Community Care Services Eligibility Handbook

1000, Program Description

1100, Program Introduction

1110 Legal Base

Revision 17-1; Effective March 15, 2017

Community Care Services Eligibility (CCSE) is a group of services purchased by the Texas Health and Human Services Commission (HHSC) in response to recommendations of the Texas Legislature. CCSE provides services in a person's own home or community for aged or disabled Texans who are not self-sufficient, and who might otherwise be subject to premature institutionalization or to abuse, neglect or exploitation. CCSE includes the following direct services for eligible individuals (detailed descriptions of the services are in 4000, Specific CCSE Services):

- Adult Foster Care (AFC) — 24-hour care in a family home or small group home.
- Day Activity and Health Services (DAHS) — up to 10 hours of care per day in a licensed facility, with supervision by a licensed nurse.
- Emergency Response Services (ERS) — an electronic signaling device for use in emergencies.
- Meals Services — Home-Delivered Meals (HDM).
- Personal Attendant Services (PAS) — assistance with personal care and housekeeping tasks:
    - Community Attendant Services (CAS) — provides in-home attendant services to individuals with an approved medical need for assistance with personal care tasks. CAS Services are provided under Title XIX of the Social Security Act.
    - Family Care (FC) — provides in-home attendant services to eligible adults. FC serves individuals who may or may not need personal care. FC services are provided under Title XX of the Social Security Act.
    - Primary Home Care (PHC) — provides in-home attendant services to an individual with an approved medical need for assistance with personal care tasks. PHC serves individuals with Supplemental Security Income Medicaid benefits. PHC services are provided under Title XIX of the Social Security Act.
- Residential Care — 24-hour care in a group setting, including
    - Emergency Care (EC) — care given to individuals who need immediate shelter or 24-hour care, or
    - Residential Care (RC) — 24-hour care in licensed assisted living facilities.
- Special Services to Persons with Disabilities (SSPD) — a variety of in-home care and advocacy services for disabled individuals.

HHSC also provides CCSE case management, information and referral (I&R) to other service resources. Case management is direct assistance to eligible individuals in managing the services that have been mutually planned and that use the individuals' own resources as well as community resources. These services are planned to enable individuals to carry out activities of daily living and to continue living in the community. (For details see 2000, Case Management.)

See also Appendix XXIV, Legal Basis for Community Care Programs.

1120 Program Goals

Revision 17-1; Effective March 15, 2017

CCSE goals are:

- to enable aged and disabled individuals to achieve or maintain personal self-sufficiency, to help them reduce or prevent dependency, and to help them accept and understand dependency when it occurs because of illness, accident, or normal aging;
- to prevent or reduce unnecessary institutional care by providing home-based and other less intensive care and to help individuals access institutional services when necessary and appropriate; and
- to prevent abuse and neglect, including adult self-neglect, and to refer to Adult Protective Services (APS) those adults who appear to be victims of abuse, neglect, or exploitation by others.

1130 Definitions

Revision 17-1; Effective March 15, 2017

Definitions are located in 40 Texas Administrative Code (TAC) §48.1201.

1140 Disclosure of Information

Revision 17-1; Effective March 15, 2017

1141 Confidential Nature of the Case Record

Revision 17-1; Effective March 15, 2017

Information that is collected in determining initial or continuing eligibility is confidential. The restriction on disclosing information is limited to information about individuals. HHSC may disclose general information about policies, procedures, or other methods of determining eligibility, and any other information that is not about or does not specifically identify an individual.

An individual may review all information in the case record and in HHSC handbooks that contributed to the decision about his eligibility.

1141.1 Confidential Information on Notifications

Revision 17-1; Effective March 15, 2017

HHSC is committed to protecting all confidential information supplied by the applicant or individual during the eligibility determination process. This covers inclusion of confidential information by HHSC staff to third parties who receive a copy of a notification of eligibility form. Staff must ensure they do not include confidential information on the eligibility notice that should not be shared with the service provider or another third party. For example:

An individual is being denied Family Care due to an increase in income. It is a **violation of confidentiality** to record on Form 2065-A, Notification of Community Care Services, "Your income of $2,892 exceeds the eligibility limit of $2,022." The comment should simply state, "Your income exceeds the eligibility limit."

Another applicant is being denied Primary Home Care services because he does not meet the medical diagnosis criterion. It is a **violation of confidentiality** to record on Form 2065-A, "Your diagnosis of Schizophrenia does not meet the medical diagnosis criterion for eligibility for the Primary Home Care Program." The comment should simply state, "You do not have a medical diagnosis resulting in a functional limitation, as required for eligibility."

In the examples above, revealing the amount of the individual's income or his diagnosis is a violation of his right to confidentiality. In all cases, HHSC staff must assess any information provided by the individual to determine if its release would be a confidentiality violation.

1142 Establishing Identity for Contact Outside the Interview Process

Revision 17-1; Effective March 15, 2017

Keep all information HHSC has about an individual or any individual on the individual's case confidential. Confidential information includes, but is not limited to, individually identifiable health information.

Before discussing or releasing information about an individual or any individual on the individual's case, take steps to be reasonably sure the individual receiving the confidential information is either the individual or a person the individual has authorized to receive confidential information (for example, an attorney or personal representative).

1142.1 Telephone Contact

Revision 21-4; Effective December 1, 2021

Before discussing or releasing case information over the phone, establish the caller’s identity.

For callers who claim to be the applicant or recipient or the applicant’s or recipient’s personal or Authorized Representative (AR), establish identity by using the caller’s knowledge of the applicant’s or recipient’s:

- SSN;
- date of birth;
- other identifying information; or
- knowledge of same information about the applicant’s or recipient's representative.

Establishing the caller’s identity can also be done by calling the applicant or recipient to confirm the identity of the caller.

Establish the identity of attorneys or legal representatives by asking:

- the legal representative to provide a complete Form H1826, Case Information Release, signed by the recipient.
- the ARs to provide a complete and signed Form H1003, Appointment of an Authorized Representative.

1142.2 In-Person Contact

Revision 17-1; Effective March 15, 2017

Establish the identity of the individual who presents himself as an individual or individual's representative at an HHSC office by using sources such as:

- driver's license,
- date of birth,
- Social Security number, or
- other identifying information.

Establish the identity of other HHSC staff, federal agency staff, researchers, or contractors by using sources such as:

- employee badge, or
- government-issued identification card with a photograph.

Identify the need for other HHSC staff, federal staff, research staff, or contractors to access confidential information through:

- official correspondence or a telephone call from a state or regional office.
- contact with regional attorney.

Contact appropriate regional or state office staff when federal agency staff, contractors, researchers, or other HHSC staff come to the office without prior notification or adequate identification and request permission to access HHSC records.

1142.3 Verification and Documentation

Revision 17-1; Effective March 15, 2017

If disclosing individually identifiable health information, document how the identity of the person was verified when contact is outside the interview.

Verify the identity of the person who requests disclosure of individually identifiable health information using sources such as:

- valid driver's license or Department of Public Safety ID card,
- birth certificate,
- hospital or birth record,
- adoption papers or records,
- work or school ID card,
- voter registration card,
- wage stubs, and
- U.S. passport.

1143 Custody of Records

Revision 17-1; Effective March 15, 2017

Records must be safeguarded. Use reasonable diligence to protect and preserve records and to prevent disclosure of the information they contain, except as provided by HHSC regulations.

"Reasonable diligence" for employees responsible for records includes:

- keeping records in a locked office when the building is closed;
- keeping records properly filed during office hours; and
- keeping records in the office at all times, except when authorized to remove or transfer them.

1144 Disposal of Records

Revision 17-1; Effective March 15, 2017

To dispose of documents with individual-specific information, follow the HHSC procedures for destruction of confidential data in the *Records Management Manual*.

1145 When and What Information May Be Disclosed

Revision 21-4; Effective December 1, 2021

Staff must make reasonable efforts to limit the use or disclosure of individually identifiable health information to the minimum necessary to determine eligibility and operate the program. The disclosure of individual medical information from HHSC records must be limited to the minimum necessary to accomplish the requested disclosure. For example, if a person authorizes release of income verification, including disability income, do not release related case medical information unless specifically authorized by the person.

Do not respond to inquiries from the applicant's or recipient's relatives or friends requesting addresses or personal information without the applicant's or recipient's consent. Inform the applicant or recipient of any inquiries. Allow the applicant or recipient to determine if they wish to share the information before providing the information to the inquiring party.

The applicant or recipient authorizes the release of information by completing and signing:

- Form H1826, Case Information Release; or
- a document containing all the following information:
  - the person's full name (including middle initial) and case number, **or** full name (including middle initial) and either their date of birth or Social Security number;
  - a description of the information to be released;
    - if a general release is authorized, provide the information that can be disclosed to the person; and
    - withhold confidential information from the case record, such as names of people who disclosed information about the household without the household's knowledge, and the nature of pending criminal prosecution;
  - a statement specifically authorizing HHSC to release the information;
  - the name of the person or entity to whom the information can be released;
  - the purpose of the release;
  - an event that triggers an expiration of the authorization or an expiration date of the release;
  - a statement about whether refusal to sign the release affects eligibility for delivery of services;
  - a statement describing the person's right to revoke the authorization to release information;
  - the date the document is signed; and
  - the signature of the person or legally authorized representative (LAR).

If the case information to be released includes individually identifiable health information, the document must clearly indicate that the applicant or recipient understands any information released may no longer be private and may be released further by the person receiving the information.

When information is requested from the case records of a deceased person, the privacy of the deceased person and their survivors must be protected. Follow policy to determine who can act on behalf of a deceased person about individually identifiable health information.

Do not include Form H1826 or other information or release authorization documents in application packets.

The HHSC Office of the Chief Counsel handles questions about the release of information under the Open Records Act. All questions and issues encountered by people concerning release of information should be referred to the Open Records Division, Office of the Chief Counsel. Regional staff should direct questions and issues to the regional attorney.

Follow Confidential Nature of Medical Information – HIPAA policy for restrictions on the release of a person's protected health information under the Health Insurance Portability and Accountability Act (HIPAA) privacy regulations.

Related Policy

1145.1, Request for Release of Information Related to a Deceased Individual
1146 ,Confidential Nature of Medical Information – HIPAA

1145.1 Request for Release of Information Related to a Deceased Individual

Revision 17-1; Effective March 15, 2017

This section provides guidance for handling requests for release of information related to a deceased applicant/individual. A request for such information is likely to occur in relation to the Medicaid Estate Recovery Program. HHSC does not provide a form to document when someone requests information. In lieu of a form, the following methods are acceptable for documenting the request for this type of release of information to the requestor:

- A release form or statement signed by the applicant/individual prior to death, and not revoked by the applicant/individual, authorizing release of information to the specific person requesting the information.
- A copy of an order from a probate court appointing the requestor as estate administrator or guardian.
- A copy of another type of order from a court authorizing the requestor to administer the affairs of the deceased.
- Documentation demonstrating the requestor has authority under Texas law to act for the deceased.

A person who has authority under Texas law to act on behalf of a deceased applicant/individual or the deceased's estate includes a surviving spouse, an adult child, a parent or an heir.

Regional staff should first ask the requestor for any available document (noted above). If a document is not available, staff must determine and document if the requestor has authority under Texas law to act for the deceased applicant/individual. Regional staff may release information to the requestor if one of the documentation requirements above is met and filed/recorded in the case record.

1146 Confidential Nature of Medical Information – HIPAA

Revision 17-1; Effective March 15, 2017

Health Insurance Portability and Accountability Act (HIPAA) is a federal law that sets additional standards to protect the confidentiality of individually identifiable health information. Individually identifiable health information is information that identifies or could be used to identify an individual and that relates to the:

- past, present, or future physical or mental health or condition of the individual;
- provision of health care to the individual; or
- past, present, or future payment for the provision of health care to the individual.

1147 Privacy Notice

Revision 21-4; Effective December 1, 2021

HIPAA requires HHSC to provide a notice of privacy practices that explains:

- the person’s privacy rights;
- the duties of HHSC to protect the person’s health information; and

- how HHSC may use or disclose the person's health information without authorization*.

  *For example, HHSC may share health information with the person's provider to arrange for services, or with other government entities to report suspected abuse or neglect.

Form 0401, Notice of Privacy Practices (English), or Form 0401-S, Aviso de Normas Sobre la Privacidad, (Spanish), as appropriate, must be provided to each person enrolled in a Title XX program who is not categorically financially eligible.

Provide Form 0401 or Form 0401S to each Title XX applicant:

- at initial certification; and
- at recertification when recertifying after a break in services of more than 180 days.

Note: Categorically eligible applicants receive notice of privacy practices from AES eligibility staff at certification and recertification.

Form 0403, Explanation to Health Information Privacy Rights, provides a reminder of privacy practices and where to locate Form 0401.

Provide Form 0403 in person during the home visit or by mail to each Title XX recipient:

- at each annual recertification;
- after a break in services of at least 30 days but not more than 180 days; or
- when a new person is added to a case.

1148 Reserved for Future Use

Revision 21-4; Effective December 1, 2021

1149 Minimum Necessary

Revision 17-1; Effective March 15, 2017

Reasonable efforts must be made to limit the use, request, or disclosure of individually identifiable health information to the minimum necessary to determine eligibility and operate the program. The disclosure of individual medical information from HHSC records must be limited to the minimum necessary to accomplish the requested disclosure. **Example:** If an individual authorizes release of income verification, including disability income, do not release related case medical information unless specifically authorized by the individual.

1150 Personal Representatives

Revision 17-1; Effective March 15, 2017

Only the individual or the individual's personal representative can exercise the individual's rights with respect to individually identifiable health information. Therefore, only the individual or individual's personal representative may authorize the use or disclosure of individually identifiable health information or obtain individually identifiable health information on behalf of an individual.

Exception: HHSC is not required to disclose the information to the personal representative if the individual is subjected to domestic violence, abuse, or neglect by the personal representative. Consult the regional attorney if it is believed that health information should not be released to the personal representative.

Note: A responsible party is not automatically a personal representative.

1151 Adults and Emancipated Minors

Revision 17-1; Effective March 15, 2017

If the individual is an adult or emancipated minor, including married minors, the individual's personal representative is a person who has the authority to make health care decisions about the individual and includes a:

- person the individual has appointed under a medical power of attorney, a durable power of attorney with the authority to make health care decisions, or a power of attorney with the authority to make health care decisions;
- court-appointed guardian for the individual; or
- person designated by law to make health care decisions when the individual is in a hospital or nursing home and is incapacitated or mentally or physically incapable of communication. Follow regional procedures to contact the regional attorney for approval.

1152 Unemancipated Minors

Revision 17-1; Effective March 15, 2017

A parent is the personal representative for a minor child except when:

- the minor child can consent to medical treatment by him or herself. Under these circumstances, do not disclose to a parent information about the medical treatment to which the minor child can consent. A minor child can consent to medical treatment by him or herself when the:
    - minor is on active duty with the U.S. military;
    - minor is age 16 or older, lives separately from the parents, and manages his own financial affairs;
    - consent involves diagnosis and treatment of disease that must be reported to local health officer or state health services;
    - minor is unmarried and pregnant and the treatment (other than abortion) relates to the pregnancy;
    - minor is age 16 years or older and the consent involves examination and treatment for drug or chemical addiction, dependency, or use at a treatment facility licensed by the Texas Council on Alcohol and Drug Abuse;
    - consent involves examination and treatment for drug or chemical addiction, dependency, or use by a physician or counselor at a location other than a treatment facility licensed by the Texas Council on Alcohol and Drug Abuse;
    - minor is unmarried, is the parent of a child, has actual custody of the child, and consents to treatment for the child; or
    - consent involves suicide prevention or sexual, physical, or emotional abuse.
- a court is making health care decisions for the minor child or has given the authority to make health care decisions for the minor child to an adult other than a parent or to the minor child. Under these circumstances, do not disclose to a parent information about the health care decisions not made by the parent.

1153 Deceased Individuals

Revision 17-1; Effective March 15, 2017

The personal representative for a deceased individual is an executor, administrator, or other person with authority to act on behalf of the individual or the individual's estate. These include:

- an executor, including an independent executor;
- an administrator, including a temporary administrator;
- a surviving spouse;
- a child;
- a parent; and
- an heir.

Consult the regional attorney if there are questions about whether a particular person is the personal representative of an applicant or individual.

1160 Correcting Information

Revision 17-1; Effective March 15, 2017

An individual has a right to correct any information that HHSC has about the individual and any other individual on the individual's case.

A request for correction must be in writing and:

- identify the individual asking for the correction;
- identify the disputed information about the individual;
- state why the information is wrong;
- include any proof that shows the information is wrong;
- state what correction is requested; and
- include a return address, telephone number, or email address at which HHSC can contact the individual.

If HHSC agrees to change individually identifiable health information, the corrected information is added to the case record, but the incorrect information remains in the file with a note that the information was amended per the individual's request.

Notify the individual in writing within 60 days (using current HHSC letterhead) that the information is corrected, or will not be corrected, and the reason. Inform the individual if HHSC needs to extend the 60-day period by an additional 30 days to complete the correction process or obtain additional information.

If HHSC makes a correction to individually identifiable health information, ask the individual for permission before sharing with third parties. HHSC will make a reasonable effort to share the correct information with persons who received the incorrect information from HHSC if they may have relied or could rely on it to the disadvantage of the individual. Follow regional procedures to contact the HHSC Privacy Officer for a record of disclosures.

Note: Do not follow above procedures when the accuracy of information provided by an individual is determined by another review process, such as a:

- fair hearing,
- civil rights hearing, or
- other appeal process.

The decision in that review process is the decision on the request to correct information.

1170 Alternate Means of Communication

Revision 17-1; Effective March 15, 2017

HHSC must accommodate an individual's reasonable requests to receive communications by alternative means or at alternate locations.

The individual must specify in writing the alternate mailing address or means of contact, and include a statement that using the home mailing address or normal means of contact could endanger the individual.

2000, Case Management

2100, Case Management

2110 Description of Case Management

Revision 17-1; Effective March 15, 2017

40 Texas Administrative Code §48.2917 — Clients must meet the eligibility criteria for CCSE services, but they do not have to receive services to receive case management. Ineligible applicants receiving only information and referral are not eligible for case management.

Case management is a set of actions taken by a Texas Health and Human Services Commission (HHSC) case worker to determine:

- whether a person requesting service is eligible for HHSC services,
- what services the person needs, and
- who will provide those services.

Case management also includes:

- referring eligibles to service providers and facilitating the referral,
- monitoring the referral to ensure that the services are initiated,
- monitoring the service provision to ensure that services are meeting the individual's needs, and
- periodically reassessing the individual's financial and functional eligibility.

Nine is the lowest score an individual can have and still qualify for a Community Care for Aged and Disabled service on the basis of his score on Form 2060, Needs Assessment Questionnaire and Task/Hour Guide. An individual must score at least nine on Form 2060 to be eligible for case management only.

2120 Case Management Process

Revision 17-1; Effective March 15, 2017

Case management involves six individual functions.

1. Intake — Requests for service or information are made by an individual, or someone on the individual's behalf, by telephone, letter or in person. Texas Health and Human Services Commission (HHSC) intake staff:
    - determine exactly what is being requested;
    - record certain information given by the requester;
    - give the requester certain information;

- determine whether an immediate, expedited or routine response is necessary; and
- refer the request to the appropriate unit for further action.

For detailed intake procedures, see 2200, Intake Procedures.

