solicitud de beneficios se ha negado debido a que:

_____

_____

☐ **You will not be eligible for benefits after**

_____

(Eligibility End Date)

because: _____

_____

(Only the checked box applies to you.)

Usted no será elegible para recibir beneficios después

_____

(Fecha en que termina su derecho a participar)

porque: _____

_____

(Sólo la casilla marcada se aplica a usted).

If you believe this decision is not correct, you may submit written notification requesting an appeal to the Department of State Health Services, Office of General Counsel, Fair Hearings Officer, P.O. Box 149347, Austin, TX, 78714-9347. Si cree que esta decisión es incorrecta, puede presentar una notificación en la que solicite una apelación ante el Departamento Estatal de Servicios de Salud de Texas. Si tiene alguna pregunta, por favor póngase en contacto con Asuntos Gubernamentales DSHS al P.O. Box 149347, Austin, TX, 78714-9347.

Signature/Firma: _____

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

_____ **Signature**/Firma

_____ **Date**/Fecha

SYSTEM

Promotor(a) or Community Health Worker **APPENDIX E**

Definition

"Promotor(a)" or "Community Health Worker"--A person who, with or without compensation is a liaison and provides cultural mediation between health care and social services, and the community. A promotor(a) or community health worker: is a trusted member, and has a close understanding of, the ethnicity, language, socio-economic status, and life experiences of the community served. A promotor(a) or community health worker assists people to gain access to needed services and builds individual, community, and system capacity by increasing health knowledge and self-sufficiency through a range of activities such as outreach, patient navigation and follow-up, community health education and information, informal counseling, social support, advocacy, and participation in clinical research.

Promotores or community health workers demonstrate skills in eight core competencies:

- Communication skills
- Interpersonal skills
- Service coordination skills
- Capacity-building skills
- Advocacy skills
- Teaching skills
- Organizational skills
- Knowledge base

Promotor(a) or Community Health Worker Training and Certification Program

Texas law, Chapter 48, Health and Safety Code, provides authority to DSHS to administer a certification program for promotores or community health workers. The statute notes that certification is mandatory for a promotor(a) or community health worker receiving compensation for services provided.

The Promotor(a) or Community Health Worker Training and Certification Program provides certification for:

- Promotores or Community Health Workers
- Instructors
- Training Programs.

Certification Requirements for Promotores or Community Health Workers

- Completion of an approved 160-hour competency-based Community Health Worker training program certified by DSHS

  OR

- Experience – At least 1,000 cumulative hours of community health work services within the most recent six (6) years. Experience is verified with the supervisor(s) noted in the application.

Certification is for two years. Promotores or community health workers must complete 20 hours of continuing education and submit an application for renewal of their certification.

Applications and additional information may be found at http://www.dshs.state.tx.us/mch/chw.shtm

For more information, please contact the Promotor(a) or Community Health Worker Training and Certification Program at chw@dshs.state.tx.us or call 512-776-2570 or 512-776-2624.

Chapter 261 of the Texas Family Code

DSHS Child Abuse Screening, Documenting, and Reporting Policy for Contractors Providers
Revised effective January 1, 2009

Against the Law in Texas for Children under the age of 17 to have SEX
Penal Code §21.11 (sexual indecency with a child)

Rider

DSHS Legislative Mandate to Monitor Potential Child Abuse

Less than 14 years of age

Positive Pregnancy

Positive STD/STI not acquired through perinatal transmission

Report

Chapter 261 patients who are less than 14 years old Sexually Active

There is no affirmative defense for sex with a minor under the age of 14

Report

Chapter 261 Sexually Active

Less than 17 years of age (14, 15, 16 year olds)

Affirmative Defense

Sexual partner not more than 3 year age difference than patient

No force, violence or coercion

Sexual partner is not of same sex

Do Not Report

INSTRUCTIONS FOR COMPLETING THE MONTHLY REIMBURSEMENT REQUEST

Reimbursement Requests should be submitted, along with the Purchase Voucher Form 4116, within 30 days following the end of the month covered by the bill. A final closeout reimbursement request must be submitted not later than 45 days following the end of the contract term. It is important all requested information is entered on the form. All forms must be sent together in the Excel format. An incomplete form, missing a form, or not in the Excel format may delay the processing of your reimbursement request. If you have questions about completing the form please call (512) 776-6443 for assistance.

*** Required Information will either be completed by the contractor or auto populated. The rest of the top section headings remain blank on the MRR and will be filled in on the Purchase Voucher Form 4116.**

Section	Entry
***Contractor Name**	Contractor must enter the Legal name of contractor as reflected in the contract attachment
DSHS Program	
Payee Name	
Purchase Order #	
Payee Address	
Contract #	
Attachment #	
Payee Address	
City, ST, Zip	
Contract Term	
Payee Vendor ID No	
Type of Entity	
***Period Covered by this Report**	Contractor must enter the contract month and year covered by this report (month, year)
***Services and Amount**	Will auto populate.
***Less Program Income**	Enter the amount of HHSC's' share of program income (PI) collected during the month.
***Less Non-HHSC funding**	If the reported expenditures are being partially funded by non-HHSC sources (i.e. agency's own funds, other State/Federal sources, local funds, etc), and all costs of the effort are reflected in the reported expenditures, enter the cumulative amount of non-HHSC funding here.
***Reimbursement Requested**	Will auto populate.

SAMPLE

For Internal Use Only: Voucher#

TEXAS Department of State Health Services

MONTHLY REIMBURSEMENT REQUEST

TITLE V MCH FEE FOR SERVICE PROGRAM (Child Health & Child Dental)

For contractor's services rendered in the performance of the DSHS contract attachment identified below.

Contract Term: 9/1/2016 through 8/31/2017

Contractor Name:			
Payee Name:			
Address 1:		DSHS Program	**CHS/TV-CHILD HLTH**
Address 2:		Purchase Order #	
City, ST, Zip:		Contract #	
Payee Vendor ID#		Attachment #	
Type of Entity		Period Covered by this Report (Mo/Yr):	

Ages 1-21 Years (185):		***Ages 0-11 Months (186)***		***Totals:***	
Amt of Services:		**Amt of Services:**		**Amt of Services:**	
Child Health	$ -	**Child Health**	$ -	**Child Health**	$ -
Less Program Income:		**Less Program Income:**		**Less Program Income:**	$ -
Total:	$ -	**Total:**	$ -	**Total:**	$ -
Child Dental	$ -	**Child Dental**	$ -	**Child Dental**	$ -
Less Program Income:		**Less Program Income:**		**Less Program Income:**	$ -
Total:	$ -	**Total:**	$ -	**Total:**	$ -
Total for 185	**$ -**	**Total for 186**	**$ -**	**Total for 185+186**	**$ -**

For Internal Use Only:		
	LESS: NON-DSHS FUNDING	
	OTHER	
Received Date	**REIMBURSEMENT REQUESTED =**	**$ -**

Prepared BY:	**Telephone #**

TITLE V Maternal-Child Services Report (Child Health)

Children and Adolescent Ages 1-21 Years (185)

