



Title V Genetic Fee-for-Service Policies and Procedures Manual Fiscal Year 2011

Genetic Services Program
Newborn Screening Unit
Specialized Health Services Section

September 2010

Table of Contents

TABLE OF CONTENTS	2
INTRODUCTION	6
PURPOSE OF MANUAL.....	6
PROGRAM INFORMATION	6
General Purpose and Program Goals	6
Background.....	6
TITLE V SPECIAL REQUIREMENTS.....	7
Children’s Health Insurance Program (CHIP) Perinatal Program.....	7
Title V Genetic Services.....	8
Termination of Contract or Defunding.....	8
Specific Contract Information.....	8
DEFINITIONS.....	9
ACRONYMS.....	13
SECTION I: ADMINISTRATIVE POLICIES.....	15
CLIENT ACCESS.....	15
CHILD ABUSE REPORTING.....	15
CLIENT RIGHTS	16
Confidentiality	16
Non-Discrimination.....	16
Termination Of Services	18
Resolution Of Grievances	18
CLIENT RECORDS MANAGEMENT.....	19
PERSONNEL POLICIES AND PROCEDURES	20
FACILITY POLICIES AND PROCEDURES.....	21
Hazardous Materials	21
Fire Safety.....	21
Medical Equipment	21
Smoking Ban.....	21
Disaster Response Plan	21
QUALITY MANAGEMENT	22
SECTION II: CLIENT SERVICES POLICIES AND PROCEDURES	25
CLIENT ELIGIBILITY	25
Contractor Responsibilities	25
Applicant’s Responsibility for Providing Proof	26
Waiving Proof of Family Composition, Residency, and Income.....	26
Client’s Responsibility for Reporting Changes.....	27
Interviews.....	27
SCREENING AND ELIGIBILITY DETERMINATION	27
DSHS Funding Source.....	28
Family Composition	28
Children and Family Composition.....	29
Documentation of Family Composition	29
Residency	29
Documentation of Residency.....	30
Temporary Absences from State	30
Income	31
Documentation of Income.....	33
Income Determination Procedure	34

Eligibility Determination.....	36
Appeal Eligibility Determination	37
Date Eligibility Begins	37
Presumptive Eligibility	37
Clients Screened Potentially Eligible for Other Benefits	38
Annual Re-Certification	40
Assessment Of Co-Pay/Client Fees	41
Other Fees	41
Services	41
CLINICAL INFORMED CONSENT	42
General Informed Consent.....	42
Clinical Informed Consent.....	42
TMDP Consent	42
Parental Consent For Services To Minors.....	43
Consent For HIV Tests	43
CLIENT HEALTH RECORD (MEDICAL RECORD)	44
Mandatory Documentation.....	45
SECTION III: CLINICAL GUIDELINES	48
GENETIC EVALUATION.....	48
Health History	48
Medical Genetics Physical Examination	48
Psychosocial Genetic Assessment.....	50
CASE MANAGEMENT.....	50
GENETIC COUNSELING	50
Medical Genetic Counseling	50
Psychosocial Genetic Counseling	50
GENETIC EVALUATION AND COUNSELING CODES	51
GENETIC LABORATORY PROCEDURES	51
PRIOR APPROVAL.....	53
GENETIC SERVICES CHANGES	53
PROTOCOLS, STANDING DELEGATION ORDERS, AND PROCEDURES	54
EMERGENCY RESPONSIVENESS.....	55
SECTION IV: BILLING AND REPORTING	57
OVERVIEW	57
BILLING REQUIREMENTS	57
Billing Errors.....	58
Non-Reimbursable Expenditures	58
Charging Clients for Title V Services	59
Program Income (Co-Payments)	59
REPORTING REQUIREMENTS	59
Financial Reports	60
Monthly Aggregate Program Reports	60
Maintenance of Records	60
Sanctions Due to Non-Compliance with Reporting.....	61
SECTION V: TITLE V CONTRACTOR FORMS AND REPORTS.....	63
DSHS FUNDING SOURCE – Screening and Eligibility Form.....	63
DSHS FUNDING SOURCE - Worksheet	65
Eligibility and Benefits by Federal Poverty Level (FPL)	66
Statement of Applicant’s Rights and Responsibilities	67
Presumptive Eligibility – Title V Genetic Services.....	68
Notice of Eligibility/Aviso de Elegibilidad - Title V Genetic Services.....	70
Instructions for Completing the Procedure Code Reports	72
Title V Genetic Services Procedure Code Report (185)	73

Title V Genetic Laboratory Tests (185)	74
Title V Genetic Services Procedure Code Report (186)	75
Title V Genetic Laboratory Tests (186)	76
Instructions for Completing the New Client Reports	77
FY 11 Monthly New Client Report for Title V Genetic Services	78
FY 11 Monthly New Client Report for Title V Genetic Services	79
State Of Texas Purchase Voucher Instructions	80
State of Texas Purchase Voucher	81
Request for Information – Title V Genetic Services	82
Statement of Self-Employment Income.....	83
Employment Verification - Title V Genetic Services.....	85
APPENDIX: STATE RESOURCES	87

Introduction

General Information

Introduction

PURPOSE OF MANUAL

The Department of State Health Services (DSHS) Title V Genetic Fee-for-Service Policy and Procedures Manual is a guide for contractors who deliver clinical genetic services using Maternal and Child Health Services (MCH) Title V Block Grant funds in Texas. The policy manual has been structured to provide contractor staff with information needed to comply with Title V MCH administrative, client services activities, reimbursement, and data collection and reporting policies.

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

PROGRAM INFORMATION

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

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

States submit a standardized application for the block grant funds with an annual report by July 15th of each year. As a result of OBRA '89, each state must provide state funds at a level at least equal to the amount that had been dedicated to maternal and child health programs in federal fiscal year 1989 to

receive federal funds through the MCH Title V Block Grant. This is referred to as the state's "maintenance of effort." States are required to use federal funds awarded as follows:

- at least 30% for preventive/primary care for children;
- at least 30% for services for children with special health care needs; and
- no more than 10% on administration.

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

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

TITLE V SPECIAL REQUIREMENTS

The MCH Title V Block Grant requires a percentage of the total federal funding which DSHS receives each year to be dedicated to services provided to children and adolescents, age 1 through 21. As part of the Title V genetic contract requirements, at least 25% of the total contract amount (dollars billed) must represent provision of fee-for-service direct health care/enabling services to individuals age 1 through 21. To meet this 25% requirement, contractors should monitor all services provided to individuals age 1 through 21, including all genetic services.

Records must be maintained by each contractor to verify that the respective 25% requirement is maintained. DSHS will require service delivery plans to reflect this intent and will conduct monitoring of monthly billings to assess each contractor's compliance with this requirement.

Children's Health Insurance Program (CHIP) Perinatal Program - Senate Bill 1, HHSC Rider 70 (79th Legislature, Regular Session, 2005) authorized HHSC to expend appropriated funds "to provide unborn children with health benefit coverage under the Texas Title XXI Health Plan." This expanded health insurance coverage for children was established by the State Children's Health Insurance Program (S-CHIP) as part of Title XXI of the Social Security Act.

As a result of this mandate, HHSC created the CHIP Perinatal Program to provide health coverage to unborn children of pregnant women up to 200% of the federal poverty level (FPL) who are ineligible for Medicaid due to income or immigration status. Implementation of this program began January 1, 2007. The benefits and eligible services are limited to prenatal and postpartum care (the same as Title V Prenatal Services). The goal of the CHIP Perinatal Program is to

provide perinatal services for the unborn child as soon as possible for the best outcome.

Beginning September 2007, contractors were no longer allowed to bill Title V Genetic Services for biochemical, cytogenetic, and DNA testing; amniocentesis; and ultrasounds for pregnant women. Title V Genetic Services will only cover preconception genetic services and prenatal genetic counseling for women of childbearing age.

Title V Genetic Services - Contractors and their subcontractors are expected to:

- Provide adequate automation systems to ensure direct communication with DSHS.
- Show evidence of new hire and annual periodic orientation of all staff to Title V concepts and revisions as applicable to their job descriptions.
- Notify DSHS of any issues, concerns, or questions regarding the program.
- Establish and implement eligibility, clinical, reporting, and billing systems for Title V.
- Screen all participants with an approved screening process and refer clients to other programs/funding sources, as appropriate. Failure to adequately screen is deemed as unsatisfactory performance and may result in defunding.
- Develop a referral system with effective follow-up.
- Develop a working relationship with other programs to ease the referral process for clients.
- Comply with eligibility, clinical, reporting, and billing mandates outlined in this manual.
- Work in collaboration with DSHS to improve performance deemed unsatisfactory.

Termination of Contract or Defunding - Either the contractor or DSHS may give 30 days notice to terminate the contract. DSHS has the right to withhold reimbursement of payment if reports to DSHS are not timely and accurate. DSHS may either defund with 30 days notice or choose not to award for the next state fiscal year if contractor performance is deemed unsatisfactory.

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

DEFINITIONS

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

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

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

If the child does not meet the above criteria, he/she will be considered a separate household of one.

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

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

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

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

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

Contractor – Any entity DSHS has contracted with to provide services. The contractor is the responsible entity even if there is a subcontractor involved who actually implements the services.

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

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

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

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

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

Documentation – Process of recording eligibility and/or health information provided by the applicant.

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

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

Federal Poverty Level (FPL) – The set minimum amount of income that a family needs for food, clothing, transportation, shelter, and other necessities. In the U. S., this level is determined by the Department of Health and Human Services. FPL varies according to family size. The number is adjusted for inflation and reported annually in the form of poverty guidelines. Public assistance programs, such as Medicaid in the U.S., define eligibility income limits as some percentage of FPL.

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

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

Informed Consent – The process by which a health care provider ensures that the benefits and risks of a diagnostic or treatment plan, the benefits and risks of other appropriate options and the benefits and risk of taking no action are explained to a patient in a manner that is understandable to that patient and

allows her/him to participate and make sound decisions regarding her/his own medical care.

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

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

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

Monthly Program Report – Report a contractor must submit to the DSHS Genetic Services Program within 30 days after the end of the prior month.

New Client Report – Part of the monthly program report contractors must submit to the DSHS Genetic Services Program. It includes the number of new patients receiving services for the first time in a state fiscal year, reported by age and ethnicity.

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

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

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 an immediate medical need exists as determined by a medical professional and the client screens potentially eligible for services.

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

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

Procedure Code Report – Part of the monthly program report contractors must submit to the DSHS Genetic Services Program. It serves as documentation of services provided and billed.

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

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

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

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

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

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

State Fiscal Year - September 1 – August 31.

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

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

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

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

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

Unduplicated Client – Clients are counted only once per category regardless of the number of services they receive; client can be counted once in prenatal,

dysplasia, family planning, and child health, as appropriate. One client seen four times in one category is counted as one unduplicated client and a family of three seen once is counted as three unduplicated clients.

ACRONYMS

Acronym	Term
ADA	Americans with Disabilities Act
CDSB	Contract Development and Support Branch
CHIP	Children's Health Insurance Program
CIHCP	County Indigent Health Care Program
CLIA	Clinical Laboratory Improvement Amendments
CMB	DSHS Contract Management Branch
DHHS	U.S. Department of Health and Human Services
DSHS	Texas Department of State Health Services
EMR	Electronic Medical Record
FPL	Federal Poverty Level
FQHC	Federally Qualified Health Center
FSR	Financial Status Report
HIPAA	Health Insurance Portability and Accountability Act of 1996
HHSC	Texas Health and Human Services Commission
HSR	DSHS Health Service Region
LEP	Limited English Proficiency
MCH	Maternal and Child Health Services
PMU	DSHS Performance Management Unit
PPCU	DSHS Preventive and Primary Care Unit
QA	Quality Assurance
QM	Quality Management
QMB	DSHS Quality Management Branch
RFP	Request for Proposal
SSA	Social Security Administration
TAC	Texas Administrative Code
TANF	Temporary Assistance for Needy Families

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.

Section I: Administrative Policies

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;
- 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) <http://www.lep.gov/>, and speech or sensory impairments;
- Have a policy in place that requires qualified staff to assess and prioritize client's needs;
- Provide referral resources for individuals that cannot be served or cannot receive a specific service; and
- Manage funds to ensure that established clients continue to receive services throughout the budget year.

CHILD ABUSE 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 adult and child abuse and neglect reporting laws in Texas.

To report abuse or neglect, call 1-800-252-5400 or use the secure website: <http://www.txabusehotline.org>.

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*. Contractors must develop a 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.

The following outlines how the DSHS Quality Management Branch (QMB) staff will review for contractor compliance with these requirements.

Policy – Contractors/providers will be monitored to ensure compliance with screening for child abuse and reporting according to Chapter 261 of the Texas Family Code and the *DSHS Child Abuse Screening, Documenting, and Reporting Policy for Contractors/Providers*.

CLIENT RIGHTS

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

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

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

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).

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

1. Title VI of the Civil Rights Act of 1964 (42 U.S.C. §2000d *et seq.*);
2. Section 504 of the Rehabilitation Act of 1973 (29 U.S.C. §794);
3. Americans with Disabilities Act (ADA) of 1990 (42 U.S.C. §12101 *et seq.*);
4. Age Discrimination Act of 1975 (42 U.S.C. §§6101-6107);
5. Title IX of the Education Amendments of 1972 (20 U.S.C. §§1681 1688);
6. Food Stamp Act of 1977 (7 U.S.C. §200 *et seq.*); and
7. HHSC's administrative rules, as set forth in the Texas Administrative Code, to the extent applicable.

