

**Medicaid for the Elderly and People with Disabilities (MEPD)
Referral Cover Sheet**

DO NOT photocopy, staple or permanently attach anything to this cover sheet!



Form T-H1746-A
Rev. 12/2011
Page 1
ENG

*REQUIRED fields

APPLICANT / CONSUMER INFORMATION	TIERS Case Number	Zip Code*	County*
	Individual Social Security Number	Individual Number	
	Individual Last Name*	<input type="radio"/> Select if applicant is also requesting HHSC TW programs	
	Individual First Name*	Spouse Individual Number	
	Date of Birth (MMDDYY)	Spouse Name	

ACTION

*Select **only one** and **completely fill** in the circle like this ●

Application (Include application form)
 Supporting Documents (financial verifications, other documents, etc.)
 Redetermination Provide Reason: _____
 Significant Change
 Program Transfer / Addition (Refer to Appendix XXXII to determine if an application form is needed)

PROGRAM

*Select **only one** and **completely fill** in the circle like this ●

CAS CBA State Supported Living Center MDCP DBMD
 NF ICF-MR TxHmL CLASS CWP
 PACE DFPS Medicaid HCS YES STAR+PLUS

Information for MEPD Worker MERP shared LTSS Information shared

Has applicant moved or is moving into an assisted living or adult foster care facility, provide expected move date. _____

SENDER

*Agency: DADS MRA SSLC CLASS DFPS DSHS DBMD PACE NF HHSC

Date: _____ From: _____ Telephone: _____
 City: _____ County: _____ Fax: _____

Additional Comments:

Medical Necessity was established by [Name of OHP] at [phone number]. The Level of Care is Approved. The possible Start of care date is [Date of CED].

[Also include contact information of the case manager.]

INSTRUCTIONS:

NOTE: Either fax or mail; **DO NOT** fax and mail the same documents.
 Mail to: Document Processing Center or Fax to: 1-877-236-4123
 P.O. Box 14600
 Midland, TX 79711-9907