2. Assessment — HHSC case workers respond to intake by visiting the person at home or other setting to conduct a face-to-face assessment of eligibility and needs. The assessment process includes:
   - determining financial eligibility;
   - determining functional eligibility relative to performance of activities of daily living;
   - assessing the individual's home, social/environmental supports and resources;
   - determining services the individual needs and whether those needs are currently being met by family or community resources; and
   - assessing the individual's physical condition and determining whether that condition, in combination with the environment, poses any degree of risk.

For detailed assessment procedures, see 2400, Assessment Process.

3. Service planning — After completing the assessment, case workers develop a service plan with each eligible individual. Service planning includes:
   - determining what services and environmental adaptations are required to satisfy the individual's personal unmet needs, health and safety;
   - determining and specifying what services will be secured from whom or from where, how much will be provided and on what schedule;
   - specifying how often the case worker will monitor the provision of services and individual satisfaction; and
   - obtaining the individual's concurrence with the service plan.

For detailed service planning procedures, see 2500, Service Planning.

4. Service authorization
   1. Non-Medicaid services — If non-Medicaid HHSC services are to be purchased as part of the service plan, the case worker:
      - authorizes the services according to program policies and procedures;
      - sends the service plan and individual referral information to the provider selected by the individual; and
      - discusses the plan with the potential provider, as necessary.
   2. Medicaid services — If Medicaid services are to be purchased as part of the service plan, the case worker:
      - designates the services according to Medicaid program policies and procedures;
      - obtains, if necessary, consultation from the regional nurse regarding medical need for services;
      - sends the service plan and individual referral information to the provider selected by the individual;
      - discusses the plan with the provider supervisor, if requested; and
      - discusses the plan with the regional nurse, as necessary.

For detailed service authorization procedures, see 2600, Authorizing and Reassessing Services.

5. Service monitoring and evaluation — The case worker:
   - contacts each individual after service referral, according to case management requirements, to ensure that services were initiated as scheduled and to determine the individual's satisfaction with the service;
   - contacts and visits each individual according to the individualized case management plan or upon request by the individual or others;
   - accompanies regional nurses on utilization review home visits, when requested;

- evaluates the individual's condition, needs and service provision on an ongoing basis, according to HHSC procedures and individual requirements;
- requests consultation and joint home visits with the regional nurse or provider nurse, or both, when indicated because of the individual's health condition or risk status;
- receives information from providers about the individual's ongoing needs and conditions; and
- reassesses individual's needs and reviews and reauthorizes service plans according to required schedules.

For detailed procedures concerning service monitoring, see 2700, Service Monitoring, Changes and Transfers.

6. The case worker is also responsible for assisting individuals who have lost their Your Texas Benefits (YTB) Medicaid card or never received it. For detailed procedures, see 2130, Your Texas Benefits Medicaid Card and Replacement.

2130 Your Texas Benefits Medicaid Card and Replacement

Revision 17-1; Effective March 15, 2017

Form H3087, Medicaid Identification, is no longer issued and has been replaced by the Your Texas Benefits (YTB) Medicaid card.

The YTB Medicaid card is a plastic card. Providers must verify eligibility before providing services as the card is not proof of ongoing Medicaid eligibility. Medicaid recipients must take the card to doctor or dental appointments and to the pharmacy. This card is expected to be for permanent use and the Texas Health and Human Services Commission (HHSC) will only issue a new card if the card is lost or if the information printed on the card changes.

The individual may call 1-855-827-3748 if the card is lost and the individual needs a replacement card. Medicaid providers and pharmacies can verify eligibility by phone using a provider-dedicated line, so even if a card is lost, the Medicaid recipient can receive services or fill a prescription. The card should not be thrown away, even if the recipient is denied Medicaid, since the card will be reused if the individual later regains eligibility.

Requesting Form H1027-A, Medicaid Eligibility Verification

Form H1027-A, Medicaid Eligibility Verification, is a secure form, not available on the website and must be ordered. However, the form instructions are available on the Texas Health and Human Services Forms website for completion of the form. Designated HHSC staff may continue to assist individuals in the following situations:

- Ongoing Medicaid Recipients — HHSC staff may assist with a manual Form H1027-A upon request because the recipient either lost the YTB Medicaid card or did not receive it. HHSC staff issuing Form H1027-A should inform the recipient of the following:
  - Call 1-855-827-3748 for a replacement card.
  - The burden of verifying Medicaid eligibility is with the provider. An individual who is Medicaid eligible, but does not have written proof of eligibility, should still be able to get services from his provider or to fill a prescription. Medicaid providers and pharmacies can verify eligibility by phone using a provider-dedicated line or by using the Texas Medicaid & Healthcare Partnership (TMHP) TexMedConnect website.
- New Medicaid Recipients — Eligibility information is not immediately available for providers/pharmacies to verify after Medicaid is approved. HHSC staff must refer the recipient to the HHSC Benefits office to issue Form H1027-A between the time the eligibility is determined and the time the eligibility is available in the on-line system.

Once the recipient receives the replacement card, he presents it to the Medicaid provider or pharmacy any time services are requested. The recipient may call 1-800-252-8263 or 2-1-1 to confirm Medicaid coverage if he is not sure of his eligibility status.

More information about the new card is available at: www.yourtexasbenefits.com.

2200, Intake Procedures

Revision 17-1; Effective March 15, 2017

For interest list procedures involving managed care, see the *STAR+PLUS Handbook*.

2210 Requests for Services

Revision 17-1; Effective March 15, 2017

A request for services may begin with

- telephone or written referrals from other agencies, organizations, and HHSC divisions; or
- telephone, written, or walk-in requests from individuals or their relatives, friends, or other interested persons.

2211 Applications and Referrals Routed from the Austin Document Processing Center

Revision 17-1; Effective March 15, 2017

When the Austin Document Processing Center (DPC) receives an application in which a request for an HHSC referral exists, the DPC will fax the first three pages of the application and a cover sheet to the HHSC local office. Upon receipt of the application, HHSC staff will review each of the referrals and contact the individual to determine if the individual is interested in HHSC services and take the following actions:

- If it is determined the individual is interested in an HHSC program without an interest list, HHSC staff will complete an intake for the services requested and access the HHSC Benefits Portal to print out the rest of the application.

  To print out the application, access the HHSC Benefits Portal. Click on the PT Inquiry tab. Once the PT Inquiry is open, click on Inbound Correspondence Image Repository Search and search for the individual. Select the appropriate document and click "view." When the PDF document opens, click on the printing icon to print the document.
- If the individual is only interested in a program with an interest list, the individual will be placed on the interest list and staff will not need to print the remainder of the application.
- If the individual is not interested in an HHSC program or a program with an interest list, file the fax from DPC following local office procedures.

The document processing center address is:
Document Processing Center
P.O. Box 149024
Austin, TX 78714-9024
Fax Number: 877-236-4123

2220 Response to Requests for Service

Revision 18-1; Effective June 15, 2018

When a request for service is received by telephone, written referral or in person, the HHSC staff who conducts intake for community care services or who receives a request for service gives the requester information about HHSC CCSE services and determines what service is being requested and whether HHSC provides that service.

Upon receipt of a written/faxed referral, the applicant or responsible party may be contacted by intake staff or the referral may be accepted, entered in the Intake (NTK) system and assigned to a case worker. The case worker would then make the initial contact, provide information about HHSC and screen for appropriate services.

The intake staff or case worker who conducts intake for community care services or who receives a request for service:

- gives the requester information about HHSC, including CCSE services, as needed;
- determines what service is being requested and whether HHSC provides that service;
- refers the request for non-HHSC services to the appropriate state or community agency and documents the request;
- refers individuals who are currently in nursing facilities and still require skilled services, but would like to return to the community, to STAR+PLUS Home and Community Based Services (HCBS);
- screens all applicants indicating a need for skilled services for a nursing facility diversion (NFD) slot placement when slots are available and completes the NFD tab in NTK if the applicant responds there is a chance he would have to move to a facility. If slots are not available, refer the individual to the STAR+PLUS HCBS interest list;
- transfers to appropriate staff any requests for HHSC services other than community care services;
- identifies reports of suspected need for Adult Protective Services (APS) and immediately provides these reports to APS staff;
- obtains eligibility-related financial information about the applicant; and
- gives the requester general information about CCSE eligibility, emphasizing that exact eligibility information cannot be given until the individual is interviewed by a case worker.

If the requester does not want to apply for CCSE services, the requester is transferred to appropriate staff for requests for HHSC services other than community care services or referred to other appropriate resources. See Appendix XV, Services Available from Other State Agencies, and 2530, Other Resource Services. The information is not entered into NTK and an intake is not completed. This information is recorded in an Information and Referral Log.

If the individual wishes to apply for CCSE services, the intake person:

- completes the intake by entering the information into the automated system for intakes or completes Form 2110, Community Care Intake, according to the form instructions, completing only the required sections if some information is not available;
- documents on the form or on a log any requests for information and referral according to regional procedures;
- refers walk-in requesters to the appropriate unit for the completion of applications;
- determines whether the requester can and will complete an application for the applicant;
- identifies a responsible party who will help with the application process;
- identifies and documents which persons have no relative or responsible person to help with the application process;
- assesses the urgency of the request and immediately routes all requests to appropriate units for further action (See 2310, Criteria for Immediate or Expedited Responses to Service Requests); and
- informs the requester that a case worker will contact the applicant to further discuss the application process.

For all individuals who currently do not receive Supplemental Security Income (SSI) or SSI-related Medicaid and are requesting personal attendant services (PAS), the intake screener must assign the intake to a case worker as an application for Community Attendant Services (CAS). Intake screeners must not screen applicants for a specific service or determine if an applicant should only be assigned for Family Care or placed on the interest list for Family Care services. The intake screener does not place the individual on the Family Care interest list. The case worker determines whether the individual will be placed on the interest list, as described below.

All individuals who are not currently receiving Medicaid and wish to apply for PAS must be seen by a case worker and assessed for CAS. During the initial interview, the case worker screens all applicants for potential eligibility for CAS and determines whether or not the applicant will be referred to MEPD for CAS.

Certain services require special intake procedures. For details, see 4000, Specific CCSE Services.

2221 Requests for Services in STAR+PLUS Areas

Revision 18-1; Effective June 15, 2018

When the Texas Health and Human Services Commission (HHSC) receives a request for services, staff must assess whether the request for services should be forwarded for processing to the:

- appropriate HHSC unit;
- Program Support Unit (PSU); or
- managed care organization (MCO).

Refer to the charts in the *STAR+PLUS Handbook* for additional information.

Individuals awaiting managed care enrollment may be assessed for interim services from HHSC.

HHSC will enroll individuals into Primary Home Care (PHC) who meet the PHC immediate or expedited criteria, as described in 2310, Criteria for Immediate or Expedited Responses to Service Requests, when they are listed in the Texas Integrated Eligibility Redesign System (TIERS) as a candidate for STAR+PLUS enrollment. However, mandatory STAR+PLUS individuals who are not yet enrolled with an MCO, and do not meet immediate or expedited criteria, will be referred to the Enrollment Broker. Individuals who are already enrolled with an MCO and request PHC or Day Activity and Health Services (DAHS) from HHSC must be advised to contact their MCO.

HHSC will not enroll individuals in DAHS when they are listed in TIERS as a candidate for STAR+PLUS enrollment. Since there are no immediate or expedited criteria for DAHS enrollment, individuals seeking these services will be available upon enrollment into the STAR+PLUS program. DAHS facility initiated referrals which take place for individuals pending STAR+PLUS enrollment will not be reimbursed by HHSC.

For a list of mandatory and non-mandatory STAR+PLUS participants, refer to the *STAR+PLUS Handbook*, Section 3221, Mandatory Groups, and Section 3222, Excluded Groups.

2222 Reinstatement Procedures for Individuals Reapplying for Services After Loss of Financial Eligibility

Revision 17-1; Effective March 15, 2017

If an individual has lost categorical or financial eligibility creating a gap in service, the following procedures are applicable.

If financial or categorical eligibility is re-established within 60 days of the denial date and the individual reapplies for services, the case worker may use the information currently on file to determine eligibility. A new Form 2110, Community Care Intake, must be completed. The case worker must note in the Comments section of Form 2110 that reinstatement procedures are being used within 60 days of the denial date. See 3441.2, Reinstatement Procedures After Denial, for complete procedures.

2223 Caregiver Support Assessment Initiative

Revision 17-1; Effective March 15, 2017

Background

Senate Bill (SB) 271, 81st Legislature, Regular Session, 2009, relating to informal caregiver support services, directs Texas Health and Human Services Commission (HHSC) staff to:

- raise awareness of services available to caregivers;
- perform outreach functions to informal caregivers; and
- gather information about the needs of caregivers, including the:
    - collection of profile data on informal caregivers;
    - referral provided to support services, when appropriate; and
    - implementation of a standardized caregiver assessment tool to evaluate the needs of caregivers.

SB 271 requires HHSC to use the information collected to refer informal caregivers to available support services and to:

- evaluate the needs of assessed informal caregivers;
- measure the effectiveness of certain informal caregiver support interventions;
- improve existing programs;
- develop new services, as necessary, to sustain informal caregivers; and
- determine the effect of informal caregiving on employment and employers.

The Caregiver Status Questionnaire (CSQ) is designed to meet the requirements of SB 271. The information collected will be analyzed and included in the HHSC report to the governor and the Legislative Budget Board. HHSC is required to submit this report in December of each even-numbered year, beginning Dec. 1, 2012.

Completion of the CSQ

The CSQ is available in the Long Term Care Services Intake (NTK) System and is completed at the time of the intake contact, when possible. The CSQ and a script for the interview are available in English and Spanish in Appendix XXXVIII, Caregiver Support Assessment Initiative. If not feasible, one additional contact with the caregiver must be attempted within five business days. (In situations where it is necessary to go beyond the five-business-day period, document the reason in the comments section of the CSQ.) When a follow-up contact is made, enter the date on the top right corner of the CSQ, just under the NTK menu bar. Check the appropriate box to indicate if the attempt to contact failed or if the caregiver declined to participate.

Staff should always assume there is no assessment and proceed as usual. If the caller states he has completed the caregiver assessment in the past, staff should not ask him to complete the assessment again. Staff may exit the caregiver screen by selecting "yes" at the top of the page to the question: "Caregiver declined to answer?", In the comments section at the bottom of the page, document that an assessment has already been conducted for that caregiver.

The purpose of the CSQ is to collect the information described above. This information **is not** being used to determine if the unmet need criteria for Community Care services has been met, and will not be forwarded to the

case worker.

Question Sensitivity

Some staff may find it awkward to ask some of the questions on the CSQ. While understandable, all the questions must be asked and a response recorded for each. It is not acceptable to skip a question. If an individual seems resistant to answer any of the questions, **do not insist on a response**. Simply document the individual refuses to answer and continue to the next question.

Caregiver Employment

Check boxes have been provided as a means to record the ways caregiving responsibilities have affected the caregiver's employment. After asking the open-ended question, listen to the caregiver's comments and check all of the boxes that apply. You are not expected to read aloud each possible response to the employment question; however, the list can be used as a prompt if the responder is unsure how to answer. If the individual seems uncertain, you may read aloud the response category headings. **Example:** "Has caregiving affected your employment schedule, pay, leave, performance or work relationships?" If further clarification is necessary, you may ask, "For example, have you had to take extra leave or change your work schedule to meet your caregiver responsibilities?"

Referral to the Area Agency on Aging (AAA)

If the individual meets one of the following criteria, he may qualify for services from the AAA. If so, and if the individual indicates he would like assistance, make the referral according to regional procedures.

AAA Eligibility Screening Criteria

The individual may qualify for services from AAA if the individual is:

- 60 years of age or older and is caring for an individual of any age;
- 55 years of age or older and is caring for a grandchild under the age of 18 in his/her home because:
    - the biological or adoptive parents are unable or unwilling, or
    - he/she has legal custody or guardianship, or is raising the child informally; or
    - he/she is caring for an individual age 19-59 with severe disabilities; or
    - he/she is a caregiver for an individual of any age who has Alzheimer's or dementia.

Accessing the CSQ

The manual copy of the CSQ should be used when the automated system is unavailable; however, all information must be entered in the automated system as soon as possible. The version of the CSQ, which includes a script and instructions on recording responses, may be useful for staff completing the CSQ for the first few times. Follow the instructions below to complete the CSQ.

1. Conduct intake per usual procedures using the NTK system.
2. At the Client Information screen, document whether the individual requesting services has a caregiver. If there is a caregiver, the CSQ must be completed at the end of the intake process if the caregiver is available. If the caregiver is not available, document the caregiver contact information. At least one follow-up attempt must be made to contact the caregiver at a later date.
3. Select the "Caregiver" tab on the NTK section selection menu.
4. Enter the information on the Caregiver screens, as requested.
5. If, at the end of the CSQ, it appears the individual requesting services may qualify for services from the AAA, make a referral following regional procedures.

Collection of legislatively mandated information will enable the state to refer caregivers to available support services and to develop additional services to meet caregiver needs.

2230 Interest List Procedures

Revision 18-1; Effective June 15, 2018

Individuals who express interest in a Community Services program which has an interest list will be registered on the Community Services Interest List (CSIL), regardless of the program's enrollment status. CSIL will record the date and time of the expressed interest. If the individual is first on the list and the region is releasing and enrolling for that program, the individual may be immediately released and assigned for the enrollment process.

If no Title XX funds are available, consult with the individual to decide whether his needs can be met through other services. If the individual agrees, add the individual's name to the appropriate interest lists by entering the information in the CSIL system if no other service is available or suitable. Individuals who request placement on an interest list must reside in the state of Texas. An out-of-state address can be used as a contact if the power of attorney/guardian or legally authorized representative is residing out of state. Additional exceptions may be made for individuals who have been placed on an interest list while residing in Texas, and who then move temporarily out of the state because of military assignments.

Individuals on military assignments who are temporarily out of state include:

- Military member - A member of the United States military serving in the Army, Navy, Air Force, Marine Corps or Coast Guard on active duty who has declared and maintains Texas as the member's state of legal residence in the manner provided by the applicable military branch;
- Military family member - A person who is the spouse or child (regardless of age) of a military member or a former military member; or
- Former military member - A person who served in the United States Army, Navy, Air Force, Marine Corps or Coast Guard who declared and maintained Texas as the person's state of legal residence in the manner provided by the applicable military branch while on active duty or who was killed in action or died while in service, or whose active duty otherwise ended.

Individuals are released from the interest list on a first-come, first-served basis; eligibility determinations are conducted when an individual is released from the interest list.

When an individual on an interest list transfers from one region to another, he must be added to the receiving region's list using the original intake date for the service as documented by the losing region. The staff person who first becomes aware that the individual has transferred to another region (whether losing or gaining) is responsible for notifying the other region. This ensures that both regions' lists are accurate.

When an individual is released from the interest list, the case worker must contact the individual to determine his continued interest in services and if interested, schedule a home visit if required by the service. If the individual is no longer interested in services and voluntarily withdraws, the case worker enters the appropriate CSIL closure code in the CSIL system. No entries in the Service Authorization System Online (SASO) are required and Form 2065-A, Notification of Community Care Services, is not sent.

During routine interest list contacts, individuals on the interest list who do not reside in Texas should be removed from the list and informed they must be a resident of Texas to be on an interest list. Exceptions may be made for individuals on military assignments who are temporarily residing out of state.

If the individual is interested in services, the case will be processed as a routine intake.

For more information regarding the CSIL system, refer to:

- 2231, Community Services Interest List Bypass Criteria; and
- 2232, The Community Services Interest List System.

