FISCAL YEAR (FY) 2016

DEPARTMENT OF STATE HEALTH SERVICES

PRIMARY HEALTH CARE (PHC) PROGRAM

FY 2016
PHC POLICY MANUAL
SEPTEMBER REVISION

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

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Introduction
General Information

PROGRAM AUTHORIZATION AND SERVICES

Program Background

Chapter 31, Health & Safety Code

In the early 1980s, economic recession and cost containment measures on the part of employers and government agencies led to a decrease in the availability and accessibility of health care services for many Texans. A gubernatorial and legislative task force identified the provision of primary health care to the medically indigent as a major priority. The task force recommended the following:

- A range of primary health care services shall be made available to the medically indigent residing in Texas.
- The Department of State Health Services (DSHS) shall provide or contract to provide primary health care services to the medically indigent. These services should complement existing services and/or should be provided where there is a scarcity of services.
- Health education should be an integral component of all primary care services delivered to the medically indigent population. Preventive services should be marketed and made accessible to reduce the use of more expensive emergency room services.

These recommendations become the basis of the indigent health care legislative package enacted by the 69th Texas Legislature in 1985. The Primary Health Care Services Act, H.B. 1844, was part of this legislation and is the statutory authority for Primary Health Care Services (PHC) administered by DSHS. The Act delineates the specific target population, eligibility, reporting, and coordination requirements for PHC.

Rules

The state rules for PHC services, including EPHC, in Texas can be found in the Texas Administrative Code (TAC), Title 25, Part 1, Chapter 39, Subchapter A. PHC program rules require that, at a minimum, a contractor must provide the following six priority primary health care services:

- diagnosis and treatment;
- emergency medical services;
- family planning services;
- preventive health services;
- health education; and
- laboratory, x-ray, nuclear medicine, or other appropriate diagnostic services.

PHC provides primary health care services for individuals who are at or below 200% of the Federal Poverty Level (FPL) and are unable to access the same care through other funding sources or programs. Contractors must assure that services provided to clients

are accessible in terms of cost, scheduling and distance, and are provided in a way that is sensitive to the individual's culture.

Scope Of Services

1) Diagnosis and Treatment of common acute and chronic disease that affect the general health of the client. Services include first contact with a client for an undiagnosed health concern as well as continuing care of varied medical conditions not limited by cause or organ system. Services must not be limited to only one service (i.e. family planning, breast and cervical cancer screening, or podiatry).

   (a) Physician services. Services must be medically necessary and provided by a physician in the doctor's office, clinic, or facility other than a hospital setting.

   (b) Physician assistant (PA) services. These services must be medically necessary and provided by a PA under the direction of a physician and may be billed by and paid to the supervising physician.

   (c) Advanced practice nurse (APN) services. An APN must be licensed as a registered nurse (RN) within the categories of practice, specifically, a nurse practitioner, a clinical nurse specialist, a certified nurse midwife (CNM), and a certified registered nurse anesthetist (CRNA), as determined by the Board of Nurse Examiners. APN services must be medically necessary, provided within the scope of practice of an APN, and covered in the Texas Medicaid Program and under the direction of a physician.

2) Emergency medical services. Services must be for urgent care for an unexpected health condition requiring immediate attention as determined by the appropriate medical staff, and must be services that can be treated in a primary care clinic or setting.

3) Family planning services. These are preventive health and medical services that assist an individual in controlling fertility and achieving optimal reproductive and general health. Services include:

   a. health check-up and physical exam;
   b. birth control methods (pills, IUD, condoms, shot, ring, etc.);
   c. natural family planning;
   d. lab tests for: sexually transmitted infections (STI); pregnancy testing;
   e. counseling regarding:
      - abstinence;
      - pre-conception counseling (planning for a healthy pregnancy);
      - nutrition; and
      - infertility.

4) Preventive health services. Services that may be included are:

   (a) Immunizations. These services are provided in appropriate setting for diseases that are preventable by vaccines.

   (b) Cancer screening services. Services must be medically necessary and by clinical recommendation. Services include:
   - clinical breast examinations,
   - mammograms,
   - pelvic examinations, and
   - cervical cancer screening.

   Specialty care services such as mammograms may be provided by a subcontractor.

   (c) Screenings for chronic conditions. These services may include screenings for hypertension, diabetes and other chronic conditions as indicated.

   (d) Health screening. Screening to determine the need for intervention and possibly a more comprehensive evaluation. Health screenings may include taking a personal and family health history and performing a physical examination, laboratory tests or radiological examination, and may be followed by counseling, education, referral or further testing. Some examples of these services include blood pressure, blood sugar, and cholesterol screening.

5) Health education. Planned learning experiences based on sound theories that provide individuals, groups, and communities the opportunity to increase knowledge and skills needed to make quality health decisions.

6) Diagnostic laboratory and radiological services. Services must be medically necessary. These are technical laboratory and radiological services ordered and provided by, or under the direction of a physician in an office or a facility other than a hospital inpatient setting.

PURPOSE OF THE MANUAL

The *Department of State Health Services (DSHS) Primary Health Care (PHC) Policy Manual* is a guide for contractors who deliver primary health care services in Texas. The policy manual has been structured to provide contractor staff with information needed to comply with program legislation and rules.

Federal and state laws related to reporting abuse, operation of health facilities, professional practice, insurance coverage, and similar topics also impact primary health care services. Contractors are required to be aware of and comply with existing laws.

DEFINITIONS

The following words and terms, when used in this manual, have the following meanings:

Applicant – A person who is applying for services.

Barrier to Care – a factor that hinders a person from receiving health care (i.e. proximity (or distance), lack of transportation, documentation requirements, co-payment amount, etc.).

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

Case Management – Case management services refer to an individualized approach for each client. Case management is a broad category that fits within the larger field of human services. Generally, case management involves coordination of care, advocacy and discharge planning; however, counseling and therapeutic support may also be offered. Case management aims to assist the individual to navigate social service systems and attain the highest quality of care.

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

Class D (Clinic) Pharmacy License – A pharmacy license issued to a pharmacy to dispense a limited type of drug or devices under a prescription drug order (e.g., XYZ Health Clinic). Information to apply for a Class D Pharmacy License may be found at: http://www.tsbp.state.tx.us/files_pdf/INSTRUCTIONS_CLASS_D_PHY.pdf.

Client – An individual who has been screened, determined to be eligible for services, and has successfully completed the eligibility process. "Client" and "patient" may be used interchangeably throughout this policy and procedure manual.

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.

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.

Contraception – The means of pregnancy prevention, including temporary and permanent methods.

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

Co-payment (co-pay) – Monies collected directly from clients for services. The amount collected each month should be deducted from the Monthly Purchase Voucher (Form B -13) and is considered program income.

Core Tool – A standardized instrument used by the Quality Management Branch to review all Community Health Services contractors. The instrument is designed to ensure compliance with basic requirements for operating a clinic that provides health services, as reflected in the DSHS Standards for Public Health Clinic Services.

Corrective Action Plan – A step-by-step plan of action and schedule for correcting a process or area of non-compliance.

Dental Services – Diagnostic, preventive, and therapeutic dental services that are provided to eligible individuals and are performed in a dental office or clinic.

Department of State Health Services (DSHS) – State 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).

Diagnosis and Treatment – Diagnosis and treatment of common acute and chronic disease that affect the general health of the client. Services include first contact with a client for an undiagnosed health concern as well as continuing care of varied medical conditions not limited by cause or organ system. Services must not be limited to specialized care such as family planning services only.

Diagnostic Services – activities related to the diagnosis made by a physician or nurse practitioner, which may also be performed by nurses or other health professionals.

Diagnostic Studies or Diagnostic Tests – Tests ordered by the client's health care practitioner(s) to evaluate an individual's health status for diagnostic purposes.

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

Eligibility Date – Date the contractor determines an individual to be eligible for the program. The eligibility expiration date will be twelve months after the eligibility date. (Also see "Presumptive Eligibility" definition.)

Emergency Services – Urgent care services provided for an unexpected health condition requiring immediate attention. Clinical emergency situations include conditions such as anaphylaxis, syncope, cardiac arrest, shock, hemorrhage, and respiratory difficulties and in response to environmental emergencies (including natural and man-made disaster situations).

Environmental Health – "Environmental health addresses all the physical, chemical, and biological factors external to a person, and all the related factors impacting behaviors. It encompasses the assessment and control of those environmental factors that can potentially affect health. It is targeted towards preventing disease and creating health-supportive environments. This definition excludes behavior not related to environment, as well as behavior related to the social and cultural environment, and genetics."[1]

Family Composition/Household – 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.

Family Planning Services - Services that assist women and men in planning their families, whether it is to achieve, postpone, or prevent pregnancy. Family planning services should include the following: pregnancy test (if indicated), health history, physical examinations, basic infertility services, lab tests, STD services (including HIV/AIDS), and other preconception health services (e.g. screening for obesity, smoking, and mental health), counseling/education, and contraceptive supplies.

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, define eligibility income limits as some percentage of FPL.

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

Good Faith Effort –Sustained effort made with deliberate intention to produce desired or required result. Agencies or entities must make a 'good faith effort' in such functions as client follow-up, client referrals, and other clinical operations as defined in policy, contract, and contractor proposal.

[1] http://www.who.int/topics/environmental_health/en/

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 to an individual or to a group of individuals.

Health and Human Services Commission (HHSC) – State agency with administration and oversight responsibilities for designated Health and Human Services agencies, including DSHS.

Health Screening – The provision of tests, (e.g., blood glucose, serum cholesterol, fecal occult blood) as a means of determining the need for intervention and perhaps more comprehensive evaluation.

Health Service Region (HSR) –Counties grouped within a specified geographic area throughout the state.

Home Health Care – In-home services provided by a Registered Nurse (RN) or a Licensed Vocational Nurse (LVN) including skilled observation, assessment and treatment as ordered by a physician. A home health aide to assist with administering medication is also covered.

Household - (For the purpose of eligibility determination) - The household consists of 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 are legally responsible for the support of the other person. If an unmarried applicant lives with a partner, ONLY count the partner's income and children as part of the household group IF the applicant and his/her partner have mutual children together. Unborn children should also be included. Treat applicants who are 18 years of age as adults. No children aged 18 and older or other adults living in the home should be counted as part of the household group.

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 risks of taking no action are explained to a patient in a manner that is understandable to that patient and allows the patient to participate and make sound decisions regarding his or her own medical care.

Laboratory – (informally, **lab**) Facility that measures or examines materials derived from the human body for the purpose of providing information on diagnosis, monitoring prevention or treatment of disease.

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

Managing Conservator – A person designated by a court to have daily legal responsibility for a child.

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

Minor – In Texas, a minor is a person under 18 years of age who has never been married and never been declared an adult by a court (emancipated). See Texas Family Code Sections 101.003, 31.001-31.007, 32.003-004, 32.202. In this manual, "minor" and "child" may be used interchangeably.

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. Information may be provided to an individual, 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 clients.

Patient – An individual who is eligible to receive medical care, treatment, or services. "Client" and "patient" may be used interchangeably in this manual.

Payor Source – Programs, benefits, or insurance that pays for the service provided.

Podiatry Services – The study and care of the foot, including its anatomy, pathology, and medical/surgical treatment.

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 90 days) when the client screens potentially eligible for services but lacks verification to achieve full eligibility. For clients who are determined to be fully eligible during the presumptive period, the eligibility expiration date will include the days of presumptive eligibility (expiration date is 365 days beginning the first date of eligibility determination).

Preventive Health Care Services – Medical care that focuses on disease prevention and health maintenance, including early diagnosis of disease, discovery and identification of people at risk of development of specific problems, counseling, and other necessary intervention to avert a health problem. Included are screening tests, 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 men, women, and children.

Program Income – Monies collected directly by the contractor/subcontractor/ provider for services provided under the contract award (i.e., third-party reimbursements, such

as Title XIX, TWHP, private insurance, and patient co-pay fees.). Program income also includes client donations.

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

Readiness – Respondent has the specified attributes to support a given service, the ability to meet program and contractual requirements, and the capacity to achieve service levels based on awarded funds.

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; or direct to a source for help or information.

Referral Agency – An agency that will provide a service for the client that the contractor or one of its sub-contractors does not provide.

Reproductive Life Plan – A plan that outlines a client's personal goals regarding whether to have children, the desired number of children, and the optimal timing and spacing of children. Counseling should include the importance of developing a reproductive life plan and information about reproductive health, family planning methods and services, and obtaining preconception health services, as appropriate.

Resident Alien – A person who is not an U.S. citizen, and has an immigration document.

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.

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

Transportation – Services provided to a client for the purpose of receiving a required health care service. 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 Alien – A person who is not an U.S. citizen, and has no immigration documentation.

Unduplicated Client – Clients are counted only one time during the program's fiscal year, regardless of the number of visits, encounters, or services they receive (e.g., one client seen four times during the year is counted as one unduplicated client.)