Contractor Name: 0

Report Period: Jan-00

Office Visits

Code	Brief Description	Rate	Qty	$Amt
99382	Well child visit - new (1-4 yr)	$92.47		$ -
99383	Well child visit - new (5-11 yr)	$92.09		$ -
99384	Well child visit - new (12-17 yr)	$100.43		$ -
99385	Well child visit - new (18-21 yr)	$100.43		$ -
99392	well child visit - established (1-4 yr)	$79.28		$ -
99393	Well child visit - established (5-11 yr)	$84.72		$ -
99394	Well child visit - established (12-17 yr)	$92.40		$ -
99395	Well child visit - established (18-21 yr)	$92.40		$ -
99429-U5	Oral evaluation and fluoride varnish in the medical home	$34.16		$ -
99202 CH	Sick visit - new	$45.56		$ -
99203 CH	Sick visit - new	$61.56		$ -
99204 CH	Sick visit - new	$90.07		$ -
99205 CH	Sick visit - new	$111.98		$ -
99211 CH	Sick visit - established; well follow-up	$14.96		$ -
99212 CH	Sick visit - established	$25.04		$ -
99213 CH	Sick visit - established	$37.64		$ -
99214 CH	Sick visit - extablished	$52.86		$ -
99215 CH	Sick visit - established	$81.38		$ -
			0	$ -

Counseling

Code	Brief Description	Rate	Qty	$Amt
S9470	Nutrition counseling	$55.02		$ -
			0	$ -

Case Management

Code	Brief Description	Rate	Qty	$Amt
G9012-U5-U2 (TH)	Comprehensive visit	$146.16		$ -
G9012-U5-TS (TH)	Follow-up visit (face to face)	$122.31		$ -
G9012-TS	Follow-up (telephone)	$29.36		$ -
			0	$ -

TITLE V Maternal-Child Services Report (Child Health)

Children and Adolescent Ages 1-21 Years (185)

Contractor Name: 0

Report Period: Jan-00

Laboratory

Code	Brief Description	Rate	Qty	$Amt
99000	Lab handling fee	$ 9.30		$ -
80061	Lipid Profile w/cholesterol	$ 18.22		$ -
81000	Urinalysis, by dipsticdk or tablet, non-automated, with microscopy	$ 4.31		$ -
81001	Urinalysis, by dipstick or tablet, automated, with microscopy - done in office	$ 4.31		$ -
81002	Urinalysis, dipstick or tablet, nonautomated	$ 3.48		$ -
81003	Urinalysis, by dipstick or tablet, automated, without microscopy	$ 3.06		$ -
81015	Urinalysis, microscopic only	$ 4.14		$ -
81025	Urine pregnancy test, visual comparison methods- done in office	$ 8.61		$ -
82465	Cholesterol, Total	$ 5.92		$ -
82947	Glucose, blood, except reagent strip	$ 5.34		$ -
82948	Glucose, blood, reagent strip - done in office	$ 4.31		$ -
83020	Hemoglobin Electrophoresis	$ 17.52		$ -
83655	Lead	$ 16.47		$ -
85013	Microhematocrit, spun -done in office	$ 3.23		$ -
85014	Hematocrit	$ 3.23		$ -
85018	Hemoglobin	$ 3.23		$ -
85025	CBC with differential, automated	$ 10.58		$ -
85027	CBC, automated	$ 8.81		$ -
86580	Tb skin test, intradermal - done in office	$ 6.17		$ -
86592	Syphilis	$ 5.81		$ -
86695	Herpes simplex, type 1	$ 17.95		$ -
86696	Herpes simplex, type 2	$ 26.34		$ -
86689	HTLV/HIV confirmatory test	$ 26.34		$ -
86701	HIV-1 antibody	$ 12.09		$ -
86703	HIV-1 and HIV-2, single assay	$ 18.66		$ -
86762	Rubella antibody	$ 19.58		$ -
86803	Hepatitis C antibody	$ 19.42		$ -
87070	Culture, bacterial; any source other than blood or stool; with presumptive identification of isolates	$ 11.72		$ -
87086	Urine culture, bacterial, quantitative	$ 10.99		$ -
87088	Urine culture, bacterial, with presumptive identification of isolates	$ 11.02		$ -
87102	Culture, fungi, with presumptive identification of isolates, source other than blood, skin, hair or nail	$ 11.43		$ -
87110	Chlamydia culture	$ 26.66		$ -
87184	Susceptibility Test	$ 9.39		$ -
87205	Smear with interpretation, routine stain for bacteria, fungi or cell types	$ 5.81		$ -
87210	Wet mount for infectious agents (e.g. saline, India ink, KOH preps)	$ 5.81		$ -
87220	Tissue examination by KOH slide of samples from skin, hair or nails for fungi, ectoparasite ova, mites	$ 5.81		$ -
87252	Virus isolation, tissue culture inoculation and presumptive identification (herpes)	$ 35.48		$ -
87340	Hepatitis B surface antigen, by enzyme immunoassay technique	$ 14.06		$ -
87389	HIV-1 AG with HIV 1 & 2 AB	$ 32.77		$ -
87480	Candida species, direct probe technique	$ 27.29		$ -
87491	Chlamydia, amplified probe technique	$ 47.76		$ -
87510	Gardnerella vaginalis, direct probe technique	$ 27.29		$ -
87591	Gonorrhea, amplified probe technique	$ 47.76		$ -
87623	Human Paillomavirus, low-risk types (warts)	$ 47.87		$ -
87624	HPV, types 16,18,31,33,35,39,45,51,52,56,58,59	$ 47.87		$ -
87625	HPV, types 16 and 18 only includes type 45, if performed	$ 47.87		$ -
87660	Trichomonas vaginalis, direct probe technique -	$ 27.29		$ -
87800	Infectious agent, multiple organisms, direct probe	$ 54.59		$ -
87810	Chlamydia, immunoassay w/ direct optical observation.	$ 16.32		$ -
87850	Gonorrhea, immunoassay with direct optical observation	$ 16.32		$ -
88142	Cytopathology, cervical/vaginal, liquid based, automated	$ 27.57		$ -
88150	Cytopathology, cervical/vaginal,slides, manual, the Bethesda System	$ 14.38		$ -
88164	Cytopathology, cervical/vaginal,slides, manual, the Bethesda System	$ 14.38		$ -
88175	Cytopathology, cervical/vaginal, any reporting system, fluid based, automated screening with manual rescreening or review.	$ 36.05		$ -
			0	$ -
		Total Amount:	0	$ -

Prepared by: *Telephone #:*

TITLE V Maternal-Child Services Report (Dental)

APPENDIX H

Children and Adolescent Ages 1-21 Years (185)

Contractor Name: 0

Report Period: Jan-00

Code	Brief Decription	Rate	Qty	$Amt
D0120	Periodic oral evaluation	$29.44		$ -
D0140	Limited oral evaluation	$19.16		$ -
D0150	Comprehensive oral evaluation	$36.04		$ -
			0	$ -

Radiology

Code	Brief Decription	Rate	Qty	$Amt
D0272	Bitewings (2)	$23.86		$ -
D0274	Bitewings (4)	$35.32		$ -
D0210	Intraoral Complete series (Including bitewings)	$72.08		$ -
D0220	Periapical First Film (x-ray)	$12.82		$ -
D0230	Periapical Additional Film (x-ray)	$11.74		$ -
D0330	Panoramic Film	$65.08		$ -
			0	$ -