To ensure compliance with DSHS non-discrimination policies, DSHS contractors must:

- Have a written policy that states the agency does not discriminate on the basis of race, color, national origin including LEP, religion, disability, age, or sex;
- Sign a written assurance as to compliance with applicable federal and state civil rights laws and regulations;

- Have a procedure for notifying the HHSC Civil Rights Office of any program or service-related discrimination allegation or complaint no more than ten (10) calendar days of the allegation or complaint;
- Notify all clients and applicants of the contractor's non-discrimination policies and complaint procedures;
- Ensure that all contractor staff is trained in the agency's non-discrimination policies and complaint procedures; and
- 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 the client's interpreter if requested and as long as the family member or friend does not compromise the effectiveness of the service or violate client confidentiality.

Under this agreement, the contractor must notify HHSC's Civil Rights Office of any civil rights complaints received relating to its performance. This notice must be delivered no more than ten (10) calendar days after receipt of a complaint. Notice provided pursuant to this section must be directed to:

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

The contractor must prominently display in client common areas, including lobbies and waiting rooms, front reception desks, and locations where clients apply for services the following two 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**.

The contractor must have available, completed, and signed copies of the *Non-Discrimination Policies and Procedures Survey*, *ADA/Section 504 Policies and Procedures Survey*, the *Americans with Disabilities Act Checklist for Readily Achieving Barrier Removal* required for each clinic site and *Limited English Proficiency (LEP) Policies and Procedures Survey* prior to any scheduled on-site review by the QMB review team.

- More information about applicable laws and regulations can be found on HHSC's Civil Rights Office website:
<http://www.hhs.state.tx.us/aboutHHS/CivilRights.shtml>.
- The Non-Discrimination Policies and Procedures Survey, ADA/Section 504 Policies and procedures Survey, the ADA Checklist for Readily Achieving Barrier Removal, and LEP Policies and Procedures Survey and their instructions can be downloaded at the QMB website at:
<http://www.dshs.state.tx.us/qmb/contractor.shtm>.

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

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

Resolution Of Grievances - 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, contractors shall not terminate services to the client until a final decision is rendered.

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

RESEARCH (HUMAN SUBJECT CLEARANCE)

Contractors considering clinical or sociological research using Community Health Services Section's (CHSS) grant-funded clients as subjects must obtain prior approval from their own internal Institutional Review Board (IRB) or the Texas Department of State Health Services IRB #1. The IRB is responsible for the review of human subjects' research and the review of requests for release of data, including protected health information.

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

Request for Proposals (RFPs) and grant renewal applications will include a checkbox to indicate if a contractor is performing research on any CHSS grant-funded clients. If so, the contractor must submit documentation of IRB approval along with the RFP or renewal application. A person within CHSS will be assigned to review each such submission to ensure the policy requirements are being met and to ensure compliance with any grant restrictions pertaining to research.

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

CLIENT RECORDS MANAGEMENT

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

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

The written consent of the client is required for the release of personally identifiable information, except as may be necessary to provide services to the client or as required by law, with appropriate safeguards for confidentiality. HIV information should be handled according to law (see <http://www.dshs.state.tx.us/hivstd/policy/laws.shtm>).

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

Contractors, providers, subrecipients, and subcontractors must maintain for the time period specified by DSHS all records pertaining to client services, contracts, and payments. Record retention requirements are found in Title 1, Part 15 Texas Administrative Code § 354.1003 (relating to Time Limits for Submitted Claims) and Title 22, Part 9 Texas Administrative Code §165 (relating to Medical Records). Contractors must follow contract provisions and the DSHS Retention Schedule for Medical Records. All records relating to services must be accessible for examination at any reasonable time to representatives of DSHS and as required by law. DSHS guidelines for medical record retention are available at: <http://www.dshs.state.tx.us/records/medicalrec.shtm>.

All medical records and supporting documentation for Title XIX Medicaid services must be maintained in accordance with Medicaid rules as outlined in the 2009 Texas Medicaid Provider Procedures Manual, Section 1.4.3 (page 1-12). http://www.tmhp.com/TMPPM/2010/Vol1_01_Provider_Enrollment.pdf

PERSONNEL POLICIES AND PROCEDURES

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

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

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

All medical care must be provided under the supervision, direction, and responsibility of a qualified Medical Director.

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

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

Contractors must also include orientation and in-service training for all personnel, including volunteers. There must be documentation of initial employee orientation and continuing education.

FACILITY POLICIES AND PROCEDURES

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

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

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

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

Medical Equipment - Contractors must have a written policy and maintain documentation of the maintenance, testing, and inspection of medical equipment. Documentation must include:

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

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

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

For additional resources on facilities and equipment, you can visit <http://www.osha.gov/>.

QUALITY MANAGEMENT

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

Contractors are expected to develop quality processes based on the four core QM principles of focusing on:

- The client;
- Systems and processes;
- Measurement; and
- Teamwork.

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

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

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

The QM 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 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 used; and
- Outline reporting to the QM Committee.

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

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

Data from these activities must be presented to the QM 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 DSHS's Quality Management Branch, as well as policies and review tools, can be found at:

<http://www.dshs.state.tx.us/qmb/default.shtm>.

Section II

Client Services Policies and Procedures

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

Section II: Client Services Policies and Procedures

CLIENT ELIGIBILITY

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

- Gross family income at or below 185% FPL;
- Texas resident; and
- Not eligible for other programs/benefits providing the same services.

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

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

The contractor will:

- Use the DSHS Funding Source – Screening and Eligibility Form (Form EF05-13229); and DSHS Funding Source – Worksheet (Form EF05-13227); and verification/documentation procedures established by DSHS or completion of a comparable paper or electronic screening and eligibility tool that has the required DSHS information for determining eligibility;
- Assist the applicant with accurately completing the application for screening and eligibility determination purposes;
- Ensure that the documentation the individual provides is sufficient to make an eligibility decision. Request for Information (Form 104) may be used to assist applicants with requested verification requirements;
- Accept reasonable documentation provided by the individual;
- Document oral designations of any additional contacts;
- Determine eligibility for Title V services based on the three (3) eligibility criteria;
- Provide the eligible individual information regarding the services he/she is entitled to receive and his/her rights and responsibilities;
- Advise the client of his/her responsibility to report changes; and
- Determine the effect reported changes have on the client's eligibility by re-screening and completing the eligibility determination process.

Verification of documentation is generally not necessary, except for contradictory or discrepant information and/or information that does not sufficiently explain the circumstances to support an eligibility decision. The contractor shall allow the individual an opportunity to resolve any discrepancy by providing documentary evidence or designating a suitable contact to verify information. If the individual fails or refuses to do so, eligibility can be denied. Document this information on the DSHS Funding Source – Screening and Eligibility Form and DSHS Funding Source – Worksheet.

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

Applicant's Responsibility for Providing Proof –

- Complete the DSHS Funding Source – Screening and Eligibility Form or request assistance for completion;
- Applicants are responsible for providing documents requested by the contractor. Failure to document all required information will result in denial of eligibility. If documentation is not available or is insufficient to determine eligibility, contractor staff should ask the individual to designate a contact person to provide the information. Information about the individual designated to confirm the applicant's information is for contact purposes and does not need to be collected if that source is an individual listed on the application form or is present during the interview.

Waiving Proof of Family Composition, Residency, and Income - Requiring proof may assist some contractors who are struggling with the demand for services and lack the amount of funding needed to provide these services. In some instances, requiring proof of income may allow contractors to manage in a fiscally responsible manner.

Requiring proof may be waived, however, if the contractor has a legitimate reason for doing so. For example, if this requirement may deter prenatal clients from seeking care.

This requirement may be waived for a service category (genetic services) or for one or more service category. If this requirement is waived for a service category, all clients seeking care within that service category must be treated equally. In other words, a contractor may not require proof of income for one client and not for another.

At the beginning of each state fiscal year, contractors must have a written policy outlining how the eligibility policy has been implemented.

The eligibility determination process for Title V Genetics is based upon the stated eligibility criteria and supporting documentation that evidences the client's declarations regarding income, residency, and family composition. The client's information is to be recorded on the DSHS Funding Source – Screening and Eligibility Form and DSHS Funding Source – Worksheet with copies of supporting documentation maintained in the client record. The determination process may be repeated upon the occurrence of any factor impacting the eligibility, such as change in pregnancy status, family composition, or income, but must be repeated no less than annually for a client to continue to receive Title V-funded services.

Client's Responsibility for Reporting Changes - A client must report changes in the following areas: income, family composition, residence, address, employment, types of medical insurance coverage, and receipt of Medicaid and/or other third-party coverage benefits. The client may report changes by mail, telephone, in-person, or through someone acting on the individual's behalf. Changes must be reported no later than 30 days after the client is aware of the change. If changes affect eligibility and are not reported within 30 days, the individual is denied continued eligibility. By signing the required forms, the individual attests to the truth of the information provided.

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

SCREENING AND ELIGIBILITY DETERMINATION

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

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

after August 31, 2006. The re-certification can be preformed before the anniversary date the client was deemed eligible for Title V Genetic Services or before services are provided on the first visit after the anniversary date.

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

- Completion of the DSHS Funding Source – Screening and Eligibility Form and DSHS Funding Source – Worksheet; or
- Completion of a comparable paper or electronic screening and eligibility tool that has the required DSHS information and been reviewed and approved by DSHS Title V Genetic Services for determining eligibility. A copy of the DSHS Funding Source Screening and Eligibility Form must be maintained in the medical record.

For Title V Genetic Services purposes, contractors may use the HHSC-*Your Texas Benefits* website (www.yourtexasbenefits.com) to assist in the determination of client eligibility. The website offers access to information on HHSC benefits including Medicaid, Supplemental Nutrition Assistance Program (SNAP), Temporary Assistance for Needy Families (TANF), Children’s Health Insurance (CHIP), and nursing home care and other services for people who are elderly or have disabilities. The use of this system may replace the DSHS Funding Source - Worksheet, but can not replace the DSHS Funding Source - Application.

DSHS Funding Source – Screening and Eligibility Form and DSHS Funding Source - Worksheet – The individual is responsible for completing page one of his/her own DSHS Funding Source – Screening and Eligibility Form. If assistance is needed in completing the form, the contractor shall provide knowledgeable staff to assist. One form must be completed for each family member being screened for eligibility. To expedite the process, it is acceptable to fill out the form once and photocopy the form for the number of family members needed. The family member name listed under the family composition chart on question 1 can be highlighted or circled to indicate the intended client record in which it shall be filed. Each Title V Genetic Services eligible client, who is a legal adult, is required to sign and date the form. If confidentiality of services is a concern, separate forms for spouses may be completed. The signature of anyone assisting in completion of the form is required as well. The form is filed in the client record.

Family Composition - Establishing family size is an important step in the eligibility process. Assessment of income eligibility relies on an accurate count of family members. A family is defined as a person living alone or a group of two or more persons related by birth, marriage (including common law), or adoption, which reside together and are legally responsible for the support of the other person. Unborn children are also included in family size.

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

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

If the child does not meet the above criteria, he/she will be considered a separate household of one.

A child may be considered part of a family when living with relatives other than natural parents if documentation can be provided that verifies the relationship. Acceptable documents include birth certificates or other legal documents that demonstrate the relationship between the caretaker and the child. If the child is not biologically related to the care provider, document the relationship on the DSHS Funding Source - Screening and Eligibility Form and DSHS Funding Source – Worksheet.

Documentation of Family Composition - To document family relationships, one of the following items shall be provided, if questionable:

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

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

Residency - To be eligible for Title V Genetic Services, an individual must be physically present within the geographic boundaries of Texas and:

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

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

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

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

Individuals described below are not eligible to receive Title V Genetic Services:

- Inmates of correctional facilities.
- Residents of state schools.
- Patients in state psychiatric hospitals.

Documentation of Residency - Document proof of residency provided by the client on the DSHS Funding Source – Worksheet and explain why residency is questionable, if necessary. For documentation of residency, one of the following items shall be provided:

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

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

- Observance of personal effects and living arrangements.
- Statements from a landlord, neighbor, or other reliable sources.

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

Income - To be eligible for Title V Genetic Services, clients must have a gross family income at or below 185% FPL. The table below details sources of earned and unearned income that contribute to the calculation of gross family income as well as income that is exempt from being counted.

Types of Income	Countable	Exempt
Adoption Payments		X
Cash Gifts and Contributions*	X	
Child Support Payments*	X	
Child's Earned Income		X
Crime Victim's Compensation*		X
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 Administration*	X	X
Wages and Salaries, Commissions*	X	
Worker's Compensation*	X	

**Explanation of countable income provided below*

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

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

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

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

Disability Insurance Payments/Social Security Disability Insurance (SSDI) – Countable. SSDI 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 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.

Retirement, Survivors, and Disability Insurance (RSDI)/Social Security Payments – Count the 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 total gross earned, minus the allowable costs of producing the self-employment income.

Supplemental Security Income (SSI) Payments – Exempt.

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 an overpayment.

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

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

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

Documentation of Income - Documentation of income must be provided to complete the DSHS Funding Source - Screening and Eligibility Form and DSHS Funding Source – Worksheet. Declarations of “unknown” will not be accepted as representations of required facts and documentation. Incomplete or inadequately documented eligibility determination will result in limitations in the provision of funded services. To document income, the following documentation shall be provided for a minimum of four (4) consecutive current pay periods or one month's pay, only if paid same gross amount on a monthly basis, unless special circumstances are noted on the DSHS Funding Source - Screening and Eligibility and DSHS Funding Source – Worksheet:

- Copy(ies) of the most recent paycheck(s).
- Copy(ies) of the most recent paycheck stub/monthly earning statement(s).
- Employer's written verification of gross monthly income or the Employment Verification Form (Form 128).
- Award letters.
- Domestic relation printouts of child support payments.
- Letter of support.
- Unemployment benefits statement or letter from the TWC.
- Award letters, court orders, or public decrees to verify support payments.
- Notes for cash contributions.
- Other documents or proof of income determined valid by the contractor.