ACRONYMS

Acronym	Term
ADA	Americans with Disabilities Act
ADA	American Dental Association
AED	Automated External Defibrillator
AMA	American Medical Association
BCCS	Breast and Cervical Cancer Services
CAD	Computer Aided-Detection
CAM	Complementary and Alternative Medications
CBE	Clinical Breast Exam
CD	Cervical Dysplasia
CDC	Centers for Disease Control and Prevention
CDSB	Contract Development and Support Branch
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
CMS	Centers for Medicaid and Medicare
CPR	Cardiopulmonary Resuscitation
CPT	Current Procedure Terminology
DES	Diethylstilbestrol
DHHS	U.S. Department of Health and Human Services
DSHS	Texas Department of State Health Services
ECC	Endocervical Curettage
EDI	Electronic Data Exchange
EHR	Electronic Health Record
E/M	Evaluation and Management Services
EMR	Electronic Medical Record
EOB	Explanation of Benefit
EPHC	Expanded Primary Health Care
EPT	Expedited Partner Therapy
FDA	Federal Drug Administration
FFS	Fee for Service
FP	Family Planning
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
HSV	Herpes simplex virus

IRB	Institutional Review Board
IUC	Intrauterine Contraception
IUD	Intrauterine Device
LEP	Limited English Proficiency
MBCC	Medicaid for Breast and Cervical Cancer
MCH	Maternal and Child Health Services
MRI	Magnetic Resonance Imaging
NBCCEDP	National Breast & Cervical Cancer Early Detection Program
NPI	National Provider Identifier
NPPES	National Plan and Provider Numeration System
OTC	Over the Counter
PHC	Primary Health Care
PMU	DSHS Performance Management 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
TAC	Texas Administrative Code
TANF	Temporary Assistance for Needy Families
TMHP	Texas Medicaid Healthcare Partnership
TMPPM	Texas Medicaid Provider Procedures Manual
TPI	Texas Provider Identifier
TWHP	Texas Women's Health Program
USPSTF	United States Preventive Services Task Force
WIC	Special Supplemental Nutrition Program for Women, Infants and Children

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 non-discriminatory manner. The contractor must:

- have a policy in place that delineates the timely provision of services;
- have policies in place to identify and eliminate possible barriers to client care;
- comply with all applicable civil rights laws and regulations including Title VI of the Civil Rights Act of 1964, the Americans with Disabilities Act (ADA) 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 (LEP) and speech or sensory impairments.
- have a policy in place that requires qualified staff to assess and prioritize client needs.
- provide referral resources for individuals that cannot be served or cannot receive a specific needed service.
- manage funds to ensure that established clients continue to receive services throughout the budget year.
- continue to provide services to established clients after allocated funds are expended.
- ensure that family planning services are provided to clients in a timely manner, preferably within 30 days of the request for services. (Clients who request contraception but cannot be immediately provided a clinical appointment must be offered a nonprescription method.)
- ensure clinic/reception room wait times are reasonable so as not to represent a barrier to service.

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 to be familiar with and comply with child abuse and neglect reporting laws in Texas.

To report abuse or neglect, call **800-252-5400** or use the secure website: **https://www.txabusehotline.org/Login/Default.aspx** or call any local or state law enforcement agency for cases that pose an imminent threat or danger to the client.

CHILD ABUSE REPORTING

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.

Policy – Contractors must adopt the DSHS Child Abuse Screening, Documenting and Reporting Policy for Contractors/Providers and 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 site monitoring of contractors by QMB the following procedures will be utilized to evaluate compliance:

1) The contractor's 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 that the contractor:

    a) has adopted DSHS Policy;

    b) has an internal policy which 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;

    c) follows their internal policy and the DSHS Policy; and

    d) documents staff training on child abuse reporting requirements and procedures.

2) All records of clients under 14 years of age who are pregnant or have a confirmed diagnosis of an STI 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. The review of the records will involve verification that the DSHS Child Abuse Reporting Form was utilized; appropriately, a report was made; and the report was made within the proper timeframes required by law.

3) 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 with the DSHS Policy. 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 immediately report. 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 six (6) weeks from the date of the review, which is the usual process for Site Monitoring Reports.

5) The contractor will have six weeks to respond with a written corrective action plan (CAP) to all findings. If the contractor does not provide corrective actions during the required time period, 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 261 and the DSHS Policy.

6) If the contractor has other findings that warrant technical assistance or accelerated monitoring review, either regional 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.

7) 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 visit solely to review child abuse reporting will not be conducted. For agencies that receive technical assistance visits as a result of a quality assurance review, the agency child abuse reporting processes will be reviewed again for compliance. Included in the review, will be the child abuse reporting requirements that the agency failed to comply. 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 and/or technical assistance visit will be required to complete the DSHS Progress Report, Compliance with Child Abuse Reporting within three (3) months after the corrective actions are begun (no later than six (6) months from the initial visit). Failure to submit a Progress Report within the required time period 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 and the contractor will be referred for financial sanctions.

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, PHC 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 on human trafficking which includes the provision of annual staff training.

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.

Contractors must have a written policy to assess and prevent IPV, including providing annual staff training.

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.

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. All employees, volunteers, sub-contractors, and board members and/or advisory board members must sign a confidentiality statement during orientation.

The client's preferred method of follow-up to clinic services (cell phone, email, work phone, and/or text) 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 Reporting, Section I Chapter 2).*

*Minors and Confidentiality

Except as permitted by law, a provider is legally required to maintain the confidentiality of care provided to a minor. Confidential care does not apply when the law requires parental notification or consent, or when the law requires the provider to report health information, such as in the cases of contagious disease or abuse. The definition of privacy is the ability of the individual to maintain information in a protected way. Confidentiality in health care is the obligation of the health-care provider not to disclose protected information. While confidentiality is implicit in maintaining a patient's privacy, confidentiality between provider and patient is not an absolute right.

The HIPAA privacy rule requires a covered entity to treat a "personal representative" the same as the individual with respect to uses and disclosures of the individual's protected health information. In most cases, parents are the personal representatives for their minor children, and they can exercise individual rights, such as access to medical records, on behalf of their minor children. (Code of Federal Regulations [45CFR164.504]).

NON-DISCRIMINATION

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

- Title VI of the Civil Rights Act of 1964 (42 U.S.C. §2000d *et seq.*),
- Section 504 of the Rehabilitation Act of 1973 (29 U.S.C. §794),
- Americans with Disabilities Act of 1990 (42 U.S.C. §12101 *et seq),*

- Age Discrimination Act of 1975 (42 U.S.C. §§6101-6107),
- Title IX of the Education Amendments of 1972 (20 U.S.C. §§1681et seq.),
- Administrative rules for HHS agencies, as set forth in the Texas Administrative Code (TAC).

More information about non-discrimination laws and regulations can be found on the HHSC Civil Rights website.

Contract Terms and Conditions

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

- have a written policy that states the agency does not discriminate on the basis of race, color, national origin, including Limited English Proficiency (LEP), sex, age, religion, disability, or sexual orientation;
- have a policy that addresses client rights and responsibilities that is applicable to all clients requesting primary health care services;
- sign a written assurance to comply with applicable federal and state non-discrimination laws and regulations;
- notify all clients and applicants of the contractor's non-discrimination policies, including LEP policies, and HHS complaint procedures; and
    - Ensure that all contractor staff is trained in the contractor's non-discrimination policies and complaint procedures; and
    - Notify the HHSC Civil Rights Office of any discrimination allegation or complaint related to its programs and services no more than ten (10) calendar days after receipt of the allegation or complaint.

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

Limited English Proficiency

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

- take reasonable steps to ensure that LEP persons have meaningful access to its programs and services, and not require a client with LEP to use friends or family members as interpreters. However, a family member or friend may serve as a client's interpreter, if requested, and the family member or friend does not compromise the effectiveness of the service nor violate client confidentiality; and

- make clients and applicants with language service needs, including persons with LEP and disabilities, aware that the contractor will provide an interpreter free of charge.

Civil Rights Posters

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

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

- **"Need an Interpreter"** [Language Translation] [American Sign Language]
  Size: 8.5" x 11" (standard size sheet of paper)
  Posting Instructions: Post the "Language Translation" version and "American Sign Language" version next to each other
  Questions: Contact the HHSC Civil Rights Office

- **Americans with Disabilities Act** [English A] [Spanish A] [English B] [Spanish B]
  Size: 8.5" x 11" or 8.5" x 14"
  Posting instructions: Post with other civil rights posters
  Questions: Contact the HHSC Civil Rights Office

Questions concerning this section and civil rights matters can be directed to the HHSC Civil Rights Office.

Civil Rights Surveys

Contractors can use the Self-Assessment for Civil Rights Compliance to conduct a self-assessment concerning civil rights compliance, and 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: qmb@dshs.state.tx.us.

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 his or her own safety, clinic staff, or other clients.

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

RESOLUTION OF COMPLAINTS

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

Any client complaint must be documented in the client's record.

RESEARCH (HUMAN SUBJECT CLEARANCE)

Any DSHS PHC contractor that wishes to participate in any proposed research that would involve the use of DSHS PHC clients as subjects, the use of DSHS PHC clients' records, or any data collection from DSHS PHC clients, must obtain prior approval from the DSHS PHC Program and be approved by the DSHS Institutional Review Board #1 (IRB #1).

Contractors should:

- First contact the DSHS PHC Program at (primaryhealthcare@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 primaryhealthcare@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 PHC Program, as well as the DSHS IRB, prior to instituting any research activities. The contractor must also ensure that all staff is made aware of this policy through staff training. Documentation of training on this topic must be maintained.

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 records must be kept confidential and secure, as follows:

- safeguarded against lost and used by unauthorized persons;
- secured by lock when not in use or 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.

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

Contractors, providers, sub-recipients, and subcontractors must maintain for the time period specified by DSHS all records pertaining to client services, contracts, and payments. Record retention requirements are found in 15 TAC §354.1004 (relating to Time Limits for Submitted Medicaid Claims) and 22 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.

PERSONNEL POLICY AND PROCEDURES

Contractors must develop and maintain personnel policies and procedures to ensure that clinical staff are hired, trained, and evaluated appropriately to their job position. Contracted staff must also be trained and evaluated according to their responsibilities. Job descriptions, including those for contracted personnel, must specify required qualifications and licensure. All staff must be appropriately identified with a name badge.

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.

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. All employees and board members must complete a conflict of interest statement during orientation. All medical care must be provided under the supervision, direction, and responsibility of a qualified Medical Director. The Primary Health Care Program Medical Director must be a licensed Texas physician; the Program Dental Director must be a U.S. licensed dentist.

Contractors must ensure that all dental services are provided under the supervision, direction, and responsibility of a qualified 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.

Staff development must include orientation and in-service training for all personnel and volunteers. (Non-profit entities must provide orientation for board members and government entities must provide orientation for their advisory committees). 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 hazardous waste, 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.

Radiology Equipment and Standards - All facilities providing radiology services, including dental x-rays, 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.

For information on x-ray machine registration, see the Texas Department of State Health Services, Radiation control Program.

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.e., 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, see the Occupational Safety and Health Administration website.

QUALITY MANAGEMENT

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

Contractors are expected to develop quality processes based on the four core Quality Management principles that focus on:

- the client;
- systems and processes;
- measurements; and
- teamwork.

Contractors must have a Quality Management program individualized to their organizational structure and based on the services provided. The goals of the quality program should ensure availability and accessibility of services, and quality and continuity of care.

A Quality Management program must be developed and implemented that provides for ongoing evaluation of services. Contractors should have a comprehensive plan for the internal review, measurement and evaluation of services, the analysis of monitoring data, and the development of strategies for improvement and sustainability.

Contractors who subcontract for the provision of services must also address how quality will be evaluated and how compliance with DSHS policies and basic standards will be assessed with the subcontracting entities.

The Quality Management Committee, whose membership consists of key leadership of the organization, including the Executive Director/CEO and the Medical and Dental Director and other appropriate staff where applicable, annually reviews and approves the quality work plan for the organization. (The PHC Program Medical Director must be a licensed Texas physician. The 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 and 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 credentialing and peer review of clinicians;
- identify individuals responsible for implementing monitoring, evaluating and reporting;
- establish timelines for quality monitoring activities;
- identify tools/forms to be utilized; and
- outline reporting to the Quality Management Committee.

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

- on-going eligibility, billing, and clinical record reviews to assure compliance with program requirements and clinical standards of care;
- tracking and reporting of adverse outcomes;
- client satisfaction surveys;
- annual review of facilities to maintain a safe environment, including an emergency safety plan;
- annual review of policies, clinical protocols and standing delegation orders (SDOs) to ensure they are current; and
- performance evaluations to include primary license verification, DEA, and immunization status 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:

- annual license verification (primary source verification);
- clinical record review;
- billing and eligibility review;
- facility on-site review;
- annual client satisfaction evaluation process; and
- child abuse training and reporting – subcontractor staff.

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

Information on the operating process of the DSHS Quality Management Branch as well as policies and review tools can be located at here.

Section II

Eligibility, Client Services, Community Activities, and Clinical Guidelines

Purpose: Section II provides policy requirements for eligibility, client services, community activities, and clinical guidelines.

ELIGIBILITY GUIDELINES

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

- Texas resident;
- Gross family income at or below 200% of the adopted Federal Poverty Level (FPL); and
- Not a beneficiary of other non-DSHS programs/benefits providing the same services.

OTHER BENEFITS

In general, individuals are not eligible for the PHC Program if they are enrolled in another third party payor such as private health insurance, Medicaid or Medicare, TRICARE, Worker's Compensation, Veteran's Administration Benefits, or other federal, state, or local public health care coverage that provides the same services.

If an individual is determined potentially eligible for another program that covers the same services provided by the PHC program, the client may still be potentially eligible for the PHC program. Contractors should assist applicants to complete the eligibility determination process for any program for which the person may be eligible.

THIRD-PARTY INSURANCE

Individuals with third-party insurance may be eligible for services provided by PHC if the applicant's confidentiality is a concern or if the applicant's insurance deductible is 5% or greater than their income.