Procedures

Code	Brief Decription	Rate	Qty	$Amt
D0145	Diagnostic and Preventive Services performed for child 12-36 months	$144.97		$ -
D1110	Dental Cleaning - 13-21 yrs	$56.00		$ -
D1120	Dental Cleaning - 1 to 12 years	$37.50		$ -
D1206	Topical application of fluoride varnish	$15.00		$ -
D1208	Topical application of fluoride	$14.70		$ -
D1351	Sealants - Permanent	$28.82		$ -
D1351	Sealants - Primary if medically necessary	$28.82		$ -
D2140	1 Surface Amalgam - Primary	$61.98		$ -
D2140	1 Surface Amalgam - Perm	$65.72		$ -
D2150	2 Surface Amalgam - Primary	$82.90		$ -
D2150	2 Surface Amalgam - Perm	$87.46		$ -
D2160	3 Surface Amalgam - Primary	$90.01		$ -
D2160	3 Surface Amalgam - Perm	$111.42		$ -
D2161	Amalgam - 4 or more surfaces - Primary	$109.70		$ -
D2161	Amalgam - 4 or more surfaces - Permanent	$125.00		$ -
D2330	Resin - 1 surface / anterior	$79.34		$ -
D2331	Resin - 2 surface / anterior	$105.14		$ -
D2332	Resin - 3 surface / anterior	$137.28		$ -
D2335	Resin-based composite - 4 or more surfaces or involving the incisal angle (anterior)	$170.38		$ -
D2391	Resin - 1 surface / posterior - Primary	$67.91		$ -
D2391	Resin - 1 surface / posterior - Perm	$84.08		$ -
D2392	Resin - 2 surface / posterior - Primary	$98.98		$ -
D2392	Resin - 2 surface / posterior - Perm	$110.20		$ -
D2393	Resin - 3 surface / posterior - Primary	$104.17		$ -
D2393	Resin - 3 surface / posterior - Perm	$121.00		$ -
D2930	Stainless steel crown - Primary	$156.06		$ -
D2931	Stainless steel crown - Perm	$162.50		$ -
D3220	Therapeutic pulpotomy	$87.96		$ -
D3310	Anterior Root Canal	$355.98		$ -
D7140	Extraction	$67.04		$ -
D9230	Analgesia, anxiolysis, inhalation of nitrous oxide	$28.38		$ -
			0	$ -
		Total Amount:	0	$ -

Prepared by:

Telephone #:

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TITLE V Maternal-Child Services Report (Child Health)

Infants Ages 0-11 Months (186)

APPENDIX H

Contractor Name:	0
Report Period:	Jan-00

Office Visits

Code	Brief Description	Rate	Qty	$Amt
99381	Well child visit - new (< 1 yr)	$84.51		$ -
99391	Well child visit - established - (< 1 yr)	$77.75		$ -
99429-U5	Oral evaluation and fluoride varnish in the medical home	$34.16		$ -
99202 CH	Sick visit - new	$45.56		$ -
99203 CH	Sick visit - new	$61.56		$ -
99204 CH	Sick visit - new	$90.07		$ -
99205 CH	Sick visit - new	$111.98		$ -
99211 CH	Sick visit - established; well follow-up	$14.96		$ -
99212 CH	Sick visit - established	$25.04		$ -
99213 CH	Sick visit - established	$37.64		$ -
99214 CH	Sick visit - extablished	$52.86		$ -
99215 CH	Sick visit - established	$81.38		$ -
			0	**$** -

Counseling

Code	Brief Description	Rate	Qty	$Amt
S9470	Nutrition counseling	$55.02		$ -
			0	**$** -

Case Management

Code	Brief Description	Rate	Qty	$Amt
G9012-U5-U2 (TH)	Comprehensive visit	$146.16		$ -
G9012-U5-TS (TH)	Follow-up visit (face to face)	$122.31		$ -
G9012-TS	Follow-up (telephone)	$29.36		$ -
			0	**$** -

The linked image cannot be displayed. The file may have been moved, renamed, or deleted. Verify that the link points to the correct file and location.

TITLE V Maternal-Child Services Report (Child Health)

Infants Ages 0-11 Months (186)

APPENDIX H

Contractor Name: 0

Report Period: Jan-00

Laboratory

Code	Brief Description	Rate	Qty	$Amt
99000	Lab handling fee	$ 9.30		$ -
80061	Lipid Profile w/cholesterol	$ 18.22		$ -
81000	Urinalysis, by dipstick or tablet, non-automated, with microscopy	$ 4.31		$ -
81001	Urinalysis, by dipstick or tablet, automated, with microscopy - done in office	$ 4.31		$ -
81002	Urinalysis, dipstick or tablet, nonautomated	$ 3.48		$ -
81003	Urinalysis, by dipstick or tablet, automated, without microscopy	$ 3.06		$ -
81015	Urinalysis, microscopic only	$ 4.14		$ -
82465	Cholesterol, Total	$ 5.92		$ -
82947	Glucose, blood, except feagent strip	$ 5.34		$ -
82948	Glucose, blood, reagent strip - done in office	$ 4.31		$ -
83020	Hemoglobin Electrophoresis	$ 17.52		$ -
83655	Lead	$ 16.47		$ -
85013	Microhematocrit, spun -done in office	$ 3.23		$ -
85014	Hematocrit	$ 3.23		$ -
85018	Hemoglobin	$ 3.23		$ -
85025	CBC with differential, automated	$ 10.58		$ -
85027	CBC, automated	$ 8.81		$ -
86580	Tb skin test, intradermal - done in office	$ 6.17		$ -
86592	Syphilis	$ 5.81		$ -
86689	HTLV/HIV confirmatory test	$ 17.95		$ -
86695	Herpes simplex, type 1	$ 26.34		$ -
86696	Herpes simplex, type 2	$ 26.34		$ -
86701	HIV-1 antibody	$ 12.09		$ -
86703	HIV-1 and HIV-2, single assay	$ 18.66		$ -
86762	Rubella antibody	$ 19.58		$ -
86803	Hepatitis C antibody	$ 19.42		$ -
87070	Culture, bacterial; any source other than blood or stool; with presumptive identification of isolates	$ 11.72		$ -
87086	Urine culture, bacterial, quantitative	$ 10.99		$ -
87088	Urine culture, bacterial, with presumptive id of isolates	$ 11.02		$ -
87102	Culture, fungi, with presumptive id of isolates, source other than blood,	$ 11.43		$ -
87110	Chlamydia culture	$ 26.66		$ -
87184	Susceptibility Test	$ 9.39		$ -
87205	Smear with interpretation, routine stain for bacteria, fungi or cell types	$ 5.81		$ -
87210	Wet mount for infectious agents (e.g. saline, India ink, KOH preps)	$ 5.81		$ -
87220	Tissue examination by KOH slide of samples from skin, hair or nails for fungi, ectoparasite ova, mites	$ 5.81		$ -
87252	Virus isolation, tissue culture inoculation and presumptive identification (herpes)	$ 35.48		$ -
87340	Hepatitis B surface antigen, by enzyme immunoassay technique	$ 14.06		$ -
87389	HIV-1 AG with HIV 1 & 2 AB	$ 32.77		$ -
87480	Candida species, direct probe technique	$ 27.29		$ -
87491	Chlamydia, amplified probe technique	$ 47.76		$ -
87510	Gardnerella vaginalis, direct probe technique	$ 27.29		$ -
87591	Gonorrhea, amplified probe technique	$ 47.76		$ -
87623	Human Paillomavirus, low-risk types (warts)	$ 47.87		$ -
87624	HPV, types 16,18,31,33,35,39,45,51,52,56,58,59	$ 47.87		$ -
87625	HPV, types 16 and 18 only includes type 45, if performed	$ 47.87		$ -
87660	Trichomonas vaginalis, direct probe technique -	$ 27.29		$ -
87800	Infectious agent, multiple organisms, direct probe	$ 54.59		$ -
87810	Chlamydia, immunoassay w/ direct optical observation.	$ 16.32		$ -
87850	Gonorrhea, immunoassay with direct optical observation	$ 16.32		$ -
88142	Cytopathology, cervical/vaginal, liquid based, automated	$ 27.57		$ -
88150	Cytopathology, cervical/vaginal, slides, manual, the Bethesda System	$ 14.38		$ -
88164	Cytopathology, cervical/vaginal, slides, manual, the Bethesda System	$ 14.38		$ -
88175	Cytopathology, cervical/vaginal, any reporting system, fluid based, automated screening with manual rescreening or review.	$36.05		$ -
			0	$ -
		Total Amount:	0	$ -