If all attempts to document income are unsuccessful because the employer/payer fails or refuses to provide information or threatens continued employment, and no other proof can be found, staff may determine an amount to use on the form based on the best available information and document the determined income on the DSHS Funding Source -- Screening and Eligibility Form and DSHS Funding Source – Worksheet.

Income Determination Procedure - Count income already received and any income the family expects to receive. When an individual has not received income for new employment, use the best estimate of the amount to be received. If telephone verification regarding new or terminated employment is made, it must be documented by the contractor on the DSHS Funding Source – Worksheet.

Count terminated income in the month received. Use actual income and do not use conversion factors if terminated income is less than a full month's income.

Use at least four consecutive, current pay periods to calculate projected monthly income. If client is paid one time per month and receives the same gross pay each month, then one pay period will suffice.

If actual or projected income is not received monthly, convert it to a monthly amount using one of the following methods:

- Weekly income x 4.33
- Every two weeks x 2.17
- Twice a month x 2.0

Dependent childcare expenses shall be deducted from total income in determining eligibility. Allowable deductions are actual expenses up to \$200 per child per month for children under age 2 and \$175 per child per month for children age 2 to 12 or age 2 to 18 if child is disabled.

Legally-obligated child support payments made by a member of the household

group shall also be deducted. Payments made weekly, every two weeks, or twice a month must be converted to a monthly amount by using one of the above listed conversion factors.

Self-Employment Income – If an applicant earns self-employment income, it must be added to any income received from other sources.

- Annualize self-employment income that is intended for an individual or family's annual support, regardless of how frequently the income is received.
- Determine the cost of producing self-employment income by allowing the following deductions:
 - Capital asset improvements
 - Capital asset purchases, such as real property, equipment machinery and other durable goods, i.e., items expected to last at least 12 months
 - Fuel
 - Identifiable costs of seed and fertilizer
 - Insurance premiums
 - Interest from business loans on income-producing property
 - Labor
 - Linen service
 - Payments of the principal of loans for income-producing property
 - Property taxes
 - Raw materials
 - Rent
 - Repairs that maintain income-producing property
 - Sales tax
 - Stock
 - Supplies
 - Transportation costs. The person may choose to use 50.0 cents per mile instead of keeping track of individual transportation expenses. Do not allow travel to and from place of business
 - Utilities

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

- If the self-employment income is only intended to support the individual or family for part of the year, average the income over the number of months it is intended to cover.
- If the individual has had self-employment income for the past year, use the income figures from the previous year's business records or tax forms.
- If current income is substantially different from income the previous year, use more current information, such as updated business ledgers or daybooks. Remember to deduct predictable business expenses.

- If the individual or family has not had self-employment income for the past year, average the income over the period of time the business has been in operation and project the income for one year.
- If the business is newly established and there is insufficient information to make a reasonable projection, calculate the income based on the best available estimate and follow-up at a later date.
- A signed statement from individuals who are self-employed and have no documentation of their income will be accepted for a period of six (6) months. Title V Genetic Services coverage cannot be extended on subsequent applications without formal documentation of self-employment income.

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

Employment Terminated/New Employment – When the individual has been terminated, resigned, or laid off, the income from that job will then be disregarded. When an individual has not yet received income for new employment, use the best estimate of the amount to be received. If telephone verification regarding new or terminated employment is made, it must be documented by the contractor on the DSHS Funding Source – Screening and Eligibility Form and DSHS Funding Source – Worksheet.

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

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

Eligibility Determination - The eligibility determination criteria are residence, income, and ineligibility for other programs providing the same services. The contractor must consider the information provided by the client and document the basis for the eligibility decision on the DSHS Funding Source – Screening and Eligibility Form and DSHS Funding Source – Worksheet.

After approving an application, provide the eligible individual information regarding the services he/she is entitled to receive and his/her rights and responsibilities. The client must sign the Statement of Applicants Rights and Responsibilities to complete the eligibility determination.

This form does not have to be signed again unless there is a break in services longer than two years. It is required that after determining eligibility, the provider gives the client a copy of the Statement of Applicants Right and Responsibilities and Notice of Eligibility (Section V) stating that either the family or individual is:

- Eligible
 - The individual/family is eligible for assistance;
 - The date eligibility begins and expires; and
 - The services the individual/family is entitled to receive.
- Ineligible
 - The individual/family is denied eligibility;
 - The reason the application was denied;
 - The effective date of denial;
 - The individual's right to appeal; and
 - The appropriate referrals to alternative agencies/programs for services.

Appeal Eligibility Determination - Individuals and families can appeal to the DSHS Title V contractor regarding the eligibility determination for Title V, if they feel that information was incorrectly considered. Applicants may submit additional information to establish eligibility, or repeat the application process.

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

<http://www.dshs.state.tx.us/regions/default.shtm>

Date Eligibility Begins - An individual is entitled to services beginning on the date the completed application was submitted.

Presumptive Eligibility - Individuals, who have not had final eligibility for services determined but present with an **immediate medical need**, may receive Title V funded services on a presumptive eligibility basis during the time that eligibility for services is pending. Presumptive eligibility may be effective for up to 90 days from the date the client is first seen by the medical provider. A client shall be enrolled on a presumptive eligibility basis only once in a 12-month period.

If the individual has not already applied for Title V Genetic Services, an application for services should occur at the time of receiving services. If a medical condition makes eligibility determination impossible, an appointment to complete the process should be made at the first possible opportunity. If the client has applied for another program, the contractor is responsible for updating the individual's eligibility status on a timely basis. Documented proof of eligibility within the other funding sources is required. If services are needed immediately

and are not provided by another program, services may be provided during this 90-day period. If the client becomes Medicaid eligible, the services must be billed to Medicaid under the “90-days prior provision.”

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

A Presumptive Eligibility Form and Statement of Applicant’s Rights and Responsibilities must be completed when a client is determined presumptively eligible.

Clients Screened Potentially Eligible for Other Benefits - Contractors must work to ensure that individuals seeking Title V genetic-covered services use other programs or benefits first. If individuals are determined potentially eligible for other benefits, contractors must refer them to the specific programs and assist them in completing the eligibility determination process. It is possible that a family will be referred to several programs as a result of the eligibility determination process. Programs/benefits that must be used first include:

- Private/Employer Insurance
- Medicare
- Medicaid
- TRICARE
- County Indigent Health Care Program (CIHCP)
- Children with Special Health Care Needs Services Program
- CHIP (other than family planning services)
- Title V, Title X, Title XIX (including the Women’s Health Program) and Title XX Family Planning
- Breast and Cervical Cancer Services
- Worker’s Compensation
- Veteran’s Administration Benefits
- CHIP Perinatal Program

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

- Benefits that were created by the establishment of a city or county hospital, a joint city-county hospital, a county hospital authority, a hospital district, or by the facilities of a publicly supported medical school would not disqualify individuals from using Title V services.
- Contractors are not expected to refer clients to the CIHCP if the county of residence does not have state supported funds to provide CIHCP services or the client does not meet the county’s eligibility criteria for the program.

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

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

CHIP Perinatal Program – Eligibility

HHSC created the CHIP Perinatal Program to provide health benefit coverage to unborn children of pregnant women up to 200% FPL who are ineligible for Medicaid due to income or immigration status. Implementation of this program began January 1, 2007. The benefits and eligible services are limited to prenatal and postpartum care, similar to Title V Prenatal Services. The goal is to provide perinatal services for the unborn child as soon as possible for the best outcome.

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

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

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

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

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

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

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

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

Annual Re-Certification - The contractor will determine the system used to track clients' status and renewal for eligibility. Eligibility determination using the DSHS Funding Source – Screening and Eligibility Form and DSHS Funding Source – Worksheet is required for all clients. Eligibility services must be re-determined for each individual/family at least once every 12 months.

At least 30 days prior to the anniversary of their original eligibility date, Title V clients should be notified that they must renew eligibility by their anniversary date or lose their benefits until they are re-certified by the program. If renewal has not been completed by the anniversary date, the individual/family record should be

removed from active status and placed in the inactive files. The individual/family should be notified of the status change. A client can be a new client only once. Regardless of the time lapse between the initial application and the renewal application, former clients will not be classified as new.

Contractors should mail out notices, either postcards or letters, requesting that the individual or family representative come to the office for re-certification. A contractor may include a new application in the letter and ask the individual to return with documentation. If an actual interview is chosen, appointment times may be given to prevent long wait periods.

For each record being reviewed, whether in person or by mail, the eligibility provider staff shall complete a new DSHS Funding Source -- Screening and Eligibility Form and DSHS Funding Source – Worksheet using updated information provided by the client. Sending a Notice of Eligibility is encouraged, but is not required, to inform the individual/family of continued eligibility. The contractor shall assist clients who request help in completing forms or providing documentation.

Assessment Of Co-Pay/Client Fees - Title V Genetic Services contractors may assess a fee for services from Title V clients whose family income exceeds 100% FPL and is below 185% FPL. Client co-pay shall not exceed 25% of the total Title V reimbursement amount for a particular service. The contractor must waive the fee if a client self-declares an inability to pay. No Title V Genetic Services client shall be denied services based on an inability to pay. Co-pays must be reported as program income on the Monthly Reimbursement Request and fiscal reporting Form 270.

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

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

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

Upon award expenditure, contractors are not required to screen new clients for Title V Genetic Services eligibility; however, if screening is completed, the contractor is required to provide services to the Title V-eligible clients per Title V

Genetic Services policy. No Title V Genetic Services client can be denied services for the inability to pay. For the unscreened clients it is allowable to make these clients self-pay and consider doing a sliding scale fee.

CLINICAL INFORMED CONSENT

General Informed Consent - Contractors must obtain the patient's written, informed, voluntary general consent to receive services prior to receiving any clinical services. A general informed consent explains the types of services provided and how client/patient 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 patient does not receive services, a new general consent must be signed prior to reinitiating delivery of services.

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

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

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

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

List A procedures can be found at the following Texas Administrative Code link:
[http://info.sos.state.tx.us/pls/pub/readtac\\$ext.ViewTAC?tac_view=4&ti=25&pt=7&ch=601&rl=Y](http://info.sos.state.tx.us/pls/pub/readtac$ext.ViewTAC?tac_view=4&ti=25&pt=7&ch=601&rl=Y).

Parental Consent For Services To Minors - The general rule is that parents must consent for minors (Family Code §151.001). However, there are certain circumstances under which a minor may consent for her/his own treatment. Requirements for parental consent for provision of family planning services to minors vary according to the funding source subsidizing the services. The department and providers may provide family planning services, including prescription drugs, without the consent of the minor's parent, managing conservator, or guardian only as authorized by Chapter 32 of the Texas Family Code or by federal law or regulations.

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

- is on active duty with the armed services.
- is at least 16 years old, living apart from a parent or guardian and managing his or her own financial affairs. You do not have to prove the child is emancipated if the minor so declares in writing.
- is consenting to diagnosis and treatment of an infectious, contagious, or communicable disease required to be reported to the local health officer or DSHS.
- consents to examination and treatment for drug or chemical addiction, dependency, or any other condition directly related to drug or chemical use.
- is unmarried and pregnant and seeking treatment related to the pregnancy, unless it's an abortion.
- has custody of his/her biological child and also consents to the child's medical, dental, psychological, or surgical treatment of the child.
- is seeking a diagnosis or treatment for a sexually transmitted disease, including HIV.
- is seeking counseling for chemical dependency or addiction; suicide prevention; or sexual, physical, or emotional abuse.

(See DSHS Consent for Medical and Mental Health Care of a Minor:

<http://www.dshs.state.tx.us/adolescent/consent-%20providers2003.shtm>)

The Texas Family Code, Chapter 32, may be found at the following website:

<http://www.statutes.legis.state.tx.us/?link=FA>.

Consent For HIV Tests - Texas Health and Safety Code §81.105 and §81.106 is as follows:

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

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

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

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

CLIENT HEALTH RECORD (MEDICAL RECORD)

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

All client records must be:

- Complete, legible, and accurate, documenting all clinical encounters, including those by telephone, in ink without erasures or deletions; or by
- Electronic Medical Record (EMR)
 - Electronic signatures are allowable to document provider review of care. However, stamped signatures are not allowable.
 - Scanned original signed DSHS FUNDING SOURCE – Screening and Eligibility Form is allowable.
- Signed by the provider making the entry, including name of provider, provider title, and date for each entry.
- Readily accessible to assure continuity of care and availability to client.
- Systematically organized to allow easy documentation and prompt retrieval of information.
- Maintained to safeguard against loss or unauthorized access and to assure confidentiality (complying with HIPAA regulations).
- Secured by lock when not in use.

The client's record must include:

- Client identification and personal data;

- Completed DSHS Funding Source – Screening and Eligibility Form and DSHS Funding Source – Worksheet;
- Completed Statement of Applicant’s Rights and Responsibilities signed by the client or responsible party;
- Copies of acceptable documentation establishing income, residency, and family composition;
- Copy of Medicaid and/or CHIP denial letter, if applicable;
- Preferred language/method of communication;
- Where and how to contact the client (to facilitate continuity of care and assure confidentiality, adhering to HIPAA regulations);
- Medical history, (in Medical History and Risk Assessment);
- Physical examination (in Physical Assessment);
- Laboratory and other diagnostic tests orders, results, and follow-up;
- Assessment or clinical impression;
- Plan of care, including education/counseling, treatment, special instructions, and referrals;
- Scheduled revisits;
- 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.