Most insurance deductibles are given as an annual amount. Household incomes are generally figured as a monthly amount. To compare an annual deductible with a monthly income, multiply the monthly income by 12 and then determine what 5% of that amount is. For example, if the monthly income is $1000, the household annual income is $12,000 ($1000 x 12). Five percent (5%) of $12,000 is $600 ($12,000 x 0.05). If the applicant's annual insurance deductible is any amount over $600, then they are eligible under this criterion for PHC.

Another way to make the comparison is to divide the annual deductible into a monthly amount. For example, if the annual deductible is $6000, the *monthly* deductible amount is $500 ($6000 ÷ 12). If the applicant's monthly household income is $1000, 5% of her income is $50.00 ($1000 x 0.05). If the client's *monthly* deductible is more than $50.00, then they are eligible under this criterion for PHC.

SUPPLEMENTAL BENEFITS

In some cases, individuals receiving benefits from other programs such as Medicaid or Medicare may be eligible for partial PHC coverage. This "supplemental' or

"wraparound" coverage is limited to services provided by PHC but not covered by other sources. An example of supplemental benefits would be providing health education services to a Medicaid-eligible individual, since Medicaid does not provide health education services. The contractor must communicate to the client that supplemental services are of limited scope.

SCREENING FOR PHC PROGRAM ELIGIBILITY

DSHS PHC contractors must perform an annual eligibility screening assessment on all clients who present for PHC services using the most recent version of one of the following eligibility tools:

- DSHS Family & Community Health Services (FCHS) Division Individual Eligibility Form (Form EF05-14215), or
- DSHS (FCHS) Division Household Eligibility Form (Form EF05-14214).

A comparable paper or electronic eligibility tool may be used, but must have the required DSHS information for eligibility determination, the applicant's signature, and be reviewed and approved by DSHS staff.

The completed eligibility form must be maintained in the client medical record, indicating the client's poverty level and the co-pay amount the person will be charged. Contractors must conduct an annual client eligibility assessment either by phone or in person, and a completed screening tool must be maintained in the client record.

DETERMINING PHC PROGRAM ELIGIBILITY

Eligibility Requirements -- Eligible clients must be:

- Texas resident;
- at or below 200% of the federal poverty level (FPL); and,
- not a beneficiary of other non-DSHS programs/benefits providing the same services.

For the purposes of determining PHC eligibility, the following definitions will be used:

Household -- Household is self-declared.

The household consists of a person living alone or two or more persons related by birth, marriage including common-law, or adoption, who reside together and are legally responsible for the support of the other person.

Legal responsibility for support exists between:

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

For example: If an unmarried applicant lives with a partner, ONLY count the partner's income and their children as part of the household IF the applicant and his/her partner have mutual minor children together. Unborn children should also be included. Treat applicants who are 18 years of age as adults. No individuals aged 18 and older or other adults living in the household should be counted as part of the household.

Residency – Texas residency is self-declared.

Managing Conservator — A person designated by a court to have daily legal responsibility for a child.

Income -- Contractors must require income verification. If the methods used for income verification jeopardize the client's right to confidentiality or impose a barrier to receipt of services, the contractor must waive this requirement. Reasons for waiving verification of income must be noted in the client record.

All income received must be included. Income is calculated before taxes (gross). Include sources of income as defined in PHC Definition of Income (See Appendix C.)

Verification/Documentation of Income – Verification and documentation of income must be provided to complete the eligibility screening process. If income verification jeopardizes the client's right to confidentiality or imposes a barrier to receipt of services, the contractor must waive this requirement. If a barrier to care exists, the contractor may waive the requirement and approve the person's eligibility.

Contractors must have a written policy regarding income verification/ documentation and circumstances under which the requirement may be waived. Reasons for waiving income verification must be noted in the client record; otherwise, documentation must be included on either:

- DSHS Family and Community Health Services (FCHS) Individual Eligibility Form (Form EF05-14215); or
- Household Eligibility Form (Form EF05-14214) *and* the Household Eligibility Worksheet (Form EF05-13227).

Income Deductions – Dependent care expenses must be deducted from total income in determining eligibility. Allowable deductions are actual expenses up to:

- $200.00 per child per month for children under age 2;
- $175.00 per child per month for each dependent age 2 or older; and/or
- $175.00 per adult with disabilities per month.

Deduct the actual payment amount of child support payments made by a member of the PHC household group. Payments made weekly, every two weeks or twice a month must be converted to a monthly amount by using one of the conversion factors below.

Monthly Income Calculation – If income payments are received in lump sums or at longer intervals than monthly, such as seasonal employment, the income is prorated over the period of time the income is expected to cover, as follows:

- Weekly income is multiplied by 4.33;
- Income received every two weeks is multiplied by 2.17;
- Income received twice monthly is multiplied by 2.

ADJUNCTIVE ELIGIBILITY

An applicant is considered adjunctively (automatically) eligible for PHC Program services at an initial or renewal eligibility screening, if the individual is currently enrolled in one of the following programs:

- Children's Health Insurance Program (CHIP) Perinatal;
- Medicaid for Pregnant Women;
- Special Supplemental Nutrition Program for Women, Infants, and Children (WIC);
- Supplemental Nutrition Assistance Program (SNAP)
  or
- Texas Women's Health Program (TWHP).

An applicant must be able to provide proof of active enrollment in the adjunctively eligible program. Acceptable eligibility verification documentation may include:

PROGRAM	DOCUMENTATION
CHIP Perinatal	*CHIP Perinatal benefits card*
Medicaid for Pregnant Women	*"Your Texas Benefits" card (Medicaid card)***
WIC	*WIC verification of certification letter, printed WIC-Approved shopping list, or recent WIC purchase receipt with remaining balance*
SNAP	*SNAP eligibility letter*
TWHP	*"Your Texas Benefits" card (Medicaid card)***

**NOTE: Presentation of the "Your Texas Benefits" card does not completely verify current eligibility in the Texas Women's Health Program or the Medicaid for Pregnant Women program. To verify eligibility, contractors can go to www.YourTexasBenefitsCard.com, call TMHP at 1-800-925-9126, or access TexMedConnect on the TMHP website at www.tmhp.com to enter or give the applicant's Medicaid ID number (PCN) as listed on the card.

If the applicant's current enrollment status cannot be verified during the eligibility screening process, adjunctive eligibility would not be granted. The contractor would then determine eligibility according to usual protocols.

CALCULATION OF APPLICANT'S FEDERAL POVERTY LEVEL PERCENTAGE

If a contractor collects a client co-payment, contractor must determine the applicant's actual household Federal Poverty Level (FPL) percentage. The steps to determine the percentage are:

1. determine the applicant's household size;
2. determine the applicant's total monthly income amount;
3. divide the applicant's **total monthly income** amount by the **maximum monthly income** amount at 100% FPL for the appropriate **household size**;
4. multiply by 100%.

The maximum monthly income amounts by household size are based on the Department of Health and Human Services federal poverty guidelines. The guidelines are subject to change around the beginning of each calendar year.

Example:
Applicant has a total monthly income of $2,093 and counts three (3) family members in her household.

Total Monthly Income		Maximum Monthly Income (Household Size of 3)						Actual Household FPL%
$2,093	/	$1,674	=	1.25	x	100%	=	125% FPL

DATE ELIGIBILITY BEGINS

An individual/family is eligible for services beginning with the date the contractor determines the individual/family is eligible for the program and signs the completed application. This includes the date an individual/family is determined eligible for Presumptive Eligibility.

PRESUMPTIVE ELIGIBILITY

PHC emphasizes the importance of prevention and early intervention. The goal of PHC is for clients to be part of the health care system and not rely on episodic, acute care. An applicant's medical needs shall be met quickly and appropriately, using available resources in the community.

An individual who has submitted either the DSHS FCHS Individual Eligibility Form (Form EF05-14215), or both the Household Eligibility Form (Form EF05-14214) *and* the Household Eligibility Worksheet (EF05-13227), and has not had a final eligibility determination may receive Presumptive Eligibility services when screened to be potentially eligible for PHC.

Presumptive eligibility is effective for 90 days from the date the individual is first seen by the medical provider. The individual shall be enrolled on a presumptive eligibility basis only once in a 12-month period. If at the end of the 90 day presumptive eligibility period the individual has not produced the final eligibility documentation to confirm the individual's eligibility, the contractor must evaluate the situation to determine if

producing the final documentation creates a barrier to care for the applicant. If the contractor determines that producing the final documentation creates a barrier to care, the contractor may waive the requirement and approve full eligibility. When full eligibility is granted during or at the end of the 90 days, the eligibility period end date is 12 months from the presumptive eligibility effective date.

Individuals who are determined potentially eligible for another benefit by either the DSHS FCHS Individual Eligibility Form (Form EF05-14215,) or the Household Eligibility Form (Form EF05-14214) *and* the Household Eligibility Worksheet (Form EF05-13227), but fail to fully complete the required application process for the benefit, will not be eligible to receive PHC-funded services beyond those services delivered during the 90-day presumptive eligibility period. If within 90 days a client fails to complete the eligibility determination process for another benefit, the contractor may bill PHC for the services delivered during the 90-day period only. Contractors should make clients aware that failing or refusing to complete the appropriate eligibility determination processes may result in determining the person to be a self-pay client.

ANNUAL RE-CERTIFICATION

Annual eligibility determination and recertification is required for all clients who receive PHC services. Client eligibility must be re-determined every 12 months, using either the DSHS FCHS Individual Eligibility Form (Form EF05-14215), or both the Household Eligibility Form (Form EF05-14214) *and* the Household Eligibility Worksheet (Form EF05-13227). Contractors must have a system in place to track client eligibility and renewal status on an annual basis.

CLIENT FEES/CO-PAYMENTS

PHC contractors *may* (but are not required to) assess a co-payment (co-pay) for services from PHC clients. The PHC co-pay sliding scale is revised and sent to contractors annually when the federal income guidelines are updated. The contractor must waive the fee if a client self-declares an inability to pay. No PHC client shall be denied services based on an inability to pay. Client co-pays must be reported as program income on the monthly State Purchase Voucher (Form B-13) and the quarterly Financial Status Report (FSR or Form 269a).

Co-pay Guidelines

- Appendix D is the PHC sliding fee co-pay schedule for contractor use. The maximum co-pay amount that a client may be charged for PHC services must not exceed $40.00, based on the person's income.
- The fee scale must be updated annually when the revised Federal Poverty Income Guidelines are released. Contractors must have policies and procedures regarding fee collection, which must be approved by the contractor's Board of Directors.

- Client co-pays collected by the contractor are considered program income and must be used to support the delivery of DSHS PHC services.

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 PHC allowable services, if the service is provided at the client's request, and the client is made aware of her responsibility for paying for the charges.

CONTINUATION OF SERVICES

Contractors who have expended their awarded PHC funds are required to continue to serve their existing PHC clients through the end of the contract period.

If other funding sources are used to provide PHC services, the funds must be reported as non-DSHS funds on the monthly State Purchase Voucher (Form B-13) and the quarterly Financial Status Report (FSR or Form 269a).

PAYOR OF LAST RESORT

As mentioned above, individuals seeking PHC-covered services may be dually-eligible for other DSHS funded programs within an agency that provides the same services, such as DSHS Family Planning, Breast and Cervical Cancer Screening Services, or Title V Prenatal or Dental Program(s). In such cases, it is up to the contractor to determine the best use of funds within their agency.

PHC is the payor of last resort for a client who is enrolled in any other non-DSHS program that provides payment for the cost of the same primary care services at the time he or she presents for those services.

GENERAL CONSENT

Contractors must obtain the client's written, informed, voluntary general consent prior to receiving any services. A general 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.

Consent information must be effectively communicated to every client in a manner that is understandable. This communication must allow the client to participate, make sound decisions regarding their own medical care, and address any disabilities that impair communication, in compliance with Limited English Proficiency (LEP) regulations. Only the client may consent, except when the client is legally unable to consent (e.g., 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.

In addition, as described below, the contractor must obtain informed consent of the client for procedures as required by the Texas Medical Disclosure Panel.

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

Parental Consent for Services Provided 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 and never been declared an adult by a court (emancipated). However there are certain circumstances under which a minor may consent for their 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.

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

PROCEDURE-SPECIFIC INFORMED CONSENTS

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.

Texas Medical Disclosure Panel Consent

The Texas Medical Disclosure Panel (TMDP) was established by the Texas Legislature to 1) determine which risks and hazards related to medical care and surgical procedures must be disclosed by health care providers or physicians to their clients or persons authorized to consent for their clients, and 2) 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, which can be found in the Texas Administrative Code (TAC).

For all other procedures not listed on List A, the physician must disclose, through a procedure specific consent, all risks that a reasonable client would want to know. This includes all risks that are inherent to the procedure (one which exists in and is inseparable from the procedure itself) and that are material (could influence a reasonable person in making a decision whether or not to consent to the procedure).