Prepared by: *Telephone #*

TITLE V Maternal-Child Services Report (Dental)

Infants Ages 0-11 Months (186)

Contractor Name: 0

Report Period: Jan-00

Code	Brief Description	Rate	Qty	$Amt
D0120	Periodic oral evaluation	$29.44		$ -
D0140	Limited oral evaluation	$19.16		$ -
D0150	Comprehensive oral evaluation	$36.04		$ -
			0	$ -

Radiology

Code	Brief Description	Rate	Qty	$Amt
D0272	Bitewings (2)	$23.86		$ -
D0274	Bitewings (4)	$35.32		$ -
D0210	Intraoral Complete series (including bitewings)	$72.08		$ -
D0220	Periapical First Film (x-ray)	$12.82		$ -
D0230	Periapical Additional Film (x-ray)	$11.74		$ -
D0330	Panoramic Film	$65.08		$ -
			0	$ -

Procedures

Code	Brief Description	Rate	Qty	$Amt
D0145	Diagnostic and Preventive Services performed for child 6 mo. - 12mo.	$144.97		$ -
D1120	Dental Cleaning - <1 Yr	$37.50		$ -
D1206	Topical application of fluoride varnish	$15.00		$ -
D1208	Topical application of fluoride	$14.70		$ -
D1351	Sealants - Primary if medically necessary	$28.82		$ -
D2140	1 Surface Amalgam - Primary	$61.98		$ -
D2150	2 Surface Amalgam - Primary	$82.90		$ -
D2160	3 Surface Amalgam - Primary	$90.01		$ -
D2161	Amalgam - 4 or more surfaces - Primary	$109.70		$ -
D2330	Resin - 1 surface / anterior	$79.34		$ -
D2331	Resin - 2 surface / anterior	$105.14		$ -
D2332	Resin - 3 surface / anterior	$137.28		$ -
D2335	Resin-based composite - 4 or more surfaces or involving the incisal angle (anterior)	$170.38		$ -
D2391	Resin - 1 surface / posterior - Primary	$67.91		$ -
D2392	Resin - 2 surface / posterior - Primary	$98.98		$ -
D2393	Resin - 3 surface / posterior - Primary	$104.17		$ -
D2930	Stainless steel crown - Primary	$156.06		$ -
D3220	Therapeutic pulpotomy	$87.96		$ -
D7140	Extraction	$67.04		$ -
D9230	Analgesia, anxiolysis, inhalation of nitrous oxide	$28.38		$ -
			0	$ -

Total Amount:	0	$ -

Prepared by:

Telephone #:

Title V Maternal & Child Health (MCH) Fee for Service (FFS) Child Health & Child Dental — Monthly Activity Report

Contractor: 0

Period Covered by this Report: **01/00**

Total MCH Services Monthly Activity Report — **Unduplicated Clients Receiving Services Billed to Title V FFS**

AGE	RACE	CHILD HEALTH CLIENTS		CHILD DENTAL CLIENTS		
		Hispanic/Latino	Not Hispanic/Latino	Hispanic/Latino	Not Hispanic/Latino	
0-11M	White					
0-11M	Black or African American					
0-11M	Asian					
0-11M	American Indian or Alaskan Native					
0-11M	Native Hawaiian or other Pac. Islander					
0-11M	Unknown					
1-5Y	White					
1-5Y	Black or African American					
1-5Y	Asian					
1-5Y	American Indian or Alaskan Native					
1-5Y	Native Hawaiian or other Pac. Islander					
1-5Y	Unknown					
6-12Y	White					
6-12Y	Black or African American					
6-12Y	Asian					
6-12Y	American Indian or Alaskan Native					
6-12Y	Native Hawaiian or other Pac. Islander					
6-12Y	Unknown					
13-17Y	White					
13-17Y	Black or African American					
13-17Y	Asian					
13-17Y	American Indian or Alaskan Native					
13-17Y	Native Hawaiian or other Pac. Islander					
13-17Y	Unknown					
18-19Y	White					
18-19Y	Black or African American					
18-19Y	Asian					
18-19Y	American Indian or Alaskan Native					
18-19Y	Native Hawaiian or other Pac. Islander					
18-19Y	Unknown					
20-21Y	White					
20-21Y	Black or African American					
20-21Y	Asian					
20-21Y	American Indian or Alaskan Native					
20-21Y	Native Hawaiian or other Pac. Islander					
20-21Y	Unknown					
>22Y	White					
>22Y	Black or African American					
>22Y	Asian					
>22Y	American Indian or Alaskan Native					
>22Y	Native Hawaiian or other Pac. Islander					
>22Y	Unknown					

*Unduplicated clients are those billed for the first time within a type of service in each fiscal year

For Internal Use Only: Voucher#

MONTHLY REIMBURSEMENT REQUEST

TITLE V MCH FEE FOR SERVICE PROGRAM (Prenatal Medical and Prenatal Dental)

For contractor's services rendered in the performance of the DSHS contract attachment identified below.

Contract Term: 9/1/2016 through 8/31/2017

Contractor Name:			
Payee Name:			
Address #1:		DSHS Program	**CHS/TV-PRENATAL**
Address #2:		Purchase Order #	
City, ST, Zip:		Contract #	
Payee Vendor ID#		Attachment #	
Type of Entity		Period Covered by this Report (Mo/Yr):	

Ages 1-21 Years (185)		***Ages 22 & Older (186)***		***Totals:***	
Amt of Services:		**Amt of Services:**		**Amt of Services:**	
Prenatal Medical	$ -	**Prenatal Medical**	$ -	**Prenatal Medical**	$ -
Less Program Income:		**Less Program Income:**		**Less Program Income:**	$ -
Total:	$ -	**Total:**	$ -	**Total:**	$ -
Prenatal Dental	$ -	**Prenatal Dental**	$ -	**Prenatal Dental**	$ -
Less Program Income:		**Less Program Income:**		**Less Program Income:**	$ -
Total:	$ -	**Total:**	$ -	**Total:**	$ -
Total for 185	**$ -**	**Total for 186**	**$ -**	**Total for 185+186**	**$ -**

For Internal Use Only:	**LESS: NON-DSHS FUNDING**	
	OTHER	
Received Date	**REIMBURSEMENT REQUESTED =**	**$ -**

Prepared By:	**Telephone #**

TITLE V Maternal-Child Services Report (Prenatal Medical)

Children and Adolescent Ages 1-21 Years (185)