Mandatory Documentation: Client Medical Record – Title V Requirements

Each client must have a case record with documentation of eligibility for Title V services, regardless of whether the individual was referred from a Title V MCH provider, a non-Title V MCH provider, or is a self-referral.

Referred by a Title V MCH Provider:

If a client is referred by a Title V MCH provider, and the client has completed the eligibility process with that provider, the genetic services contractor has two options:

- The contractor can accept copies of the completed, signed and dated screening and eligibility documentation from the referring provider; or
- The contractor can repeat the entire eligibility process.

If the contractor selects option 1, he/she must secure copies of the following documents from the referring provider:

- A copy of the completed Screening and Eligibility Determination Form for Medical Services Assistance, with the eligibility decision noted on the form. The document must be completed correctly, and signed and dated by the client and referring Title V MCH provider; and

- A copy of the Statement of Applicant's Rights and Responsibilities. The document must be signed and dated by the client and contractor staff.

This documentation must be kept in the client record.

If the contractor cannot secure copies of the client's screening and eligibility documentation, the eligibility determination process must be repeated.

Referred Without Documentation and Self-Referrals:

If a client is referred by a Title V MCH provider without the required documentation; is referred from a non-Title V provider; or is a self-referral, the contractor must assure that the client completes the entire eligibility process.

The client's record must contain the following eligibility documentation:

- A completed Screening and Eligibility Determination Form for Medical Services Assistance, with the eligibility decision documented on the form, signed and dated by the client and contractor staff;
- A Statement of Applicant's Rights and Responsibilities, signed and dated by the client and contractor staff;
- Copies of acceptable documentation establishing family composition, residency and income;
- Copies of denial letters from other programs, if applicable; and
- Documentation of reported changes in the client's family composition, residency, or income and its impact on eligibility, when applicable.

Section III

Clinical Guidelines

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

Section III: Clinical Guidelines

The purpose of this section is to describe the components of genetic evaluation, genetic counseling, and procedures that may be billed to Title V Genetic Services. Contractors must have a medical director who 1) is a physician licensed in the State of Texas and 2) is board certified or has active candidate status in clinical genetics or clinical biochemical genetics. Contractors must also have a team that includes at least one of the following: a registered nurse, a certified genetic counselor, or a social worker to provide genetic services.

GENETIC EVALUATION

The genetic evaluation consists of a health history, medical genetics physical examination, and psychosocial genetic assessment. Each of these components is described below.

Health History

1. Detailed Family Genetic Health History – The interviewer meets with the family to gather extensive medical and family history covering three matriarchal and patriarchal generations. A pedigree is constructed. The history includes any affected individuals in the immediate or extended family, information on pregnancy, plus a developmental, educational, and social history.

2. Genetic Family Health History Update – This is performed to update the detailed genetic health history. This update will note changes in the health of the client under evaluation, for example, the loss of eyesight or change in muscle control, whether related to the genetic diagnosis or not. Genetic-related problems identified in newborns and other family members should be included in the interval history update.

Medical Genetics Physical Examination

The medical genetics physical examination varies according to specific patient needs, but typically consists of the following:

Anthropomorphic measurements that will include

- occipital frontal circumference;
- height; and
- weight.

Other anthropometric measurements may include

- measurement of inner canthal and outer canthal distances with calculations of interpupillary distances;
- measurements of ear size and ear placement on the head;
- measurement of philtrum length;
- measurement of internipple distance; and

- measurements of finger and palm lengths.

The physical examination itself usually entails examination of

- the head;
- the eyes, including fundoscopic examination;
- the nose, mouth, and oral pharynx;
- the ears, including assessment of tympanic membranes;
- the neck, including assessment of thyroid gland size;
- the chest, including breasts and heart;
- the abdomen, including assessment of organ size and assessment for abnormal masses;
- genitalia, and often measurement of size of genital components;
- the back;
- the extremities, including specific measurement of any joint limitations;
- the skin for abnormalities, which often includes Woods light examination of fluorescent depigmented areas; and
- neurological assessment, including cranial nerve examination, examination of deep tendon reflexes, and assessment of cerebellar and long track motor functions.

Photographs may be taken of the patient, antero-posterior (AP) and lateral, both face and body. Additional photographs may be taken of any abnormalities noted upon physical examination for further consultative work and review.

1. Physical Examination (Standard) – This is appropriate for follow-up examinations. This examination includes a review of all the information derived from the health history and detailed family genetic history or pedigree construction. The physical usually encompasses most of the examinations outlined above except for highly specific anthropomorphic tests, such as dermatoglyphics.

2. Physical Examination (Complex) – This examination is appropriate for referred clients in whom genetic diseases of a more complex nature are suspected or partially confirmed. The physical encompasses all of the examinations outlined above, as well as a review of the health history and detailed family genetic history or pedigree construction.

3. Physical Examination (Comprehensive) – This examination is used for referred clients in whom complex genetic disorders are suspected that require complete and extensive workup. This examination includes the completion of all tasks listed above under “medical genetics physical examination” and requires extensive time to make a diagnosis and disposition.

Psychosocial Genetic Assessment

1. **Standard** – A detailed social history related to the stated reason for referral is obtained to assess family dynamics and psychosocial functioning. The client's primary psychosocial problems and needs are evaluated.
2. **Complex** – Clients may receive additional counseling services when more severe family or individual dysfunction is evident as related to the primary reason for referral.

CASE MANAGEMENT

Clients who need additional counseling or case management should be referred to appropriate case management providers, social workers, or psychologists. The Children with Special Health Care Needs (CSHCN) Services Program provides case management services throughout Texas through DSHS regional offices and through contracts with local providers. A list of CSHCN Services Program case management providers can be found at: <http://www.dshs.state.tx.us/cshcn/pdf/regionalManagerSW-eng.pdf>.

GENETIC COUNSELING

Genetic counseling consists of medical genetic and psychosocial genetic counseling. Counseling must be provided by a professional trained in genetics.

Medical Genetic Counseling

1. **Prenatal Counseling** – Includes a review of all information obtained in the health history, detailed family genetic history and pedigree construction, as well as the diagnosis established after completion of the medical genetic physical examination. The family is counseled as to how the prenatal diagnosis applies to their case regarding recurrence risks as well as prenatal diagnostic procedures.
2. **Medical Genetic Counseling** – The family is advised of the results of the health history, detailed family genetic history and pedigree construction, and the nature of the diagnosis. It is the counselor's responsibility to explain the diagnosis and establish the implications for the affected individual, immediate family, and extended family. This counseling includes prognosis, recurrence risks, family planning implications, and the options available to family members who are at increased risk for giving birth to an individual(s) with the same condition.
3. **Follow-up Genetic Counseling** – Conducted to review the medical genetic counseling results and provide additional information as indicated.

Psychosocial Genetic Counseling

1. **Initial Psychosocial Genetic Counseling** – Client reactions relating to the genetic disorder are explored and a practical plan of action concerning the client

and the family is formulated using the information obtained from the interpretation of the genetic assessment.

2. Follow-up Psychosocial Genetic Counseling – Conducted to review the psychosocial genetic counseling and provide additional information as indicated.

GENETIC EVALUATION AND COUNSELING CODES

DSHS will reimburse contractors for the following procedure codes for Title V-eligible clients. Billing for any other services must have prior approval from Title V Genetic Services.

Service	Procedure Code	Limitations	Maximum Fee
Detailed Family Genetic Health History Comprehensive Genetic Physical Exam Complex Psychosocial Genetic Assessment	G-99245	One every three years	\$370.48
Detailed Family Genetic Health History Complex Genetic Physical Exam Standard Psychosocial Genetic Assessment	G-99244	One every three years	\$248.68
Medical Genetic Counseling Initial Psychosocial Genetic Counseling	G-99215	One per year	\$147.18
Genetic Health History Update Standard Genetic Physical Exam	G-99214	None	\$81.20
Follow-up Medical Genetic Counseling Follow-up Psychosocial Genetic Counseling	G-99213	None	\$50.76
Detailed Genetic Health History Prenatal Counseling	G-99404	One every three years	\$152.25
Prenatal Counseling	G-99402	One per pregnancy	\$50.75
Face-to-Face Medical Genetics and/or Genetic Counseling Services; 30 minutes	G-96040	None	\$26.73
Inpatient consultation for new or established patient, moderate complexity; 80 minutes	G-99254	One every three years	\$248.68
Inpatient consultation for new or established patient, high complexity; 110 minutes	G-99255	One every three years	\$370.48
NOTE: Any other evaluation and counseling codes will not be reimbursed unless prior approval is obtained from Title V Genetic Services.			

GENETIC LABORATORY PROCEDURES

DSHS will reimburse contractors for the following laboratory procedures for Title V-eligible clients. These procedures are limited to clients who are not pregnant.

Other testing may be available with prior approval. In certain circumstances, some prenatal genetic testing may be allowed with prior approval.

A goal of Title V is to provide comprehensive clinical services to all Title V clients. There is no mechanism for obtaining a laboratory test on an individual who is not a patient. In order to obtain laboratory procedures on parents and/or siblings of a proband, the family member must be provided a clinical service and meet all other Title V eligibility requirements. Effective October 15, 2009, a clinical service (genetic counseling in most cases) must be provided in order for the laboratory procedure to be reimbursable by Title V. Contractors seeking Title V reimbursement for laboratory services must register clients and provide a clinical service (e.g., clinical counseling) prior to conducting lab procedures.

DSHS provides a wide array of laboratory services to contractors delivering personal health services. Contractors are required to have a laboratory submitter number if they send specimens to the DSHS Austin Laboratory, DSHS Women's Health Laboratory, or DSHS South Texas Laboratory. A laboratory submitter number is assigned by the laboratory staff to a contractor upon request and is used only to identify the entity ordering the laboratory test/service. (The laboratory submitter number will not be used to bill services to 3rd party payors.) It is allowable for a contractor and any individual clinic sites to have one or more submitter numbers.

If the appropriate submitter number is not included on lab slips or does not match what was provided on the Title V Genetic Fee-for-Services FY 2011 Contract, the contractor will be billed for services.

GENETICS CPT CODE	LOCAL CODE	SERVICE	RATE
G-84999	4838Z	DNA-CF	\$152.25
G-84999	4839Z	DNA-DMD	304.50
G-84999	4847Z	DNA-Factor VIII (non-fetal)	253.75
G-84999	4840Z	DNA-FRX	253.75
G-84999	4841Z	DNA-MYD	253.75
G-84999	4842Z	DNA-SC	253.75
G-88230		Tissue Culture-BLD	161.00
G-88233		Tissue Culture-Skin	194.49
G-88245		Chromosome Analysis for Breakage	205.72
G-88248		Chromosome Analysis, Score 50-100	239.32
G-88249		Breakage Syndromes	239.32
G-88261		Chromosome Analysis, 45 cells	244.24
G-88262		Chromosome Analysis, 15-20 cells	172.25
G-88263		Chromosome Analysis, 45 cells	207.67
G-88264		Chromosome Analysis, 20-25 cells	172.25
G-88271		Molecular Cytogenetics-FISH DNA Probe	29.60
G-88272		Molecular Cytogenetics-FISH, 3-5 cells	37.00

G-88273		Molecular Cytogenetics-FISH, 10-30 cells	44.40
G-88274		Molecular Cytogenetics-FISH, 25-99 cells	48.10
G-88275		Molecular Cytogenetics-FISH, 100-300 cells	55.50
G-88280		Additional Karyotyping	34.68
G-88283		Additional Specialized Banding	94.79
G-88289		Chromosome Analysis-High Res.	47.58
G-88291		Molecular Cytogenetics-I & R	5.54
G-84999	Y8169	Amino Acids	128.91
G-84999	Y8182	Enzyme Screen	186.18
G-84999	Y8241	Urine Org Acids	126.88
G-84999	Y8246	Phenylalanine	12.84
G-84999	Y8257	Urine Screen MPS	38.52

PRIOR APPROVAL

Prior approval of services and laboratory procedures other than those listed in this manual may be allowed with prior approval from Title V Genetic Services. For more information on the process, contractors should contact the Genetic Services Program. Contractors will be required to submit written documentation including:

- Service and/or laboratory procedure being requested;
- Reason for the request;
- Rule-out diagnosis;
- Name of the person making the request;
- Name of the patient's physician and signature; and
- Other supporting documentation, if necessary.

All approved requests for prior approval must be carried out within the contractors' current year Title V award (i.e. no additional funding will be made available for services other than those approved in this manual).

GENETIC SERVICES CHANGES

The following diagnostic and laboratory procedures may no longer be billed to Title V Genetic Services:

- Amniocentesis, diagnostic
- Fetal cord puncture, prenatal (PUBS)
- Chorion biopsy (CVS)
- Genetic Ultrasound Testing
- Any cytogenetic/DNA/biochemical laboratory procedures on pregnant women

PROTOCOLS, STANDING DELEGATION ORDERS, AND PROCEDURES

Contractors that provide clinical services must develop and maintain written clinical protocols and standing delegation orders (SDOs) in compliance with statutes and rules governing medical and nursing practice. The written clinical protocols and/or SDOs must be signed by the Medical Director or supervising physician on an annual basis or more often if changes are made. As DSHS policy for contractors is revised; the new policy is to be incorporated into contractors' written protocols, SDOs, and procedures.

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

- <http://www.tmb.state.tx.us/> (Texas Medical Board)
- <http://www.bne.state.tx.us/> (Board of Nurse Examiners for the State of Texas).