Texas Family Code Chapter 32 Sec. 32.003. CONSENT TO TREATMENT BY CHILD: There are instances in which a child may consent to medical, dental, psychological, and surgical treatment for the child by a licensed physician or dentist if the child:

(1) is on active duty with the armed services of the United States of America;

(2) is:
   (A) 16 years of age or older and resides separate and apart from the child's parents, managing conservator, or guardian, with or without the consent of the parents, managing conservator, or guardian and regardless of the duration of the residence; and

   (B) managing the child's own financial affairs, regardless of the source of the income;

(3) consents to the diagnosis and treatment of an infectious, contagious, or communicable disease that is required by law or a rule to be reported by the licensed physician or dentist to a local health officer or the Texas Department of Health, including all diseases within the scope of Section 81.041, Health and Safety Code;

(4) is unmarried and pregnant and consents to hospital, medical, or surgical treatment, other than abortion, related to the pregnancy;

(5) consents to examination and treatment for drug or chemical addiction, drug or chemical dependency, or any other condition directly related to drug or chemical use;

(6) is unmarried, is the parent of a child, and has actual custody of his or her child and consents to medical, dental, psychological, or surgical treatment for the child; or

(7) is serving a term of confinement in a facility operated by or under contract with the Texas Department of Criminal Justice, unless the treatment would constitute a prohibited practice under Section 164.052(a)(19), Occupations Code.

CONSENT FOR HIV TESTS

Texas Health and Safety Code §81.105 and §81.106 are as follows:

§81.105. Informed Consent

a) Except as otherwise provided by law, a person may not perform a test designed to identify HIV or its antigen or antibody without first obtaining the informed consent of the person to be tested.

b) Consent need not be written if there is documentation in the medical record that the test has been explained and the consent has been obtained.

§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 the 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.

CLINICAL GUIDELINES

This chapter describes the requirements and recommendations for contractors pertaining to the delivery of direct clinical services to clients. **In addition to the requirements and recommendations found within this section, contractors should follow national evidence-based guidelines, including those found within the publication "Providing Quality Family Planning Services: Recommendations of the CDC and the U.S. Office of Population Affairs." The contractor should also review the U.S. Preventive Services Task Force (USPSTF) recommendations and provide services that incorporate USPSTF A and B recommendations that are appropriate for the target populations.**

Client Health Record (Medical Record)

Contractors must ensure that a client health record is established for every client who obtains medical services (also see Section 1, Chapter 4 – Client Records Management.)

All client health records must be:

- complete, legible and accurate documenting all client encounters, including those by phone, email or text message;
- written in ink without erasures or deletions; or documented in the electronic medical record (EMR)/electronic health record (EHR);
- signed by the provider making the entry, including the name of the provider, the provider's title, and the date for each entry;
    - electronic signatures are allowable to document the encounter and/or provider review of care. However, stamped signatures are **not** allowable.
- readily accessible to assure continuity of care and availability to clients; and
- systematically organized to allow easy documentation and prompt retrieval of information.

The client health record must include:

- client identification and personal data, including financial eligibility;
- preferred language and method of communication;
- client contact information must include the best way to reach the client to facilitate continuity of care, assure confidentiality, and adhere to HIPAA regulations;
- medical history;
- health risk assessment (HRA);
- physical examination;
- laboratory and other diagnostic tests orders, results and follow-up;
- radiographs and/or photographs, if taken;
- assessment or clinical impression;
- plan of care, including education, counseling, treatment, special instructions, scheduled visits, and referrals;
- documentation regarding follow-up of missed appointments;
- informed consent documentation;

- refusal of services documentation – when applicable;
- medication allergies and other allergic reactions recorded prominently in a specific location;
- problem list; and
- client education, including education/counseling regarding health risks identified through the HRA.

MEDICAL HISTORY AND RISK ASSESSMENT

At the initial clinical visit, a comprehensive medical history, inclusive of mental health, must be obtained on all clients. Any pertinent history must be updated at each subsequent clinical visit. Each clinic visit should include a risk assessment that meets the needs and concerns of the client. See the USPSTF recommendations.

For a checklist of family planning and related preventive health services for women and men see Appendix E, or the Morbidity and Mortality Weekly Report (MMWR) *Providing Quality Family Planning Services: Recommendations of CDC and the U.S. Office of Population Affairs*.

The client **comprehensive** medical history must address the following:

- reason for visit;
- history of present illness, if indicated;
- significant past illnesses, including hospitalizations;
  - previous surgeries and biopsies with dates, and when possible and pertinent, the results/final diagnosis/pathology;
- blood transfusions and other exposure to blood products;
- current medications, including prescription, over the counter (OTC) as well as complementary and alternative medicines (CAM);
- allergies, sensitivities or reactions to medicines and other substances (e.g.; latex, seafood);
- use of tobacco/alcohol/illicit drugs (including type, duration, frequency, route);
- immunization status/assessment (see CDC immunization schedules by age);
  - rubella status – based on a history of rubella vaccination or documented rubella serology – non-pregnant female clients of childbearing age with unknown or inadequate rubella immunity must be provided vaccination on-site or referred appropriately*
- review of systems with pertinent positives and negatives documented in the chart;
- assessment for sexual and intimate partner violence (IPV) (Mandated by Texas Family Code, Chapter 261 and Rider 19);
- assessment for environmental safety (e.g. bike helmets, seat belts, car seats, etc.);
- occupational hazards or environmental toxin exposure;
- pertinent mental health history (e.g., depression, anxiety);
- pertinent family history; and

- pertinent partner history, including injectable drug use, number of partners, STIs and HIV history and risk factors, gender of sexual partners.

**PHC contractors can voluntarily participate in the DSHS Adult Safety Net (ASN) Program or the Texas Vaccines for Children (TVFC). Both programs provide vaccines at no cost.*

Reproductive health history in female clients must include:

- menstrual history, including last normal menstrual period;
- pertinent sexual behavior history, including family planning practices (i.e., contraceptive use – past and current), number of partners, gender of sexual partners, last sexual encounter, sexual abuse;
- obstetrical history;
- gynecological and urological conditions;
- STI/STDs, and HIV history, risks, and exposure; and
- cervical cancer screening history (date and results of last Pap test or other cervical cancer screening test, note any abnormal results and treatment).

Reproductive health history in **male patients** must include:

- pertinent sexual behavior history, including family planning practices (e.g., contraceptive use – past and current), number of partners, gender of sexual partners, last sexual encounter, and sexual abuse;
- STI/STDs and HIV history, risks, and exposure; and
- genital and urologic conditions, as indicated.

Social History and Health Risk Assessment (HRA) must include:

- home environment, to include living arrangements;
- assessment for environmental safety;
- dietary/nutritional assessment;
- physical activity;
- occupational hazards or environmental toxin exposure;
- ability to perform activities of daily living (ADLs); and
- risk assessment for chronic conditions.

PHYSICAL ASSESSMENT

All clients must be provided an appropriate physical assessment as indicated by health history and health risk assessment. A physical examination is not essential prior to the provision of most contraceptive methods and should not be a barrier to the client receiving a method of contraception.

The initial physical exam may be deferred if the client history and presentation do not reveal potential problems requiring immediate evaluation. The initial physical exam should be performed within 6 months.

Program protocols should be developed accordingly and must be consistent with national evidence-based guidelines.

The following are the required components of the client's physical assessment.

Initial Primary Health Visit

The initial (new client) visit must include the following components:

All Clients

- height measurement;
- body mass index (BMI),waist measurement and/or other measurement to assess for underweight, overweight, and obesity
- blood pressure evaluation;
- cardiovascular assessment;
- other systems as indicated by history and health risk assessment (HRA) (e.g., evaluation of thyroid, lungs, abdomen).

Annual Primary Health Visit (subsequent to initial client visit)

All Clients

- height measurement annually until 5 years post menarche for females or annually until 20 years of age for males;
- weight measurement annually (to assess for underweight, overweight, and obesity);
- blood pressure evaluation;
- other systems as indicated by history (e.g., evaluation of thyroid, heart, lungs, abdomen).

Resources:
American Congress of Obstetricians and Gynecologists (ACOG)
Centers for Disease Control and Prevention (CDC)
American Cancer Society Guidelines for the Early Detection of Cancer
Morbidity and Mortality Weekly Report (MMWR) Providing Quality Family Planning Services: Recommendations of CDC and the U.S. Office of Population Affairs
Morbidity and Mortality Weekly Report (MMWR) Sexually Transmitted Diseases Treatment Guidelines, 2015.

LABORATORY TESTS

All clients presenting for an initial, annual, routine follow-up or problem-related visit must be provided appropriate laboratory and diagnostic tests **as indicated** by history, health risk assessment (HRA), physical examination and/or clinical assessment, including specific laboratory or diagnostic tests required for the provision of specific contraceptive methods.

The following tests or procedures must be provided.

- cervical cancer screening for females age 21 years and older;
- STI screening, per CDC guidelines;

- pregnancy test must be provided on-site;
- rubella serology, if status not previously established by client history and documented in chart, either on-site or by referral;
- colorectal cancer screening, in individuals 50 years of age and older;
- Human Papillomavirus (HPV) screening for female patients who are 21 years or older after an initial ASC-US Pap result.
- HIV screening; and
- other labs (such as blood glucose, lipid panel, thyroid stimulating hormone, etc.) as indicated by HRA, history and physical, either on-site or by referral.

NOTE: Initial tests may be deferred until the initial physical exam is provided.

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 clients' records; and
- mechanism to notify clients of results in a manner to ensure confidentiality; privacy and prompt, appropriate follow-up; and
- provider must comply with state and local STI reporting requirements.

Cervical Cancer Screening

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; and
- 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 more frequently as determined by the clinician.

*Guidelines are determined by organizations such as: American Congress of Obstetricians and Gynecologists (ACOG), National Breast and Cervical Cancer Early Detection Program (NBCCEDP), American Cancer Society (ACS), American Society for Colposcopy and Cervical Pathology (ASCCP), American Society for Clinical Pathology (ASCP).

Chlamydia screening is recommended for:

- all sexually active females age 25 or younger at least annually, even if asymptomatic;
- women of any age, if risk factors are present, including but not limited to:
  - a new sex partner during the past 60 days;
  - multiple sex partners;
  - cervicitis or signs and/or symptoms of other STI;
  - pelvic inflammatory disease (PID) history;
  - exposed to STI in past 60 days;
  - pregnancy/currently planning pregnancy;
  - prior positive test for chlamydia or other STI within the past 12 months; and
  - women three to four months after treatment of a previous chlamydia infection, especially in adolescents, as follow-up for possible reinfection, not as a test of cure.

NOTE: There is currently insufficient evidence to recommend routine chlamydia screening in all sexually active men. It should, however, be considered in clinical areas with a high prevalence of chlamydia such as adolescent clinics and correctional facilities. Sexual risk assessment should be conducted to determine the appropriateness for screening, even if asymptomatic.

Gonorrhea screening is recommended for all sexually active men and women at increased risk for gonorrheal infection. Increased risk is defined as a history of prior gonorrheal or other sexually transmitted infections; new or multiple sexual partners; inconsistent condom use; sex work; and drug use. The U.S. Preventive Services Task Force (USPSTF) does not recommend routine screening for gonorrhea in men and women who are at low risk for infection.

HPV screening is only reimbursable for female clients who are 21 years or older after an initial abnormal squamous cells-undetermined significance (ASC-US) pap result. (See current information about HPV and HPV testing. For the management of abnormal Pap tests, see the ASCCP Cervical Cytology Consensus Guideline Algorithms.)

Herpes Simplex Virus (HSV) screening is frequently diagnosed through clinical evaluation of lesions. Viral culture and serological testing methods are also available for use.

The CDC recommends cell culture and polymerase chain reaction (PCR) for clients who present with genital ulcers or other mucocutaneous lesions. There are limitations to the ability to obtain adequate samples for culture depending on staging of the lesion:

- screening for HSV-1 or HSV-2 in the general population is not indicated;
- type specific serologic testing might be useful in the following cases:
  - a presenting client with recurrent genital symptoms or atypical symptoms with negative HSV cultures.
  - a presenting client with clinical diagnosis of genital herpes without laboratory confirmation.
  - a presenting client with a partner with genital herpes.

HIV screening**:** Contractors are required to perform on-site HIV testing. Providers should follow CDC recommendations that all clients age 13-64 years be screened routinely for HIV infection and that all persons likely to be at high risk for HIV be rescreened at least annually. CDC further recommends that screening be provided after the patient is notified that testing will be performed as part of general medical consent unless the patient declines (opt-out screening).

EXPEDITED PARTNER THERAPY

Expedited Partner Therapy (EPT) is the clinical practice of treating the sex partners of clients diagnosed with chlamydia or gonorrhea by providing prescriptions or medications to the client to take to his/her partner without the health care provider first examining the partner.

Texas Administrative Code 22 TAC §190.8 was amended to allow Expedited Partner Therapy for STI treatment. DSHS endorses the CDC recommendations for the use of EPT. Clinic sites implementing EPT should develop necessary policies, procedures and Standing Delegation Orders (SDOs) to reflect the CDC guidelines. For more information on implementing EPT see the DSHS HIV/STD website. At this time, no reimbursement is available for clinical services to individuals not seen as clients at the clinic.

RADIOLOGY PROCEDURES

PHC clients must be provided appropriate radiologic tests as indicated by history and clinical assessment related to the current reason for visit. If a provider is unable to provide radiological services on-site, the provider must have an MOU with another provider and make the services available through referral.

On occasion, a provider may need to locate a “lost” Intrauterine Contraception (IUC)/Intrauterine Device (IUD) or non-palpable contraceptive implant. The provider has the choice of using traditional X-ray or ultrasound for locating these contraceptive devices.

NUTRITION SERVICES

For those clients requiring more intensive nutritional guidance, medical nutritional therapy can be provided by the contractor as an allowable and billable service. Medical nutritional therapy, however, must be provided by a nutritionist in order to be reimbursed.