Note: The Area Agencies on Aging (AAA) can refer individuals to available services. Service needs, resources and available service providers vary across the state; not all of the services identified by AAA may be available in every area. The applicant/individual should contact the local AAA to determine whether a specific service is available. To find the telephone number for the local AAA, call 1-800-252-9240.

When the Texas Health and Human Services Commission (HHSC) intake staff determine a request is for STAR+PLUS Home and Community Based Services (HCBS), they may place the individual on the STAR+PLUS HCBS interest list.

2230.1 Adding Individual's Name Back to CSIL

Revision 17-1; Effective March 15, 2017

An individual's name may be added back to the Community Services Interest List (CSIL) at any time within 90 days after the CSIL service has been closed if the individual contacts the Texas Health and Human Services Commission (HHSC):

- within 90 calendar days of the closure date, the **original date** of request can be used; or
- more than 90 calendar days following the closure date, the **current date** must be used.

If a CSIL closure occurred during "release" or "assigned" status and the individual is added back to the interest list, the name may be released for eligibility determination, as needed, to ensure the region is fully utilizing its slot allocation.

Any exceptions for adding names back to CSIL with the original date after a 90-day period must be approved by the state office CSIL manager.

When an applicant or individual has been denied for a service, the earliest date the applicant/individual may be added back to CSIL for the same program is the date the applicant/individual is determined to be ineligible or is no longer eligible for the program.

If the individual's name is added back to CSIL prior to the last date of program eligibility, the CSIL interface match with the Service Authorization System Online (SASO) will cause the name to be removed from the interest list for that program. **Example:** An individual's Family Care (FC) services are denied and end on Aug. 13, 2015. The first date the individual can be added back to the FC interest list is Aug. 14, 2015. If the individual is already on the Home-Delivered Meals (HDM) interest list, the denial date for FC services would not impact the individual's original date on the HDM interest list.

2231 Community Services Interest List Bypass Criteria

Revision 17-1; Effective March 15, 2017

Under certain circumstances, individuals are allowed to bypass the interest list to start the enrollment process. The bypass must meet specific criteria and be approved by the regional director.

2231.1 Individuals Who May Receive Title XX Services with Regional Director Approval

Revision 18-1; Effective June 15, 2018

In the following circumstances, an individual may be given a bypass code to be placed at the top of the interest list. The regional director makes the decision if the individual may bypass the interest list and begin the enrollment process.

Personal Attendant Services (PAS)

Individuals who meet criteria for immediate or expedited intakes and need immediate service initiation may be given a bypass code and go to the top of the interest list. Individuals in the following programs may be considered for the criteria:

- Family Care.
- STAR+PLUS Home and Community Based Services (HCBS) individuals denied STAR+PLUS HCBS.
- Individuals who have been denied Primary Home Care (PHC) due to loss of Medicaid.
- Individuals denied Community Attendant Services (CAS) due to denial of financial eligibility by Medicaid for the Elderly and People with Disabilities (MEPD) for reasons other than failure to cooperate or refusal to sign up for the Medicaid Estate Recovery Program (MERP).

The criteria are:

- the applicant has no available caregiver; **and**
- has personal care needs that are not being met; **and**
- cannot go without personal care services for a full day; **or**
- the applicant needs personal care and the need for services has increased during the five days prior to the service request, or will increase during the five days following the service request. (See 2310, Criteria for Immediate or Expedited Responses to Service Requests, for additional information).
- An individual authorized for any Title XX service who is transferring to a new region will be allowed to continue receiving that service.
- An individual in a STAR+PLUS HCBS Residential Care facility who is denied STAR+PLUS HCBS may go to CCSE Residential Care. If a bed is not available, the individual is placed on the Community Services Interest List (CSIL) and given a bypass code to move to the top of the interest list.

All individuals meeting bypass criteria will be placed at the top of the specific program interest list. Additionally, the bypass criteria will now apply to individuals meeting the criteria who are no longer eligible for STAR+PLUS or STAR+PLUS HCBS, or individuals denied financial eligibility for CAS. The Regional Director will make the decision whether an individual can be released immediately or will remain on the interest list until the next slot is available. The decision must be documented in the case record.

2231.2 Bypass Criteria for Additional Services

Revision 18-1; Effective June 15, 2018

Individuals in the following circumstances may be given a bypass code and placed at the top of an interest list. The regional director makes the decision whether the individual can be released immediately or will remain on the interest list until the next slot is available. The decision must be documented in the case record.

- Title XIX Day Activity and Health Services (DAHS) individuals denied Medicaid but who remain eligible for Title XX DAHS.
- Individuals in a STAR+PLUS Home and Community Based Services (HCBS) Residential Care facility who are denied STAR+PLUS HBCS may go to Community Care Services Eligibility (CCSE) Residential Care. If a bed is not available, the individual remains at the top of the interest list until a placement is available.
- Individuals in an STAR+PLUS HCBS Adult Foster Care (AFC) who are denied STAR+PLUS HCBS may go to a CCSE AFC. If a bed is not available, the individual is placed at the top of the interest list until a placement becomes available.

- Individuals denied STAR+PLUS HCBS who had received additional services through STAR+PLUS HCBS, such as Home-Delivered Meals or Emergency Response Services, may be given a bypass code for those services.

Individuals authorized for any Title XX service that transfer to a new region will be allowed to continue receiving that service.

2231.3 Individuals Who May Not Bypass the Interest List

Revision 17-1; Effective March 15, 2017

An individual who has been denied Primary Home Care (PHC) because he does not need assistance with a personal care task should be placed on the Family Care (FC) interest list using the date of the PHC **denial**. He may not bypass the FC interest list.

Individuals leaving a nursing facility are not eligible to bypass the interest list unless they meet the criteria for immediate or expedited as listed in 2231.1, Individuals Who May Receive Services with Regional Director Approval.

For individuals who have a temporary loss of categorical status or financial eligibility, follow the procedures in 3441, Loss of Categorical Status or Financial Eligibility, and 3441.1, Procedures Pending Reinstatement.

2231.4 Bypass Approval

Revision 17-1; Effective March 15, 2017

The final decision on whether an individual is approved to bypass the interest list will be made by the regional director or his designee, rather than the regional budget officer or the contract manager. Releasing a name from the interest list and offering services to an individual still remains subject to available regional funds and slots.

2232 The Community Services Interest List System

Revision 17-1; Effective March 15, 2017

Interest lists for community care services are registered on the Community Services Interest List (CSIL) system.

Initial requests for services are documented using Form 2110, Community Care Intake, or the Long Term Care Service Intake (NTK) system, regardless of whether slots for the requested service exist. If the individual needs a service that is currently unavailable, use the interface on the NTK system or enter the individual on the CSIL. Complete and send the individual:

- Form 2111, Interest List Notification, and
- Appendix XXXV, Long Term Services and Supports.

Only individuals who reside in the state of Texas may be placed on an interest list for Texas Health and Human Services Commission (HHSC) community services. An out-of-state address can be used as a contact if the power of attorney/guardian or legally authorized representative is residing out of state.

Information provided by the individual for the interest list must include a Texas address as the contact location for the individual requesting services. Exceptions may be made for individuals who are temporarily out of the state due to military assignments.

Exceptions involving military members and military family members, as described in 2230, Interest List Procedures, apply when:

- the applicant is a military family member living outside of Texas:
  - while the military member is on active duty; or
  - for less than one year after the former military member's active duty ends; or
- the applicant declines the offer of a Community Services program with an interest list and the applicant is a military family member living outside of Texas:
  - while the military member is on active duty; or
  - for less than one year after the former military member's active duty ends.

If the case worker is making a home visit to assess the individual for other services, it is preferable for the case worker to assist in completing appropriate application forms at that time. If not, this task may be accomplished by mail. If Form 2111 and Appendix XXXV are mailed, they must be sent within two workdays of intake. Forms being filled out in person at the time of the home visit must be completed within the time frames as indicated in 2320, Case Worker Response, as determined by intake priority.

Within five workdays of intake, staff enter all relevant data into the CSIL. Staff may choose to use Form 2113, Community Services Interest List Registration and Follow-Up, to manually record interest list information to be data entered. Although use of Form 2113 is not mandatory, regional staff are responsible for entering all applicable data fields it contains into the CSIL.

Staff may **not** perform functional or financial determinations at the time the individual is being added to the interest list, even if staff are not using the determination to screen the applicant off the interest list. If an individual insists that he be assessed for eligibility immediately, even though staff have assured him that no slot is currently available, staff are required to do so. This action is considered an application, not an interest list case; all notification and civil rights procedures apply.

Individuals on an interest list are contacted annually to confirm that they wish to remain on the list. Form 2247, Interest List Contact Letter, is mailed to the individual.

If an individual does not respond and no update is made to the annual contact date in CSIL within 120 days past the annual contact due date, CSIL will automatically update the individual's record as inactive. An annual contact is no longer required for individuals in an inactive status. An individual with a status of inactive will not lose his place on the interest list. If/when the CSIL individual record is updated with a current contact date, the record will automatically go back into an active status.

Staff are reminded the CSIL must also be updated within five workdays of the case worker's determination and the date that a completed Form 2065-A, Notification of Community Care Services, is mailed/given to the individual. Within five workdays of the case action, the case worker records whether the case was certified, application denied or closed without application. If the case was closed or denied, the reason for closure/denial must be indicated.

See Appendix XXV, Community Services Interest List (CSIL) Closure Code User's Guide, or the *CSIL User's Guide* found on the intranet (for staff use only).

2240 Regional Procedures

Revision 17-1; Effective March 15, 2017

2241 Supervisor Responsibilities

Revision 17-1; Effective March 15, 2017

CCSE unit supervisors ensure that their units have procedures for

- receiving service requests;
- mailing applications to requesters of service, when appropriate; calling requesters to ensure that applications were received; and instructing applicants or their families or both about completing applications;
- assigning service requests to appropriate case workers, within required time frames;
- when appropriate, notifying case workers about applicants who may need help in completing applications;
- ensuring that the intake priority is accurate and reassigning the response category if documentation indicates the need; and
- monitoring and tracking requests for service, beginning with the date the request is received or assigned.

2242 Case Worker Responsibilities

Revision 17-1; Effective March 15, 2017

CCSE case workers are responsible for:

- establishing a date for a home visit by calling an individual, when feasible;
- determining if the applicant is categorically eligible through the HHSC automated systems and printing verification, if eligible;
- mailing an application to the non-categorically eligible applicant who requires a routine response to his service request, if the applicant is capable of completing the form or has assistance available;
- informing an applicant about the financial documentation, if any, that must be available at the time of the visit, such as verification needed when the applicant is applying for Community Attendant Services (CAS);
- requesting that a person with knowledge of the individual's financial affairs be available at the time of the visit, if possible and appropriate;
- requesting that the individual's caregiver be present at the time of the visit, if possible;
- mailing the appropriate individual letter; and
- changing the intake priority, if additional information warrants. (Initial and date any changes using a different color ink.)

2243 Conflicts of Interest

Revision 19-1; Effective January 25, 2019

Texas Health and Human Services Commission (HHSC) staff control and direct significant amounts of public funds and must avoid the appearance of impropriety or conflict of interest. This applies to the awarding of Community Care for Aged and Disabled (CCSE) benefits and in determining how these benefits are to be provided.

Staff must not work on or review an ongoing CCSE case, nor assist an applicant or individual to receive CCSE benefits, if the applicant or individual is a relative (by blood or marriage), roommate, dating companion, supervisor or someone under the individual's supervision. Staff may not determine eligibility, need for CCSE services nor the amount of service they may receive. HHSC staff may provide anyone with an application for services and inform them how and where to apply. It is also permissible to help any person gather documents needed to verify eligibility and the need for services. Staff must not perform any other role in determining eligibility for CCSE services.

Case workers must consult with their supervisors if the applicant or individual is a friend or an acquaintance. Generally, staff should not work on cases or applications involving these individuals, but the degree and nature of the relationship should be taken into account.

If staff have a relative (by blood or marriage), roommate, dating companion or close friend who owns or is employed by a provider that contracts with HHSC to provide CCSE services, he must not demonstrate any special consideration toward that provider. Referrals of individuals to a provider must be based strictly on individual preference and the individual's need for the service provided. In addition, instructions (or lack of instructions) to the provider concerning the delivery of service must be based solely on the individual's needs and HHSC policy.

If a staff member suspects that a conflict exists, use intranet Form 2035, Employee Disclosure Statement, to notify the supervisor that a conflict of interest may exist that could result in an unethical or biased business relationship. The supervisor will record on the Supervisory Response section what action, if any, may be necessary and return the signed/dated form to the sender.

All CCSE staff are required to complete Form 2035 regardless of potential conflict of interest when:

- hired;
- the annual performance review occurs;
- transferring between units and/or programs; and
- assigned to another supervisor.

The form is also used to notify the first-line supervisor whether or not a potential conflict of interest exists that involves provider employees, applicants or individuals, even if staff are not involved in the eligibility determination for the applicant or individual. Staff must complete Form 2035 if the potential conflict involves an individual who is:

- residing in his/her home;
- a dating companion;
- his/her supervisor;
- a relative; or
- reporting directly to him/her.

2300, Responding to Requests for Service

2310 Criteria for Immediate or Expedited Responses to Service Requests

Revision 17-1; Effective March 15, 2017

An individual requires an **immediate response** to his service request if he has no available caregiver, he has personal care needs which are not now being met, and he is unable to do without personal care services for a full day.

The following examples of situations requiring immediate response are just that — **examples**. This list, and other lists within this section, are not intended to be all inclusive.

The individual:

- is totally bedridden or is unable to transfer from bed to chair without help,
- cannot manage toileting tasks without personal assistance, or

- is in danger of not receiving daily nourishment because of his need for total assistance in meal preparation or feeding.

An individual requires an **expedited response** to his service request if he needs personal care, he has no available caregiver, and his need for services has increased during the five days prior to the service request, or will increase during the five days following the service request. For example, the individual:

- is being or has been released from a hospital or nursing home within five calendar days of the request, and has no available caregiver to provide necessary care,
- is experiencing or recovering from a major illness and has no available caregiver, or
- loses his caregiver within five days of the request and has no available substitute.

All persons with AIDS or HIV infection requesting CCSE services should be carefully screened to determine if an immediate or expedited response is needed. CCSE regional nurses can provide consultation if needed. Persons with AIDS or HIV infection are often very ill and may need services initiated as soon as possible. It is **essential** that intake screeners and CCSE case workers follow the procedures for immediate or expedited responses, for all persons with AIDS or HIV infection **who meet the criteria**.

2320 Case Worker Response

Revision 18-1; Effective June 15, 2018

Respond to requests for Community Care Services Eligibility (CCSE) services according to the following program standards:

If Applicant Requires . . .	Then . . .
an immediate response,	***Program Standard:*** *The case worker to whom the case is assigned visits the applicant within 24 hours of the case assignment to the case worker.* (**Example**: The case worker must respond to a case assignment received at 4 p.m. Tuesday no later than 4 p.m. Wednesday, or must respond to a case assignment received at 11 a.m. Friday no later than 11 a.m. Saturday).
an expedited response,	***Program Standard:*** *The case worker to whom the case is assigned visits the applicant within five calendar days of the date of the case assignment to the case worker.* (**Example**: A response to a case assignment received on Wednesday must be made no later than Monday, or a response to a case assignment received on Monday must be made no later than Saturday.)
a routine response,	***Program Standard:*** *The case worker to whom the case is assigned visits the applicant within 14 calendar days of the date of the case assignment to the case worker.* (**Example**: A response to a case assignment on April 1 must be made no later than April 15.)

If the person with AIDS or HIV infection does not need an immediate or expedited response at intake, the case worker should closely monitor the situation during the routine referral process.

If the applicant's health condition suddenly deteriorates, make every effort to obtain services for the individual as quickly as possible.

After talking with the applicant or family, the case worker may alter the urgency of the request, as long as the change is made before the deadline for the intake priority. The case worker may contact the applicant after the period specified above if the:

- intake states that the applicant or family requests a delay in the visit and the visit is made on the date requested; or

- case worker makes two attempted contacts within the designated period. One attempted contact must be an attempted face-to-face contact (such as a home, hospital or nursing home visit) with the applicant or the authorized representative, referral source or other knowledgeable party if the applicant is unable to respond to the assessment questions. The second attempted contact must be either another attempted face-to-face contact or an attempted telephone contact with the applicant, his authorized representative, referral source or other knowledgeable party, if the intake does not identify an authorized representative for the applicant.

If the case worker contacts the applicant to schedule an appointment and the applicant refuses and states he does not want services, the case worker must close the intake in the Intake (NTK) system. The case worker may use the denial codes from the Community Services Interest List (CSIL) system in the comments in NTK. No entries in the Service Authorization System Online (SASO) are required and Form 2065-A, Notification of Community Care Services, is not sent.

The case worker should make every effort to ensure that the initial visit is conducted as close as possible to the date of the case assignment to the case worker. For service control purposes, this standard should be measured by comparing the date/time of the case assignment on Form 2110, Community Care Intake, to that on Form 2060, Needs Assessment Questionnaire and Task/Hour Guide. Use the date of the initial assessment contact for Day Activity and Health Services (DAHS)-only cases. If the intake priority (for all except DAHS) is not checked (or information indicating priority level is not contained in case documentation), it is assumed to be immediate.

Although 14 days are allowed for a routine referral, timelines cannot be used as a justification to delay contact with the individual. If the two attempted contacts both occur near the end of the 14-day period, the case worker or supervisor may choose to call a timeliness error if a justifiable reason for delay is not documented in the case record.

Example: A case assignment for services is received March 1. The case worker makes the first attempted contact on March 11, and the second on March 14. In order to meet the program standard relating to timeliness of initial contact, the case worker must document why the delay could not have been avoided.

2330 Scheduling the Initial Interview

Revision 18-1; Effective June 15, 2018

40 Texas Administrative Code §48.3901(b) — The applicant is entitled to a face-to-face interview during the department's determination of his eligibility for CCAD services.

Determining eligibility for Community Care Services Eligibility (CCSE) services normally begins with a face-to-face assessment of the person, preferably in the home. Home visits are required for all CCSE applications, except for applications requesting Emergency Response Services, Home-Delivered Meals, or Day Activity and Health Services. Initial home visits for any one of these three services are required only at the applicant's request. A face-to-face home visit is required if, during the telephone interview, it is determined attendant care is needed or requested, as indicated in Section 2431, Form 2060, Part A, Functional Assessment, and Section 4651, Assessing the Individual’s Needs.

Case workers must make at least two attempted contacts with an individual before closing an intake. These two contacts should not be on the same day. The case worker may schedule the appointment by telephone or by appointment letter using Form 2068, Application Redetermination, or Monitoring for Community Care Services. When feasible, ask the person's current caregiver to be present during the assessment. Home visits must be scheduled for a time that is convenient to the applicant. If the appointment cannot be kept for any reason, the applicant or authorized representative must be notified in advance that the appointment will have to be rescheduled. Do not visit the applicant without informing the person in advance of the visit. If the individual is not home for the scheduled appointment, the case worker should leave contact information such as a business

card or letter, with relevant office and case worker contact information, for the individual. The case worker should try to make a second attempt at contacting the individual. The second attempt may be by phone or by home visit and if either is unsuccessful, the case worker may close the intake. The case worker cannot close out the intake until at least the second business day after the second contact attempt. The case worker needs to give the individual time to contact them back.