Contractor Name: 0

Report Period: Jan-00

Office Visits

Code	Brief Description	Rate	Qty	$Amt
99202 TH	Office Visit, New Client, Expanded focus, Straightforward decision-making (20 min)	$45.56		$ -
99203 TH	Office Visit, New Client, Detailed exam, Low Complexity decision-making	$61.56		$ -
99204 TH	Initial Prenatal Visit/Office Visit, New Client, Comprehensive Exam, Moderate Complexity decision-making (45 min)	$90.07		$ -
99205 TH	Office Visit New Client, Comprehensive exam, High Complexity decision-making (60 min)	$111.98		$ -
99211 TH	Office Visit, Established Client, Very brief, Straightforward decision-making (5 min)	$14.96		$ -
99212 TH	Office Visit, Established Client, Expanded focus, Straightforward decision-making (10 min)	$25.04		$ -
99213 TH	Office Visit, Established Client, Detailed exam, Low Complexity decision-making (15 min)	$37.64		$ -
99214 TH	High Risk antepartum care visit, Established Client, Moderate Complexity decision-making (25 min)	$52.86		$ -
99215 TH	Office Visit, Established Client, Comprehensive exam, High Complexity decision-making (40 min)	$81.38		$ -
59430 TH	Postpartum Visit	$97.09		$ -
			0	$ -

Case Management

Code	Brief Description	Rate	Qty	$Amt
G9012-U5-U2 (TH)	Comprehensive visit	$146.16		$ -
G9012-U5-TS (TH)	Follow-up visit (face to face)	$122.31		$ -
G9012-TS (TH)	Follow-up (telephone)	$29.36		$ -
			0	$ -

Radiology

Code	Brief Description	Rate	Qty	$Amt
76805	Complete ultrasound	$124.34		$ -
76816	Followup or limited ultrasound	$99.64		$ -
59025	Non-stress test	$35.23		$ -
76818	Biophysical Profile	$103.85		$ -
			0	$ -

Supplies & Injectables

Code	Brief Description	Rate	Qty	$Amt
A4253	Blood glucose test strips	$28.28		$ -
A4258	Springload Device for lancet	$14.65		$ -
A4259	Lancets (100 box)	$11.10		$ -
J2790	Rho (D) immune globulin	$75.92		$ -
90656	Influenza Virus vaccine, split virus, preservative free	$ 13.28		$ -
90658	Influenza Virus vaccine, split virus,	$ 16.16		$ -
90686	Influenza Virus vaccine, quadrivalent, split virus, perservative free	$ 16.94		$ -
90688	Influenza Virus vaccine, quadrivalent, split virus	$ 15.87		$ -
90715	Tetanus, diphtheria toxoids & acellular pertussis vaccine (Tdap)	$ 27.17		$ -
			0	$ -

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TITLE V Maternal-Child Services Report (Prenatal Medical)

Children and Adolescent Ages 1-21 Years (185)

Contractor Name: 0

Report Period: Jan-00

Laboratory

Code	Brief Description	Rate	Qty	$Amt
80061	Lipid profile w/cholesterol	$ 18.22		$ -
81000	Urinalysis, by dipstick or tablet, non-automated, with microscopy	$ 4.31		$ -
81001	Urinalysis by dipstick or tablet, automated, with microscopy	$ 4.31		$ -
81002	Urinalysis, dipstick or tablet, nonautomated	$ 3.48		$ -
81003	Urinalysis by dipstick or tablet, automated, without microscopy	$ 3.06		$ -
81015	Urinalysis, microscopic only	$ 4.14		$ -
81025	Urine pregnancy test, visual comparison methods	$ 8.61		$ -
82105	Alpha-fetoprotein (AFP)	$ 22.83		$ -
82677	Estriol (uE3)	$ 32.91		$ -
82947	Glucose, blood, except reagent strip	$ 5.34		$ -
82948	Glucose, blood, reagent strip	$ 4.31		$ -
82951	Serum Glucose - 3 specimens	$ 17.52		$ -
84436	T4	$ 9.35		$ -
84443	TSH	$ 22.87		$ -
84479	T3 uptake	$ 8.81		$ -
84702	Human Chorionic Gonadotropin (hCG)	$ 11.89		$ -
84703	Chorionic gonadotropin, qualitative (pregnancy test)	$ 10.23		$ -
85013	Microhematocrit, spun	$ 3.23		$ -
85014	Hematocrit	$ 3.23		$ -
85018	Hemoglobin	$ 3.23		$ -
85025	CBC with differential, automated	$ 10.58		$ -
85027	CBC, automated	$ 8.81		$ -
86336	Inhibin-A	$ 21.21		$ -
86580	TB skin test, intradermal	$ 6.92		$ -
86592	Syphilis	$ 5.81		$ -
86689	HTLV/HIV confirmatory test	$ 26.34		$ -
86695	Herpes simplex, type 1	$ 17.95		$ -
86696	Herpes simplex, type 2	$ 26.34		$ -
86701	HIV-1 antibody	$ 12.09		$ -
86703	HIV-1 and HIV-2, signle assay-rapid HIV test	$ 18.66		$ -
86762	Rubella antibody	$ 19.58		$ -
86777	Toxoplasmosis, IgGIFA	$ 19.58		$ -
86778	Toxoplasma, IGM	$ 17.39		$ -
86803	Hepatitis C antibody	$ 19.42		$ -
86850	Blood, antibody screen	$ 6.92		$ -
86900	Blood typing, ABO	$ 4.06		$ -
86901	Rh typing	$ 4.06		$ -
87070	Culture, bacterial; any source other than blood or stool; with presumptive identification of isolates	$ 11.72		$ -
87081	GBS culture	$ 9.02		$ -
87086	Urine culture, bacterial, quantitative	$ 10.99		$ -
87088	Urine culture,bacterial, with presumptive id of isolates	$ 11.02		$ -
87102	Culture, fungi, with presumptive id of isolates, source other than blood, skin, hair or nail	$ 11.43		$ -
87110	Chlamydia culture	$ 26.66		$ -
87184	Susceptibility Test	$ 9.39		$ -
87205	Smear with interpretation, routine stain for bacteria, fungi or cell types	$ 5.81		$ -
87210	Wet mount for infectious agents (e.g. saline, India ink, KOH preps)	$ 5.81		$ -

87220	Tissue examination by KOH slide of samples from skin, hair or nails for fungi, ectoparasite ova, mites	$ 5.81		$ -
87252	Virus isolation, tissue culture inoculation and presemptive indentification (herpes)	$ 35.48		$ -
87340	Hepatitis B surface antigen, by enzyme immunossay technique	$ 14.06		$ -
87389	HIV-1 AG with HIV 1 & 2 AB	$ 32.77		$ -
87480	Candida species, direct probe technique	$ 27.63		$ -
87491	Chlamydia, amplified probe technique	$ 47.76		$ -
87510	Gardnerella vaginalis, direct probe technique	$ 27.29		$ -
87591	Gonorrhea, amplified probe technique	$ 47.76		$ -
87623	Human Paillomavirus, low-risk types (warts)	$ 47.87		$ -
87624	HPV, types 16,18,31,33,35,39,45,51,52,56,58,59	$ 47.87		$ -
87625	HPV, types 16 and 18 only includes type 45, if performed	$ 47.87		$ -
87660	Trichomonas vaginalis, direct probe technique	$ 27.29		$ -
87800	Infectious agent, multiple organisms, direct probe	$ 54.59		$ -
87810	Chlamydia, immunoassay w/direct optical observation	$ 16.32		$ -
87850	Gonorrhea, immunoassay with direct optical observation	$ 16.32		$ -
88142	Cytopathology, cervical/vaginal, liquid based, automated	$ 27.57		$ -
88150	Cytopathology, cervical/vaginal, slides, manual, the Bethesda System	$ 14.38		$ -
88164	Cytopathology, cervical/vaginal, slides, manual, the Bethesda System	$ 14.38		$ -
88175	Cytopathology, cervical/vaginal, any reporting system, fluid based, automated screening with manual rescreening or review.	$ 36.05		$ -
99000	Lab handling fee	$ 9.30		$ -
			0	$ -
		Total Amount:	0	$ -