CONTRACEPTIVE EDUCATION AND COUNSELING SERVICES

Client education and counseling is an essential and integral component of a preventive or primary health office visit. One of the goals of primary health care/family planning is to assist clients to maintain or reach their desired family size, which may involve avoiding or delaying pregnancy or achieving a desired pregnancy. Another purpose of counseling in the primary care/family planning setting is to assist clients in reaching an informed decision regarding her/his reproductive health, as well as her/his choice and

continued use of family planning methods and services. This is often called a reproductive life plan. Counseling should include the importance of a reproductive life plan with all family planning clients, and providing preconception health services as a part of family planning services, as appropriate.

All counseling must be guided by the wishes of the client. Counseling must provide neutral, factual information and be nondirective.

Contractors must have written plans for client education that ensure consistency and accuracy of information provided, as well as identify a mechanism to determine client Client education and counseling should be client-centered, based on the client's history, risk assessment and need.

Client education must be:

- documented in the client record;
- appropriate to client's age, level of knowledge and socio-cultural background; and
- presented in an unbiased manner.

Initial education must provide clients with information needed to:

- make informed decisions about family planning;
- be aware of available contraceptive methods, including benefits and efficacy;
- reduce risks of STI/STDs and HIV;
- understand range of services available and how to access specific services needed;
- understand the importance of recommended screening tests, health promotion and disease prevention strategies (e.g., cervical cancer screening, colorectal cancer screening, smoking cessation, proper diet or physical activity guidelines), and;
- understand breast or testicular awareness/self-examination, as appropriate.

Persons providing counseling should:

- be knowledgeable, objective, non-judgmental, and sensitive to the rights and differences of individual clients;
- provide accurate, consistent, current information about available contraceptive methods, including benefits, risks, safety, effectiveness, potential side effects, complications, danger signs, any other pertinent issues, and;
- document session in the client record.

Method Counseling

Clients being provided contraceptive method specific information must receive individualized dialogue that covers:

- results of physical exam and evaluation;

- correct use of the contraceptive method(s) selected for personal use by the client, as well as possible side effects and complications;
- back up methods, including information about emergency contraception and discontinuation issues;
- scheduled revisits;
- access for urgent and emergency care, including 24-hour emergency telephone number; and
- appropriate referral for additional services as needed.

Providers are encouraged to present the most effective methods of contraception first, before presenting information on less effective methods. This information should state that long-acting reversible contraception (LARC) methods are safe and effective for most women, including those who have never given birth. A visual depiction of contraceptive methods arranged in order of typical effectiveness can be found at in appendix F or here.

Problem Counseling

Problem counseling may be provided when a client wishes to discuss issues that are not directly related to a contraceptive method. Examples include sexuality concerns, options counseling for an unintended pregnancy, and nutrition performed by a registered dietitian or weight reduction counseling.

All clients must receive accurate and thorough client-centered counseling about STIs and HIV to include:

- discussion about personal risks;
- risk reduction and infection prevention information, to address sexual abstinence, mutual monogamy with an uninfected partner, and/or condom use, as appropriate for the client; and
- referral services.

HIV Counseling

Contractors may provide negative HIV test results to patients in-person, by telephone, or by the same method or manner as the results of other diagnostic or screening tests. The provision of negative test results by telephone must follow procedures that address patient confidentiality, identification of the client, and prevention counseling. Contractors must always provide positive HIV test results to patients in a face-to-face encounter with an immediate opportunity for counseling and referral to community support services.

Test results must be provided by staff knowledgeable about HIV prevention and HIV testing. Clients whose risk screenings assessment reveals high risk behaviors should be provided directly or referred for, more extensive risk reduction counseling by a DSHS HIV/STD Program trained risk reduction specialist. To find a DSHS HIV/STD Program contractor, visit the DSHS HIV/STD website.

Preconception Counseling

Preconception counseling is an integral part of a reproductive life plan and should be provided to clients who may become pregnant in the future. The counseling discussion should include the importance of a reproductive life plan with all family planning clients, providing preconception health services as a part of preventive health services, as appropriate.

For more information on preconception counseling see:

DSHS Family Planning website;
Some Day Starts Now campaign;
Morbidity and Mortality Weekly Report (MMWR) Providing Quality Family Planning Services: Recommendations of CDC and the U.S. Office of Population Affairs; and
American Congress of Obstetricians and Gynecologists website.

Pregnancy Counseling

The visit should include a discussion about the client's reproductive life plan and a medical history that includes asking about any coexisting conditions (e.g., chronic medical illnesses, physical disability, and psychiatric illness).

Pregnancy counseling must be provided according to the needs of the client, as follows:

- Clients with positive pregnancy test results should be given information about good health practices during early pregnancy and provided a confirmatory physical assessment and prenatal care as soon as possible, preferably within 15 days.
- If ectopic pregnancy is suspected, the client is referred for immediate diagnosis and treatment.
- Clients with positive pregnancy test results must be offered and, upon client request, provided options counseling regarding prenatal care and delivery; infant care, foster care, or adoption; and pregnancy termination. If requested, the contractor must provide neutral, factual information and nondirective counseling on each of the options, and referral upon request, except with respect to any option(s) about which the pregnant woman indicates she does not wish to receive such information and counseling.
- Clients with negative pregnancy test results must be offered and, upon client request, provided information about the availability of contraceptive and infertility services, as appropriate.

Counseling Adolescents

Adolescents age 17 and younger must be provided individualized family planning counseling and medical services that meet their specific needs. Appointments should be available to them for counseling and medical services as soon as possible. It is important not to assume that adolescents are sexually active simply because they have come for family planning services.

Contractors must address these issues in counseling adolescents:

- all methods of contraception, including abstinence;
- discussion about contraceptive options and safer sex practices that reduce risk of STI/HIV and pregnancy;
- identifying and resisting sexual coercion; and
- discussion about partner, dating, and/or family violence, as well as available resources and/or assistance.

Minors and Confidentiality

Except as permitted by law, a provider is legally required to maintain the confidentiality of care provided to a minor. Confidential care does not apply when the law requires parental notification or consent or when the law requires the provider to report health information, such as in the cases of contagious disease or abuse. The definition of privacy is the ability of the individual to maintain information in a protected way. Confidentiality in health care is the obligation of the health-care provider not to disclose protected information. While confidentiality is implicit in maintaining a patient's privacy, confidentiality between provider and patient is not an absolute right.

The HIPAA privacy rule requires a covered entity to treat a "personal representative" the same as the individual with respect to uses and disclosures of the individual's protected health information. In most cases, parents are the personal representatives for their minor children, and they can exercise individual rights, such as access to medical records, on behalf of their minor children (Code of Federal Regulations - 45 CFR §164.504).

For more information see: Adolescent Health – A Guide for Providers.

REFERRAL AND FOLLOW-UP

Contractors should assist clients to meet identified primary health care needs, either directly or by referral. When services required as part of the DSHS PHC contract are to be provided by referral, the contractor must establish a written agreement with a referral resource for the provision of services and reimbursement of costs and assure that the client is charged no more than the appropriately assessed fee.

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. These policies must be sensitive to clients' concerns for confidentiality and privacy and must be in compliance with state or federal requirements for transfer of health information.

Before a contractor can consider a client as "lost to follow-up," the contractor must have at least three documented separate attempts to contact the client and the provider must comply with state and local STI reporting requirements.

For services determined to be necessary, but which are not provided by the contractor, clients must be referred to other resources for care. Contractors are expected to have established communications with Federally Qualified Health Centers (FQHCs) or DSHS funded organizations that provide breast cancer and cervical cancer services for referral

purposes, if there are any such providers within their service area. Whenever possible, clients should be given a choice of referral resources from which to select.

When a client is referred to another resource because of an abnormal finding or for emergency clinical care, the contractor must:

- make arrangements for the provision of pertinent client information to the referral resource (obtaining required client consent with appropriate safeguards to ensure confidentiality – i.e., adhering to HIPAA regulations);
- advise client about her/his responsibility in complying with the referral;
  follow up to determine if the referral was completed; and
  document the outcome of the referral.

Health services available through DSHS-funded organizations can be found by searching the DSHS Family & Community Health Services Clinic Locator.

Clients who have abnormal clinical breast exam (CBE) or cervical cytology findings may be scheduled to return for repeat exams if this is considered to be appropriate follow up by the clinician. For clients whose cervical cytology test or CBE results in an abnormal finding that requires referral for services beyond those available through primary health care, contractors are encouraged, whenever possible, to refer to a DSHS Breast and Cervical Cancer Services (BCCS) contractor. In order to promote the most effective use of limited resources, PHC contractors' clinicians should be familiar with nationally recognized guidelines and algorithms describing recommended practice regarding abnormal cervical cytology and CBE results.

METHODS OF FERTILITY REGULATION

One of the goals of family planning/preventive health care is to assist clients develop a reproductive life plan, which may involve avoiding or delaying pregnancy or achieving a desired pregnancy to reach their optimal family size. Contractors are expected to have multiple strategies available to clients within their family planning services.

In addition to client counseling - which would include abstinence from sexual intercourse, fertility awareness methods (FAM) (e.g., natural family planning), and postpartum lactational amenorrhea method (LAM) - a broad range of Federal Drug Administration (FDA) approved methods of contraception must be made available to the client, either directly or by referral to another provider of contraceptive services. Having a broad range of contraceptive methods is central to client-centered care, a core aspect of providing quality services. Individual clients need to have a choice so they can select a method that best fits their particular circumstances. This is likely to result in a more accurate and consistent use of the chosen methods.

Not all brands of the different contraceptive methods need to be made available, but each numbered contraceptive method must be made available on-site or by referral.

Most Effective

1. Contraceptive Implant (e.g., Nexplanon)

2. Intrauterine Devices (IUD) (e.g., Mirena, ParaGard, Skyla, Liletta)
3. Female Sterilization

Moderately Effective

4. Contraceptive Injections (e.g., Depo-Provera)
5. Oral Contraceptive Pills
6. Transdermal Hormonal Contraceptive (e.g., the patch)
7. Vaginal Hormonal Contraceptive Ring (e.g., the ring)
8. Diaphragm

Least Effective

9. Cervical cap
10. Female condom
11. Male condom
12. Sponge
13. Vaginal spermicide
14. Withdrawal

Note**:** Provision of emergency contraceptive (EC/ECP) is optional.

A visual depiction of contraceptive methods arranged in order of typical effectiveness can be found on the CDC website.

Long Acting Reversible Contraception (LARC), intrauterine devices [IUDs] and implants, have definite benefits related to client contraceptive efficacy, client convenience, and long term costs. Contractors should discuss and offer these methods for consideration to all women, as medically appropriate. As with all methods, the client's preference after receiving unbiased, factual, nondirective education should be respected.

For more information on LARC methods, see:

- ACOG Long Acting Reversible Contraception Program;
- LARC First;
- Bedsider.

A specific contraceptive method that requires additional clinical expertise outside the training of the PHC contractor clinicians (i.e. sterilization) may be provided by referral. If a contractor provides a method or service by referral, the method or service must be provided to clients at the referral site at no fee or at the same discounted client fee that would be charged if the method or service were provided on-site. The referring site must have a written agreement with the referral site to provide the method or service to clients under this condition.

Sterilization procedures, when performed or arranged for by the contractor, must be in compliance with consent requirements for sterilization of persons in federally assisted family planning projects. The federally mandated consent form is necessary for both abdominal and transcervical sterilization procedures in women and vasectomy in men.

Contractors may develop a written policy related to provision of the more expensive contraceptive methods (excluding oral contraceptives) that establishes a process for prioritizing clients to whom these methods would be made available. Examples of methods that would require a policy are sterilization surgery, IUD/IUC and/or implant. A client who is not offered a more expensive method, according to the policy, still must have access to a range of available methods to meet the individual needs of the client. For some clients a longer duration method, such as the contraceptive implant or an IUD, would be an acceptable alternative to sterilization.

Note: Abortion is not considered a method of family planning and no state funds appropriated to the department shall be used to pay the direct or indirect costs (including overhead, rent, phones and utilities) of abortion procedures provided by contractors.

Contractors should make **basic infertility services** available on-site to women desiring such services and have a written policy addressing infertility services. Basic services include initial infertility interview, education, physical examination, counseling, and appropriate referral. For information on basic infertility services see the MMWR Providing Quality Family Planning Services: Recommendations of CDC and the U.S. Office of Population Affairs, *Basic Infertility Services*.

PERINATAL CLINICAL GUIDELINES

Prenatal and postpartum services should be provided based on American Congress of Obstetricians and Gynecologists (ACOG) guidelines.

COMPONENTS OF INITIAL PRENATAL INTERVENTIONS/SCREENING

Initial Prenatal Visit – The initial encounter with a pregnant client includes: complete history, physical examination, assessment, planning, treatment, counseling and education, referral as indicated, and routine prenatal laboratory tests and additional laboratory tests 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.

COMPONENTS OF RETURN ANTEPARTUM INTERVENTIONS/SCREENING

Return Prenatal Visit - Follow up prenatal visit includes interval history, physical examination, risk assessment, medical services, nutritional counseling, psychosocial counseling, family planning counseling, and client education about maternal and child health topics. Hemoglobin and/or hematocrit, and urinalysis for protein and glucose are also included.

COMPONENTS OF POSTPARTUM INTERVENTIONS/SCREENING

Postpartum Visit – The postpartum visit includes an interval history, physical examination, assessment, family planning, counseling and education, and referral as indicated, and routine postpartum, laboratory tests and additional laboratory tests as indicated by history, physical exam and/or assessment.