Example 1: Intake assigned to case worker Friday, March 2. On Monday, March 5, the case worker mails an appointment letter for an appointment on the following Monday, March 12. The case worker makes the home visit, but no one is at home. The case worker leaves a letter with the office and case worker information on the door for the individual. The case worker follows up by attempting to contact the individual by phone on Wednesday, March 14. The case worker is unsuccessful as they are unable to either reach the individual or leave a message as the voice mail for the individual's number is not set up to accept messages. If the individual has not responded, the case worker may close the intake Friday, March 16 as they have made two attempts, a home visit and a phone call, to contact the individual and may close the intake on the second business day after the second attempt.

Example 2: Intake assigned to case worker Friday, March 2. On Monday, March 5, the case worker calls and reaches the individual's daughter whose phone number is the only number listed on the intake. The daughter states she is the power of attorney (POA) and lives with her mother who is the individual who needs services. The daughter agrees to a home visit on Friday, March 9. The case worker verifies the address and asks if there are any other phone numbers which need to be listed. The daughter verifies the address. The case worker makes the home visit, but no one is at home. The case worker leaves a business card with the case worker and office information on the door for the individual and her daughter. The case worker has made two attempted contacts, the first by phone to set the appointment and the second with the home visit attempt. If the individual has not responded, the case worker may close the intake Tuesday, March 13 as it is the second business day after the second attempt to contact the individual.

If a case worker contacts an applicant to schedule a home visit and the applicant states he has a contagious illness such as influenza, the case worker must document the contact and the reason for the delay of the home visit, including the stated illness. If possible, the case worker should schedule a future date for the visit when the applicant thinks he will be better. If unable to schedule the visit for a future date, the case worker must contact the applicant at least weekly until the home visit can be made. Each contact must be documented in the case record. This documentation will be considered as an acceptable reason for delaying a required home visit.

Although a face-to-face visit with a person in a nursing home, hospital, prison or jail facility is acceptable, this visit does not allow the case worker to assess the person in the home environment or to assess family resources and how they function at home. If the initial visit and eligibility determination must be done in a location other than the person's home and in-home services are subsequently initiated, conduct a home visit within 30 days after service initiation and make any necessary revisions to the service plan according to Section 2663, Reassessment of Functional Need. Document the home visit on Form 2059, Summary of Client's Need for Service (Item 4 or 8), or in the case narrative.

A person who is already receiving services from the Texas Health and Human Services Commission (HHSC), or for whom the Social Security Administration has already verified that the individual is financially eligible for Supplemental Security Income (SSI), is not required to submit an application form.

A person who is not receiving services from HHSC, not receiving SSI, or who needs a financial eligibility determination from Medicaid for the Elderly and People with Disabilities (MEPD) must complete an Application for Assistance. The preferred form is Form H1200-EZ, Application for Assistance – Aged and Disabled. If an applicant has completed Form H1200, Application for Assistance – Your Texas Benefits, the case worker may accept those forms and send to MEPD.

The form may be mailed if the applicant is capable of completing the form or has assistance available. If the applicant is not capable of completing the form, it is the case worker's responsibility to provide the form and assist the applicant with completing the form at the initial interview. If the form has been mailed to the applicant,

it is the case worker's responsibility at the initial interview to review the form for completion and assist the applicant in completing the form, if necessary.

The official date of application is the date HHSC staff receive a completed, signed and dated Application for Assistance. The application date on the Service Authorization System screen is the date of:

- receipt of the application, as defined above; or
- the initial home visit, for categorically eligible applicants for whom an application form is not required.

2331 Information and Referral (I&R)

Revision 17-1; Effective March 15, 2017

If, during the initial interview it is determined that the individual could use services from other agencies in the community, refer him to the appropriate agency or community resource. Fully discuss the referral with him and his family, if they are present. Give complete information about Community Care Services Eligibility (CCSE) services and about any other Texas Health and Human Services Commission (HHSC) services (for example, the Supplemental Nutrition Assistance Program (SNAP) or the Qualified Medicare Beneficiary program) that might be helpful. See Appendix XV, Services Available from Other State Agencies.

Always refer an applicant or individual to the Social Security Administration if the individual appears eligible for Supplemental Security Income (SSI) but does not receive SSI. Consult with Medicaid for the Elderly and People with Disabilities (MEPD) staff if there are questions about SSI eligibility.

When referring an individual to other agencies or other HHSC services, fully inform him about where he must go to apply. Help set up his appointment, if necessary. Provide the office address, telephone number, name of the correct person to contact, and the appointment date and time (if known).

Provide I&R services to individuals without regard to their incomes. Do not register with the Service Authorization System Online (SASO) persons who receive only I&R services. Document I&R services as required by regional policy.

2332 Requests for Services from Individuals Under Age 21

Revision 17-1; Effective March 15, 2017

Children who have a medical need and meet other eligibility requirements may receive Community Attendant Services (CAS). The age requirements that apply to other community care programs do not apply to CAS. However, the applicant under age 21 must meet all other eligibility criteria, including medical, financial, functional and unmet need.

Upon receipt of a request for services from an individual under age 21, the case worker must contact the regional nurse and arrange for a joint visit for the initial home visit assessment. The regional nurse will assist in the screening of the individual for medical need, determine if there are skilled tasks that cannot be performed by a personal attendant, and determine whether the caregiver must be present in the home to perform skilled tasks or react to emergency medical situations while the personal attendant is in the home.

See Appendix XXXIII, Requests for Services from Individuals Under 21 Years of Age, for additional information.

2333 Applications

Revision 17-4; Effective May 23, 2017

An **application** for services has been made if any one of the following occurs:

- a home visit in relation to an intake or interest list release has occurred;
- the case worker has completed or has begun to complete any part of Form 2060, Needs Assessment Questionnaire and Task/Hour Guide; or
- an Application for Assistance has been completed.

The preferred form for the Application for Assistance is Form H1200-EZ, Application for Assistance – Aged and Disabled. If an applicant has completed Form H1200, Application for Assistance – Your Texas Benefits, the case worker may accept those forms.

Once an application has begun, the case worker must record the disposition of the application in the Service Authorization System Online (SASO).

Examples:

Example 1 (Request for Services Only): A hospital social worker contacts HHSC on behalf of a patient who is being discharged the following day. The social worker notes that the patient lives alone and believes the patient's condition will result in a need for personal attendant services (PAS). In response to the social worker's call, an intake specialist contacts the individual and he states that his daughter will be living with him during the weeks following release from the hospital and will be able to provide all his needs. He states that he will call HHSC if PAS is needed at a later time.

This is not an intake but is an example of a request for services that is appropriately screened and determined CCSE services are not needed at this time. Although the intake specialist contacted the individual and some information may have been recorded, Form 2110, Community Care Intake, was not completed in the Intake (NTK) system and a case worker was not assigned to the case. There is no need to send Form 2065-A, Notification of Community Care Services. No entries in SASO are required.

Example 2 (Intake Only): An individual contacts HHSC requesting Home-Delivered Meals (HDM). The intake specialist completes Form 2110 and assigns the intake to a case worker. When the case worker calls to set up an appointment, the applicant states that he has changed his mind and does not want HHSC services. The case worker records the correct denial code (from the Community Services Interest List (CSIL) denial codes) for voluntary withdrawal in the NTK system comments section. There is no need to send Form 2065-A. No entries in SASO are required.

Example 3 (Application): An individual contacts HHSC and requests Primary Home Care. The case worker schedules the home visit and upon arriving at the individual's home, the applicant states he is moving out of state and he does not need services. Because a home visit was made, this is considered an application and must be entered in SASO and Form 2065-A sent to the applicant.

2333.1 Required SASO Entries for Applications Withdrawn Early in the Process

Revision 17-1; Effective March 15, 2017

All **applications** must be entered in the Service Authorization System Online (SASO) within 30 calendar days of the home visit date or receipt of the application. See Section 2611, Processing Time Frames, for additional information. This includes situations such as the one described in Example 3 in Section 2333, Applications, where very little information has been gathered. The type of SASO entries required depends on the type and amount of information collected by the case worker.

2340 The Initial Interview and Application Process

Revision 17-1; Effective March 15, 2017

During the initial home visit interview, the case worker:

- explores the applicant's needs and which services can meet those needs, including services available from other agencies;
- assists the applicant in the completion of the Application for Assistance, if the applicant is not categorically eligible;
- screens the applicant for the Community Attendant Services (CAS) program, if requesting attendant services and not categorically eligible;
- completes the functional assessment, including assessing the applicant's functional eligibility relative to the performance of activities of daily living and assessing the applicant's home, social/environmental supports and resources;
- presents Appendix XXXV, Long Term Services and Supports;
- reviews and explains Form 2307, Rights and Responsibilities, including information on confidentiality, and have the applicant sign the acknowledgment;
- offers to assist the applicant in registering to vote;
- reviews and explains the available service delivery options and complete the required documentation as explained in Section 6000, Service Delivery Options; and
- reviews and explains the Medicaid Estate Recovery Program (MERP), if requesting CAS, and has the applicant sign Form 8001, Medicaid Estate Recovery Program Receipt Acknowledgement.

If the applicant is only able to sign documents with an "X," the case worker may make the required documentation and then date and initial the entry.

The case worker also must be alert for indications of abuse, neglect or exploitation when assessing CCSE individuals. Anyone who has reason to believe an elderly person or an individual with a disability is being abused, neglected or exploited must report this information to the Department of Family and Protective Services (DFPS) Adult Protective Services (APS) (Title 2, §48.306 of the Texas Resources Code). Immediately notify APS of any reports received that indicate an elderly person or individual with a disability has been abused, neglected or exploited.

If a CCSE individual has been referred to APS in the past and it is possible another referral may be needed now for the same problems, contact APS to discuss the situation before a formal referral is made. Document the APS response in the CCSE case record. See Appendix XV-E, Department of Family and Protective Services (DFPS), for more information.

2341 Financial Application Process

Revision 17-10; Effective October 6, 2017

40 Texas Administrative Code (TAC) §48.3901(c) — Applicants or their representatives applying for services provided with regard to income must sign an application for assistance form. Non-Medicaid applicants or their representatives applying for retroactive reimbursement for Medicaid-covered attendant services must also sign an application for assistance form. The date of application is the date the department receives the signed application. Applicants must provide accurate information about income and resources.

40 TAC §48.3901(e) — Non-Medicaid applicants or their representatives applying for Medicaid-covered attendant services may be reimbursed for services provided up to three months prior to the month of receipt of a completed, signed, and dated application.

If an application is denied for any reason, the previously completed application form is valid for 90 days following the date of denial. A written, dated and signed statement of request to reapply must be obtained from the applicant or authorized representative. The statement must be sent to Medicaid for the Elderly and People

with Disabilities by the close of business the second business day. Documentation in the case record must indicate whether any changes have occurred since the original application date.

The case worker submits the written statement and the documentation with Form H1746-A, MEPD Referral Cover Sheet, marked "Application." The case worker must clearly note on Form H1746-A that the applicant is requesting to reapply for Community Attendant Services. The case worker includes all identifying information on Form H1746-A, and any additional information that will help identify the original application, and faxes Form H1746-A and documentation to the Austin Document Processing Center.

The case worker will also be able to use Form H1200-EZ, Application for Assistance – Aged and Disabled, on file for up to 90 days following the denial date of Form 2065-A, Notification of Community Care Services. The case worker may also use Form 2060, Needs Assessment Questionnaire and Task/Hour Guide, the additional forms signed at the initial home visit, and verifications on file. The case worker does not need to make an additional home visit, but must review Form H1200-EZ and Form 2060 with the applicant and document any changes which have occurred since the initial visit. The case worker will need to follow appropriate time frames for annual reassessments as the annual reassessment will still be due within 12 months of the initial home visit.

2341.1 Application for Assistance Form

Revision 17-4; Effective May 23, 2017

Individuals applying for services without categorical eligibility status apply for Community Care Services Eligibility (CCSE) services by completing Form H1200-EZ, Application for Assistance – Aged and Disabled.

Use Form H1200-EZ for individuals who are:

- not Medicaid recipients and apply or appear to be eligible for community Attendant Services (CAS); or
- non-Medicaid applicants who are not categorically eligible and who apply or appear to be eligible for:
  - Title XX CCSE services; or
  - Qualified Medicare Beneficiaries (QMB) or Specified Low-Income Medicare Beneficiaries (SLMB).

Although Form H1200-EZ is the preferred form, a completed Form H1200, Application for Assistance – Your Texas Benefits, should not be refused.

An application is incomplete until it contains the individual's signature. If unable to sign, it is acceptable to allow the individual to make an "X," along with two witnesses' signatures. Unless no other option is available, the case worker should not be one of the witnesses.

If Form H1200 or Form H1200-EZ is being sent to Medicaid for the Elderly and People with Disabilities (MEPD), the signature must be on the form. Unsigned applications will be returned to the sender. HHSC staff must ensure applications are signed prior to referring to MEPD. If MEPD receives an unsigned application from HHSC with either Form H1746-A, MEPD Referral Cover Sheet, or Form 2067, Case Information, MEPD will return the application to HHSC with an annotation on the cover form (Form 2067 or Form H1746-A) that the application is unsigned and must be signed before HHSC can establish a file date. Once HHSC staff receive an unsigned application from MEPD, it is their responsibility to coordinate with the individual in getting the application signed and returned to MEPD for processing.

Sending unsigned applications delays the MEPD and HHSC eligibility processes and could adversely affect service delivery to individuals.

2341.2 Application for Assistance Form Completion and Receipt Date

Revision 17-6; Effective June 28, 2017

The Application for Assistance form may be mailed if the applicant is capable of completing the form or has assistance available. If the applicant is not capable of completing the form, it is the case worker's responsibility to provide the form and assist the applicant with completing the form at the initial interview.

If the Application for Assistance form has been mailed to the applicant, it is the case worker's responsibility at the initial interview to review the form for completion and assist the applicant in completing the form, if necessary.

Ensure that the person completes the entire application, signs and dates it, and understands the penalties for fraud in the event the person deliberately gives false information. Do not make any changes to the Application for Assistance form after the applicant has signed it. Document any changed or additional information on Form 2064, Eligibility Worksheet.

For applicants or individuals requiring a Medical Assistance Only (MAO) determination to be sent to Medicaid for the Elderly and People with Disabilities (MEPD), the case worker must assist the applicant/individual with completion of the application form and provide the most complete packet possible to MEPD. The case worker should ensure the following items are included to facilitate the financial eligibility process:

- Bank accounts (for Community Attendant Services) – bank name, account number and balance;
- Award letters showing amount and frequency of income payments;
- Life insurance policy – company name, policy number, face value or copy of the policy;
- A signed and dated Form H0003, Agreement to Release Your Facts;
- Confirmation that Medicaid Estate Recovery Program and Appendix XXXV, Long Term Services and Supports, were shared with the applicant by checking the appropriate boxes on Form H1746-A, MEPD Referral Cover Sheet or Form 2067, Case Information;
- Preneed funeral plans – name of company, policy/plan number, copy of preneed agreement;
- Correct up-to-date phone numbers; and
- Power of Attorney or Guardianship – copy of the legal document.

While it may not be possible to obtain everything on the list, the case worker should gather whatever information is available, as it will prevent the applicant from a delay in certification. The case worker should explain to the applicant that failure to submit the required documentation to MEPD could delay completion of the application or cause the application to be denied.

When a signed and dated Application for Assistance form is received by the case worker at the home visit, or is mailed or hand delivered to a Texas Health and Human Services Commission (HHSC) office, the **date of receipt** becomes the official date of application.

If Form H1200-EZ, Application for Assistance – Aged and Disabled, has not been returned by the 30th day from the initial home visit, the case worker may deny the application. The case worker sends Form 2065-A, Notification of Community Care Services, with Rule Reference 40 Texas Administrative Code §48.3901(c): "Applicants or their representatives applying for services provided with regard to income must sign an application for assistance form." In the comments section, the case worker enters: "HHSC is unable to make an eligibility decision within 30 days due to your failure to furnish information." The case worker must document all contact in the case record.

When an income eligible individual is receiving services and the individual's spouse subsequently applies, the individual's form (if it is less than one year old) may be used for the spouse. Review the Application for Assistance form to ensure the information is still valid, have the spouse sign and date it for the current application, and complete a new eligibility determination.

2341.3 Categorical Eligibility

Revision 17-1; Effective March 15, 2017

If a financial determination has already been made for the applicant by Social Security or another program within the Texas Health and Human Services Commission (HHSC), then the applicant may be considered categorically eligible. The applicant is categorically eligible if receiving:

- Supplemental Security Income,
- Temporary Assistance for Needy Families,
- Supplemental Nutrition Assistance Program,
- Medicaid,
- Medicaid Buy-In (MBI) benefits*,
- Qualifying Individual (QI) benefits,
- Specified Low-Income Medicare Beneficiary (SLMB) benefits,
- Qualified Medicare Beneficiary (QMB) benefits, or
- other Community Care Services Eligibility (CCSE) services.

***Note:** Medicaid Buy-In benefits provide categorical eligibility only for the following programs:

- all Long Term Services and Supports Title XX programs,
- Day Activity and Health Services Title XIX,
- Primary Home Care, and
- Texas Home Living waiver program.

Completion of the Application for Assistance form is not required for a categorically eligible applicant. The date of the initial home visit with the person is considered the date of application.

See Section 7110, TIERS Inquiries, for complete information on how existing coverage affects eligibility for CCSE services.

2341.3.1 Effect of QI Benefits on Eligibility for Community Care Services

Revision 17-1; Effective March 15, 2017

The Qualifying Individuals (QI) program was created by Public Law 105-33, as part of the Balanced Budget Act of 1997. The legislation specifies that QI recipients cannot be eligible under any other Title XIX-funded program and simultaneously receive QI benefits. Therefore, applicants and individuals receiving QI benefits are not eligible for Primary Home Care (PHC), Community Attendant Services (CAS) or Title XIX Day Activity and Health Services (DAHS). QI recipients are eligible to receive Title XX Family Care (FC) or Title XX DAHS, or both, provided all other eligibility criteria are met.

Identification of QI Coverage

At the time of application for Title XIX services and at each subsequent annual reassessment, case workers must check the Texas Integrated Eligibility Redesign System (TIERS) to determine if the individual is receiving QI services. TIERS designates QI coverage as Type Program (TP) of Assistance TP-26.

Procedure for Applicants

If an applicant specifically requests PHC, CAS or DAHS, explain that individuals may not receive QI while receiving any other Title XIX-funded service. Inform the individual that there is no prohibition against receiving Title XX FC or DAHS at the same service levels. Applicants requesting DAHS must be certified for Title XX DAHS. Receipt of QI services does not preclude applicants from being placed on any existing interest list.

Procedure for Ongoing Individuals

When it is discovered that an individual receiving a Title XIX Community Care Services Eligibility (CCSE) service (CAS, PHC or Title XIX DAHS) has been certified for QI benefits, the case worker must first determine if enrollment in Title XX FC/ DAHS is open or if an interest list exists for the desired service. If no interest list exists, process the request for the desired service. If it is determined that the individual will have to be placed on a Title XX FC/ DAHS interest list, the case worker must contact the individual to give him the choice of service he wants to continue (QI or Title XIX CCSE service).

The case worker's next actions will depend on the individual's decision:

- If the individual elects to continue receiving the Title XIX CCSE service, explain that this will require that his QI benefits be denied. Send Form 2067,
- Case Information, to the Medicaid for the Elderly and People with Disabilities (MEPD) specialist to let MEPD know the individual's decision.
- If the individual decides to transfer to a Title XX service in order to keep his QI benefits, grant that service (if regional budgetary conditions allow) without placing him on the interest list. Otherwise, the individual should be placed at the top of the interest list. Title XIX service cannot remain open while the individual waits for an available slot.
- Follow up with written notification using Form 2065-A, Notification of Community Care Services.