Prepared by:

Telephone #:

EF21-12005 9/2016

TITLE V Maternal-Child Services Report (Prenatal Dental)

Children and Adolescent Ages 1-21 Years (185)

Contractor Name: 0

Report Period: Jan-00

Code	Brief Description	Rate	Qty	$Amt
D0120	Periodic oral evaluation	$29.44		$ -
D0150	Comprehensive oral evaluation	$36.04		$ -
			0	$ -

Radiology

Code	Brief Description	Rate	Qty	$Amt
D0210	Intraoral - complete series (including bitewings)	$72.08		$ -
D0220	Intraoral - periapical first film (x-ray)	$12.82		$ -
D0230	Intraoral - periapical additional film (x-ray)	$11.74		$ -
D0272	Bitewings - two films	$23.86		$ -
D0274	Bitewings - four films	$35.32		$ -
			0	$ -

Procedures

Code	Brief Description	Rate	Qty	$Amt
D1110	Prophylaxis - adult	$56.00		$ -
D1206	Topical application of fluoride varnish	$15.00		$ -
D1208	Topical application of fluoride	$14.70		$ -
D1351	Sealants - per tooth	$28.82		$ -
D2140	Amalgam - one surface	$65.72		$ -
D2150	Amalgam - two surfaces	$87.46		$ -
D2160	Amalgam - three surfaces	$111.42		$ -
D2161	Amalgam - four or more surfaces	$125.00		$ -
D2330	Resin-based composite one surface, anterior	$79.34		$ -
D2331	Resin-based composite - two surfaces, anterior	$105.14		$ -
D2332	Resin-based composite - three surfaces, anterior	$137.28		$ -
D2335	Resin-based composite - four or more surfaces, anterior	$170.38		$ -
D2391	Resin-based composite - one surface, posterior	$84.08		$ -
D2392	Resin-based composite - 2 surfaces, posterior	$110.20		$ -
D2393	Resin-based composite - three surfaces, posterior	$121.00		$ -
D2394	Resin-based composite - four or more surfaces, posterior	$135.00		$ -
D2791	Crown - full cast predominantly based metal	$264.00		$ -
D2931	Prefabricated stainless steel crown - permanent tooth	$162.50		$ -
D4341	Periodontal scaling and root planning - four or more teeth per quadrant	$56.25		$ -
D4355	Full mouth debridement to enable comprehensive evaluation and diagnosis	$75.00		$ -
D5110	Complete denture - maxillary (upper)	$375.00		$ -
D5120	Complete denture - mandibular (lower)	$375.00		$ -
D5211	Maxillary partial denture - resin base	$275.00		$ -
D5212	Mandibular partial denture - resin base	$275.00		$ -
D5213	Maxillary partial denture - cast metal framework	$400.00		$ -
D5214	Mandibular partial denture - cast metal framework	$400.00		$ -
D7140	Extraction, erupted tooth or exposed root	$67.04		$ -
D7210	Surgical removal of erupted tooth requiring removal of bone and or sectioning of tooth	$102.81		$ -
			0	$ -
		Total Amount:	0	$ -

Prepared by:

Telephone #:

TEXAS Department of State Health Services

TITLE V Maternal-Child Services Report (Prenatal Medical)

Women Ages 22 & Over (186)

Contractor Name: 0

Report Period: Jan-00

Office Visits

Code	Brief Description	Rate	Qty	$Amt
99202 TH	Office Visit, New Client, Expanded focus, Straightforward decision-making (20 min)	$41.09		$ -
99203 TH	Office Visit, New Client, Detailed exam, Low Complexity decision-making	$55.52		$ -
99204 TH	Initial Prenatal Visit/Office Visit, New Client, Comprehensive Exam, Moderate Complexity decision-making (45 min)	$81.24		$ -
99205 TH	Office Visit New Client, Comprehensive exam, High Complexity decision-making (60 min)	$101.00		$ -
99211 TH	Office Visit, Established Client, Very brief, Straightforward decision-making (5 min)	$13.49		$ -
99212 TH	Office Visit, Established Client, Expanded focus, Straightforward decision-making (10 min)	$22.59		$ -
99213 TH	Office Visit, Established Client, Detailed exam, Low Complexity decision-making (15 min)	$33.95		$ -
99214 TH	High Risk antepartum care visit, Established Client, Moderate Complexity decision-making (25 min)	$47.68		$ -
99215 TH	Office Visit, Established Client, Comprehensive exam, High Complexity decision-making (40 min)	$73.40		$ -
59430 TH	Postpartum Visit	$92.47		$ -
			0	$ -

Case Management

Code	Brief Description	Rate	Qty	$Amt
G9012-U5-U2 (TH)	Comprehensive visit	$146.16		$ -
G9012-U5-TS (TH)	Follow-up visit (face to face)	$122.31		$ -
G9012-TS (TH)	Follow-up (telephone)	$29.36		$ -
			0	$ -

Radiology

Code	Brief Description	Rate	Qty	$Amt
76805	Complete ultrasound	$118.42		$ -
76816	Followup or limited ultrasound	$94.89		$ -
59025	Non-stress test	$33.55		$ -
76818	Biophysical Profile	$98.90		$ -
			0	$ -

Supplies & Injectables

Code	Brief Description	Rate	Qty	$Amt
A4253	Blood glucose test strips	$28.28		$ -
A4258	Springload Device for lancet	$14.65		$ -
A4259	Lancets (100 box)	$11.10		$ -
J2790	Rho (D) immune globulin	$75.92		$ -
90656	Influenza Virus vaccine, split virus, preservative free	$ 13.28		$ -
90658	Influenza Virus vaccine, split virus,	$ 16.16		$ -
90686	Influenza Virus vaccine, quadrivalent, split virus, perservative free	$ 16.94		$ -
90688	Influenza Virus vaccine, quadrivalent, split virus	$ 15.87		$ -
90715	Tetanus, diphtheria toxoids & acellular pertussis vaccine (Tdap)	$ 27.17		$ -
			0	$ -

TEXAS Department of State Health Services

TITLE V Maternal-Child Services Report (Prenatal Medical)

Women Ages 22 & Over (186)