PERINATAL HISTORIES

Initial Prenatal Visit

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

- reason for visit/chief complaint;
- current health status, including acute and chronic medical conditions, with history of present illness if indicated;
- significant past health illnesses, including hospitalizations
- previous surgeries and biopsies
- blood transfusions and other exposure to blood products;
- mental health history (e.g., depression, anxiety);
- current medications, including prescription, over the counter (OTC) as well as complementary and alternative medicines (CAM);
- allergies, sensitivities or reactions to medicines and other substances (e.g.; latex, seafood);
- immunization status/assessment, including rubella status;

- reproductive health history, including;
  - pertinent sexual behavior history, including family planning practices (i.e., contraceptive use – past and current), number of partners, gender of sexual partners, last sexual encounter, sexual abuse;
  - sexually transmitted infections (STIs) (including hepatitis B and C), and HIV history, risks, and exposure;
    - pertinent partner history, including injectable drug use, number of partners;
    - STIs and HIV history and risk factors, gender of sexual partners;
  - menstrual history, including last normal menstrual period;
  - obstetrical history, detailed;
  - gynecological conditions;
    cervical cancer screening history (date and results of last Pap test or other cervical cancer screening test, note any abnormal results and treatment); and
- social history/health risk assessment (HRA), including:
  - 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);
  - 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 (ADLs);
  - risk assessment including but not limited to:
    - diabetes;
    - heart disease;
    - intimate partner violence;
    - human trafficking;
    - injury;
    - malignancy;
- family history, including genetic conditions;
- 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).

POSTPARTUM VISITS

Interval history includes:

- labor and delivery history, with maternal and neonatal complications;
- infant bonding;
- breast feeding/infant feeding issues;
- symptoms of infections;
- symptoms of excessive/abnormal vaginal bleeding;
- assessment for postpartum depression; and
- family planning/contraception (current method and/or future plans).

PHYSICAL ASSESSMENTS

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 client health record.

Initial Prenatal Visit

- height measurement;
- weight measurement, with documentation of pre-pregnancy weight and assessment for underweight, overweight, and obesity;
- body mass index (BMI);
- blood pressure evaluation;
- cardiovascular assessment;
- clinical breast exam;
- visual inspection of external genitalia and perianal area;
- 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; and
- 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

PERINATAL LABORATORY AND 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 client;
- tracking of test results and documentation in client 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 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) (Mandated by Health and Safety Code §81.090);
  - HIV, unless declined by client, who must then be referred to anonymous testing (Mandated by Health and Safety Code §81.090);
    - Review CDC's revised recommendations for HIV testing for adults, adolescents, and pregnant women.
  - Syphilis serology (Mandated by Health and Safety Code §81.090);
- hemoglobin and/or hematocrit;
- rubella serology, or positive immune status /immunization documented in chart;
- cervical cancer screening test (e.g., Pap test) for women 21 years and older;
- hemoglobinopathy screening, as indicated;
- urine screen or culture;
- TB skin test as indicated by risk assessment, history, or physical exam (see the Heartland National TB Center algorithm for pregnant clients here);
- ultrasound, as clinically indicated; and
- other laboratory and diagnostic tests as indicated by risk assessment, history and physical exam

Return Prenatal Visits Laboratory and Diagnostic Tests

- quadruple testing for antenatal screening offered to clients presenting prior to 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 clients onsite or by referral;

- diabetes screen (24 – 28 weeks);
- glucose tolerance test (GTT) for abnormal diabetic screen;
- antibody screen for Rh negative clients, 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-based 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];
- ultrasound, 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; and
- Other laboratory and diagnostic as indicated by risk assessment, history and physical exam.

Postpartum Visits Laboratory and Diagnostic Tests 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 client health record.

OTHER DIAGNOSTIC TESTS AND INTERVENTIONS

Ultrasounds

Obstetrical ultrasounds will be reimbursed when clinically indicated, including the following:

- estimation of gestational age for women with uncertain clinical dates;
- 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; and

- 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. It 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. It may be billed as often as the provider deems the procedure to be medically 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. It may be billed as often as the provider deems the procedure to be medically necessary.

PERINATAL EDUCATION AND COUNSELING SERVICES

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

Client education and counseling must be:

- documented in the client health record;
- appropriate to client's age, level of knowledge and socio-cultural background; and
- presented in an unbiased manner.

Client 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;
- family and 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 tests;
- 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); and
- other education and counseling as indicated by risk assessment, history and physical exam.

Client 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; and
- 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 clients with a high risk condition, e.g., gestational diabetes, inappropriate weight gain, hyperemesis.

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 client'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).*

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 and other resources available in the state, and selecting appropriate child care.

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

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).*

All documents (unless otherwise noted) may be ordered or downloaded from our web site Literature Ordering Link and Online Catalog.

For questions related to *Information for Parents of Newborns* or *A Parent's Guide to Raising Healthy, Happy Children*, please contact infoforparents@dshs.state.tx.us.

For questions related to *Information on Umbilical Cord Blood Donation,* call Title V Maternal and Child Health at 512-776-7373 or titlev@dshs.state.tx.us.

Client 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
- interconception counseling
- depression/postpartum depression

DENTAL CLINICAL GUIDELINES

Dental services include comprehensive and periodic oral evaluations, radiographs, fluoride treatment, and therapeutic services.

DENTAL HEALTH 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 medical standards and state laws, including those governing record retention.

All client records must be:

- complete, legible, and accurate, documenting all clinical encounters, including those by telephone;
- written in ink without erasures or deletions; or by electronic medical record (EMR) (scanned original signed DSHS FCHS individual or household eligibility 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 HER.

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;
- 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; and
- 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 medical history:
  - o allergies, sensitivities or reactions to medicines or other substances (i.e., latex);
  - o current medications, including prescription, over the counter (OTC), and complementary and alternative medicines (CAM);
  - o medical illnesses (i.e. HIV +);
  - o pertinent previous surgery or biopsies; and
- other:
  - o use of tobacco/alcohol including type, duration, frequency and route;
  - o 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;
- blood pressure and pulse, as indicated;
- radiographs, as indicated;
- prescription, if indicated;
- treatment plan of care; and
- procedures/treatment.

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; and
- 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;
- procedures/treatment.

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

- developing and/or reinforcing positive oral health behaviors; and
- educating on proper oral health care.

DENTAL 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; and
- counsel client on the importance of the referral and follow-up method.

CLINICAL PROTOCOLS, STANDING DELEGATION ORDERS, AND PROCEDURES AND CLIENT EDUCATION

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, dental 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 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 procedures.

Protocols

Contractors that employ Advanced Practice Nurses or Physician Assistants must have written protocols to delegate authorization to initiate medical aspects of client care. The protocols 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. **The protocols must be reviewed, agreed upon, signed, and dated by the supervising physician and the physician assistant and/or advanced practice nurse, at least annually, and maintained on-site**.

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 problems or sets of symptoms, must have written SDOs in place.

SDOs are distinct from specific orders written for a particular patient. SDOs are instructions, orders, rules, regulations or procedures that specify under what set of conditions and circumstances actions should be instituted. SDOs provide authority for RNs, LVNs or non-licensed healthcare providers to initiate client treatment, as prescribed in advance, when a physician or advance practice provider is not on the premises, and/or prior to the client being examined or evaluated by a physician or advance practice provider. Example: SDO for assessment of blood pressure/blood sugar which includes an RN, LVN or 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 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-infective for vaginal use;
  - oral anti-parasitic drugs for treatment of pinworms;
  - topical anti-parasitic drugs; or
  - antibiotic drugs for treatment of STIs.
- handling medical emergencies - to include on-site management as well as possible transfer of client;
- giving immunizations; or
- performing pregnancy testing.

The SDOs must be reviewed, signed, and dated by the supervising physician who is responsible for the delivery of medical care covered by the orders and other appropriate staff, at least annually and maintained on site.

Client Education

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

RESOURCES

Requirements addressing scope of practice and delegation of medical and nursing acts can be accessed at the following websites:

- Texas Medical Board
- Texas Board of Nursing

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).

EMERGENCY RESPONSIVENESS

Clinical Emergencies

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.
- Each site must have staff trained in basic cardiopulmonary resuscitation (CPR) and emergency medical action. Staff trained in 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 clients are present.
- Documentation must be maintained in personnel files that staff has been trained regarding these written plans or protocols.

Emergency Preparedness

- There must be a written safety plan that includes maintenance of fire-safety equipment, an emergency evacuation plan, and a disaster response plan.

PREVENTIVE SERVICES

Contractors are strongly encouraged to visit the USPSTF Web site for recommendations regarding appropriate preventive services.
Here is the current *Guide to Clinical Preventive Services,* developed by the U.S. Preventive Services Task Force.

Section III
Reimbursement, Data Collection and Reporting

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

REIMBURSEMENT FOR PRIMARY HEALTH CARE SERVICES

All services will be reimbursed on a cost reimbursement basis. Payments will be made for costs incurred and will be supported by reporting to show services provided and some client-level data.

Billing – PHC services contract amounts are ceilings against which contractors may bill for services provided to PHC eligible clients. Once this ceiling has been reached, no further funds will be available for reimbursement. Contractors may only bill for services provided to clients who have been screened for potential Medicaid and other benefit programs and been determined PHC eligible.

Categorical

The DSHS PHC categorical funding (cost reimbursement) is used to develop and maintain contractor infrastructure for the provision of primary health services. The funding can be used to support clinic facilities, staff salaries, utilities, medical and office supplies, equipment, and travel, as well as direct medical services. Costs may be assessed against any of the following categories the contractor identifies during their budget development process:

- Personnel;
- Fringe Benefits;
- Travel;
- Equipment and Supplies;
- Contractual;
- Other; and
- Indirect Costs.

DSHS PHC funds are disbursed to contractors through a voucher system as expenses are incurred during the contract period. Program income must be expended before categorical funds are requested through the voucher process. Contractors must still submit vouchers monthly even if program income equals or exceeds program expenses, or if the contract reimbursement limit has been met. When program expenses exceed program income, the monthly voucher will result in a payment. Program income includes all fees paid by the clients (client co-pay).

Categorical reimbursement for the cost of providing services shall be billed monthly on the State of Texas Purchase Voucher (Form B-13) and submitted simultaneously to the Contract Development & Support Branch (CDSB) (cdsb@dshs.state.tx.us) and the Accounting Section/Claims Processing Unit (CPU) (invoices@dshs.state.tx.us). See Form B-13 in the Forms Section for the PHC State of Texas Purchase Voucher and an example of a completed PHC Purchase Voucher.

Each request will cover services provided, or expenses incurred, in the preceding month as applicable to the contract attachment. Requests should be submitted within 30 days of the end of the preceding month and within 60 days of providing the service. Appropriate financial records must be maintained for review by DSHS through the quality assurance review process and/or fiscal monitoring and/or programmatic desk reviews.

To be paid promptly, Purchase Vouchers must identify the Vendor Identification Number, DSHS document number and Attachment number, and the 10-digit Purchase Order Number. Incorrect identification numbers may delay payment. Failure to complete these sections will delay payment.

A monthly PHC Form 225 must be submitted with the monthly voucher. Reimbursement requests submitted without the required program reports will not be approved for payment. Vouchers and/or reports submitted with incorrect or missing information will be rejected and the contractor will be contacted to remedy the problem.

Contractors must continue to submit a State Purchase Voucher and supporting monthly program reports even after contract ceilings have been reached. Any cost over the contract ceiling after deducting program income should be reflected under “Non-DSHS Funding” on the voucher and on the FSR. This submission is required to continue reporting expenditures on any program income collected monthly, and to provide DSHS with statistical information about the use of services.

Non-Reimbursable Expenditures - PHC will not reimburse services for individuals enrolled in another program or clients who do not complete the respective eligibility process, except for clients who meet the presumptive eligibility criteria. Payment for clients that were treated under presumptive eligibility may be eligible for services only during the 90-day time period. If clients fail to fully comply with all requirements to apply for Medicaid services, they will not be considered eligible for PHC services after the presumptive time period expires.

Reimbursable Expenditures - Services may be provided to clients whose screening results indicate they are potentially Medicaid eligible, but the client has not yet completed the application process. With the exception of presumptive eligibility, services provided on the initial day of service may be billed to PHC for reimbursement with proper documentation of client’s eligibility status.

Submission of Vouchers – PHC Form 225, Monthly Reports, as applicable, should be submitted within 30 days following the end of the month covered by the bill. If expenses are overstated on one month’s voucher, the following month’s expenses should be reduced accordingly. All claims for reimbursement for services delivered must be submitted within 45 days of the end of the contract term. If contractors have services that occurred during the contract

period left to bill after the August Purchase Voucher has been submitted, contractors can bill those services using a Purchase Voucher and a PHC Form 225 report marked SUPPLEMENTAL and FINAL and submit the forms on or before October 15th. PHC contracts require closure of the contract attachment within 45 days of the end of the contract term. All requests for reimbursement must be submitted by email to CDSB.

The Purchase Voucher must be submitted by fax or email to Contract Development and Support Branch (CDSB) and the Claim Processing Unit (CPU). Requests received more than 45 days following the end of the Contract Attachment will not be paid. A signed Financial Status Report (Form 269A) final report must be filed with the CPU and the Contract Development and Support Branch (CDSB) by email to CDSB no later than 45 days after the contract term. The 269A must be marked as FINAL and include all reimbursements and adjustments in payments for the contract term.