Rules that are most pertinent to this topic are:

- Texas Administrative Code, Title 22, Part 9, Chapter 193
- Texas Administrative Code, Title 22, Part 11, Chapters 221 and 224
- Texas Administrative Code, Title 22, Part 9, Chapter 185 (Physician Assistant Scope of Practice)

Contractors that employ advanced practice nurses or physician assistants must have written protocols to delegate authorization to initiate medical aspects of client care. The protocols must be agreed upon and signed by the supervising physician and the physician assistant and/or advanced practice nurse, reviewed and signed at least annually, and maintained on site. The protocols need not describe the exact steps that an advanced practice nurse or a physician assistant must take with respect to each specific condition, disease, or symptom.

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

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

EMERGENCY RESPONSIVENESS

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

- There must be a written plan for the management of on-site medical emergencies, emergencies requiring ambulance services and hospital admission, and emergencies requiring evacuation of the premises.
- Each site where sterilization procedures are performed must have an arrangement with a licensed facility for emergency treatment of any surgical complication. If sterilization procedures are performed in a freestanding surgical care center or on an inpatient basis in a hospital, Medicare standards applicable to the facility and staff must be met.
- Each site must have staff trained in basic cardiopulmonary resuscitation (CPR) and emergency medical action. Staff trained in 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.
- Documentation must be maintained in personnel files that staff has been trained regarding these written plans or protocols.

Section IV

Billing and Reporting

Purpose: Section III provides policy requirements for submitting reimbursements and required reports.

Section IV: Billing and Reporting

OVERVIEW

Title V Genetic Fee-for-Services contract awards are “ceilings” against which contractors may bill for the delivery of clinical genetic services to Title V-eligible clients. Once this dollar ceiling has been reached, no further funds will be available for reimbursement. However, it is a DSHS requirement that contractors continue to submit monthly purchase vouchers and the supporting program reports even after they have reached contract ceilings. This enables contractors to continue reporting on any program income collected and provides DSHS with statistical information about the use of services.

Reimbursement for Title V Genetic Services is set at Texas Medicaid rates.

Contractors may only bill Title V for the service(s) if:

- The client was screened for potential Medicaid, CHIP, CHIP Perinatal Program, and/or CSHCN Services Program eligibility;
- The client was determined not eligible for Medicaid, CHIP, CHIP Perinatal Program, CSHCN Services Program, or another funding source; and
- The client is determined to be eligible for Title V services.

BILLING REQUIREMENTS

Purchase vouchers must include the payee identification number and the current document number in order to be processed. Payments will be delayed if:

- The voucher does not include the identification numbers listed above, or the numbers are incorrect;
- The mathematical calculations are inaccurate;
- Payment is requested for unauthorized services; or
- Program reports have not been submitted.

It is a contractual requirement that purchase vouchers be submitted to DSHS within 30 days following the end of the month for which services are being billed.

Monthly purchase vouchers are submitted on a State of Texas Purchase Voucher to both the DSHS Claims Processing Unit and the Genetic Services Program. Instructions for completing the State of Texas Purchase Voucher along with an example are found in Section V of this manual. Purchase vouchers may be mailed, faxed, or emailed to:

Claims Processing Unit/Accounts Payable
Mail Code 1940
Department of State Health Services
P.O. Box 149347
Austin, Texas 78714-9347
Fax: 512-458-7442
Email: invoices@dshs.state.tx.us

and

Genetic Services Program
Mail Code 1918
Department of State Health Services
P.O. Box 149347
Austin, Texas 78714-9347
Fax: 512-458-7593

Monthly purchase vouchers must be approved by the Genetic Services Program before they are processed for payment.

Billing Errors

Errors in billing may result in over- or under-payment for services provided.

Over-billing or calculation errors can be corrected by submitting a revised purchase voucher. The corrected purchase voucher should be clearly marked "REVISED", include the billing month, and be sent to the Claims Processing Unit and the Genetic Services Program.

Under-billing should be corrected by submitting a supplemental purchase voucher to the Claims Processing Unit and the Genetic Services Program. The purchase voucher must be clearly marked "SUPPLEMENTAL" or "ADDENDUM" and include the billing month. Any supplemental vouchers sent to the Genetic Services Program must include the corresponding program reports.

Non-Reimbursable Expenditures

Title V Genetic Services contractors cannot request Title V reimbursement for services provided to individuals if:

- The individual is potentially eligible for another program or funding source,
- The individual did not complete the eligibility process, and/or
- The individual does not meet the eligibility requirements for Title V services.

Title V may cover a client's first visit if the individual screens as potentially eligible for Medicaid, CHIP, or another funding source, and is waiting to hear if he/she has been accepted or rejected.

If the individual is denied Medicaid or CHIP coverage and is determined eligible for Title V, the contractor may continue to bill Title V for services provided to the individual. Denial of eligibility from other funding sources must be documented in the client's file.

If the individual is determined eligible to receive Medicaid, CHIP, or another funding source that covers the services, the contractor may not continue to bill Title V for services provided to the individual. The contractor should retroactively bill the funding source for the individual's initial visit, and credit the reimbursement to DSHS on the next purchase voucher submitted.

Charging Clients for Title V Services

Contractors are allowed to bill clients for services not reimbursed as a Title V allowable service, if the service is provided at the client's request, and the client is made aware of their payment responsibility prior to receiving the service.

Contractors are allowed to bill clients for services, once the funding ceiling has been reached, if the service is provided at the client's request, and the client is made aware of their payment responsibility prior to receiving the service.

Program Income (Co-Payments)

Title V contractors may assess a co-payment for services reimbursed by Title V from clients whose family incomes exceed 100% FPL, and are at or below 185% FPL. Contractors charging a co-payment must develop written policies and procedures that are in accordance with the following requirements:

- Co-payments for Title V clients shall not exceed 25% of the established Medicaid rate for the service provided.
- No co-payment may be charged or collected from a Title V client whose family income is at or below 100% FPL for the provision of services reimbursed by Title V.
- The contractor must waive co-payment if a client declares an inability to pay.

No eligible Title V client shall be denied services based on an inability to pay. Revenue collected as co-payment from clients whose services are reimbursed with Title V funds must be identified and reported as program income in compliance with the Contractor's Financial Procedures Manual, which may be found at <http://www.dshs.state.tx.us/contracts/docs/cfpm08.doc>.

REPORTING REQUIREMENTS

Title V Genetic Fee-for-Services contractors must submit financial and program reports in accordance with the contract scope of work and general provisions.

Financial Reports

1. State of Texas Purchase Voucher (B-13) – Monthly reimbursement requests (purchase vouchers) must be sent within 30 days following the end of the month for which services are being billed, to the DSHS Claims Processing Unit and the Genetic Services Program. Purchase vouchers may be mailed, faxed, or emailed.

2. Form #GC-10 (270): Request for Advance or Reimbursement – Annual financial report for the contract term: September 1 through August 31. This report includes the contractor's total Title V reimbursable charges, co-payments, and DSHS payments received during the contract term. Form #GC-10 (270) must be completed and submitted within 60 days of the end of the contract term – no later than October 30 – to the Claims Processing Unit. The form must be marked as final, include all reimbursements and adjustments in payments for the contract term, and contain the original signature of the authorized official. Form #GC-10 (270) may be downloaded at <http://www.dshs.state.tx.us/grants/forms.shtm>.

Monthly Aggregate Program Reports

The following monthly reports must be submitted to the DSHS Genetic Services Program, along with the respective purchase voucher.

1. Monthly Title V Genetic Services Procedure Code Report – Documents services provided and serves as the basis for the monthly reimbursement request (purchase voucher). The report consists of two pages: one for services provided to women and infants (activity code 186), and the other for services provided to children and adolescents (activity code 185).

2. Monthly New Client Report for Title V Genetic Services – Provides information on the number of new patients receiving services for the first time in the state fiscal year, as well as age and race/ethnicity information. This information is collected by the DSHS Office of Title V and Family Health and used to develop reports, including those required for the Title V Maternal and Child Health Services Block Grant. The report consists of two pages: one for women and infants (activity code 186), and the other for children and adolescents (activity code 185).

Monthly program report forms and instructions for completion are included in Section V of this manual. These forms also may be downloaded from:

<http://www.dshs.state.tx.us/genetics/contract.shtm>.

Maintenance of Records

Contractors must maintain records that document the necessary information for services provided and billed for reimbursement. Documentation will be audited during DSHS on-site quality assurance reviews and Office of the Inspector General financial monitoring reviews. For guidance on financial administrative

requirements refer to the Contractor's Financial Procedures Manual for DSHS Contractors. Contractors must maintain a monthly Title V billing log (automated or manual) to support monthly Title V reports. The log should contain, at a minimum, the client's name, date, and procedure code of each service billed. These logs will be audited during DSHS on-site quality assurance reviews and Office of the Inspector General fiscal monitoring.

Sanctions Due to Non-Compliance with Reporting

Purchase vouchers and supporting program reports are due within 30 days following the end of the month for which services are billed and reported. If purchase vouchers and/or program reports have not been received by fifteen (15) calendar days after they are due, contractors will be sent written notification requesting that the voucher and reports be submitted within five (5) business days. If this deadline is not met, contract management will review past reporting practices, and recommend appropriate action to be taken. For example, technical assistance may be provided. However, if the contractor has frequently been late in submitting vouchers and reports, contract sanctions may be imposed. The Fiscal Year 2011 Performance Contract General Provisions, which is a contract Attachment, can be accessed from:

<http://www.dshs.state.tx.us/grants/gen-prov.shtm>.

Section V

Title V contractor Forms and Reports

Section V: Title V Contractor Forms and Reports

DSHS FUNDING SOURCE – Screening and Eligibility Form

DSHS La Fuente – Investigación de la financiación y la elegibilidad forman

Applicant Information/Información del solicitante							
Name (Last, First, Middle) Nombre (Apellido, primero, segundo)			Home Telephone Number Teléfono de la casa			Email Address correo electrónico	
Texas Residence Address (Street or P.O. Box)/ Dirección de Residencia de Tejas (Calle o P.O. Caja)			City Ciudad	County Condado	State Estado	ZIP Zona Postal	
Household Information/ Información de la unidad familiar							
Fill in the first line with information about yourself. Fill in the remaining lines for everyone who lives in the house with you for which you are legally responsible. / Llene la primera línea con información acerca de usted mismo. Llene las líneas restantes acerca de todos que viven con usted, y es legalmente responsable.							
Name (Last, First, Middle) Nombre (Apellido, primero, Segundo)	SSN (optional) Núm. De Seguro Social (opcional)	Date of Birth Fecha de nacimiento	Age Edad	Sex Sexo	Race Raza	What Relation to you? Parentesco con usted	U.S. Citizen Ciudadano estadounidense Yes/Si or No
1.						Self/ Yo mismo	<input type="checkbox"/> Yes/Si <input type="checkbox"/> No
2.							<input type="checkbox"/> Yes/Si <input type="checkbox"/> No
3.							<input type="checkbox"/> Yes/Si <input type="checkbox"/> No
4.							<input type="checkbox"/> Yes/Si <input type="checkbox"/> No
5.							<input type="checkbox"/> Yes/Si <input type="checkbox"/> No
6.							<input type="checkbox"/> Yes/Si <input type="checkbox"/> No
List all of your household's income below. Be sure to include the following: Government checks; money from work; money you collect from charging room and board; cash gifts, loans, or contributions from parents, relatives, friends, and others; sponsor's income; school grants or loans; child support; and unemployment. / Haga una lista de los ingresos de la unidad familiar a continuación. Asegúrese de anotar: Cheques del gobierno ; ingresos o de capacitación ; dinero que recibe de cobros de cuarto y comida ; regalos en efectivo, préstamos, o aportaciones de sus padres, familiares, amigos, y otras personas ; los ingresos del patrocinador ; becas o préstamos de la escuela ; manutención de niños, o pagos por desempleo.							
Name of person receiving money Nombre de la persona que recibe el dinero	Name of agency, person, or employer who provides the money Nombre del patrón o la agencia que paga el dinero		Amount received Cantidad Recibida		How often received? (daily, weekly, every two weeks, twice a month, monthly?) ¿Con qué frecuencia lo recibe? (¿diariamente, por semana, cada quincena, una vez al mes?)		
Do you have an immediate medical need? ¿Tiene usted una necesidad médica inmediata?						<input type="checkbox"/> Yes/Si <input type="checkbox"/> No	
Do you – does any one in your household – have health care coverage (Medicaid, Medicare, CHIP, health insurance, V.A., Tricare, etc.)? ¿Tiene usted o alguien de la unidad familiar la cobertura médica (Medicaid, Medicare, CHIP, seguro medico, V.A., Tricare, etc.)						<input type="checkbox"/> Yes/Si <input type="checkbox"/> No	
If yes, who? /Si contesta "Si," ¿quién? Name of person: Nombre de la persona :							
Do you – does any one in your household – have any special circumstances? ¿Le hace – hace cualquiera en su casa – tiene alguna circunstancia especial?						<input type="checkbox"/> Yes/Si <input type="checkbox"/> No	
If yes, who? /Si contesta "Si," ¿quién? Name of person: Nombre de la persona :							
The statement I have made, including my answers to all questions, are true and correct to the best of my knowledge and belief. I agree to give eligibility staff any information necessary to prove statements about my eligibility. I understand that giving false information could result in disqualification and repayment. A mi leal saber y entender, las declaraciones que he hecho, y mis respuestas a todas las preguntas, son verdaderas y correctas. Me comprometo a dar al personal que verifica la elegibilidad toda la información necesaria para comprobar mis declaraciones sobre la elegibilidad. Yo entiendo y acepto que al proporcionar información falsa puede resultar en que yo no califique y que tenga que devolver el pago al Programa.							
Signature – Applicant / Firma – Solicitante			Date / Fecha		Signature – Spouse / Firm – Esposo o Esposa (if applicable)		Date / Fecha
Signature – Person Who Helped Complete this Application – Firma – Persona que ayudo completar esta aplicacion			Relationship to Client / Relacion al cliente		Date / Fecha		

EF05-13229

DSHS FUNDING SOURCE – Screening and Eligibility Form
DSHS La Fuente – Investigación de la financiación y la elegibilidad forman

APPLICATION FOR HEALTH CARE ASSISTANCE

1. Complete your name and address;
2. Applicant and spouse (if applicable) must sign and date the application; and
3. Answer as many questions as you can on this application

Turn in or mail back the application today even if all the questions are not answered.