Contractor Name: 0

Report Period: Jan-00

Laboratory

Code	Brief Description	Rate	Qty	$Amt
80061	Lipid profile w/cholesterol	$ 18.22		$ -
81000	Urinalysis by dipstick or tablet, non-automated, with microscopy	$ 4.31		$ -
81001	Urinalysis by dipstick or tablet, automated, with microscopy	$ 4.31		$ -
81002	Urinalysis, dipstick or tablet, nonautomated	$ 3.48		$ -
81003	Urinalysis by dipstick or tablet, automated, without microscopy	$ 3.06		$ -
81015	Urinalysis, microscopic only	$ 4.14		$ -
81025	Urine pregnancy test, visual comparison methods	$ 8.61		$ -
82105	Alpha-fetoprotein (AFP)	$ 22.83		$ -
82677	Estriol (uE3)	$ 32.91		$ -
82947	Glucose, blood, except reagent strip	$ 5.34		$ -
82948	Glucose, blood, reagent strip	$ 4.31		$ -
82951	Serum Glucose - 3 specimens	$ 17.52		$ -
84436	T4	$ 9.35		$ -
84443	TSH	$ 22.87		$ -
84479	T3 uptake	$ 8.81		$ -
84702	Human Chorionic Gonadotropin (hCG)	$ 11.89		$ -
84703	Chorionic gonadotropin, qualitative (pregnancy test)	$ 10.23		$ -
85013	Microhematocrit, spun	$ 3.23		$ -
85014	Hematocrit	$ 3.23		$ -
85018	Hemoglobin	$ 3.23		$ -
85025	CBC with differential, automated	$ 10.58		$ -
85027	CBC, automated	$ 8.81		$ -
86336	Inhibin-A	$ 21.21		$ -
86580	TB skin test, intradermal	$ 6.92		$ -
86592	Syphilis	$ 5.81		$ -
86689	HTLV/HIV confirmatory test	$ 26.34		$ -
86695	Herpes simplex, type 1	$ 17.95		$ -
86696	Herpes simplex, type 2	$ 26.34		$ -
86701	HIV-1 antibody	$ 12.09		$ -
86703	HIV-1 and HIV-2, signle assay-rapid HIV test	$ 18.66		$ -
86762	Rubella antibody	$ 19.58		$ -
86777	Toxoplasmosis, IgGIFA	$ 19.58		$ -
86778	Toxoplasmosis, IGM	$ 17.39		$ -
86803	Hepatitis C antibody	$ 19.42		$ -
86850	Blood, antibody screen	$ 6.92		$ -
86900	Blood typing, ABO	$ 4.06		$ -
86901	Rh typing	$ 4.06		$ -
87070	Culture, bacterial; any source other than blood or stool; with presumptive identification of isolates	$ 11.72		$ -
87081	GBS culture	$ 9.02		$ -
87086	Urine culture, bacterial, quantitative	$ 10.99		$ -
87088	Urine culture, bactgerial, with presumptive id of isolates	$ 11.02		$ -
87102	Culture, fungi, with presumptive id of isolates, source other than blood, skin, hair or nail	$ 11.43		$ -
87110	Chlamydia culture	$ 26.66		$ -
87184	Susceptibility Test	$ 9.39		$ -
87205	Smear with interpretation, routine stain for bacteria, fungi or cell types	$ 5.81		$ -
87210	Wet mount for infectious agents (e.g. saline, India ink, KOH preps)	$ 5.81		$ -
87220	Tissue examination by KOH slide of samples from skin, hair or nails for fungi, ectoparasite ova, mites	$ 5.81		$ -
87252	Virus isolation, tissue culture inoculation and presumptive identification (herpes)	$ 35.48		$ -
87340	Hepatitis B surface antigen, by enzyme immunossay technique	$ 14.06		$ -
87389	HIV-1 AG with HIV 1 & 2 AB	$ 32.77		$ -
87480	Candida species, direct probe technique	$ 27.63		$ -
87491	Chlamydia, amplified probe technique	$ 47.76		$ -
87510	Gardnerella vaginalis, direct probe technique	$ 27.29		$ -
87591	Gonorrhea, amplified probe technique	$ 47.76		$ -
87623	Human Paillomavirus, low-risk types (warts)	$ 47.87		$ -
87624	HPV, types 16,18,31,33,35,39,45,51,52,56,58,59	$ 47.87		$ -
87625	HPV, types 16 and 18 only includes type 45, if performed	$ 47.87		$ -
87660	Trichomonas vaginalis, direct probe technique	$ 27.29		$ -
87800	Infectious agent, multiple organisms, direct probe	$ 54.59		$ -
87810	Chlamydia, immunoassay w/direct optical observation	$ 16.32		$ -
87850	Gonorrhea, immunoassay with direct optical observation	$ 16.32		$ -
88142	Cytopathology, cervical/vaginal, liquid based, automated	$ 27.57		$ -
88150	Cytopathology, cervical/vaginal, slides, manual,the Bethesda System	$ 14.38		$ -
88164	Cytopathology, cervical/vaginal, slides, manual,the Bethesda System	$ 14.38		$ -
88175	Cytopathology, cervical/vaginal, any reporting system, fluid based, automated screening with manual rescreening or review.	$ 36.05		$ -
99000	Lab handling fee	$ 9.30		$ -
			0	$ -
		Total Amount:	0	$ -

Prepared by: *Telephone #:*

TITLE V Maternal-Child Services Report (Prenatal Dental)

Women Ages 22 & Over (186)

Contractor Name: 0

Report Period: Jan-00

Code	Brief Description	Rate	Qty	$Amt
D0120	Periodic oral evaluation	$29.44		$ -
D0150	Comprehensive oral evaluation	$36.04		$ -
			0	$ -

Radiology

Code	Brief Description	Rate	Qty	$Amt
D0210	Intraoral - complete series (including bitewings)	$72.08		$ -
D0220	Intraoral - periapical first film (x-ray)	$12.82		$ -
D0230	Intraoral - periapical additional film (x-ray)	$11.74		$ -
D0272	Bitewings - two films	$23.86		$ -
D0274	Bitewings - four films	$35.32		$ -
			0	$ -

Procedures

Code	Brief Description	Rate	Qty	$Amt
D1110	Prophylaxis - adult	$56.00		$ -
D1206	Topical application of fluoride varnish	$15.00		$ -
D1208	Topical application of fluoride	$14.70		$ -
D1351	Sealants - per tooth	$28.82		$ -
D2140	Amalgam - one surface	$65.72		$ -
D2150	Amalgam - two surfaces	$87.46		$ -
D2160	Amalgam - three surfaces	$111.42		$ -
D2161	Amalgam - four or more surfaces	$125.00		$ -
D2330	Resin-based composite one surface, anterior	$79.34		$ -
D2331	Resin-based composite - two surfaces, anterior	$105.14		$ -
D2332	Resin-based composite - three surfaces, anterior	$137.28		$ -
D2335	Resin-based composite - four or more surfaces, anterior	$170.38		$ -
D2391	Resin-based composite - one surface, posterior	$84.08		$ -
D2392	Resin-based composite - 2 surfaces, posterior	$110.20		$ -
D2393	Resin-based composite - three surfaces, posterior	$121.00		$ -
D2394	Resin-based composite - four or more surfaces, posterior	$135.00		$ -
D2791	Crown - full cast predominantly based metal	$264.00		$ -
D2931	Prefabricated stainless steel crown - permanent tooth	$162.50		$ -
D4341	Periodontal scaling and root planning - four or more teeth per quadrant	$56.25		$ -
D4355	Full mouth debridement to enable comprehensive evaluation and diagnosis	$75.00		$ -
D5110	Complete denture - maxillary (upper)	$375.00		$ -
D5120	Complete denture - mandibular (lower)	$375.00		$ -
D5211	Maxillary partial denture - resin base	$275.00		$ -
D5212	Mandibular partial denture - resin base	$275.00		$ -
D5213	Maxillary partial denture - cast metal framework	$400.00		$ -
D5214	Mandibular partial denture - cast metal framework	$400.00		$ -
D7140	Extraction, erupted tooth or exposed root	$67.04		$ -
D7210	Surgical removal of erupted tooth requiring removal of bone and or sectioning	$102.81		$ -
			0	$ -
		Total Amount:	0	$ -

Prepared by:

Telephone #:

Title V Maternal & Child Health (MCH) Fee for Service (FFS) Prenatal Medical & Prenatal Dental Monthly Activity Report

Contractor: 0

TITLE **Period Covered by this Report:** **01/00**

Total MCH Services Monthly Activity Report **Unduplicated Clients Receiving Services Billed to Title V FFS**