Altering of Forms - Contractors are required to use the Excel format for ease of processing. None of the billing or the reporting forms may be altered in any manner. State Purchase vouchers should not be altered to itemize expenses for PHC services provided. Vouchers should be submitted for the total monthly reimbursement amount only. Please use at least 10 pt sized font when entering data. Illegible information will be questioned and/or returned, and payment may be delayed.

ADDITIONAL RESOURCES

The Contractor's Financial Procedures Manual (CFPM) provides DSHS contractors with a comprehensive guide on basic accounting and financial management system requirements.

DATA COLLECTION & REPORTING

PROGRAM INFORMATION:
Program Name: Primary Health Care (PHC)
Contract Type: Categorical
Contract Term: September 1 through August 31

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

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

Instructions: Submit one Form B-13 voucher to CDSB and CPU. Must submit to both email addresses in the same email.

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

VOUCHER: Report 1 - Supporting
Report Name: PHC-225 Monthly Report Form in PDF format
Submission Date: By the last business day of the following month. Final report due within 45 days after end of contract term.
Submit Copy to:

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

Instructions: Submit one PHC-225 form to CDSB and CPU. Must submit to both email addresses in the same email..

NOTE: Voucher form B-13 and PHC-225 must be submitted at the same time to both CDSB and CPU email boxes. Vouchers will not be processed unless the PHC-225 is received with the voucher form B-13. All forms must be submitted in their original format, to two email addresses, in the same email - no exceptions!

REPORT: Report 1
Report Name: Financial Status Report 269A
Submission Date: Quarterly, Sept 1-Nov 30, Dec 1-Feb 28, Mar 1-May 31, June 1-Aug 31. Submit 30 days after the end of each quarter. The final quarterly FSR is due 45 days after the end of the contract term. The final quarter report includes all final charges and expenses associated with the program contract. Mark it as "FINAL."

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

Instructions: Form 269A must have an original signature (signed and scanned in email accepted).

REPORT: Report 2
Report Name: PHC Annual Report
Submission Date: Within 60 days following the end of the contract period.
Submit to:

Name of Unit/Branch	Original Signature Required Yes	No	Accepted Method of Submission	# of Copies
Community Health Services Section (CHSS)		X	Email	1

Instructions: Submit PHC Annual Report Form to PCG only.

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

Last Updated/Reviewed: 7/28/2015

Section IV
APPENDICES

APPENDIX A

DSHS Family & Community Health Services Division
INDIVIDUAL Eligibility Form

TEXAS Department of State Health Services

PART I - APPLICANT INFORMATION

Name (Last, First, Middle)	Telephone Number		Email Address		
Texas Residence Address (Street or P.O. Box)	City	County	State	ZIP	
SSN (optional)	Date of Birth	Age	Race	Ethnicity	Sex

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

b) Do you 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 you have 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 box with the number of people in your household. This number will include you and anyone who lives with you for whom you are legally responsible. Minors should include parent(s)/legal guardian(s).

How many people are in your household? ☐

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 me.

Signature – Applicant _____ Date _____

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

PART V – PROVIDER ELIGIBILITY CERTIFICATION (to be completed by provider)

Eligibility effective date / /

1. Texas resident	☐ Yes	☐ No	
2. Total monthly household income	$		
3. Household FPL	%		
4. Proof of income	☐ Yes	☐ Waived	
5. Verification of adjunctive eligibility	☐ Yes	☐ No	☐ n/a
6a. Presumptively eligible	☐ Yes	☐ No	☐ n/a
6b. Full eligibility met	☐ Yes		
6c. Full eligibility met date	/ /		

7. Is the client eligible for the following program(s)?

	Yes	No	n/a	Co-payment amount (if applicable)
BCCS	☐	☐	☐	$_____
DSHS FP	☐	☐	☐	$_____
EPHC	☐	☐	☐	$_____
PHC	☐	☐	☐	$_____
Title V/MCH	☐	☐	☐	$_____

Notes:

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

DSHS Family & Community Health Services Division
INDIVIDUAL Eligibility Form Instructions

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 benefits 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 box with the number of people in your household. This number will include you and anyone 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

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)

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.

PART V – PROVIDER ELIGIBILITY CERTIFICATION (to be completed by provider)

(1) Check the appropriate box (*yes* or *no*) for Texas resident. (2) Total the *amount received per month* to fill in the *Total monthly household income* box. (3) Calculate the client's household FPL using the applicable DSHS program policy (include applicable deductions) and fill in the *Household FPL* box. Check the appropriate box (*yes, no, waived,* or *n/a*) for (4) *Proof of* income and (5) *Verification of adjunctive eligibility.*

If client is presumptively eligible, fill in the light gray box. (6a) Check the appropriate box (*yes, no,* or *n/a*) for *Presumptively eligible.* Once the client completes the requirements for full eligibility, (6b) check *Yes* for *Full eligibility met* and fill in the (6c) *Full eligibility met date* box.

(7) Check the appropriate box (*yes*, *no*, or *n/a*) for each program regarding the client's eligibility. If yes, fill in the client's co-payment amount for the program based on their household and income information.

Use the space provided in *Notes* to document other appropriate information concerning eligibility and screening.
Fill in the *Eligibility effective date* box in the top right corner of Part V. Fill in the *Name of Agency*, sign, and date.

APPENDIX A **División de Servicios de Salud Familiar y Comunitaria del Departamento Estatal de Servicios de Salud (DSHS)**

Formulario para la participación INDIVIDUAL

TEXAS Department of State Health Services

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	
Número de Seguro Social (SSN) (opcional)	Fecha de nacimiento	Edad	Raza	Origen étnico	Sexo

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

b) ¿Tiene usted 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 usted 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 las casillas con el número de personas que hay en su familia. Este número le incluye a usted y a cada persona que viva con usted y de la que usted sea legalmente responsable. Los menores de edad deben incluir al padre, a la madre o al tutor legal.

¿Cuántas personas viven en su casa? ☐

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 de los apoyos recibidos.

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 _____

PART V – PROVIDER ELIGIBILITY CERTIFICATION (debe ser completada por el proveedor)

Eligibility effective date / /

1. Texas resident	☐ Yes	☐ No	
2. Total monthly household income	$		
3. Household FPL	%		
4. Proof of income	☐ Yes	☐ Waived	
5. Verification of adjunctive eligibility	☐ Yes	☐ No	☐ n/a
6a. Presumptively eligible	☐ Yes	☐ No	
6b. Full eligibility met	☐ Yes		
6c. Full eligibility met date	/ /		

7. Is the client eligible for the following program(s)?

	Yes	No	n/a	Co-payment amount (if applicable)
BCCS	☐	☐	☐	$_____
DSHS FP	☐	☐	☐	$_____
EPHC	☐	☐	☐	$_____
PHC	☐	☐	☐	$_____
Title V/MCH	☐	☐	☐	$_____

Notes:

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

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

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)*
- *TWHP (El Programa 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 las casillas con el número de personas que hay en su familia. Este número le incluye a usted y a cada persona que viva con usted y de la que 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

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).

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.

PARTE V – PROVIDER ELIGIBILITY CERTIFICATION (debe ser completada por el proveedor)

(1) Check the appropriate box (*yes* or *no*) for Texas resident. (2) Total the *amount received per month* to fill in the *Total monthly household income* box. (3) Calculate the client's household FPL using the applicable DSHS program policy (include applicable deductions) and fill in the *Household FPL* box. Check the appropriate box (*yes, no, waived,* or *n/a*) for (4) *Proof of* income and (5) *Verification of adjunctive eligibility.*

If client is presumptively eligible, fill in the light gray box. (6a) Check the appropriate box (*yes, no,* or *n/a*) for *Presumptively eligible.* Once the client completes the requirements for full eligibility, (6b) check *Yes* for *Full eligibility met* and fill in the (6c) *Full eligibility met date* box.

(7) Check the appropriate box (*yes*, *no*, or *n/a*) for each program regarding the client's eligibility. If yes, fill in the client's co-payment amount for the program based on their household and income information.

Use the space provided in *Notes* to document other appropriate information concerning eligibility and screening.
Fill in the *Eligibility effective date* box in the top right corner of Part V. Fill in the *Name of Agency*, sign, and date.

APPENDIX B

DSHS Family & Community Health Services Division
HOUSEHOLD Eligibility Form

Use with HOUSEHOLD Worksheet (Form EF05-13227)

TEXAS Department of State Health Services

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 _____

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)

APPENDIX B **División de Servicios de Salud Familiar y Comunitaria del Departamento Estatal de Servicios de Salud (DSHS)**

Formulario para la participación FAMILIAR

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 _____

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)*
- *TWHP (El Programa 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)

DSHS Family & Community Health Services Division
HOUSEHOLD Eligibility Worksheet

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

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.

PHC Program
Definition of Income

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**
Disability Insurance Benefits	**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**	
Lump-Sum Payments*	**X**	**X**
Military Pay*	**X**	
Mineral Rights*	**X**	
Pensions and Annuities*	**X**	
Reimbursements*	**X**	
RSDI /Social Security Payments*	**X**	
Self-Employment Income*	**X**	
SSDI	**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 as income after deducting $75 from the total monthly child support payments the household receives.

Disability Insurance Payments/SSDI – Countable. Social Security Disability Insurance is a payroll tax-funded, federal insurance program of the Social Security Administration.

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.

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

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

SAMPLE
DSHS Primary Health Care (PHC) Program Fee Scale
Based On Monthly Federal Poverty Guidelines

	≤100%FPL	101 - 133% FPL	134 - 150% FPL	151 - 185% FPL	186 - 200% FPL
Family Size	**$10.00 Co-Pay**	**$15.00 Co-Pay**	**$25.00 Co-Pay**	**$30.00 Co-Pay**	**$40.00 Co-Pay**
1	0 - 990.00	990.01 - 1,317.00	1,317.01 - 1,485.00	1,485.01 - 1,832.00	1,832.01 - 1,980.00
2	0 - 1,335.00	1,335.01 - 1,776.00	1,776.01 - 2,003.00	2,003.01 - 2,470.00	2,470.01 - 2,670.00
3	0 - 1,680.00	1,680.01 - 2,235.00	2,235.01 - 2,520.00	2,520.01 - 3,108.00	3,108.01 - 3,360.00
4	0 - 2,025.00	2,025.01 - 2,694.00	2,694.01 - 3,038.00	3,038.01 - 3,747.00	3,747.01 - 4,050.00
5	0 - 2,370.00	2,370.01 - 3,153.00	3,153.01 - 3,555.00	3,555.01 - 4,385.00	4,385.01 - 4,740.00
6	0 - 2,715.00	2,715.01 - 3,611.00	3,611.01 - 4,073.00	4,073.01 - 5,023.00	5,023.01 - 5,430.00
7	0 - 3,061.00	3,061.01 - 4,071.00	4,071.01 - 4,592.00	4,592.01 - 5,663.00	5,663.01 - 6,122.00
8	0 - 3,408.00	3,408.01 - 4,532.00	4,532.01 - 5,112.00	5,112.01 - 6,304.00	6,304.01 - 6,815.00
9	0 - 3,755.00	3,755.01 - 4,994.00	4,994.01 - 5,632.00	5,632.01 - 6,946.00	6,946.01 - 7,509.00
10	0 - 4,101.00	4,101.01 - 5,455.00	5,455.01 - 6,152.00	6,152.01 - 7,587.00	7,587.01 - 8,202.00
11	0 - 4,448.00	4,448.01 - 5,916.00	5,916.01 - 6,672.00	6,672.01 - 8,228.00	8,228.01 - 8,895.00
12	0 - 4,795.00	4,795.01 - 6,377.00	6,377.01 - 7,192.00	7,192.01 - 8,870.00	8,870.01 - 9,589.00
13	0 - 5,141.00	5,141.01 - 6,838.00	6,838.01 - 7,712.00	7,712.01 - 9,511.00	9,511.01 - 10,282.00
14	0 - 5,488.00	5,488.01 - 7,299.00	7,299.01 - 8,232.00	8,232.01 - 10,152.00	10,152.01 - 10,975.00
15	0 - 5,835.00	5,835.01 - 7,760.00	7,760.01 - 8,752.00	8,752.01 - 10,794.00	10,794.01 - 11,669.00

Effective March 1, 2016

The contractor must waive the fee if a client self-declares an inability to pay. No PHC client shall be denied services based on an inability to pay.

Co-payment may not exceed the cost of the visit.

APPENDIX E

From: Morbidity and Mortality Weekly Report (MMWR) Providing Quality Family Planning Services: Recommendations of CDC and the U.S. Office of Population Affairs

Recommendations and Reports

April 25, 2014 / 63(RR04);1-29

http://www.cdc.gov/mmwr/preview/mmwrhtml/rr6304a1.htm?s_cid=rr6304a1_e

pp.22-23: Summary of Recommendations for Providing Family Planning and Related Preventive Health Services

The screening components for each family planning and related preventive health service are provided in summary checklists for women (Table 2) and men (Table 3). When considering how to provide the services listed in these recommendations (e.g., the screening components for each service, risk groups that should be screened, the periodicity of screening, what follow-up steps should be taken if screening reveals the presence of a health condition), providers should follow CDC and USPSTF recommendations cited above, or, in the absence of CDC and USPSTF recommendations, the recommendations of professional medical associations. Following these recommendations is important both to ensure clients receive needed care and to avoid unnecessary screening of clients who do not need the services.