RESPONSIBILITIES

Applicants are responsible for completing page one of the screening and eligibility form for medical services assistance.

Applicants are responsible for providing documents requested by the contractor. Some examples of items that may be needed for proof and documents that can be used for proof are:

Where You Live and Plan to Continue Living

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

Applicant Income

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

Other Health Care Coverage

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

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

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

SOLICITUD DE ASISTENCIA DE ATENCIE

1. Su nombre y dirección;
2. El solicitante y el/la cónyuge (de ser aplicable) deben firmar y fechar la solicitud y
3. Conteste tantas preguntas que pueda sobre esta solicitud

Entregue su solicitud, o mándela por correo, hoy mismo aunque no conteste todas las preguntas.

RESPONSABILIDADES

Los solicitantes son responsables de completar primera página de la investigación y la elegibilidad forma para la ayuda médica de servicios.

Los solicitantes son responsables de proporcionar documentos solicitados por el contratista. Los siguientes son ejemplos de las cosas podrían necesitar como omprobantes y los documentos que pueden usarse como comprobantes:

Donde Usted Vivey el Plan a Seguir Viviendo

- o Posibles Pruebas: Licencia de conducir válida de Texas
- o Actual de registro de votantes
- o Recibos de alquiler o la utilidad de un mes antes del mes de aplicación
- o Registro de vehículos de motor
- o Registros escolares
- o Tarjetas de medicos u otros beneficios similares tarjetas Impuesto sobre bienes inmuebles
- o la recepción o correo dirigido a la solicitante, su cónyuge, o si los niños que viven juntos
- o Otros documentos considerados válidos por el contratista

Ingresos de los solicitantes

- o Posibles Pruebas: Talones del cheques de pago
- o Cheques de pago
- o W-2 formularios de impuestos o de impuestos
- o Historiales de ventas
- o Declaraciones de los empleadores
- o Cartas de adjudicación
- o Documentos legales
- o Las declaraciones de las personas o dando dinero

Otras Coberturas de atención Médica

- o Posibles Pruebas: Premio o reclamación cartas
- o Pólizas de seguros
- o Los documentos de la corte
- o Otros documentos legales

Información sobre números de seguridad social debe darse si se dispone de esa información. Información sobre el sexo (hombres / mujeres) es voluntario. Estos tipos de información no afectará su elegibilidad .

Usted debe dar información sobre la atención de la salud de seguros y cualquier otro tercero financieramente responsable de los servicios de atención médica.

DSHS FUNDING SOURCE – Worksheet

Today's Date	Client/Case #	Type of Determination <input type="checkbox"/> New <input type="checkbox"/> Re-certification
Applicant Name	Case Record Action <input type="checkbox"/> Approved <input type="checkbox"/> Presumptive <input type="checkbox"/> Supplemental <input type="checkbox"/> Denied	Eligibility Effective Date (MM-DD-YYYY)
Eligibility Items		Documentation (if applicable)
Family Composition – Legal Responsibility		
1.		
2.		
3.		
4.		
5.		
6.		
Residency – Must be physically present within the geographic boundaries of Texas.		Documentation of Residency (if applicable)
Type of Income	Name of Member w/Income	Documentation of Income (if applicable)
Gross Earned Income		
Cash Gifts/Contributions		
Child Support Income		
Dividends/Interest/Royalties		
Loans (Non-educational)		
Lawsuit/Lump-sum Pymts.		
Mineral Rights		
Pensions/Annuities		
Reimbursements		
Social Security Payments		
Unemployment Payments		
VA Payments		
Worker's Compensation		
Total Countable Income		
Minus Dep Care/Child Sppt Pymt	-	-
Net Countable Income		FPL Used: <input type="checkbox"/> 250% <input type="checkbox"/> 200% <input type="checkbox"/> 185% <input type="checkbox"/> 150% <input type="checkbox"/> 100% >
Other Benefits – Such as Medicaid, Medicare, CHIP, CIHCP, private health insurance, V.A., Tricare, etc.		
Special Circumstances – Document any special circumstances as needed and applicable to this application		
Co-Pay/Fees – DOCUMENT CO-PAY BELOW:		
Eligible Household Member(s):		
1. <input type="checkbox"/> BCCS <input type="checkbox"/> PHC <input type="checkbox"/> Title V/FP <input type="checkbox"/> Title V/MCH <input type="checkbox"/> Title XX (only)	2. <input type="checkbox"/> BCCS <input type="checkbox"/> PHC <input type="checkbox"/> Title V/FP <input type="checkbox"/> Title V/MCH <input type="checkbox"/> Title XX (only)	3. <input type="checkbox"/> BCCS <input type="checkbox"/> PHC <input type="checkbox"/> Title V/FP <input type="checkbox"/> Title V/MCH <input type="checkbox"/> Title XX (only)
4. <input type="checkbox"/> BCCS <input type="checkbox"/> PHC <input type="checkbox"/> Title V/FP <input type="checkbox"/> Title V/MCH <input type="checkbox"/> Title XX (only)	5. <input type="checkbox"/> BCCS <input type="checkbox"/> PHC <input type="checkbox"/> Title V/FP <input type="checkbox"/> Title V/MCH <input type="checkbox"/> Title XX (only)	6. <input type="checkbox"/> BCCS <input type="checkbox"/> PHC <input type="checkbox"/> Title V/FP <input type="checkbox"/> Title V/MCH <input type="checkbox"/> Title XX (only)
Provider-Staff Signature/Date:		

Eligibility and Benefits by Federal Poverty Level (FPL)

F A M I L Y	MEDICAID								CIHCP		PHC	WIC	CHIP
	Medically Needy		Children under 1 /Pregnant Females 185% FPL		Children 1 thru 5 133% FPL		Children 6 thru 18 100% FPL		21% FPL Min. Income Standard		150% FPL	M&CH	BCCS
												Title V, XX	
	No Job	W/Job	No Job	W/Job	No Job	W/Job	No Job	W/Job	No Job	W/Job	N/A Statewide	185% FPL	200% FPL
1	\$104	\$224	\$1,670	\$1,790	\$1,201	\$1,321	\$903	\$1,023	\$190	\$405	\$1,354	\$1,670	\$1,805
2	216	336	2,247	2,367	1,615	1,735	1,215	1,335	255	503	1,822	2,247	2,429
3	275	395	2,823	2,943	2,030	2,150	1,526	1,646	321	602	2,289	2,823	3,052
4	308	428	3,400	3,520	2,444	2,564	1,838	1,958	386	699	2,757	3,400	3,675
5	357	477	3,976	4,096	2,859	2,979	2,150	2,270	452	798	3,224	3,976	4,299
6	392	512	4,553	4,673	3,273	3,393	2,461	2,581	517	896	3,692	4,553	4,922
7	440	560	5,130	5,250	3,688	3,808	2,773	2,893	583	995	4,159	5,130	5,545
8	475	595	5,706	5,826	4,102	4,222	3,085	3,205	648	1,092	4,627	5,706	6,169
9	532	652	6,283	6,403	4,517	4,637	3,396	3,516	714	1,191	5,094	6,283	6,792
10	567	687	6,859	6,979	4,931	5,051	3,708	3,828	779	1,289	5,562	6,859	7,415
For each additional member,	57		577		415		312		66		468	577	624

Effective March 1, 2009

- **Family Composition Section** – Enter the total number of family members in each category listed. Total should include a person living alone or a group of two or more persons related by birth, marriage (including common-law), or adoption, which reside together and are legally responsible for the support of the other person. For example: If an unmarried applicant lives with a partner, ONLY count the partner's income and children as part of the budget group IF the applicant and his/her partner have mutual children together. Unborn children should also be included.
- **Residency Section** – Must be physically present within the geographic boundaries of Texas.
- **Income Section** - 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 x 4.33
 - Every two weeks x 2.17
 - Twice a month x 2.0
 Dependent childcare expenses and legally obligated child support payments shall be deducted from total income in determining eligibility. Allowable deductions are actual expenses up to \$200 per child per month for children under age 2 and \$175 per child per month for children age 2-12, or age 2-18 if child is disabled. The net countable income is used to determine eligibility based on the appropriate FPL percentage.
- **FPL Used** – Determine the appropriate FPL used for each individual program.
- **Other Benefits Section** – Provider staff shall document other benefits received by or denied to the applicant that are applicable to this application. An applicant or family member is eligible for the Medicare Prescription Drug Plan (Part D) if he/she is eligible and/or receives Medicare Part A and/or Part B benefits and shall be referred to this program for prescription drug benefits.
- **Special Circumstances** – Provider staff may document any special circumstances not already noted using this section of the application, if applicable.
- **Cost Sharing/Fees** – Document cost sharing per program policies.
- **Eligible Household Members** – Identify each eligible household member and program (via number association listed on Family Composition).
- **Provider-Staff Signature/Date** – The provider staff that completes the eligibility determination process must sign and date this form.

EF05-13228

Statement of Applicant's Rights and Responsibilities

Declaración De Los Derechos Y Deberes Del Solicitante

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



Presumptive Eligibility – Title V Genetic Services

Name/Nombre		Home Telephone No./Teléfono de la casa (If no phone, give number of person who can reach applicant/ de no tener teléfono, proporcione el teléfono de la persona que pueda ponerse en contacto con el solicitante)	
Mailing Address (Street or P.O. Box)/Dirección Postal (Calle o Apdo.)	City/Ciudad	State/Estado	ZIP/Zona Postal
Home Address, if different from above. Domicilio particular, si es diferente a la dirección de arriba.			

- 1. Are you or the person applying for services a resident of Texas?**
¿Son residentes de Texas, usted o la persona que solicita servicios?..... Yes/Sí No
- 2. How many family members live with you? (Count only applicant, spouse and children for whom applicant is legally responsible.)** ¿Cuántos miembros de la familia viven con usted? (Cuenta únicamente al solicitante, esposo(a) y niños de los que el solicitante es legalmente responsable.) _____
- 3. How much money (before deductions) does your family receive each month?** ¿Cuánto dinero (antes de las deducciones) recibe su familia por mes? _____

I am in need of immediate medical care. To the best of my knowledge, I have no other way to receive medical care and am applying for Presumptive Services. I understand that within 90 days following the delivery of services, I will submit a completed application for eligibility determination. The above information is true, correct, and complete to the best of my knowledge.

Yo estoy necesitando atención médica inmediata. En lo que a mí concierne carezco de cualquier otro medio para recibir atención médica y estoy solicitando *Presumptive Services* [Servicios Condicionales.] Yo entiendo y acepto que dentro de 90 días después de recibir los servicios yo entregaré una solicitud completamente llena, para que se lleve a cabo la determinación de elegibilidad. La información arriba proporcionada es verdadera, correcta y completa según mi leal saber y entender.

Signature – Applicant / Firma – Solicitante	Date / Fecha
Signature – Provider Staff / Firma – Oficinista	Date / Fecha

I was not able to complete the eligibility determination process for the Program. My appointment for returning my complete application and interview is:

No me fue posible completar el proceso de determinación de elegibilidad para el Programa. La cita para devolver mi solicitud ya llenada y para la entrevista es

Date and Time/ Hora y Fecha	Location and Phone/ Lugar y Teléfono

I understand this is my obligation for the services received.
Yo entiendo y acepto que esta es mi obligación por los servicios recibidos.

EF21-11817

PHC 08-1
September 2008



Presumptive Eligibility Form Instructions Instructions

PURPOSE

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

PROCEDURE

When to Prepare

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

Number of Copies

Complete an original and one copy.

Transmittal

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

Form Retention

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

DETAILED INSTRUCTIONS

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

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

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

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

NOTE:

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

PHC 08-1
September 2008



Notice of Eligibility/Aviso de Elegibilidad - Title V Genetic Services

Date/Fecha	Case No./ Número de caso	Expiration Date/ Fecha de vencimiento
Office Address/ Dirección de la oficina		Office Telephone/Teléfono de la oficina
Provider Staff Name/Nombre del trabajador		

1. Your individual / family application for Title V / Primary Health Care is APPROVED / DENIED.

Su solicitud individual / familiar para el Título V / Programa de Atención Médica Primaria ha sido **APROBADA / NEGADA.**

2. If approved, the following services will be provided beginning _____.

(MM/DD/YYYY)

Si tiene derecho, se ofrecerán los siguientes servicios a partir del _____.

(mes/día/año)

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

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

Su copago es \$ _____ por servicios y \$ _____ por recetas médicas.

4. You must notify this office as soon as possible of any changes in your situation such as changes in income, property, family members or address. Usted tiene que avisar a esta oficina tan pronto sea posible de cualquier cambio en su situación como cambios de ingresos, propiedad, personas de la familia o dirección.