2341.4 Refusal to Cooperate with the Application Process

Revision 17-1; Effective March 15, 2017

If the applicant refuses to sign Form H1200, Application for Assistance – Your Texas Benefits, or Form H1200-EZ, Application for Assistance – Aged and Disabled, or otherwise refuses to participate in the assessment process, do not proceed with the application process. Advise the applicant that he will receive a notice of ineligibility in the mail. Send the applicant Form 2065-A, Notification of Community Care Services. Use Code 17, "You failed to provide the necessary information."

2341.5 Retroactive Payment Process

Revision 17-1; Effective March 15, 2017

The retroactive payment process is an option that an individual and/or the provider may use if the individual has an immediate need for assistance with personal care task(s) pending the Texas Health and Human Services Commission's eligibility decision for Medicaid eligibility. See Section 2348, Retroactive Payments.

2342 Screening for Personal Attendant Services (PAS)

Revision 21-3; Effective September 1, 2021

Program Standard: *Staff must screen all applicants and recipients for potential eligibility for Primary Home Care (PHC) and Community Attendant Services (CAS) before referring to Family Care (FC) or continuing with an authorization for FC. When appropriate, make a referral for PHC or CAS eligibility services.*

Screening Initial Applicants

Determine if the applicant is currently receiving Medicaid before the initial interview. If the person is active on Medicaid, explore eligibility for PHC using the additional screening criteria to determine if a referral to PHC is appropriate.

If the person is not on Medicaid, explore income and resources to determine if they are potentially eligible for CAS. If the person does not appear eligible for PHC or CAS, explore eligibility for FC.

If the person's income and resources appear to be within the Supplemental Security Income (SSI) limits and the person appears to have a medical need for assistance with personal care, refer them to the Social Security Administration (SSA) for an SSI application. However, staff should continue the referral for the PAS even if the applicant refuses to apply for SSI.

If the person is not receiving Medicaid and their income and resources are above SSI limits, complete Form H1200, Application for Assistance - Your Texas Benefits, during the interview or review the application form mailed to the applicant for completion. Assist the applicant in the completion of the form and obtain all required verifications that are available.

If the person cannot complete the application form during the interview, explain that is important to return the form and any additional verification documents as soon as possible. Also, explain their eligibility for attendant services cannot be determined until the form is received.

Fax the completed application and verification documents with Form H1746-A, MEPD Referral Cover Sheet, to the Austin Document Processing Center (DPC) within two business days.

Screening Ongoing FC Cases for PHC or CAS

Apply the screening exception criteria at the next annual review if a person or provider reports interim changes between annual reassessments.

Review the screening exception criteria to see if the person's circumstances have changed at each annual functional reassessment of FC.

Example: a person was placed on FC due to no personal care tasks, the annual reassessment is being completed over the phone, and the person now requires a personal care task. Staff must refer the person to CAS or PHC and complete the home visit within 14 days of the annual functional reassessment.

CAS – A referral to MEPD must be sent within two business days of the home visit for the annual functional reassessment.

PHC – If it is not mandatory to enroll the person in STAR+PLUS, the transfer to PHC must be completed within 14 calendar days. If it is mandatory to enroll the person in STAR+PLUS, leave the person on FC, but start the process for the person's enrollment in STAR+PLUS.

Financial eligibility must be redetermined for FC within 24 months of the last eligibility determination.

Example: if MEPD previously determined the person was ineligible for CAS due to resources, staff must review the person's financial status. If it appears the person would now meet CAS requirements, staff must assist the person in completing a new Form H1200, Application for Assistance – Your Texas Benefits, and obtain verification of income and resources to send to MEPD.

Related Policy

Timely Referral to MEPD, 2342.2
Exceptions to Verification Requirements, 3422
Transition Between HHSC and STAR+PLUS, 6430
Income and Resource Limits, Appendix XI

2342.1 Receipt Date of the Application Form

Revision 17-1; Effective March 15, 2017

The date of the official application is the day the application form is received by the case worker at a home visit, or received by mail or hand delivered to a Texas Health and Human Services Commission office.

See Section 2333, Applications, for a list of acceptable applications.

If the case worker receives the application form during the home visit, the case worker enters the date in the "Date Form Received" box at the top of the form.

2342.2 Timely Referral to MEPD

Revision 20-4; Effective December 1, 2020

Before the initial home visit, staff must check TIERS to determine if the applicant has an active record. If there is no active record, consider the person a "new" applicant. A new applicant is a person who is not currently authorized to receive services in TIERS.

Consider the application complete with a name, address and signature. A person does not have to fill out the application in its entirety to be considered valid. The date of receipt of the application form with the name, address and signature is considered day zero.

New Applications

No later than the close of business on the second business day after receipt of a completed application form, staff must:

- Fax the completed application and verification documents with Form H1746-A to the Austin Document Processing Center (DPC); and
- Retain the original Form H1200, Application for Assistance – Your Texas Benefits, and a copy of the successful fax transmittal confirmation in the case record. The original application form must be retained in the case record for three years after the case is denied or closed.

Prior Applications

If an active record of the applicant is found in TIERS, including current recipients requesting a program transfer, then no later than close of business on the second business day after receipt of the completed application form, CCSE staff must:

- fax the completed application and verification documents to the Austin DPC, using Form H1746-A as a cover sheet; and
- retain the original Form H1200, Application for Assistance – Your Texas Benefits in the case file. The original form must be kept for three years after the case is denied or closed. CCSE staff must also retain a copy of the successful fax transmittal confirmation in the case record.

Transmittal

All communication to MEPD must include Form H1746-A, MEPD Referral Cover Sheet.

Note: Form 2067, Case Information, is not an acceptable means of communication to MEPD staff.

If Form H1746-A is not completed correctly, an incorrect assignment to MEPD staff could result.

CCSE staff must follow the guidelines listed in the H1746-A form instructions or in Appendix V, Guidelines for Completing Form H1746-A, MEPD Referral Cover Sheet, to ensure correct assignment is made.

Related Policy

Application for Assistance Form, 2341.1
Medicaid Program Actions, Appendix XXXII
Program Transfer Guide with Form H1200, Appendix XLV
Guidelines for Completing Form H1746-A, MEPD Referral Cover Sheet, Appendix V

2342.3 Exception Criteria for Referrals to PHC or CAS

Revision 17-10; Effective October 6, 2017

The case worker must screen all applicants for potential eligibility for Primary Home Care (PHC) and Community Attendant Services (CAS) before referring to Family Care (FC). The case worker applies the following exception criteria to determine if the applicant has a reason not to be referred for CAS, or if on Medicaid, would not be eligible for PHC.

To determine if the applicant is not appropriate for a referral to PHC or CAS, screen the applicant for the following criteria:

- Does the applicant specifically state that he will accept care only from his spouse as the paid attendant, and unmet need policy does not preclude this arrangement?
  - If yes, the applicant is referred for FC or placed on the Family Care interest list and is not referred for CAS. If no, then continue the screening process.
- Does the applicant receive Qualifying Individual (QI) benefits?
  - If yes, explain the choices of benefits according to Section 2341.3.1, Effects of QI Benefits on Eligibility for Community Care Services. If the applicant elects to keep the QI benefits, he may be referred for FC or placed on the FC interest list. If the individual elects to be referred to CAS, continue the screening process.

Other Criteria:

- Does the applicant meet the citizenship requirements needed to establish eligibility for Medicaid-funded programs?
- Does the applicant have a need for at least one personal care task?
- Does the applicant have a medical condition causing a functional impairment in performing personal care tasks?
- Does the applicant have a medical diagnosis other than mental illness, intellectual disability, or both?
- Does the applicant have a practitioner willing to sign a statement that the applicant has a medical need for assistance with personal care tasks and other activities of daily living?
- Does the applicant require at least six hours of service per week or meet exemptions listed in Section 4633, Functional Eligibility?

If the applicant answers “Yes” to all other criteria, then a referral for PHC or CAS is made. If the applicant answers “No” to any one of the other criteria, then the individual is referred for FC or placed on the FC interest list and is not referred for PHC or CAS.

Placement on the FC Interest List

Within five workdays of screening for CAS or PHC, using the **original date of the request for services**, assigned staff must enter all relevant data into the Community Services Interest List (CSIL) if:

- FC enrollment is open and the applicant does not meet the screening criteria for CAS or PHC, or the case worker will authorize FC while CAS financial eligibility is pending; or
- FC enrollment is not open and the applicant does not meet the screening criteria for CAS or PHC.

The original date of the request for services is the date the applicant called in requesting services, listed on Form 2110, Community Services Intake.

FC Services Pending the CAS Eligibility Decision

If FC enrollment is open in a region, the case worker assesses the applicant for FC and, if eligible, authorizes services while the CAS eligibility decision is pending from Medicaid for the Elderly and People with Disabilities (MEPD). If an individual placed on the FC interest list is released from the interest list, the case worker must screen the individual for CAS and refer to MEPD, if screening criteria are met. The case worker also assesses the applicant for FC and, if eligible, authorizes services while the CAS eligibility decision is pending.

If the individual is determined eligible for CAS, the case worker follows the policy in Section 4652.3, Initial Referrals for Community Attendant Services, and negotiates a transfer from FC to CAS. The case worker sends Form 2065-A, Notification of Community Care Services, noting the transfer of services. If the individual is not eligible for CAS, the case worker continues FC services, unless the individual was denied CAS for refusal to cooperate.

Refusal to Cooperate with MEPD

If the individual is denied for refusal to cooperate with the financial eligibility determination process, including refusal to furnish information or withdrawing the CAS application, the case worker must follow up with the individual to explore why the individual did not cooperate. If the individual states he is unwilling to cooperate with the financial eligibility determination process, then the case worker must advise the individual his application for services is denied and if he reapplies in the future, he will be referred for CAS again. The case worker documents all contacts in the case record and sends Form 2065-A to the individual citing rule reference 40 Texas Administrative Code §48.2911 (a)(3). In the Comments section, the case worker includes the following statement: “To be eligible for Family Care, you must be ineligible to receive attendant care services funded through Medicaid. Medicaid for the Elderly and People with Disabilities has notified HHSC you failed to provide the necessary information to determine eligibility for Medicaid-funded services.” If the individual requests to be placed on the FC interest list, the individual may be placed on the list, but he must be informed that he will be referred to CAS when his name is released from the list.

If the individual is receiving FC services pending the MEPD eligibility decision and the individual refuses to cooperate with the financial eligibility determination process as described above, the case worker must deny FC services. The case worker documents all contacts in the case record and sends Form 2065-A to the individual citing rule reference 40 Texas Administrative Code §48.2911 (a)(3). In the Comments section, the case worker includes the following statement: “To be eligible for Family Care, you must be ineligible to receive attendant care services funded through Medicaid. You failed to provide the necessary information to determine eligibility for Medicaid-funded services.”

If the individual states that he cooperated and thought he submitted all requested information, the case worker may check the Comments section in the Texas Integrated Eligibility Redesign System (TIERS). The case worker may need to assist the individual in obtaining any missing requested documentation.

The individual can reapply for CAS for up to 90 days from the date of the MEPD denial without completing a new Form H1200-EZ, Application for Assistance – Aged and Disabled. The case worker must obtain a written, dated and signed statement of request to reapply from the applicant or authorized representative to establish the date of application. The case worker submits the written statement and the documentation with Form H1746-A, MEPD Referral Cover Sheet, marked “Application.” The case worker must clearly note on Form H1746-A that the applicant is requesting to reapply for CAS. The case worker includes all identifying information on Form

H1746-A, and any additional information that will help identify the original application. Fax Form H1746-A and documentation to the Austin Document Processing Center.

Applications Denied by MEPD

If a referral is sent to MEPD and the individual is denied CAS eligibility for reasons other than refusal to cooperate with the financial eligibility determination process, then the individual remains eligible for FC or is placed on the FC interest list. The assigned staff enter the information into the CSIL using the **original request date for services** when placing the individual on the interest list.

If the individual who was denied CAS eligibility for reasons other than refusal to cooperate is released from the FC interest list within 90 days of the application date, the case worker may use Form H1200-EZ, Form 2060, Needs Assessment Questionnaire and Task/Hour Guide, the additional forms signed at the initial home visit, and verifications on file to determine eligibility for FC. The case worker must review all the information provided and note any changes on Form 2064, Eligibility Worksheet. The case worker must establish that the individual meets all financial eligibility requirements for Title XX services. The case worker does not need to do an additional home visit, but must review Form H1200-EZ and Form 2060 with the applicant and document any changes which have occurred since the initial visit. The case worker will need to follow appropriate time frames for annual reassessments as the annual reassessment will still be due within 12 months of the initial home visit.

FC Annual Reassessments

See Section 4447, Reassessment, for FC reassessment procedures.

2342.4 Spouse Attendant in Family Care Services

Revision 17-1; Effective March 15, 2017

If an individual states he will accept care only from his spouse, then the individual may be assessed for Family Care services or placed on the Family Care interest list and not referred to Primary Home Care (PHC) or Community Attendant Services (CAS).

Individuals on Medicaid may elect to receive Family Care services to have a spouse attendant. The policy that states, "To be eligible for Family Care, the individual must not be eligible to receive attendant care services funded through Medicaid", does not apply if the individual elects to have a spouse attendant. Even though these individuals meet the criteria to be referred to CAS, they may elect to receive Family Care services and not be screened or referred to Medicaid for the Elderly and People with Disabilities (MEPD) for a financial determination.

Unmet need policy applies and the case worker must carefully evaluate tasks provided and tasks not currently provided by the spouse to determine the service plan purchased through Family Care services. See Section 2513, Caregiver as the Paid Attendant, and Section 2514, Who Cannot Be Hired as the Paid Attendant, for additional information. The policy must be followed and the spouse assessed as any other caregiver. One exception to the policy is that on Form 2101, Authorization for Community Care Services, the case worker must note the individual is requesting the spouse as the paid attendant.

If the arrangement for the spouse as the attendant ends, then the individual must be referred for the appropriate Medicaid funded service.

2342.5 Disability Determination for Individuals Under Age 65 Applying for CAS

Revision 17-1; Effective March 15, 2017

The Texas Health and Human Services Commission (HHSC) case worker is required to assist certain individuals under age 65 to complete the forms required by HHSC for a disability determination. Individuals age 65 or over may qualify for Medicaid or Medicaid-funded programs, such as Community Attendant Services (CAS), without a disability determination.

The case worker must review an individual's disability status by using the State On-Line Query (SOLQ) or Wire Third Party Query (WTPY) systems. An individual has a disability established by Social Security if there is a disability onset date on the SOLQ or WTPY systems. If the individual under age 65 does not have a Social Security established disability, the case worker must assist the individual with completing Form H1200-EZ, Application for Assistance – Aged and Disabled, Form H3034, Disability Determination Socio-Economic Report, and Form H3035, Medical Information Release/Disability Determination, at the initial face-to-face contact when assessing eligibility.

To determine a disability, HHSC must review evidence, signed by the individual's treating physician (that may include medical reports), detailing the degree and history of the individual's diagnosis. The case worker must inform the individual when scheduling the initial face-to-face contact that the case worker will need the required evidence at the initial contact with the individual. If the case worker schedules the face-to-face contact at least seven calendar days in advance, the case worker must send Form 2423, Request for Medical Evidence, to the individual on the same day of the telephone contact to advise the individual of the evidence requirement. If the case worker schedules the face-to-face contact less than seven calendar days in advance, the case worker must present Form 2423 at the face-to-face contact. The case worker must not delay the face-to-face contact for the purpose of allowing the individual time to obtain the medical evidence.

The case worker should include the completed Form H3034, Form H3035 and any evidence obtained at the initial face-to-face contact with Form H1200-EZ following current transmittal procedures to Medicaid for the Elderly and People with Disabilities (MEPD). If evidence was not available at the initial face-to-face contact, the case worker documents "No evidence was obtained" in the Section I, Comments about your disability, on Form H3034 prior to submitting to HHSC for a disability determination.

2343 Confidentiality

Revision 17-1; Effective March 15, 2017

40 Texas Administrative Code §48.3901(a) — Information collected to determine eligibility for services, whether collected by DHS staff or provider agencies, is confidential.

Information concerning Texas Health and Human Services Commission (HHSC) applicants and individuals is confidential and can only be used for purposes directly connected to administration of HHSC services. HHSC routinely shares confidential information with providers because the information shared is directly connected with service administration.

Information can also be shared with other entities if it is determined that the purpose is directly tied to the administration of services. Consult the unit supervisor before making the decision to share information with individuals other than the providers.

Code of Federal Regulations, Title 42, Part 431, Subpart F – Safeguarding Information of Applicants and Recipients – (a) Section 1902(a) (7) of the Act requires that a state plan must provide safeguards that restrict the use or disclosure of information concerning applicants and recipients to purposes directly connected with the administration of the plan.

Refer to Section 1140, Disclosure of Information, regarding national standards created under the Health Insurance Portability and Accountability Act to protect the confidentiality of individually identifiable health information.

2344 Individual Rights and Responsibilities

Revision 18-2; Effective November 19, 2018

During the initial visit with the applicant and, as appropriate, the responsible person (RP), discuss the information contained in Form 2307, Rights and Responsibilities. Ensure the applicant understands the significance of his rights and responsibilities.

If the applicant appears unable to understand this information or the complaint process, it is important to give the RP a copy of Form 2307. Sharing the applicant's rights and responsibilities with the RP is particularly important if it appears the applicant may not be able to fully understand his rights and responsibilities. An RP may be a guardian, family member or other individual who assists in the development of the care plan and/or who maintains regular communication with the applicant or department regarding the applicant's well-being.

The applicant must:

- provide all information needed to establish eligibility and develop a service plan. Falsifying information is illegal and may result in criminal charges filed against the applicant.
- promptly report changes in income, living arrangements, family size, loss of assistance grants or Medicaid benefits, or other changes that affect eligibility. If the applicant willfully fails to report changes that affect eligibility and receives services for which he/she is not eligible, the applicant may be prosecuted for fraud.

Rights and Responsibilities Documentation Requirements

At Application

At the initial home visit, the case worker must clearly and fully explain the information in the following forms with the applicant. Maintain copies in the case record and review with the applicant/RP as indicated in the instructions for each form.

Individuals must receive the following forms and attachments:

- Form 2307, Rights and Responsibilities;
- Attachment 2307-EVV, Electronic Visit Verification Rights and Responsibilities, if applying for Community Attendant Services, Primary Home Care or Family Care Services;
- Form 1581, Consumer Directed Services Option Overview; and
- Form 1584, Consumer Participation Choice, if applying for personal attendant services (PAS).

If the applicant selects the Consumer Directed Services (CDS) option on Form 1584, he/she must also receive:

- Form 1582, Consumer Directed Services Responsibilities; and
- Form 1583, Employee Qualification Requirements; and
- Form 1586, Acknowledgement of Information Regarding Support Consultation Services in the Consumer Directed Services (CDS) Option.

If the applicant selected the Service Responsibility Option on Form 1584, he/she must also receive:

- Form 1581-SRO, Service Responsibility Option (SRO) Overview; and
- Form 1582-SRO, Service Responsibility Option Roles and Responsibilities.

See Section 6000, Service Delivery Options, for complete information and requirements on CDS and SRO.

Individuals applying for Family Care, Community Attendant Services or Primary Home Care, Emergency Response Services (ERS) and Adult Foster Care (AFC) services must be given the following forms for the

requested service:

- Attachment 2307-A, Family Care, Community Attendant Services and Primary Home Care Rights and Responsibilities;
- Attachment 2307-B, ERS Eligibility Criteria and Responsibilities; or
- Attachment 2307-F, AFC Rights and Responsibilities.