The summary tables describe multiple screening steps, which refer to the following: 1) the process of asking questions about a client's history, including a determination of whether risk factors for a disease or health condition exist; 2) performing a physical exam; and 3) performing laboratory tests in at-risk asymptomatic persons to help detect the presence of a specific disease, infection, or condition. Many screening recommendations apply only to certain subpopulations (e.g., specific age groups, persons who engage in specific risk behaviors or who have specific health conditions), or some screening recommendations apply to a particular frequency (e.g., a cervical cancer screening is generally recommended every 3 years rather than annually). Providers should be aware that the USPSTF also has recommended that certain screening services not be provided because the harm outweighs the benefit (see Appendix F).

When screening results indicate the potential or actual presence of a health condition, the provider should either provide or refer the client for the appropriate further diagnostic testing or treatment in a manner that is consistent with the relevant federal or professional medical associations' clinical recommendations.

APPENDIX E

TABLE2. Check list of family planning and related preventive health services for women

Screening components	Family planning services (provide services in accordance with the appropriate clinical recommendation): Contraceptive services*	Pregnancy testing and counseling	Basic infertility services	Preconception health services	STD services†	Related preventive health services
History						
Reproductive life plan§	Screen	Screen	Screen	Screen	Screen	
Medical history§,**	Screen	Screen	Screen	Screen	Screen	Screen
Current pregnancy status§	Screen					
Sexual health assessment§,**	Screen		Screen	Screen	Screen	
Intimate partner violence §,¶,**				Screen		
Alcohol and other drug use§,¶,**				Screen		
Tobacco use§,¶	Screen (combined hormonal methods for clients aged ≥35 years)			Screen		
Immunizations§				Screen	Screen for HPV & HBV§§	
Depression§,¶				Screen		
Folic acid§,¶				Screen		
Physical examination						
Height, weight and BMI§,¶	Screen (hormonal methods)††		Screen	Screen		
Blood pressure§,¶	Screen (combined hormonal methods)			Screen§§		
Clinical breast exam**			Screen			Screen§§
Pelvic exam§,**	Screen (initiating diaphragm or IUD)	Screen (if clinically indicated)	Screen			
Signs of androgen excess**			Screen			
Thyroid exam**			Screen			
Laboratory testing						
Pregnancy test **	Screen (if clinically indicated)	Screen				
Chlamydia§,¶	Screen¶¶				Screen§§	
Gonorrhea§,¶	Screen¶¶				Screen§§	
Syphilis§,¶					Screen§§	
HIV/AIDS§,¶					Screen§§	
Hepatitis C§,¶					Screen§§	
Diabetes§,¶				Screen§§		
Cervical cytology¶						Screen§§
Mammography¶						Screen§§

Abbreviations: BMI = body mass index; HBV = hepatitis B virus; HIV/AIDS = human immunodeficiency virus/acquired immunodeficiency syndrome; HPV = human papillomavirus; IUD = intrauterine device; STD = sexually transmitted disease.

* This table presents highlights from CDC's recommendations on contraceptive use. However, providers should consult appropriate guidelines when treating individual patients to obtain more detailed information about specific medical conditions and characteristics (Source: CDC. U.S. medical eligibility criteria for contraceptive use 2010. MMWR 2010;59(No. RR-4).

† STD services also promote preconception health but are listed separately here to highlight their importance in the context of all types of family planning visits. The services listed in this column are for women without symptoms suggestive of an STD.

§ CDC recommendation.

¶ U.S. Preventive Services Task Force recommendation.

** Professional medical association recommendation.

†† Weight (BMI) measurement is not needed to determine medical eligibility for any methods of contraception because all methods can be used (U.S. Medical Eligibility Criteria 1) or generally can be used (U.S. Medical Eligibility Criteria 2) among obese women (Source: CDC. U.S. medical eligibility criteria for contraceptive use 2010. MMWR 2010:59[No. RR-4]). However, measuring weight and calculating BMI at baseline might be helpful for monitoring any changes and counseling women who might be concerned about weight change perceived to be associated with their contraceptive method.

§§ Indicates that screening is suggested only for those persons at highest risk or for a specific subpopulation with high prevalence of an infection or condition.

¶¶ Most women do not require additional STD screening at the time of IUD insertion if they have already been screened according to CDC's STD treatment guidelines (Sources: CDC. STD treatment guidelines. Atlanta, GA: US Department of Health and Human Services, CDC; 2013. Available at http://www.cdc.gov/std/treatment. CDC. Sexually transmitted diseases treatment guidelines, 2010. MMWR 2010;59[No. RR-12]). If a woman has not been screened according to guidelines, screening can be performed at the time of IUD insertion and insertion should not be delayed. Women with purulent cervicitis or current chlamydial infection or gonorrhea should not undergo IUD insertion (U.S. Medical Eligibility Criteria 4) women who have a very high individual likelihood of STD exposure (e.g. those with a currently infected partner) generally should not undergo IUD insertion (U.S. Medical Eligibility Criteria 3) (Source: CDC. US medical eligibility criteria for contraceptive use 2010. MMWR 2010;59[No. RR-4]). For these women, IUD insertion should be delayed until appropriate testing and treatment occurs.

APPENDIX E

TABLE 3. Checklist of family planning and related preventive health services for men

Screening components and source of recommendation	Family planning services (provide services in accordance with the appropriate clinical recommendation): Contraceptive services*	Basic infertility services	Preconception health services†	STD services§	Related preventive health services
History					
Reproductive life plan¶	Screen	Screen	Screen	Screen	
Medical history¶,††	Screen	Screen	Screen	Screen	
Sexual health	Screen	Screen	Screen	Screen	
Alcohol & other drug use			Screen		
Tobacco use¶,**			Screen		
Immunizations¶			Screen	Screen for HPV & HBV§§	
Depression¶,**			Screen		
Physical examination					
Height, weight, and BMI¶,**			Screen		
Blood pressure**,††			Screen§§		
Genital exam††		Screen (if clinically indicated)		Screen (if clinically indicated)	Screen§§
Laboratory testing					
Chlamydia¶				Screen§§	
Gonorrhea¶				Screen§§	
Syphilis¶,**				Screen§§	
HIV/AIDS¶,**				Screen§§	
Hepatitis C¶,**				Screen§§	
Diabetes¶,**			Screen§§		

Abbreviations: HBV = hepatitis B virus; HIV/AIDS = human immunodeficiency virus/acquired immunodeficiency syndrome; HPV = human papillomavirus virus; STD = sexually transmitted disease.

* No special evaluation needs to be done prior to making condoms available to males. However, when a male client requests advice on pregnancy prevention, he should be provided contraceptive services as described in the section "Provide Contraceptive Services."

† The services listed here represent a sub-set of recommended preconception health services for men that were recommended and for which there was a direct link to fertility or infant health outcomes (Source: Frey K, Navarro S, Kotelchuck M, Lu M. The clinical content of preconception care: preconception care for men. Am J Obstet Gynecol 2008;199[6 Suppl 2]:S389–95).

§ STD services also promote preconception health, but are listed separately here to highlight their importance in the context of all types of family planning visit. The services listed in this column are for men without symptoms suggestive of an STD.

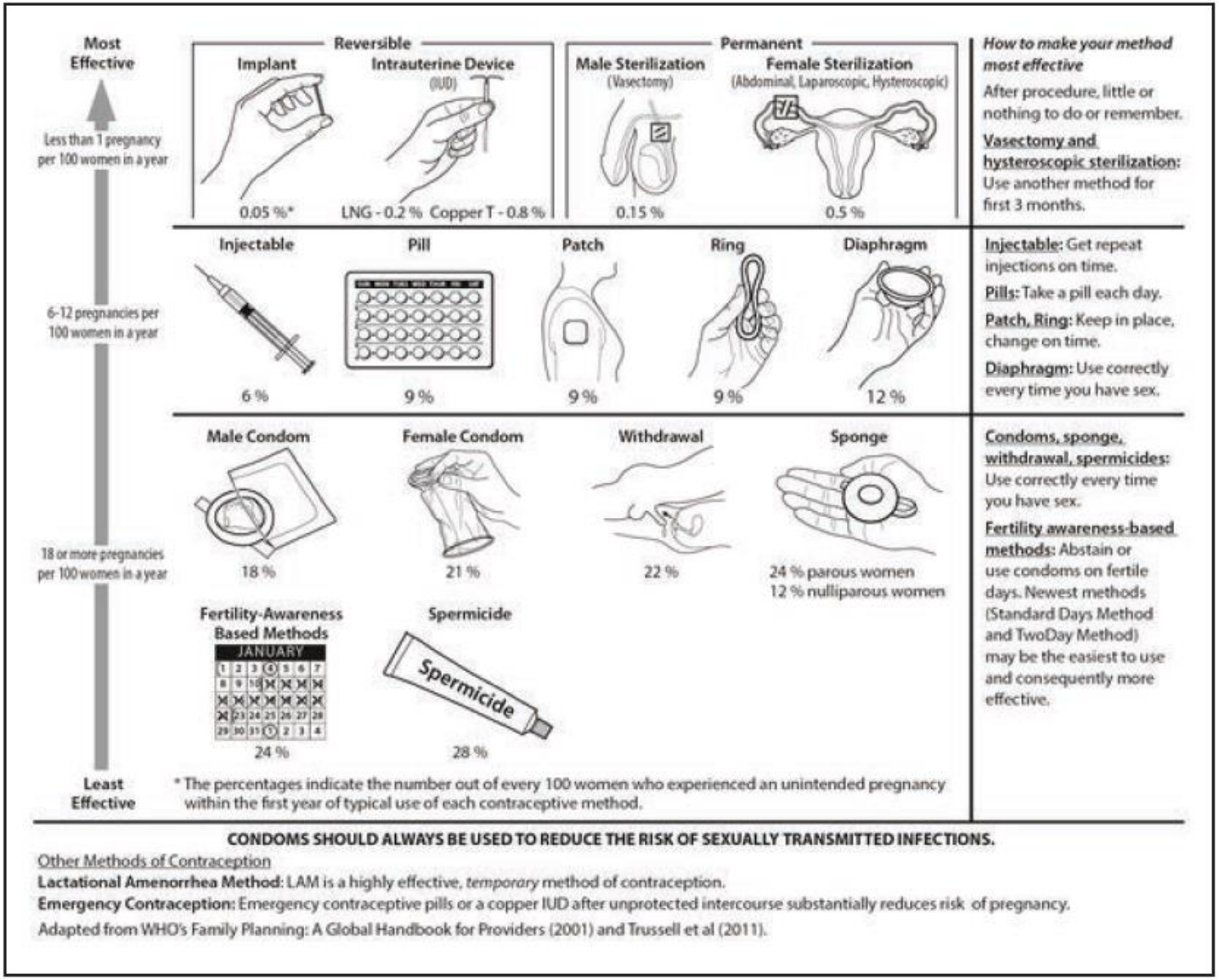
¶ CDC recommendation. ** U.S. Preventive Services Task Force recommendation.

†† Professional medical association recommendation.

§§ Indicates that screening is suggested only for those persons at highest risk or for a specific subpopulation with high prevalence of infection or other condition.

APPENDIX F **TYPICAL EFFECTIVENESS OF FDA-APPROVED CONTRACEPTIVE METHODS**

The figure shows the typical effectiveness of FDA-approved contraceptive methods, ranging from least effective (fertility-awareness based methods and spermicide) to the most effective (implants, intrauterine devices, and sterilization).
*MMWR Providing Quality Family Planning Services: Recommendations of CDC and the U.S. Office of Population Affair*s, *Recommendations and Reports.* April 25, 2014 / 63(RR04);1-29. (See http://www.cdc.gov/mmwr/preview/mmwrhtml/rr6304a1.htm?s_cid=rr6304a1_w)



APPENDIX G

2016 DSHS Primary Health Care Program Policy Manual
Dental Diagnosis Codes

DIAGNOSIS CODES

ICD-9 code(s) from the list below will be used for reporting and documentation of a client's oral status at the initial visit and at the 6 months visit in the client's record.

521 Diseases of hard tissues of teeth
- 521.0 Dental caries
  - 521.01 Dental caries limited to enamel
  - 521.01 Dental caries extending to dentin
  - 521.03 Dental caries extending into pulp
  - 521.06 Dental caries pit and fissure
  - 521.07 Dental caries of smooth surface
  - 521.08 Dental caries of root surface
- 521.3 Erosion

522 Diseases of pulp and periapical tissues
- 522.0 Pulpitis
- 522.1 Necrosis of the pulp
- 522.5 Periapical abscess without sinus
- 522.7 Periapical abscess with sinus

523 Gingival and periodontal diseases
- 523.0 Acute gingivitis
- 523.1 Chronic gingivitis
- 523.3 Aggressive and acute periodontitis
- 523.4 Chronic periodontitis

525 Other diseases and conditions of the teeth and supporting structures
- 525.1 Loss of teeth due to trauma, extraction, or periodontal disease
  - 525.10 Acquired absence of teeth, unspecified
  - 525.11 Loss of teeth due to trauma
  - 525.12 Loss of teeth due to periodontal disease
  - 525.13 Loss of teeth due to caries
- 525.4 Complete edentulism
- 525.5 Partial edentulism
- 525.6 Unsatisfactory restoration of tooth
  - 525.60 Unspecified unsatisfactory restoration of tooth
  - 525.61 Open restoration margins
  - 525.62 Unrepairable overhanging of dental restorative materials
  - 525.63 Fractured dental restorative material without loss of material
  - 525.64 Fractured dental restorative material with loss of material
  - 525.65 Contour of existing restoration of tooth biologically incompatible with oral health
  - 525.67 Poor esthetics of existing restoration
  - 525.69 Other