5. If a change occurs that makes you ineligible, and you fail to report the change as required, you may be responsible for payment of any medical services you receive after you become ineligible, or you may be subject to prosecution under the Texas Penal Code. Si ocurre un cambio que hace que pierda la elegibilidad y usted no informa del cambio como se exige, es posible que sea responsable de pagar cualquier servicio médico que reciba después de perder la elegibilidad, o puede ser que sea sujeto a enjuiciamiento bajo en Código Penal de Texas.

6. You are responsible for renewing your eligibility prior to your certification expiration date. A Screening and Eligibility Determination Form for Medical Services Assistance must be completed and submitted within thirty(30)-days of your anniversary eligibility date. Assistance will be provided if needed. Usted es responsable de renovar su elegibilidad antes de la fecha de vencimiento de la certificación. Tiene que llenar y entregar un Screening and Eligibility Determination Form for Medical Services Assistance dentro de los treinta (30) días de la fecha de su aniversario. Recibirá ayuda si es necesario.

7. If not eligible, your application for Title V/Primary Health Care benefits has been denied due to:

Si no tiene derecho, su solicitud para beneficios del Programa de Atención Médica Primaria/Title V se ha negado porque:

If you believe this decision is not correct, you may request an appeal from this office. Si cree que esta decisión no está correcta, puede pedir una súplica de esta oficina.

PHC 08-1 September 2008

Notice of Eligibility Form Instructions

PURPOSE

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

PROCEDURE

When to Prepare

Complete form for individuals applying for Title V and/or Primary Health Care.

Number of Copies

Complete an original and one copy.

Transmittal

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

Form Retention

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

DETAILED INSTRUCTIONS

Complete the information listed on the form.

Revised 09/2009

Instructions for Completing the Procedure Code Reports

- Enter contractor name and report month at the top of each procedure code report (186 and 185).
- Document the number of services provided for each code under “Quantity”.
- Multiply the number of services provided for each code by the reimbursement rate and enter this number under “Amount”.
- For laboratory services, you may use the attached form, which lists allowable laboratory procedures, or type in the procedures under “Lab Service Description” to include the Medicaid code, service description, Medicaid rate, quantity, and amount. If using the attached laboratory procedures form, be sure to add the total \$ amount billed for labs on the procedure code report.
- Total the “Amount” column, to include lab procedures, on each page (186 and 185). The totals for activity codes 186 plus 185 should then equal the total amount requested on the purchase voucher.
- Sign and date in the signature block found on the bottom of the procedure code report for activity code 185. Include contact name, phone number and email address for questions.

**Title V Genetic Services Procedure Code Report (185)
CHILDREN AND ADOLESCENTS – ACTIVITY CODE 185**

Contractor Name: _____ **Reporting Month:** _____

Use this page to report services provided to children/adolescents 1-21 years, fathers of children 1-21, and husbands/partners of females ≤ 21 .

CODE	GENETIC EVALUATION AND COUNSELING	RATE	QUANTITY	AMOUNT
G-99245*	Detailed Family Genetic Health History Comprehensive Genetic Physical Exam Complex Psychosocial Genetic Assessment	370.48		
G-99244*	Detailed Family Genetic Health History Complex Genetic Physical Exam Standard Psychosocial Genetic Assessment	248.68		
G-99215**	Medical Genetic Counseling Initial Psychosocial Genetic Counseling	147.18		
G-99214	Family Genetic Health History Update Standard Genetic Physical Exam	81.20		
G-99213	Follow-up Medical Genetic Counseling Follow-up Psychosocial Genetic Counseling	50.76		
G-99404*	Detailed Family Genetic Health History Prenatal Counseling	152.25		
G-99402+	Prenatal Counseling	50.75		
G-96040	Medical Genetics and/or Genetic Counseling Face-To-Face with Patient/Family; 30 minutes	26.73		
G-99254	Inpatient consultation for new or established patient, moderate complexity; 80 minutes	248.68		
G-99255	Inpatient consultation for new or established patient, high complexity; 110 minutes	370.48		
Genetic Evaluation and Counseling Total				\$
CODE	GENETIC LABORATORY TESTS (use attached list or write lab tests below in spaces provided)	RATE	QUANTITY	AMOUNT
Genetic Laboratory Test Total (AC 185)				
TOTAL AMOUNT BILLED FOR ACTIVITY CODE 185				

*Initial – one per 3 yrs. per provider **One per 12 months per provider +Prenatal – one per pregnancy per provider

I certify that the information provided on procedure code reports 186 and 185 is accurate.

Signature: _____ Date: _____

Contact name/phone/email: _____

Title V Genetic Laboratory Tests (185)
CHILDREN AND ADOLESCENTS – ACTIVITY CODE 185

Use this page to project laboratory services to be provided to children/adolescents 1-21 years, fathers of children 1-21, and husbands/partners of females \leq 21.

The services listed below are limited to non-pregnant clients.

GENETICS CPT CODE	LOCAL CODE	SERVICE	RATE	QUANTITY	AMOUNT
G-84999	4838Z	DNA-CF	152.25		
G-84999	4839Z	DNA-DMD	304.50		
G-84999	4847Z	DNA-Factor VIII (non-fetal)	253.75		
G-84999	4840Z	DNA-FRX	253.75		
G-84999	4841Z	DNA-MYD	253.75		
G-84999	4842Z	DNA-SC	253.75		
G-88230		Tissue Culture-BLD	161.00		
G-88233		Tissue Culture-Skin	194.49		
G-88245		Chromosome Analysis for Breakage	205.72		
G-88248		Chromosome Analysis, Score 50-100	239.32		
G-88249		Breakage Syndromes	239.32		
G-88261		Chromosome Analysis, 5 cells	244.24		
G-88262		Chromosome Analysis, 15-20 cells	172.25		
G-88263		Chromosome Analysis, 45 cells	207.67		
G-88264		Chromosome Analysis, 20-25 cells	172.25		
G-88271		Molecular Cytogenetics-FISH DNA Probe	29.60		
G-88272		Molecular Cytogenetics-FISH, 3- 5 cells	37.00		
G-88273		Molecular Cytogenetics-FISH, 10-30 cells	44.40		
G-88274		Molecular Cytogenetics-FISH, 25-99 cells	48.10		
G-88275		Molecular Cytogenetics-FISH, 100-300 cells	55.50		
G-88280		Additional Karyotyping	34.68		
G-88283		Additional Specialized Banding	94.79		
G-88289		Chromosome Analysis-High Res.	47.58		
G-88291		Molecular Cytogenetics-I & R	5.54		
G-84999	Y8169	Amino Acids	128.91		
G-84999	Y8182	Enzyme Screen	186.18		
G-84999	Y8241	Urine Org Acids	126.88		
G-84999	Y8246	Phenylalanine	12.84		
G-84999	Y8257	Urine Screen MPS	38.52		
Genetic Laboratory Test Total (AC 185)					

**Title V Genetic Services Procedure Code Report (186)
WOMEN AND INFANTS – ACTIVITY CODE 186**

Contractor Name: _____ **Reporting Month:** _____

Use this page to report services provided to females \geq 22 years, infants 0-11 months, fathers of infants 0-11 months, and husbands/partners of females \geq 22.

CODE	GENETIC EVALUATION AND COUNSELING	RATE	QUANTITY	AMOUNT
G-99245*	Detailed Family Genetic Health History Comprehensive Genetic Physical Exam Complex Psychosocial Genetic Assessment	370.48		
G-99244*	Detailed Family Genetic Health History Complex Genetic Physical Exam Standard Psychosocial Genetic Assessment	248.68		
G-99215**	Medical Genetic Counseling Initial Psychosocial Genetic Counseling	147.18		
G-99214	Family Genetic Health History Update Standard Genetic Physical Exam	81.20		
G-99213	Follow-up Medical Genetic Counseling Follow-up Psychosocial Genetic Counseling	50.76		
G-99404*	Detailed Family Genetic Health History Prenatal Counseling	152.25		
G-99402+	Prenatal Counseling	50.75		
G-96040	Medical Genetics and/or Genetic Counseling Face-To-Face with Patient/Family; 30 minutes	26.73		
G-99254	Inpatient consultation for new or established patient, moderate complexity; 80 minutes	248.68		
G-99255	Inpatient consultation for new or established patient, high complexity; 110 minutes	370.48		
Genetic Evaluation and Counseling				
Total				
CODE	GENETIC LABORATORY TESTS (use attached list or write lab tests below in spaces provided)	RATE	QUANTITY	AMOUNT
Genetic Laboratory Test Total (AC 186)				
TOTAL AMOUNT BILLED FOR ACTIVITY CODE 186				

*Initial – one per 3 yrs. per provider **One per 12 months per provider +Prenatal – one per pregnancy per provider

I certify that the information provided on procedure code report 186 is accurate.

Signature: _____ Date: _____

Contact name/phone/email: _____

Title V Genetic Laboratory Tests (186)
WOMEN AND INFANTS – ACTIVITY CODE 186

Use this page to report laboratory services provided to females ≥ 22 years, infants 0-11 months, fathers of infants 0-11 months, and husbands/partners of females ≥ 22 .

The services listed below are limited to non-pregnant clients.

GENETICS CPT CODE	LOCAL CODE	SERVICE	RATE	QUANTITY	AMOUNT
G-84999	4838Z	DNA-CF	152.25		
G-84999	4839Z	DNA-DMD	304.50		
G-84999	4847Z	DNA-Factor VIII (non-fetal)	253.75		
G-84999	4840Z	DNA-FRX	253.75		
G-84999	4841Z	DNA-MYD	253.75		
G-84999	4842Z	DNA-SC	253.75		
G-88230		Tissue Culture-BLD	161.00		
G-88233		Tissue Culture-Skin	194.49		
G-88245		Chromosome Analysis for Breakage	205.72		
G-88248		Chromosome Analysis, Score 50-100	239.32		
G-88249		Breakage Syndromes	239.32		
G-88261		Chromosome Analysis, 5 cells	244.24		
G-88262		Chromosome Analysis, 15-20 cells	172.25		
G-88263		Chromosome Analysis, 45 cells	207.67		
G-88264		Chromosome Analysis, 20-25 cells	172.25		
G-88271		Molecular Cytogenetics-FISH DNA Probe	29.60		
G-88272		Molecular Cytogenetics-FISH, 3-5 cells	37.00		
G-88273		Molecular Cytogenetics-FISH, 10-30 cells	44.40		
G-88274		Molecular Cytogenetics-FISH, 25-99 cells	48.10		
G-88275		Molecular Cytogenetics-FISH, 100-300 cells	55.50		
G-88280		Additional Karyotyping	34.68		
G-88283		Additional Specialized Banding	94.79		
G-88289		Chromosome Analysis-High Res.	47.58		
G-88291		Molecular Cytogenetics-I & R	5.54		
G-84999	Y8169	Amino Acids	128.91		
G-84999	Y8182	Enzyme Screen	186.18		
G-84999	Y8241	Urine Org Acids	126.88		
G-84999	Y8246	Phenylalanine	12.84		
G-84999	Y8257	Urine Screen MPS	38.52		
Genetic Laboratory Test Total (AC 186)					

Instructions for Completing the New Client Reports

1. Enter contractor name and report month at the top of each new client report (186 and 185).
2. Document the number of new clients served in each category.
3. Total the number of clients, in the respective categories, at the bottom of the new client report for activity code 186 and activity code 185.
4. Sign and date in the signature block found on the bottom of the new client report for activity code 185. Include contact name, phone number and email address for questions.

New clients are those billed to Title V Genetic Services for the first time in a state fiscal year.

**FY 11 Monthly New Client Report for Title V Genetic Services
CHILDREN AND ADOLESCENTS – ACTIVITY CODE 185**

Contractor Name: _____ **Report Month:** _____

Use this page for children/adolescents 1-21 years, fathers of children/adolescents 1-21, and husbands/partners of females < 21.

AGE	RACE/ETHNICITY	NUMBER	
		Hispanic or Latino	Not Hispanic or Latino
1- 5 years	White		
1- 5 years	Black or African American		
1- 5 years	Asian		
1- 5 years	American Indian or Alaskan Native		
1- 5 years	Native Hawaiian or other Pacific Islander		
1- 5 years	Unknown		
	SUBTOTAL		
6-12 years	White		
6-12 years	Black or African American		
6-12 years	Asian		
6-12 years	American Indian or Alaskan Native		
6-12 years	Native Hawaiian or other Pacific Islander		
6-12 years	Unknown		
	SUBTOTAL		
13-17 years	White		
13-17 years	Black or African American		
13-17 years	Asian		
13-17 years	American Indian or Alaskan Native		
13-17 years	Native Hawaiian or other Pacific Islander		
13-17 years	Unknown		
	SUBTOTAL		
18-19 years	White		
18-19 years	Black or African American		
18-19 years	Asian		
18-19 years	American Indian or Alaskan Native		
18-19 years	Native Hawaiian or other Pacific Islander		
18-19 years	Unknown		
	SUBTOTAL		
20-21 years	White		
20-21 years	Black or African American		
20-21 years	Asian		
20-21 years	American Indian or Alaskan Native		
20-21 years	Native Hawaiian or other Pacific Islander		
20-21 years	Unknown		
	SUBTOTAL		
Father's Lab	White		
Father's Lab	Black or African American		
Father's Lab	Asian		
Father's Lab	American Indian or Alaskan Native		
Father's Lab	Native Hawaiian or other Pacific Islander		
Father's Lab	Unknown		
	SUBTOTAL		
Husband/Partner's Lab	White		
Husband/Partner's Lab	Black or African American		
Husband/Partner's Lab	Asian		
Husband/Partner's Lab	American Indian or Alaskan Native		
Husband/Partner's Lab	Native Hawaiian or other Pacific Islander		
Husband/Partner's Lab	Unknown		
	SUBTOTAL		
	TOTAL		

**FY 11 Monthly New Client Report for Title V Genetic Services
WOMEN AND INFANTS – ACTIVITY CODE 186**

Contractor Name: _____ **Report Month:** _____

Use this page to report on infants 0-11 months, fathers of infant 0-11 months, females ≥ 22 years, and husbands/partners of females > 22, years.