All applicants must receive Form 2065-A, Notification of Community Care Services, notifying them of the eligibility decision.

Annual Reassessments and Changes

- Clearly document in the case record that the individual's rights and responsibilities were reviewed at the annual reassessment.
- Keep the current Form 2307 on file at the annual reassessment if nothing has changed affecting the individual's services. Telephone numbers and staff names do not constitute a change for completing a new Form 2307, although it is important that the individual knows how to reach the case worker (business cards are suggested).
- If the individual's services have changed, the individual/RP must complete and sign a new Form 2307.
- As appropriate, review the information on Attachment 2307-A, Attachment 2307-B, Attachment 2307-F and Attachment 2307-EVV with the individual/RP. Complete new forms if PAS, ERS or AFC are being added as new services.
- With the exception of ERS, Home-Delivered Meals (HDM), and Day Activity and Health Services (DAHS), a home visit is required to add a service to the individual's service plan.
- Review and offer the choice of service delivery options at the annual reassessment and obtain a new signed and dated Form 1581.
- Clearly document in the case record that the choice of service delivery options was reviewed at the annual reassessment.
- Obtain a new signed and dated Form 1584 at any time the individual changes his service delivery option. The case worker will also need to complete Form 1581, (or Form 1581-SRO), Form 1582, (or Form 1582-SRO) and Form 1583, as appropriate.
- Send Form 2065-A if the case action includes:
  - the addition of a new service;
  - a change in the amount of service;
  - a change in the amount of the individual's copayment;
  - a change in priority status; or
  - termination of the case or service.

See Appendix IX, Notification/Effective Date of Decision, for additional details or exceptions.

2345 Registering to Vote

Revision 18-1; Effective June 15, 2018

The National Voter Registration Act (NVRA) of 1993 requires that the Texas Health and Human Services Commission (HHSC) offer each individual applying for HHSC services the opportunity to register to vote, to record the individual's decision on Form 1019, Opportunity to Register to Vote/Declination, and to file it in the case record. Additionally, HHSC case workers must also offer the individual an opportunity to register to vote at annual reassessments and when notified of a change of address.

The HHSC case worker must provide the same degree of assistance, including bilingual assistance, to help the individual complete the voter registration forms as is provided with the completion of any HHSC forms.

The case worker may not make a determination about an individual's eligibility for voter registration other than a determination of whether the person is of voting age, which is 18 years of age, or is a U.S. citizen. An individual's age or citizenship may be verified by the case worker if the age or citizenship can be readily determined from information filed with HHSC for purposes other than voter registration. An individual must be offered voter registration assistance as provided by the NVRA if the individual's age or citizenship cannot be determined.

At the time an individual applies for services, at annual reassessments or when changing addresses, he must be given the opportunity to:

- complete Form H0025, HHSC Application for Voter Registration, and mail it to the voter registrar; or
- complete Form H0025 and provide it to HHSC staff to mail to the voter registrar.

If the individual wishes to complete Form H0025 during the interview, the case worker must review the form for completeness in the presence of the individual. If the form does not contain all the required information, including the required signature, the case worker returns it to the individual for completion. If the individual requests the case worker to mail the form, Form H0025 must be sent to the appropriate county voter registrar within five working days of signature by the individual.

When HHSC staff offer individuals the opportunity to register to vote, as required by the National Voter Registration Act, they must also inform individuals of the option of requesting a ballot by mail. Individuals may request a ballot by mail if they are:

- out of the county during early voting and on Election Day;
- age 65 or older;
- sick or disabled; or
- confined to jail.

He or she can print an application for a ballot by mail (PDF) from the Texas Secretary of State website and mail it to the Early Voting Clerk. HHSC staff must also provide assistance in completing any form while an individual is registering to vote as prescribed in current voter registration policy.

Declining to Register

If the individual does not wish to complete Form H0025, he must complete and sign Form 1019. If the individual refuses to sign Form 1019, the case worker must document the refusal on the form. The case worker must keep each declination form in the case record for at least 22 months after the date of signing.

Annual Reassessments Conducted by Telephone

If the individual receiving services wishes to register to vote during an annual reassessment that is conducted by telephone, the case worker must mail Form H0025 to the individual within three working days after the date of the phone call. If the individual does not wish to register to vote, the case worker must ask the individual to complete and sign Form 1019. The case worker must mail him Form 1019 **within three working days** after the date of the phone call. The case worker must inform the individual that Form 1019 must be returned within 30 calendar days after the date of the phone call with the case worker. If the individual refuses to sign the declination form, or the case worker does not receive the form within 30 calendar days after the date of the phone call with the individual, the case worker must enter on Form 1019 that the individual refused to sign or failed to return the declination form. HHSC staff must retain each declination form in the individual's case record for at least 22 months after the date of signing.

Change of Address

The case worker must contact the individual by phone **within five working days** after receiving notification of a change of address and offer the opportunity to register to vote. If the individual does not have a phone, the case worker must mail Form H0025 and Form 1019 **within five working days** after being notified of a change in address. If the case worker does not receive either Form H0025 or Form 1019 within 30 days of mailing the forms to the individual, the case worker must complete Form 1019 indicating that the individual failed to return Form 1019.

If the individual wishes to register to vote, the case worker must mail Form H0025 to the individual **within three working days** after the date of the phone call. If the individual does not wish to register to vote, the case worker must ask the individual to complete and sign Form 1019. The case worker must mail him Form 1019 **within three working days** after the date of the phone call. The case worker must inform the individual that Form 1019 must be returned within 30 calendar days after the date of the phone call with the case worker. If the individual refuses to sign the declination form, or the case worker does not receive the form within 30 days after the date of the phone call with the individual, the case worker must enter on Form 1019 that the individual refused to sign or failed to return the declination form. HHSC staff must retain each declination form in the individual's case record for at least 22 months after the date of signing.

Additional Guidelines

The case worker must not:

- influence an individual's political party preference;
- display any political party preference or allegiance; or
- make any statement or take any action for the purpose or effect of:
    - discouraging the individual from registering to vote; or
    - leading the individual to believe that a decision of whether to register has any bearing on the availability of or eligibility for HHSC services or benefits.

If the individual has any questions regarding the voter registration process that the case worker cannot answer, the case worker must:

- advise the individual to call the Office of the Texas Secretary of State toll-free at 1-800-252-8683; or
- give the individual the telephone number of the local county voter registrar.

2346 Service Delivery Options

Revision 17-1; Effective March 15, 2017

The Texas Health and Human Services Commission (HHSC) offers applicants and individuals three options for the delivery of personal attendant services (PAS). It is the case worker's responsibility to present information on all available service delivery options to the applicant at the initial interview and to ongoing individuals at the annual review, or whenever requested.

The service delivery options include the:

- Consumer Directed Services (CDS) service delivery option, managed by the individual;
- Service Responsibility Option (SRO), co-managed by the individual and the agency in the specific pilot area; and
- Agency Option (AO), managed by the agency.

If the applicant/individual chooses an option other than the AO, the case worker will conduct special casework procedures including, but not limited to:

- providing an overview of the option(s) the applicant/individual is interested in by using Form 1581, Consumer Directed Services Option Overview, for CDS; and/or Form 1581-SRO, Service Responsibility Option (SRO) Overview, for SRO; and
- reviewing the individual's roles and responsibilities under the chosen option by using Form 1582, Consumer Directed Services Responsibilities, for CDS; and/or Form 1582-SRO, Service Responsibility Option Roles and Responsibilities, for SRO.

Once the applicant/individual has made a choice, the case worker asks the applicant/individual to sign Form 1584, Consumer Participation Choice, to document the choice of option. Additional casework procedures are detailed in:

- Section 6100, Agency Option (AO);
- Section 6200, Service Responsibility Option (SRO); and
- Section 6300, Consumer Directed Services (CDS).

2347 Texas Medicaid Estate Recovery Program (MERP)

Revision 20-4; Effective December 1, 2020

Under the Medicaid Estate Recovery Program (MERP), the state may file a claim against the estate of a deceased Medicaid recipient, age 55 and older, who received certain long-term care services.

The following services and programs are subject to MERP claims:

- nursing facility (NF) care;
- intermediate care facilities for individuals with an intellectual disability or related condition (ICF/IID), which include state supported living centers;
- Medicaid waiver programs:
  - STAR+PLUS Home and Community Based Services (HCBS);
  - Community Living Assistance and Support Services (CLASS);
  - Deaf Blind with Multiple Disabilities (DBMD);
  - Home and Community-based Services (HCS);
  - Texas Home Living (TxHmL); and
- Community Attendant Services (CAS).

Additional information on the MERP is available on the MERP website.

Community Attendant Services

Form 8001, Medicaid Estate Recovery Program Receipt Acknowledgement, provides written information regarding the MERP.

Provide Form 8001 to a person applying for CAS at the initial home visit or face to face contact. Do not provide MERP information over the phone.

During the home visit or face to face contact, staff must:

- complete page 2 of Form 8001 by entering the name of the applicant, the applicant’s responsible person or their authorized representative (AR), if applicable, and the name of the case manager on page two;
- provide the Form 8001 to the applicant, the responsible person or the AR and request they read and acknowledge the information by signing page 2;
- provide a copy of the signed Form 8001 to the applicant; and
- retain a copy of the signed Form 8001 in the case file.

An applicant, a responsible person or an AR may sign page 2 of the Form 8001 to indicate that they received and understand the MERP information. If the applicant, the responsible person or the AR, refuses to sign the Form 8001, staff must check the box on the bottom of page 2 to document the refusal and sign the Form 8001 to indicate that the MERP information was shared with the applicant.

When providing the written MERP information during the home visit or face to face contact, staff must clearly explain the following:

- the Form 8001 is only an informational notice;
- the applicant does not have to sign the form to receive services; and
- refusal to sign the form does not exempt their estate from recovery, if it is determined that MERP is applicable at the time of death.

Staff may explain program requirements to share MERP information but must not make recommendations about the MERP or speculate if MERP will be applicable upon the applicant's death. Only the MERP unit staff can determine if an applicant meets the “grandfathered” or exempt status.

If the applicant, the responsible person or the AR has additional questions about the MERP, direct them to the contact information on page 2 of the Form 8001.

2348 Retroactive Payments

Revision 17-1; Effective March 15, 2017

40 Texas Administrative Code §47.85 (c)(1) — The provider agency may be reimbursed for services provided before the date a completed, signed, and dated copy of DHS's Application for Assistance – Aged and Disabled form is received:

(A) for up to three months for a person who does not have Medicaid eligibility at the time of the request for retroactive payment; and

(B) for an indefinite period for a person who is Medicaid eligible at the time of the request for retroactive payment.

If an application is received for retroactive attendant care services, the following actions apply. Upon receipt of a completed, signed and dated application or request for services, send Form H1236, Notification of Receipt of Application, to the provider currently serving the applicant. The notice advises the provider that its individual:

- has applied with the Health and Human Services Commission (HHSC) for services, and
- is interested in applying for retroactive payments.

The case worker must send the completed application to the appropriate Medicaid for the Elderly and People with Disabilities (MEPD) or Community Care Services Eligibility (CCSE) regional staff so that a decision can be made regarding the applicant's financial eligibility.

Note: An individual who may complete or sign an application for an applicant or individual may not be on the list of people to whom HHSC can release the applicant's individually identifiable health information. See Section 1150, Personal Representatives, for individuals who may receive or authorize the release of individually identifiable health information under the Health Insurance Portability and Accountability Act (HIPAA) privacy regulations.

A Medicaid-eligible or categorically eligible individual does not have to complete an application when requesting services. Also, an individual who requests facility-initiated Day Activity and Health Services (DAHS) does not have to complete an application if he has stopped receiving services by the time he is

contacted. The DAHS facility can be reimbursed for facility-initiated DAHS provided to an individual who was Medicaid eligible when service was received, even if the individual does not complete an application.

The following applies to individuals receiving Primary Home Care (PHC) or DAHS through provider or facility-initiated services.

If a request for DAHS is received from a Medicaid-eligible individual who is not required to complete a written application and is receiving DAHS services, then the individual must allow staff to process the initial paperwork if the individual plans to continue receiving services.

If the individual refuses to participate or allow staff to process the initial paperwork:

- for DAHS, send Form 2065-A, Notification of Community Care Services, for facility-initiated DAHS individuals with a denial date that is 12 days from the form date.
- for PHC, follow procedures in Section 4644, Applicant Approved for Retroactive Payment and Denied Continued Services by the Case Worker, to deny individuals who are receiving PHC and are applying for retroactive reimbursement.

For situations listed above, deny DAHS or PHC individuals on Form 2101, Authorization for Community Care Services, with a reason for withdrawal of services.

See Section 4640, Retroactive Payments, for complete procedures relating to retroactive payments.

2349 Procedures for Applicants Aging Out of PCS to PHC

Revision 17-1; Effective March 15, 2017

The Texas Health and Human Services Commission (HHSC) has an agreement with the Texas Department of State Health Services (DSHS) for individuals receiving Personal Care Services (PCS) to be referred for Primary Home Care (PHC) two months prior to the individual's 21st birthday. See Appendix XXXIII, Requests for Services from Individuals Under 21 Years of Age, for additional information and a listing of DSHS offices.

This time frame has been set to ensure there will not be a gap in services. The DSHS case worker will make the referral for intake 60 days prior to the individual's 21st birthday. Referrals from DSHS must be accepted, Form 2110, Community Care Intake, must be completed and the intake assigned to a case worker. Regional staff must also check the quarterly Age Out list, in case the referral from DSHS is not timely.

Since there are differences in PCS and PHC services, the HHSC case worker will thoroughly explain the allowable PHC services at the time of the initial PHC assessment. PHC may not offer some of the services provided through the PCS program.

The applicant must meet all PHC eligibility criteria, including medical, functional and unmet need. If the applicant is eligible, PHC services are negotiated to begin on the individual's 21st birthday. PCS services should end at midnight on the day before the individual's birthday. Coordinate the transition with the PCS case worker and applicant to ensure there are no gaps in services.

All time frames are applicable and processing of the intake must not be delayed. The case worker must make the home visit within 14 calendar days and send a referral Form 2101, Authorization for Community Care Services, to the selected provider within five business days. Currently, the Service Authorization System Online (SASO) will not allow the processing of referral Form 2101 due to the age edit in the system. Therefore, Form 2101 must be completed manually. This edit will be modified in the future to allow completion of the case prior to the individual's 21st birthday.

Upon receipt of Form 3052, Practitioner's Statement of Medical Need, and final eligibility determination, the case worker negotiates the start of care date for the individual's 21st birthday, completes a manual authorization

Form 2101, and sends it to the provider. Form 2065-A, Notification of Community Care Services, is sent within **two** business days of sending authorization Form 2101. Since SAS entry cannot be completed until the individual's 21st birthday, the case worker is allowed up to **five** business days after the 21st birthday to complete the data entry.

If the PCS Individual Is Ineligible for PHC

If the individual is not eligible for PHC due to a low score on Form 2060, Needs Assessment Questionnaire and Task/Hour Guide, requests voluntary withdrawal or has no unmet need, the denial code must be entered in SASO. These cases are tracked for reporting purposes.

PCS Caregiver as the Paid Attendant

Refer to Section 2422.5, Attendant Policy for Individuals Transferring from Another Personal Attendant Services (PAS) Program, for special procedures regarding caregivers as paid attendants in PCS cases. If a parent or other caregiver has been the paid attendant through PCS, he may meet the criteria to continue to be the paid attendant and would not be listed as "Do Not Hire." Caregiver support may also be appropriate in some cases.

2400, Assessment Process

2410 Overview of the Assessment Process

Revision 17-1; Effective March 15, 2017

The purpose of the assessment process is to determine whether the applicant meets all eligibility requirements, including:

- financial eligibility;
- functional eligibility; and
- having an unmet need for services.

The assessment process should produce a case record that clearly documents the results of the case worker's determination. All processes that can be performed in the Service Authorization System Online (SASO) Wizards must be performed in the system to consider that action complete, including:

- Form 2059, Summary of Client's Need for Service;
- Form 2060, Needs Assessment Questionnaire and Task/Hour Guide; and
- Form 2064, Eligibility Worksheet.

Lack of case record documentation in the following areas is considered inadequate, unless the case is being denied for an unrelated reason.

Example: The case worker conducts a home visit in response to an intake request. After completing the Form 2060 assessment, it is determined that the individual's score is too low to qualify for any of the requested services. Since the individual has already been determined functionally ineligible, it is not necessary to evaluate financial eligibility. If an Application for Assistance form has been completed, the form must be retained in the case record.

2411 Required Documentation

Revision 17-1; Effective March 15, 2017

The following must be documented in the case record:

- Individual's eligibility based on his categorical status in the Texas Integrated Eligibility Redesign System (TIERS) or current financial and functional status (Form H1200-EZ, Application for Assistance – Aged and Disabled; Form 2060, Needs Assessment Questionnaire and Task/Hour Guide; Form 2064, Eligibility Worksheet).
- Individual's medical, social, environmental and/or physical conditions that are relevant to his particular functional status (Form 2110, Community Care Intake; Form 2059, Summary of Client's Need for Service, Form 2060 and the case narrative).
- Individual's degree of self-sufficiency and the tasks he can perform (Form 2110, Form 2059 and Form 2060).
- Environmental adaptations that are being used or could be used to help the individual achieve or maintain his maximum level of self-sufficiency (Form 2059).
- People who are resources, including family, friends and community networks, that the individual now uses or who are available to perform or help with activities of daily living (Form 2059 and Form 2060, Part A).
- Agency resources in the community available to provide any of the services needed by the individual (Form 2059 and Form 2060, Part A)
- Form 8001, Medicaid Estate Recovery Program Receipt Acknowledgement, for Community Attendant Services applicants or responsible parties.

In some areas of Texas, the Area Agency on Aging may submit a completed Form 2060 based on the assessment for services it provides. If a completed Form 2060 is received, it must be reviewed for information as part of the assessment process.

Note: For detailed explanations of financial eligibility assessment and determination procedures, see Section 3000, Eligibility for Services.

2420 Assessing the Applicant's Needs

Revision 17-1; Effective March 15, 2017

During the initial home visit, as required in Section 2300, Responding to Requests for Service, the case worker completes the following assessment procedures.

2421 Review of the Community Care Intake Form

Revision 17-1; Effective March 15, 2017

Review Form 2110, Community Care Intake, for all relevant information. Make sure the practitioner is the applicant's current practitioner and the name, address and telephone number listed are correct. If the applicant provided a rural route address, ask for the updated street address. If the individual states he does not have a new address, continue to use the address provided. Take no action if the street-style address is not provided. Ask the individual to update his information with the Texas Health and Human Services Commission if he is notified by the U.S. Postal Service of a new address.

Verify that the responsible party is the primary contact for the applicant and the name, address and telephone number are correct. On Form 2110, list any other family members or informal supports who can be contacted if the applicant cannot be reached. Review the requested services and address those during the interview and in documentation.

2422 Form 2059, Summary of Client's Need for Service

Revision 17-1; Effective March 15, 2017

The purpose of Form 2059, Summary of Client's Need for Service, is to document the applicant's:

- medical diagnosis and physical condition;
- functional limitations;
- home environment;
- living arrangements; and
- family and community supports.

Record all information reported by the applicant or informal supports during the home visit on Form 2059-W, Summary of Individual's Need for Service Worksheet. This information is entered into the Service Authorization System Online Wizards (SASOW) and will generate Form 2059.