AGE	RACE	PRENATAL MEDICAL CLIENTS		PRENATAL DENTAL CLIENTS		
		Hispanic/Latino	Not Hispanic/Latino	Hispanic/Latino	Not Hispanic/Latino	
6-12Y	White					
6-12Y	Black or African American					
6-12Y	Asian					
6-12Y	American Indian or Alaskan Native					
6-12Y	Native Hawaiian or other Pac. Islander					
6-12Y	Unknown					
13-17Y	White					
13-17Y	Black or African American					
13-17Y	Asian					
13-17Y	American Indian or Alaskan Native					
13-17Y	Native Hawaiian or other Pac. Islander					
13-17Y	Unknown					
18-19Y	White					
18-19Y	Black or African American					
18-19Y	Asian					
18-19Y	American Indian or Alaskan Native					
18-19Y	Native Hawaiian or other Pac. Islander					
18-19Y	Unknown					
20-21Y	White					
20-21Y	Black or African American					
20-21Y	Asian					
20-21Y	American Indian or Alaskan Native					
20-21Y	Native Hawaiian or other Pac. Islander					
20-21Y	Unknown					
>22Y	White					
>22Y	Black or African American					
>22Y	Asian					
>22Y	American Indian or Alaskan Native					
>22Y	Native Hawaiian or other Pac. Islander					
>22Y	Unknown					

*Unduplicated clients are those billed for the first time within a type of service in each fiscal year

INSTRUCTIONS FOR COMPLETING THE PURCHASE VOUCHER FORM 4116

Purchase Voucher Form 4116 should be submitted, along with the Reimbursement Requests, within 30 days following the end of the month covered by the bill. A final closeout reimbursement request must be submitted not later than 45 days following the end of the contract term. It is important all requested information is entered on the form. All forms must be sent together in the Excel format. An incomplete form, missing a form, or not in the Excel format may delay the processing of your reimbursement request. If you have questions about completing the form please call (512) 776-6443 for assistance.

Required Blocks to complete are listed in the table. Do not fill in the other blocks.

Section	Entry
#9 Agency number	14 digit vendor ID number
#12 Purchase order number	Purchase order number that comes from Kim Relph/Jennifer Underwood
#13 Document amount	Total amount of reimbursement. This comes from the total amount on the completed MRR form.
#14 Payee name/address	Your agency name and address as set up in eGrants.
#19 Service / Del Date	Month and year of the reimbursement request. Be sure this matches the period covered month and year on the MRR form.
#20 Description of Goods or Services	1.First type in your agency name. 2.Enter the contract start and end date which will be 9/1/16 through 8/31/17. 3.Enter the HHSC contract or document number. 4.Enter the Type of entity your agency is.
#23 Amount	Enter the total reimbursement amount. Be sure this amount is the same as the amount entered in block #13
#24 Vendor Certification	Enter a contact name and phone number with extension.
#26	Leave this block blank as that is for HHSC signature.

Health & Human Services Commission

PURCHASE VOUCHER

STATE OF TEXAS

(Shaded areas not used by Agency 529)

1. Archive reference number	2. Agency number	3. Agency name	4. Current document number
	529	Health & Human Services Commission	

5. Effective date		7. Orig pmt date	CONF	8. Doc agency
				529

9. Texas identification number	10. PDT	11. PCC	12. Purchase Order number	13. Document amount
				$

14. Payee name / address	15. GSC order number	17. AGENCY USE
	16. Lease number	

18 SFX 001	Ref Doc	IC	RC	TC	PCA	FY	COBJ	AOBJ	Amount				
	APPN	Fund	Pmt due date	Invoice date	Invoice number / Account Number	Invoice Received Date							
	DeptID/Speedchart				Requested Payment Date	Interest Control	Reason Code	R					
	Cap ind	Tag #	AGENCY USE										
18 SFX 001	Ref Doc	IC	RC	TC	PCA	FY	COBJ	AOBJ	Amount				
	APPN	Fund	Pmt due date	Invoice date	Invoice number / Account Number	Invoice Received Date							
	DeptID/Speedchart				Requested Payment Date	Interest Control	Reason Code	R					
	Cap ind	Tag #	AGENCY USE										
18 SFX 001	Ref Doc	IC	RC	TC	PCA	FY	COBJ	AOBJ	Amount				
	APPN	Fund	Pmt due date	Invoice date	Invoice number / Account Number	Invoice Received Date							
	DeptID/Speedchart				Requested Payment Date	Interest Control	Reason Code	R					

19. SERVICE / DEL DATE	20. DESCRIPTION OF GOODS OR SERVICES	21. QUANTITY	22. UNIT PRICE	23. AMOUNT
	Reimbursement for services as specified in the contrac between Health and Human Services Commission and (agency name). **Program: Title V Prenatal Medical & Prenatal Denta** **Contract Term:** (start date) **thru** (end date) **HHSC Doc #** **Type of Entity:**			$

24. VENDOR CERTIFICATION	Phone *(Area code and number)*	25. Entered by
Vendor Contact Name	Phone *(Area code and number)*	

26. I approve this voucher for payment and certify that the expenses are true, correct and unpaid. (1) The goods and services covered by the document comply with the requirements of the contracts under which they were purchased; and (2) The Invoices for the goods and services are correct. This payment complies with the General Appropriations Act.

Agency contact/preparer **SIGN HERE**	Printed Name	Phone *(Area code and number)*	Date
Agency Approver **SIGN HERE**	Printed Name	Phone *(Area code and number)*	Date

Health & Human Services Commission

PURCHASE VOUCHER

STATE OF TEXAS

(Shaded areas not used by Agency 529)

1. Archive reference number	2. Agency number	3. Agency name	4. Current document number
	529	Health & Human Services Commission	

5. Effective date		7. Orig pmt date	CONF	8. Doc agency
				529

9. Texas identification number	10. PDT	11. PCC	12. Purchase Order number	13. Document amount
				$

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	DeptID/Speedchart				Requested Payment Date	Interest Control	Reason Code	R					
	Cap ind	Tag #	AGENCY USE										
18 SFX 001	Ref Doc	IC	RC	TC	PCA	FY	COBJ	AOBJ	Amount				
	APPN	Fund	Pmt due date	Invoice date	Invoice number / Account Number	Invoice Received Date							
	DeptID/Speedchart				Requested Payment Date	Interest Control	Reason Code	R					
	Cap ind	Tag #	AGENCY USE										
18 SFX 001	Ref Doc	IC	RC	TC	PCA	FY	COBJ	AOBJ	Amount				
	APPN	Fund	Pmt due date	Invoice date	Invoice number / Account Number	Invoice Received Date							
	DeptID/Speedchart				Requested Payment Date	Interest Control	Reason Code	R					

19. SERVICE / DEL DATE	20. DESCRIPTION OF GOODS OR SERVICES	21. QUANTITY	22. UNIT PRICE	23. AMOUNT
	Reimbursement for services as specified in the contrac between Health and Human Services Commission and (agency name). **Program: Title V Child Health & Child Dental** **Contract Term:** (start date) **thru** (end date) **HHSC Doc #** **Type of Entity:**			$

24. VENDOR CERTIFICATION	Phone *(Area code and number)*	25. Entered by
Vendor Contact Name	Phone *(Area code and number)*	

26. I approve this voucher for payment and certify that the expenses are true, correct and unpaid. (1) The goods and services covered by the document comply with the requirements of the contracts under which they were purchased; and (2) The Invoices for the goods and services are correct. This payment complies with the General Appropriations Act.

Agency contact/preparer **SIGN HERE**	Printed Name	Phone *(Area code and number)*	Date
Agency Approver **SIGN HERE**	Printed Name	Phone *(Area code and number)*	Date