AGE	RACE/ETHNICITY	NUMBER	
		Hispanic or Latino	Not Hispanic or Latino
0-11 months	White		
0-11 months	Black or African American		
0-11 months	Asian		
0-11 months	American Indian or Alaskan Native		
0-11 months	Native Hawaiian or other Pacific Islander		
0-11 months	Unknown		
	SUBTOTAL		
Father's Lab	White		
Father's Lab	Black or African American		
Father's Lab	Asian		
Father's Lab	American Indian or Alaskan Native		
Father's Lab	Native Hawaiian or other Pacific Islander		
Father's Lab	Unknown		
	SUBTOTAL		
Female ≥ 22 years	White		
Female ≥ 22 years	Black or African American		
Female ≥ 22 years	Asian		
Female ≥ 22 years	American Indian or Alaskan Native		
Female ≥ 22 years	Native Hawaiian or other Pacific Islander		
Female ≥ 22 years	Unknown		
	SUBTOTAL		
Husband/Partner's Lab	White		
Husband/Partner's Lab	Black or African American		
Husband/Partner's Lab	Asian		
Husband/Partner's Lab	American Indian or Alaskan Native		
Husband/Partner's Lab	Native Hawaiian or other Pacific Islander		
Husband/Partner's Lab	Unknown		
	SUBTOTAL		
	TOTAL		

I certify that the information provided on procedure code reports 186 and 185 is accurate.

Signature: _____ Date: _____

Contact name/phone/email: _____

**State Of Texas Purchase Voucher Instructions
For Genetic Fee-For-Services**

All sections listed below must be completed in order to receive payment.

SECTION	ENTRY
9. Payee Identification Number	Performing agency's 14 digit code number assigned by the State Comptroller's Office.
13. Document Amount	Amount for which performing agency is billing DSHS for the period indicated in section 19. This amount must match total expenses in section 23.
14. Payee Name/Address	Performing agency's name, address, city, state, zip. Must coincide with section 9 (payee ID no.) and State Comptroller's Office records.
19. Ser/Del Date	The month in which costs were incurred.
20. Description of Goods or Services	Provide description to include:
Reimbursement Statement	Reimbursement for services as specified in the contract between the Department of State Health Services and (name of performing agency)
Program	SHS/GEN-FEE
Type of Entity	Entity which best describes performing agency: college or university, government, non-profit, for profit, or state agency
DSHS Document No./Attachment No.	The number assigned to the contract by DSHS
Contract Term	9/1/08 – 8/31/09
23. Amount	Activity Code 186 expenses Activity Code 185 expenses Total expenses incurred for the period indicated in section 19. Net reimbursement request (same as section 13).
24. Contact Name	Enter name and phone number of person to contact with questions about the purchase voucher.

Complete all sections listed above and submit within 30 days following the end of the month for which services are being billed to:

Claims Processing Unit/Accounts Payable Mail Code 1940 Department of State Health Services P.O. Box 149347 Austin, Texas 78714-9347 Fax: 512-458-7422 Email: invoices@dshs.state.tx.us	A N D	Genetic Services Program Mail Code 1918 Department of State Health Services PO Box 149347 Austin, Texas 78714-9347 Fax: 512-458-7593
---	-------------	---

State of Texas Purchase Voucher Page ____ of ____

WFS.1 (0/93)

1. Archive reference number	2. Agency No. 501	3. Agency Name TEXAS DEPARTMENT OF HEALTH			4. Current document number
	5. Effective date	6. DOC date 05/16/96	7. Due date	8. Doc Agency 501	
9. Payee identification number	10. PDT	11. PCC	12. Requisition number		13. Document amount
14. Payee name/address		15. GSC order number		17. AGENCY USE FUND ____ BUDGET ____ CAT. ____ SERV DATE General ____ or Program ____ Activity Code	
		16. Lease number			

18. SF X 00 1	Ref Doc	SFX	M	TC	Index	PCA	AY	COBJ	AOBJ	Amount	R
	APPN	Fund	NACUBO Sub-Fund	Grant number	Grant year/phase	Project number	Project phase	Contract number		Multipurpose code	
	Invoice number			Description			AGENCY USE				
18. SF X 00 2	Ref Doc	SFX	M	TC	Index	PCA	AY	COBJ	AOBJ	Amount	R
	APPN	Fund	NACUBO Sub-Fund	Grant number	Grant year/phase	Project number	Project phase	Contract number		Multipurpose code	
	Invoice number			Description			AGENCY USE				
18. SF X 00 3	Ref Doc	SFX	M	TC	Index	PCA	AY	COBJ	AOBJ	Amount	R
	APPN	Fund	NACUBO Sub-Fund	Grant number	Grant year/phase	Project number	Project phase	Contract number		Multipurpose code	
	Invoice number			Description			AGENCY USE				

19. SER/DEL DATE	20. DESCRIPTION OF GOODS OR SERVICES	21. QUANTITY	22. UNIT PRICE	23. AMOUNT
	Contract period: Program: CHS/POP Type of entity: DSHS Document # and Attachment #: Purchase order #			

24. Contact name	Phone (Area code and number)	25. Entered by
------------------	------------------------------	----------------

26. I approve this voucher for payment. The above goods or services correspond in every particular with the contract under which they were purchased. The invoice for the goods or services is correct. This payment complies with the General Appropriations Act.

Approved sign here <	Phone (Area code and number)	Date
Fiscal Approved sign here <	Phone (Area code and number)	Date

Request for Information – Title V Genetic Services

SOLICITUD DE INFORMACIÓN

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

Your application for assistance is not complete. To determine your eligibility, we need the following additional information./Su solicitud de asistencia no está completa. Para determinar su elegibilidad, necesitamos la siguiente información.

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

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

PLEASE RETURN THE ITEMS CHECKED ABOVE BY:

HAGA EL FAVOR DE ENVIAR LOS DOCUMENTOS ENUMERADOS PARA EL:

If we do not receive the information we need and you do not contact me, I will assume that you do not want assistance. Call me if you have any questions. / Si no recibimos la información que necesitamos y usted no se comunica conmigo, supondré que usted no quiere asistencia. Si tiene alguna pregunta, hábleme.

Signature/Firma: _____

Statement of Self-Employment Income
 Declaración De Ingresos Del Negocio Propio
See Instructions on Page 2. / Veá las Instrucciones en la página 2.

Case Record Name	Case Record Number
------------------	--------------------

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

2. Give the number of months covered by this income statement.

Dé el número de meses que cubre esta declaración de ingresos.

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

4. List your business expenses and income. IMPORTANTE: Attach receipts, invoices, or other verifying papers.

Anote los gastos y ingresos de su negocio. **IMPORTANTE:** Adjunte recibos, facturas, u otros comprobantes.

Date Fecha	EXPENSES GASTOS	Amount Cantidad
		\$

Date Fecha	INCOME INGRESOS	Amount Cantidad
		\$

Total Expenses
Total de Gastos

\$



SUBTOTAL

Enter expenses here and subtract.
Anote el total de gastos y reste.

\$
—
\$

NET SELF-EMPLOYMENT INCOME
INGRESOS NETOS DEL NEGOCIO PROPIO

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

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

Signature / Firma

Date / Fecha

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

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

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

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

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

You may not claim:

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

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

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

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

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

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

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

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

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

No puede declarar:

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

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

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

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

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

Employment Verification - Title V Genetic Services

<div style="border: 1px solid black; width: 100%; height: 100%;"></div>	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 50%; padding: 2px;">Date/Fecha</td> <td style="width: 50%; padding: 2px;">Case Record No./Núm de Caso</td> </tr> <tr> <td colspan="2" style="padding: 2px;">Office Address and Telephone No./Oficina y Teléfono</td> </tr> <tr> <td colspan="2" style="padding: 2px;">Fax:</td> </tr> </table>	Date/Fecha	Case Record No./Núm de Caso	Office Address and Telephone No./Oficina y Teléfono		Fax:	
Date/Fecha	Case Record No./Núm de Caso						
Office Address and Telephone No./Oficina y Teléfono							
Fax:							

Employee	Social Security Number
----------	------------------------

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

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

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

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

I give my permission to release the information requested on this form.
 Yo doy mi permiso para que mi empleador dé la información que se pide en esta forma.

 Signature / Firma

 Date / Fecha

Comments: _____

Employment Verification

Employee Name (as shown on your records)	
Employee Address – Street, City, State, ZIP (as shown on your records)	
Is/was/will this person (be) employed by you? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes → <input type="checkbox"/> Permanent <input type="checkbox"/> Temporary	Is FICA or FIT withheld? <input type="checkbox"/> Yes <input type="checkbox"/> No

Rate of \$ <input type="text"/> Per Hour <input type="text"/> Per Day <input type="text"/> Per Week <input type="text"/> Per Month <input type="text"/> Per Job	Average Hours per Pay Period	How often is employee paid?
--	------------------------------	-----------------------------

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

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

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

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

If this person is no longer in your employ Date Final Paycheck Received: _____ Gross Amount of Final Paycheck: \$ _____
--

Is health insurance available? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, employee is → <input type="checkbox"/> Not Enrolled <input type="checkbox"/> Enrolled for Self Only <input type="checkbox"/> Enrolled with Family Members

Comments: _____

_____ Signature and Title of Person Verifying This Information	_____ Date	
Company or Employer	Address (Street, City, State, ZIP)	Telephone Number (Include area code.)

APPENDIX: State Resources

RESOURCE	WEB SITE AND CONTENTS	PHONE NUMBER
<p>Children with Special Health Care Needs Services Program</p> <p>DSHS administered program that provides services to children under 21 who have extraordinary medical needs, disabilities, and chronic health conditions.</p>	<p>www.dshs.state.tx.us/cshcn</p> <ul style="list-style-type: none"> • Program description • Health benefits • Case management services • Family support services • Client application and forms • Provider manual and application 	1-800-252-8023
<p>Client Services Contracting Unit (CSCU) website</p> <p>DSHS web site for frequently asked contracting questions and a list of contact numbers for specific questions.</p>	<p>www.dshs.state.tx.us/grants</p> <ul style="list-style-type: none"> • Contracting questions and answers • State of Texas Purchase Voucher • Form #GC-10 (270) • Financial Administrative Procedures Manual • General provisions • Laws and regulations • Funding links 	
<p>County Indigent Health Care Program (CIHCP)</p> <p>Program that provides health services to eligible residents through counties, hospital districts, and public hospitals in Texas.</p>	<p>www.dshs.state.tx.us/cihcp</p> <ul style="list-style-type: none"> • Program description • Income and eligibility criteria • Available services 	1-512-458-7706
<p>Literature and Forms Inquiry & Order Entry System</p>	<p>http://webds.dshs.state.tx.us/mamd/litcat/</p> <ul style="list-style-type: none"> • Instructions for ordering/downloading DSHS publications 	
<p>Genetic Services</p> <p>DSHS information and referral program. Oversees Title V genetic services programs across the state.</p>	<p>www.dshs.state.tx.us/genetics</p> <ul style="list-style-type: none"> • Provider list by health service region • Interagency Council for Genetic Services • Genetics information and literature 	1-512-458-7111 ext. 6675
<p>Newborn Screening (NBS)</p> <p>Texas newborns are required to be screened for certain disorders during the birth admission. DSHS maintains a NBS laboratory and provides case management services.</p>	<p>www.dshs.state.tx.us/newborn</p> <ul style="list-style-type: none"> • Screened disorders • Expansion information • Practitioner's guide • Specimen collection procedures • Available literature 	1-800-252-8023 ext. 2129
<p>Primary Health Care Program</p> <p>DSHS administered program providing primary health care services to persons at or below 150% FPL who do not qualify for other health programs.</p>	<p>www.dshs.state.tx.us/phc</p> <ul style="list-style-type: none"> • Program description • Income and eligibility criteria • Services provided • Provider list by health service region 	1-512-458-7796
<p>Quality Monitoring Branch, Performance Management Unit</p> <p>Responsible for assuring that contractors funded by DSHS meet standards and requirements of the department.</p>	<p>www.dshs.state.tx.us/qmb</p> <ul style="list-style-type: none"> • Policies, procedures, tools and instructions for on-site monitoring reviews • DSHS Standards for Public Health Clinic Services 	1-888-963-7111 ext. 6250
<p>CHIP/Children's Medicaid</p> <p>Texas families with uninsured children may be able to get health insurance through Children's Medicaid and the Children's Health Insurance Program (CHIP).</p>	<p>http://www.chipmedicaid.org/english/index.htm</p> <ul style="list-style-type: none"> • Program descriptions • Income and eligibility criteria • Client application • Consumer guide to better health 	1-877-543-7669
<p>Title V Maternal & Child Health Fee-For-Service</p> <p>Provides prenatal care, preventive and primary child care, case management for children from birth to one year and high risk pregnant women, as well as dental care for children and adolescents.</p>	<p>http://www.dshs.state.tx.us/mch/fee/default.shtm</p> <ul style="list-style-type: none"> • Program description • Income and eligibility criteria • Services provided • Provider list by health service region 	1-512-458-7796
<p>Women, Infants and Children Program (WIC)</p> <p>Federal supplemental nutrition program administered by DSHS in Texas.</p>	<p>www.dshs.state.tx.us/wichd</p> <ul style="list-style-type: none"> • Program description • Eligibility criteria • How to become a WIC client 	1-800-942-3678