Carefully observe and use interviewing skills during the initial home visit and throughout the assessment process. This is necessary to collect critical information about the individual's functional and mental abilities, and community and family resources. Individuals may demonstrate functional abilities while responding to questions about their home and living environment or medical problems. They may reveal information about family resources while responding to questions about financial eligibility. They may reveal intellectual and developmental disabilities or lack of mental clarity in the way they respond to questioning throughout the interview. During the interview, be alert for any indications of abuse, neglect or exploitation. If any of these conditions are present, refer the individual to the Texas Department of Family and Protective Services (DFPS), Adult Protective Services.

2422.1 Medical Diagnosis and Functional Limitations

Revision 17-1; Effective March 15, 2017

Ask the applicant for information regarding his medical diagnosis and physical and functional limitations. Record this information on Form 2059-W, Summary of Individual's Need for Service Worksheet.

2422.2 Home Environment

Revision 17-1; Effective March 15, 2017

The individual's functional status is always relative to the home circumstances in which the individual performs the activities of daily living. For example, the individual may have physical limitations that would not affect his abilities to perform certain personal care tasks if he lived in a home complete with all modern conveniences. If, however, his home contains only minimal household equipment, his inability to perform his personal care tasks could be compounded. Always assess an individual's functional capacity in relation to the home environment in which the tasks are performed daily. Service plans are developed to be carried out in specific home environments and each plan should relate specifically to a functional assessment done in that particular environment.

Observe and ask questions about the individual's home and immediate environment to assess his ability to perform activities of daily living. Determine whether the environment affects the individual's ability to perform these activities or otherwise affects his health and safety.

Guidelines for Assessing the Home Environment

Using the following guidelines, assess the home environment and document the results on Form 2059-W, Summary of Individual's Need for Service Worksheet, to be entered in the Service Authorization System Online Wizards (SASOW). When observing the individual's home and immediate environment, assess the following:

- Does the structure of the house or dwelling create an environment that is safe and adequate for the individual's unique needs?
- Are there assistive devices and equipment necessary for the individual to live safely or that would improve his safety? **Note:** These include ramps, grab bars, wide doors, lowered light switches and adequate light for safe visibility.
- Is the home clean enough and orderly enough to be safe for the individual's lifestyle?
- Does the home pose any critical health hazards?
- Does the individual have neighbors who are or might be resources to help with any special monitoring the individual might need because of some unique health or physical problem?
- Is the neighborhood safe to allow the individual to move safely in and out of his home as needed?
- Is the individual safe from physical harm in his own home?

Home Arrangement

Is the individual the owner of his home or does he reside in an apartment or live with friends or relatives? The individual may pay rent, own the home or live cost free.

Is the individual homeless and no friend or relative is available to provide a home? If the individual has insufficient income to rent a suitable home, he may be living in a public shelter or an exposed setting. Refer the individual to Adult Foster Care (AFC), Residential Care (RC), public housing or other community living resources. A referral to Adult Protective Services (APS) may be needed.

Home Condition

Is the individual's home:

- Adequate — Physically safe and arranged or equipped so the individual lives safely and performs normal activities of daily living? Although adjustments may be desirable, they are not necessary for safety.
- Inadequate Questionable — Residence presents serious limitations in conducting activities of daily living and/or safety hazards exist because of a need for major repairs, addition of utilities or assistive devices. Check the appropriate boxes on Form 2059-W.
- Inadequate Unsafe — Residence is an unsafe environment for the individual. The structure is in a severe state of disrepair, contains critical health hazards or prevents one from performing the normal activities of daily living. The individual may need to be moved for his health and safety. A referral to APS may be appropriate. Check the appropriate boxes on Form 2059-W.

2422.3 Living Arrangement

Revision 17-1; Effective March 15, 2017

The case worker documents on Form 2059-W, Summary of Individual's Need for Service Worksheet, Item 4, if the applicant lives alone, with a spouse, with family or friends, or if he is in adult foster care or a residential care facility. In Item 5, list the name and relationship of all household members and indicate with a "Y" that they are in the household. Note if any of the household members receive services or are applying for services.

2422.4 Documentation of Caregivers

Revision 17-1; Effective March 15, 2017

Ask the individual if he receives assistance with his activities of daily living and list the name and relationship of all caregivers. These people may be family members, friends or neighbors. List the tasks performed by each caregiver on Form 2059-W, Summary of Individual's Need for Service Worksheet. Under Caregiver Status,

indicate if there is a reason the caregiver cannot meet all of the individual's needs, such as working full time, ill health, needing caregiver support or providing continual care. For household members who are not performing any caregiver tasks, leave the caregiver status blank. If a household member states he is unwilling to assist the individual with any tasks, note this in the Caregiver Status on Form 2059-W.

The caregiver will be assessed during the functional assessment. See Section 2433.1, Assessment of the Caregiver.

Determine if the caregiver needs caregiver support as defined in Section 2512, Caregiver Support, and develop the service plan accordingly.

If the response is "No," determine the tasks for which the caregiver has been paid in the previous program and whether the individual still needs assistance with those tasks. Determine which tasks will continue as caregiver tasks and develop the service plan accordingly. Document the caregiver's response and send Form 2067, Case Information, along with the referral packet, to the provider advising that the caregiver had previously been the paid attendant and is eligible to be the paid attendant.

If the response is "Yes," evaluate if there is any unmet need or if caregiver support is required. If services continue, the caregiver cannot be hired. If there is no need for caregiver support or no unmet need, the applicant is denied services.

The case worker must follow this policy for individuals applying for HHSC Primary Home Care (PHC), Community Attendant Services (CAS) or Family Care (FC) who are transitioning from one of the programs listed above.

2422.6 Common Household Tasks, Duplicate Services and Services Provided to Other Family Members

Revision 17-1; Effective March 15, 2017

If an individual lives with others, do not purchase services that duplicate services normally provided as part of the household routine. For example, meal preparation, shopping, laundry and housekeeping for the individual are performed daily as part of the family routine. Unless the individual has unique needs, these tasks will not be purchased.

If an individual lives with others, determine whether he has needs for unique tasks that are performed apart from the household's tasks and whether performing these tasks imposes additional burdens of time and responsibility on the household members. Unique tasks are attributable to the individual's problems. Examples include incontinence, a need for a special diet, food preparation, extra shopping or special housecleaning caused by the individual's behavior. Allowable tasks also include cleaning up after personal care tasks, cleaning the individual's room and the bathroom used by the individual. If it is determined the individual's needs impose special and extra activities on the household members, document these needs on Form 2060, Needs Assessment Questionnaire and Task/Hour Guide.

Services Provided to Other Family Members

Identify whether services are being provided to any other family member by the Texas Health and Human Services Commission (HHSC) or another agency. If services are being provided, assess whether they meet some of the individual's needs and would affect his service plan.

Example: An individual's spouse receives Community Care for Aged and Disabled Family Care services and an attendant performs housecleaning, laundry and meal preparation as part of that service plan. Some of those services also benefit the individual or duplicate services that he needs. In this case, divide the time for common tasks between the individuals and authorize the task for both individuals. Refer to the maximum times listed on Form 2060 for companion cases.

Refer to Section 4400, Family Care Services, and Section 4600, Primary Home Care and Community Attendant Services, for specific information about situations in which two persons in the same household receive attendant services.

2422.7 Assessment of Social and Community Resources

Revision 17-1; Effective March 15, 2017

Assess the individual's community and social network resources, such as churches, civic clubs and voluntary affiliations to determine whether any of these entities provide services or would be able to do so. Also, identify available service agencies that serve the elderly and disabled and might be able to provide a service needed by the individual. Always determine whether any of these sources can help the individual before services from the Texas Health and Human Services Commission (HHSC) are authorized. See Appendix XV, Services Available from Other State Agencies, for assistance in identifying alternate sources of assistance. When possible, refer to local resource directories for information about services in an individual's community. Document the use of or referral to other service agencies on Form 2059-W, Summary of Individual's Need for Service Worksheet, Item 7.

All other services available to the individual must be considered and used before HHSC services are authorized.

2423 Guardianship

Revision 17-1; Effective March 15, 2017

A Community Care for Aged and Disabled individual may need a guardian if he:

- appears to be incompetent; or
- is so incapacitated that he is unable to care for himself or manage his property and financial affairs.

If the individual's incompetence or incapacity results in his being in a state of abuse, neglect or exploitation, the case worker must make a referral to Adult Protective Services (APS). Unless ordered by a court to do so, the case worker must not file a petition for guardianship or assume guardianship of the person or the estate of a Texas Health and Human Services Commission (HHSC) individual.

If the court intends to appoint the case worker as guardian, the case worker must advise the court that serving in that capacity will violate HHSC policy. If the case worker is appointed guardian by the court, the supervisor and regional attorney must be notified immediately. If a referral to APS, Texas Department of Family and Protective Services, has not already been made, one should be made at this time.

2430 Functional Assessment

Revision 17-1; Effective March 15, 2017

40 Texas Administrative Code §48.2907(a) — The Client Needs Assessment Questionnaire is used to determine an individual's functional need for CCSE services.

Form 2060, Needs Assessment Questionnaire and Task/Hour Guide, is used to make several determinations regarding the individual's eligibility. The completed form will determine:

- the individual's functional eligibility;
- his ability to carry out activities of daily living;
- what he should continue to do for himself to maintain his current level of self-sufficiency;
- what he cannot do for himself because of physical limitations, mental limitations or both;
- which resources are available to help with specific tasks;
- if the individual has an unmet need; and
- how much service the individual will receive, if eligible.

An individual's functional level is based on:

- his physical condition;
- his medical problems and the functional limitations they impose;
- his mental clarity and limitations and the effect they have on performing activities of daily living; and
- the condition of his home environment.

The age of the individual being assessed for services should not be considered when determining the level of functional need. For example, the applicant is a 3-month-old infant whose mother is applying for Community Attendant Services (CAS) for the child. Obviously, the infant will need help with most of the activities of daily living and would, therefore, score a "3" on those tasks. The fact that the functional need is the direct result of the individual's age should not be taken into consideration when assigning a score for the particular task.

If the person appears to be eligible for Community Care for Aged and Disabled services on the basis of age, income and resources, and he requests services beyond Information and Referral, complete Form 2060, Part A, to determine the functional eligibility for services. This assessment helps determine whether the person has functional needs, what kinds of functional limitations he experiences, which tasks he needs help with and whether his mental clarity contributes to his need for help.

2431 Form 2060, Part A, Functional Assessment

Revision 17-1; Effective March 15, 2017

Program Standard: *The case worker must score each item on Form 2060, Needs Assessment Questionnaire and Task/Hour Guide, Part A, Functional Assessment, and then accurately compute the total score to determine whether the individual is eligible for Community Care for Aged and Disabled services. Use the spaces under each item, as needed, to explain the person's limitations or his accommodations for his disability. For detailed information about scoring Form 2060, Part A, refer to the form instructions. Appendix XVII, Service/Score Code Guide, indicates the score requirement for each service.*

During a face-to-face interview, ask the individual each question on Form 2060, Part A, as the question is stated on the form. Then, ask further questions to gain a more complete understanding about the degree of the individual's ability or inability to carry out activities of daily living. Careful assessment of the individual reveals what he can do for himself, what he should continue to do for himself to maintain his current level of self-sufficiency, and what he cannot do for himself because of physical limitations and/or mental limitations. When conducting an assessment, use the following scale of disability and follow the detailed definitions of impairment levels found in the instructions for Form 2060, Part A.

0 = No impairment. The individual is able to conduct activities without difficulty and has no need for assistance.

1 = Minimal/mild impairment. The individual is able to conduct activities with minimal difficulty and needs minimal assistance.

2 = Extensive/severe impairment. The individual has extensive difficulty carrying out activities and needs

extensive assistance.

3 = Total impairment. The individual is completely unable to carry out any part of the activity.

To determine the severity of the individual's impairment, consider the following factors:

1. **Individual's Perception of the Impairment** — Does the individual view the impairment as a major or minor problem?
2. **Congruence** — Is the individual's response to a particular question consistent with the individual's response to other questions and also consistent with what has been observed?
3. **Individual History** — Probe for an understanding of the individual's history as it relates to the current situation and the individual's attitude about the severity of the impairment. For example, has the individual always kept a messy house and is not, therefore, concerned because he is unable to perform housekeeping tasks? Has the individual always eaten only one meal a day and is not, therefore, interested in eating more often? How has the impairment changed the individual's lifestyle?
4. **Individual's Right to Self-Determination versus Danger to Self** — Consider the consequence to the individual if he chooses not to take medications, bathe, adhere to a special diet, etc.
5. **Lack of Facilities** — Absence of facilities for bathing, laundry, telephone calls or meal preparation may indicate an impairment. The impairment and its degree will depend on the individual's accessibility to the facility, ability to use the facility and ability to make satisfactory accommodations in the absence of the facility.
6. **Adaptation** — If the individual has adapted his physical environment or clothing to the extent that he is able to function without assistance, the degree of impairment will be lessened, but the individual will still have an impairment.
   Note: Medication is not considered an adaptation to the individual's functioning in the same way a walker would be. The individual is not considered to have an impairment if the medication is working. The individual is rated on how he is functioning at the time of the interview, regardless of the status of taking medication.

The following chart provides a general guide for assessment. Whether the individual is taking medication, forgetting or refusing medication, or taking medication incorrectly, he is still assessed on his current level of functional ability.

Situation: The individual has problems with dizziness and balance, which could affect scoring on the transfer/ambulation and balance questions.

If the individual:	**then:**
is taking medication and has no problems with dizziness,	score 0 on impairment.
is taking medication but still has occasional episodes of dizziness,	score 1 on impairment.
is taking medication, but still has major problems with dizziness and balance,	score 2 on impairment.
has a prescribed medication, but is forgetting to take the medication or is taking the medication incorrectly,	the individual is still assessed based on his current level of functioning.

The case worker must clearly document the reason in situations where the task score on Form 2060 is clearly inconsistent with the amount of time allotted for that task. For example, a case reader may decide to rate Standard 10 unmet if an individual scores 1 on all Form 2060 tasks, yet the maximum amount of hours for each are purchased and case documentation does not explain the discrepancy.

2432 Scoring Persons Who Cannot Respond

Revision 17-1; Effective March 15, 2017

On some occasions, the case worker may need to assess small children, infants or individuals who are comatose or otherwise non-responsive. Use Form 2060, Needs Assessment Questionnaire and Task/Hour Guide, to conduct these assessments, even though the instrument may not seem to apply. Allow the caregiver to respond if the individual cannot do so. In scoring each item, use the caregiver's response, the case worker's observations and any knowledge the case worker may have about the individual from other sources.

2433 Determining Unmet Need in the Service Arrangement Column

Revision 17-1; Effective March 15, 2017

40 Texas Administrative Code §48.2907(b) — Regardless of a client's functional eligibility as determined by his score on the client needs assessment questionnaire he receives CCSE services only if he has an unmet need for those services.

Unmet need is defined as a requirement for assistance with activities of daily living that cannot be adequately met on an ongoing basis by friends, relatives, volunteers or other service agencies.

For any task listed on Form 2060, Needs Assessment Questionnaire and Task/Hour Guide, the Service Arrangement Column will determine if the individual has an unmet need in order to determine the individual's overall eligibility based on unmet need. Review questions 1 through 15 and ask the individual the following additional questions.

If the impairment score is "1" – Ask the individual if he is able to perform the task by himself, even though it may be difficult for him.

- If the answer is "Yes," enter "S" in the service arrangement.
- If the answer is "No," ask the individual who helps him with this task. If the individual states that a caregiver assists him, enter "C" for "Caregiver" in the service arrangement. List the caregiver's name, relationship and task on Form 2059-W, Summary of Individual's Need for Service Worksheet, if it is not already entered.
- If the individual states he receives help from another agency, enter "A" for "Other Agency" in the service arrangement. List the name of the agency on Form 2059-W.
- If the answer is "No" and the individual states he has no help from any source and needs help to perform the task, enter "P" for "Purchased" in the service arrangement.

If the impairment score is "2" or "3" – Ask the individual if he receives help with this task.

- If the answer is "Yes," ask the individual who helps him with the task. If the individual states a caregiver helps with the task, enter "C" for "Caregiver" in the service arrangement. List the caregiver's name, relationship and task on the worksheet, Form 2059-W, if it is not already entered.
- If the individual states he receives help from another agency, enter "A" for "Other Agency" in the service arrangement. List the name of the agency on Form 2059-W.
- If the answer is "No" and the individual states he has no help from any source and needs help to perform the task, enter "P" for "Purchased" in the service arrangement.

If the individual states he receives some help from others but it does not meet all of his needs for a specific task, enter "P/C." Document the part of the task performed by the caregiver in the "Tasks Performed" section on Form 2059-W.

2433.1 Assessment of the Caregiver

Revision 17-1; Effective March 15, 2017

For each task marked "C" on Form 2060, Needs Assessment Questionnaire and Task/Hour Guide, assess the capability, dependability, availability and willingness of the caregiver. Consider and discuss family and job responsibilities, as well as the physical demands of caregiving. For each task, determine by observation and by asking the applicant or caregiver the following questions:

1. Is the caregiver physically and mentally able to perform the task?
2. Is the caregiver dependable in performing the task on the required schedule?
3. Is the caregiver available at the time the individual needs the task performed (either scheduled or on demand)?
4. Is the caregiver willing to perform the task on a regular and ongoing basis?

It may be necessary to talk with the applicant's current caregiver in order to accurately assess his contribution to the applicant's care needs. If the caregiver cannot join the applicant for the initial face-to-face visit, get as much information as possible from the applicant and contact the caregiver by telephone to verify that the caregiver is willing to provide the tasks. Do not delay service initiation if the caregiver cannot be reached.

If, for any task, it appears the caregiver is not able to adequately meet the applicant's needs, discuss with the applicant if some or all of the task should be purchased. If the applicant states the caregiver is currently performing the task, but it is apparent from case worker observation that the task is not being adequately performed, discuss if the task should be purchased.

Be sensitive to any indications of abusive or neglectful behavior on the part of the caregiver and make a referral to Adult Protective Services, if necessary.

2433.2 Exploring Other Resources for Meeting the Applicant's Needs

Revision 17-1; Effective March 15, 2017

Explore other possibilities for resources with the individual. Ask if family members pay someone to help the individual and if the current assistance is adequate. Use observations about the caregiving arrangement to determine whether needed tasks are being adequately performed. If an individual's need for help with a particular task is being adequately met and the assistance can reasonably be expected to continue, do not authorize purchased services for that task. If the need for help with a particular task is not being met or is only partially met, ask the individual and family if there is anyone who would voluntarily provide the needed help. Explore the use of any identified volunteers. If voluntary help cannot be obtained, explore the use of community resources and consider service options from other groups or agencies. See Section 2535, Involvement of Volunteer Resources, and Section 2530, Other Resource Services, for possible resources to meet the individual's needs. If the individual's need for help cannot be met in any other way, enter "P" for the task on Form 2060, Needs Assessment Questionnaire and Task/Hour Guide. If Home Delivered Meals is the only service being purchased, complete the service arrangement column and do not allocate time on Form 2060.

If an individual's needs for help are now being met and the individual or family determines the present care arrangements cannot be continued, inform the individual or family that the individual may reapply for services when the current arrangement is discontinued. If, during the initial interview, the individual or his family knows the present care arrangements will discontinue within 30 calendar days, proceed with the application process.

Examples:

- An individual's sister, who is providing the care, has taken a job and will begin work on a specified date.
- A live-in relative, who is providing the care, plans to leave town on a certain date.
- A family member has been paying a caregiver but will soon be unable to continue because of new financial obligations, which will begin on a certain date.

If someone who has been paying for care intends to discontinue the arrangement on a specific date within 30 days, proceed with the application. Otherwise, offer to take an application at the time the care arrangement is discontinued. If someone will continue to purchase some of the care, determine if the applicant has an unmet need for any additional care. If someone is willing to pay for services only while the individual is on an interest list, this does not affect the individual's unmet need for services purchased by the Texas Health and Human Services Commission (HHSC). However, if someone is willing to pay for services after the individual comes off the interest list, there is no unmet need.

In some situations, a caregiver may quit employment to stay home and provide care for the applicant and is requesting to be the paid attendant. In this situation, the case worker must obtain verification that the individual quit employment within 30 days before or after the application date. The caregiver may be considered as a potential attendant. In the Service Arrangement column of Form 2060, note the tasks that the caregiver will voluntarily provide and those tasks that will be purchased. See Section 2513, Caregiver as the Paid Attendant, for additional information.

This policy also applies for ongoing cases in which a caregiver has been working full time and quits employment to stay home and provide care for the individual. The case worker must obtain verification that the individual quit employment within 30 days of the request for the change.

When the Service Arrangement Column of Form 2060 is completed, review the results to determine if the individual has an unmet need. If all responses are "S," "C" or "A," the individual has no unmet need and is not eligible for services. Advise the individual he is not eligible at this time and may reapply if his circumstances change. Be sure to adequately document this information in the Service Authorization System Wizards with the appropriate denial code and send the applicant Form 2065-A, Notification of Community Care Services.

If there are tasks marked "P" on Form 2060, continue to the Task/Hour Guide section.

2434 Support Score and Establishing Priority

Revision 17-1; Effective March 15, 2017

If an applicant for Primary Home Care (PHC), Family Care (FC) or Community Attendant Services (CAS) has a functional score of "3" and the service arrangement for a priority task (feeding, toileting, transfer, meal preparation) is a "P," then a support score must be entered for these tasks on Form 2060, Needs Assessment Questionnaire and Task/Hour Guide. Determine the likelihood of that task being done if the attendant does not show up during a normally scheduled service shift. Using the following scale, enter the score in the Form 2060 Support Score box by the appropriate item.

1 = It is **very likely** that the task would be done even if the attendant does not show up.
2 = The task will **probably** be done if the attendant does not show up.
3 = The task will **probably not** be done if the attendant does not show up.
4 = It is **very unlikely** that the task will be done if the attendant does not show up.

In determining this support score, do not consider caregivers as available if they would be at work or school, even if they could come to the individual's home if the attendant was not there. Do not enter a support score for an item if either the task is not purchased or the individual's score for that task is not "3."

If the support score is "4" on any of the priority tasks, then the individual will be designated as a priority individual. See Section 2540, Priority Status Individuals, for further information.

2440 Use of Form 2060, Part B, Task/Hour Guide, and Part C, Task/Minute and Subtask Guide

Revision 17-1; Effective March 15, 2017

For all personal attendant services (PAS) cases, the case worker uses Part B and Part C of Form 2060, Needs Assessment Questionnaire and Task/Hour Guide, to determine the quantity of purchased services needed by an individual.

The Part C, Task/Minute and Subtask Guide, provides a uniform approach in the authorization of services based on a minute range per task and impairment score. Each impairment score for each task has a minimum and maximum time that can be allotted. It is mandatory to follow the minute guideline and check the subtasks for each task as a way of documenting the type of assistance needed and to support the time allocated for that task. See the Form 2060 Instructions for complete directions for completing the form.

Form 2060, Pages 1-5, must be manually completed during the home visit initial assessment for an applicant who will receive PAS. Review the Task/Minute and Subtask Guide at each reassessment and initial the form. When there is a change in hours, either complete a new Form 2060 manually or update the current Part B and Part C.

Refer to Form 2060, Part C, for guidelines on the number of minutes to be allowed per task. The amount of time allowed for any particular task should be determined by taking into account:

- the amount of assistance the individual will usually need;
- the availability of anyone else to assist with the task;
- which specific subtasks (activities) need to be purchased;
- environmental/housing factors that may hinder (or facilitate) service delivery; and
- the individual's own unique circumstances.

Discuss fully with the individual each service task to determine whether he needs assistance with that task, how much time is required to perform each task, and how often each week the task must be performed. The total time allowed for each task must be within the minimum and maximum time limits for the impairment score, as indicated on Form 2060.

Negotiate service authorizations with individuals to reach an agreement about:

- the number of tasks and activities for which the individual needs assistance;
- how often the assistance is needed; and
- the amount of time needed by the provider to carry out those tasks and activities per week.

All appropriate subtasks must be checked to indicate the specific tasks the individual needs. An individual scoring a 2 or 3 may need all subtasks under the impairment score for 1 and additional subtasks under the impairment score of 2. The time allotted must be within the range for the impairment score.

Time outside the minute range (either above or below) may not be allotted without documented supervisory approval.

2440.1 Requesting Supervisory Approval for Time Outside the Minute Range

Revision 17-1; Effective March 15, 2017

In situations in which the individual has extenuating circumstances and requires a deviation in the time range, the case worker may request supervisory approval to authorize time above or below the minute range for the task and impairment score. The case worker must document the reason why the individual requires minutes outside the range for the task/impairment score level. The documentation is sent to the supervisor in writing or

electronic mail (email) and the supervisor must approve or disapprove in writing or by email. The documentation and the supervisor's response must be filed in the case record.

2441 Circumstances When Supervisory Approval is Not Required

Revision 17-1; Effective March 15, 2017

In some situations, the individual may have extenuating circumstances and a compelling reason that require subtasks in **a lesser impairment score** to be authorized for a task. The two situations in which the case worker may allot time for subtasks in a lesser impairment score without supervisory approval are:

- if the individual has extenuating circumstances and is requesting only subtasks in a lesser impairment score; or
- if the individual has a caregiver or other agency providing some of the subtasks.

The case worker documents the individual's extenuating circumstances and the reason tasks in a lesser impairment score are authorized, or documents the part of the task the caregiver or other agency provides.

2441.1 Exception for a Compelling Reason

Revision 17-1; Effective March 15, 2017

In some situations, an individual may request tasks not be performed for him even though he has an impairment and may not be able to perform the task for himself.

If an individual **has a compelling reason** for not wanting any of the subtasks under the appropriate impairment score, but only wants subtasks listed in a lower impairment score, the case worker must document the individual's request and allocate minutes in the minute range for the subtasks selected. The case worker must document the reason, and no supervisory approval is required.

Example: The individual scores a **2** on bathing. She needs assistance with drying. However, when discussing subtasks, she states she would like standby assistance for safety and drawing of water, all under the impairment score of **1**. She states her skin is very sensitive and she would **not** allow help with drying as she is afraid it would hurt her. The subtasks checked are all under the impairment score of **1**, so ten minutes is allowed. Documentation is required to explain the variance. No supervisory approval is required.

See Form 2060, Needs Assessment Questionnaire and Task/Hour Guide, and Instructions, for additional information.

2441.2 Exception for Assistance from a Caregiver or Other Agency

Revision 17-1; Effective March 15, 2017

If an individual has a caregiver or other agency performing part of a task and only subtasks in a lower impairment score are needed, the case worker must document the individual's request and allocate minutes in the minute range for the subtasks selected. The case worker must document the reason and the part of the task the caregiver or other agency performs. No supervisory approval is required.

Example: The individual scores a **2** for bathing, but only wants assistance with laying out supplies and drawing water because her daughter provides all hands-on assistance with the bathing task. The task is marked **P/C**. The subtasks under the impairment score of **1** are checked and ten minutes is allowed for the subtasks to be purchased. Documentation is required to explain the variance.

2441.3 Time Allocation for Companion Cases

Revision 17-1; Effective March 15, 2017

For companion cases, time allocated for general household tasks, including cleaning, shopping and meal preparation, is based on the companion minute range on Form 2060, Needs Assessment Questionnaire and Task/Hour Guide, rather than the individual range. Time is assigned per individual based on the individual's impairment score. Check the box(es) in the **Total Minutes Per Week** column for cleaning, meal preparation and/or shopping to indicate that time is authorized for these tasks to the companion case. In situations where there are more than two companions in the household, assign time based on the individual's impairment score using the companion minute ranges.

In situations where there are more than two individuals in the household, the case worker continues to use the companion minute range based on the individual's impairment score.

Example: On cleaning, Mr. Jones scores a **3** and Mrs. Jones scores a **1**. Mrs. Jones can do some light housekeeping, but due to her husband's incapacity, he needs all cleaning tasks performed in his area. Mrs. Jones is allowed the maximum of 45 minutes under impairment score **1** in the companion range. Mr. Jones is allowed the maximum of 180 minutes under impairment score **3** in the companion range.

See Form 2060 Instructions for additional examples and guidance on companion cases.

2442 Calculation of Time to be Authorized

Revision 17-1; Effective March 15, 2017

Use the following procedures to calculate the total amount of time needed each week.

1. Multiply the number of minutes needed to conduct each task by the number of times the task will be conducted each day to reach a daily total of minutes for each task. Times must be shown in five-minute increments. If necessary, round the time up to the next five-minute increment.

   Example: If an individual needs meal preparation twice a day and the meal preparation requires the maximum amount of time, multiply 30 minutes by two to reach a daily total of 60 minutes.
2. Multiply the daily total of minutes for each task by the number of days per week the attendant will conduct that task. Again, times must be shown in five-minute increments and rounded up to the next five-minute increment, if necessary.
3. Add the required weekly minutes for all tasks and divide the total by 60 minutes to determine the weekly total in hours.
4. Round the weekly number of hours to the next highest half unit to determine the number of units to be authorized. **Example:** If an individual needs 7 hours and 10 minutes of service each week, authorize 7.5 units of service. The number of hours must be correctly rounded up to ensure accurate authorization of services.

Use Form 2060, Needs Assessment Questionnaire and Task/Hour Guide, to calculate the hours of service to be purchased. The correct number of hours must be authorized on Form 2101, Authorization for Community Care Services. Write comments in the Service Authorization System Online (SASO) "Impairment Scoring" window in the Functional Wizard.

Tasks/services identified as needing to be purchased must be authorized on Form 2101. Tasks marked "P" in the "Service Arrangement" column of Form 2060 must also be marked on Form 2101. The meal preparation task may be marked "P" on Form 2060 and not marked on Form 2101, as long as the individual is receiving home-delivered meals. A separate Form 2101, authorizing meals, is sent to the home-delivered meals agency.

2443 Balancing Incentive Program, Level II Assessment

Revision 17-1; Effective March 15, 2017

The Balancing Incentive Program (BIP) provides additional Federal Matching Assistance Percentage (FMAP) funds to states that initiate reforms to increase nursing home diversions and access to non-institutional long-term services and supports. As part of the effort to increase access to additional federal funds and meet BIP requirements, the Texas Health and Human Services Commission (HHSC) administers the Level II Assessment to all individuals requesting or receiving Primary Home Care (PHC), Community Attendant Services (CAS) and Day Activity and Health Services (DAHS) Title XIX. The Level II Assessment consists of:

- Part A of the Functional Assessment of Form 2060, Needs Assessment Questionnaire and Task/Hour Guide; and
- Form 2060-B, Needs Assessment Addendum.

The BIP was created by the Affordable Care Act of 2010 and improves the state's ability to serve more individuals by increasing access to non-institutional long-term services and supports. The BIP allows states to adhere to the integration mandate of the Americans with Disabilities Act (ADA), as required by the *Olmstead* decision.

The case worker will complete the Level II Assessment, Form 2060-B, for initial assessments, annual reassessments and for a significant change request for a new service.

For changes in services, the case worker will complete:

- Form 2060, Part A, Functional Assessment, if applicable;
- Form 2060, Part B, Task/Hour Guide;
- Form 2060, Part C, Task/Minute and Subtask Guide; and
- Form 2060-B.

The following are examples of the forms that are completed when a request is made for a change in service:

Examples:

- Example A – An individual receiving CAS calls the case worker requesting transportation assistance. The case worker will complete Form 2060, Part A and Form 2060-B. Form 2060, Part B and Part C, would only need to be completed, if applicable. In reviewing the required forms, the individual is only requesting transportation and does not wish to have the service plan for his attendant care services changed. The case worker will send a referral for transportation only. No other action is required.
- Example B – An individual receiving CAS calls the case worker requesting home-delivered meals. The case worker will complete Form 2060, Part A, and Form 2060-B, and, if applicable, Form 2060 Part B and Part C. In reviewing the required forms, the case worker places the individual's name on the Home-Delivered Meals Interest List and also increases the time allotted for meal preparation for his attendant services. The case worker will complete the change per Section 2721.4, Revising the Service Plan, and Section 2721.6, Authorizing and Documenting Changes.

The case worker determines whether a referral is needed for HHSC services or non-HHSC services based on the information collected from Form 2060-B. The case worker discusses and obtains approval to make a referral with the individual to non-HHSC services. Referrals may include:

- Behavioral Health Services;
- Supported Employment/Employment Assistance;
- Transportation Assistance;
- assistance with instrumental activities of daily living; and
- assistance for other medical conditions not previously addressed.

The case worker documents the referrals made on behalf of the individual in Section III of Form 2060-B, including any need for referrals that were identified but refused by the individual. No data entry is required in the Service Authorization System Online (SASO) resulting from the completion of the Form 2060-B only.

The individual retains the right to participate in the development of his service plan and the right to refuse all or part of any services and to be informed of the likely consequences of such refusal, which include referral to non-HHSC services.

Identified needs for referrals agreed to by the individual are considered as requests for information and referral. The case worker makes use of applicable existing referral policy to assist the individual with the appropriate referral located in:

- Section 2422.7, Assessment of Social and Community Resources;
- Section 2530, Other Resource Services;
- Section 2535, Involvement of Volunteer Resources;
- Section 2743, Individuals Receiving Services through Local Authorities;
- Appendix XV, Services Available from Other State Agencies; and
- http://www.dshs.state.tx.us/sa/OSAR/, Outreach, Screening, Assessment and Referral Centers for Substance Abuse and Treatment Centers.

Referrals for behavioral health needs identified on Form 2060-B may be made to local mental health authorities using the local phone numbers available at: https://hhs.texas.gov/services/health/mental-health-substance-abuse.

2500, Service Planning

2510 Service Plan Development

Revision 17-1; Effective March 15, 2017

Program Standard: *Case workers must develop service plans that accurately authorize appropriate services for individuals based on individual needs, eligibility and priority level.*

After the completion of Form 2060, Needs Assessment Questionnaire and Task/Hour Guide, to assess the needs and unmet need of the individual, discuss service planning with the individual and/or his family members. Consider all possible resources that may be available through Community Care Services Eligibility (CCSE) services or other community resources. Evaluate if the individual is interested in receiving Home-Delivered Meals, Emergency Response Services or attending Day Activity and Health Services (DAHS) or other community centers. Be sure to review Form 2110, Community Care Intake, and address all services requested at the time of intake. Document any decisions made regarding the use of those services.

To the extent of their abilities, eligible individuals must be involved in the development of their service plans. Discuss service planning with an individual or his caregivers during the initial visit to his home. Whenever possible, complete service planning during the visit. If this is not possible, service planning may be completed after the home visit and after financial eligibility has been determined.

The discussion with the individual (and caregivers) should include the type of services that may be appropriate for purchase after unmet need has been addressed and determined. To maintain self-sufficiency and a level of independence, allow the individual the opportunity to continue performing tasks he prefers to do himself, even though they may be difficult for him. Explain to the individual that Texas Health and Human Services Commission (HHSC) programs are not designed to replace the care that caregivers now provide or are able and willing to provide over time. At the conclusion of the initial home visit, ensure that the individual fully understands exactly what HHSC may provide, the limitations of HHSC services and the importance of the existing caregiver arrangement to the development of a service plan.

The service plan should reflect consideration of all these factors:

- individual's existing problems that resulted in an application for CCSE services;
- individual's physical and mental health;
- individual's functional capacities for self care;
- individual's need for, or availability of, self-help or adaptive devices;
- existing caregivers and the specific amounts and types of assistance they give and can continue to give the individual;
- individual's home environment and available community resources;
- severity of the individual's medical and physical problems and the level of risk the problems cause;
- other HHSC services necessary to help the individual maintain self-sufficiency, including referral to Adult Protective Services when appropriate;
- additional services available in the individual's community (The 71st Texas Legislature passed Senate Bill 487 that requires, when appropriate to the individual's needs, the use of services provided by other state agencies. See Appendix XV, Services Available from Other State Agencies);
- services being provided to other individuals in the household;
- information secured from the individual's practitioner, friends or associates that may be necessary to develop a service plan suitable for the individual's needs;
- number of service units to be authorized and the rationale for the authorization;
- dates on which services are expected to begin; and
- any special monitoring or case management procedures to be followed.

Document service planning information on:

- Form 2110, Community Care Intake;
- Form 2059-W, Summary of Individual's Need for Service Worksheet, which is entered in the Service Authorization System for Form 2059, Summary of Client's Need for Service;
- Form 2101, Authorization for Community Care Services;
- Form 2060, Needs Assessment Questionnaire and Task/Hour Guide, which is entered in the Service Authorization System; and
- the case narrative.

2511 Caregiver Arrangements

Revision 17-1; Effective March 15, 2017

Discuss with the individual, and any family members or caregivers, that Community Care Services Eligibility (CCSE) services are not designed to replace the care family members and other caregivers now provide or are able and willing to provide over time. Explain that the existing caregiver arrangement is very important to the development of a service plan. If possible, confirm with the caregivers that they are able and willing to perform the tasks listed on Form 2060, Needs Assessment Questionnaire and Task/Hour Guide, that are marked "C" for caregiver. Be sure the individual and family members understand CCSE services are not intended to serve as a supplement to income. Decisions about service plans cannot be based upon the family's income or financial needs.

2512 Caregiver Support

Revision 17-1; Effective March 15, 2017

Caregiver support is defined as providing relief to a caregiver who provides the majority of the applicant's care or continual care for the applicant. This support is always provided by an attendant other than the applicant's regular caregiver. Caregiver support may be appropriate when the initial functional assessment results in no

unmet need, but the caregiver needs relief. The paid attendant will provide some of the tasks that the caregiver has been performing in order to provide relief.

Examples: Caregiving responsibilities prevent the individual's caregiver from leaving the house to conduct personal business or do the family shopping or the caregiver needs time away from his caregiving duties on a regular basis due to his health needs or for periods of rest due to the continual care.

Discuss with the caregiver how many days per week and what tasks may be needed to provide relief. Mark the appropriate items on Form 2060, Needs Assessment Questionnaire and Task/Hour Guide, with a "P," and document on each task in the comments section that support care is needed. Indicate on Form 2101, Authorization for Community Care Services, that the service plan is for caregiver support and list the caregiver as someone not to be hired. Support care may be temporary; if so, authorize it only for the time needed.

Note: There are a number of services provided through the local Area Agencies on Aging designed to support caregivers. Service availability varies by region. For service availability in a particular area, provide the toll-free telephone number, 1-800-252-9240, to persons interested in potential services.

2513 Caregiver as the Paid Attendant

Revision 17-1; Effective March 15, 2017

If the caregiver expresses an interest in being the paid attendant, inform the caregiver and applicant that the case worker cannot recommend to the provider who to hire as the paid attendant. It is the provider's responsibility to hire an attendant. Individuals who want a specific person to be the attendant should be encouraged to discuss this with provider staff. The case worker must explain to the potential attendant that he will be an employee of a home and community support services agency. He must be able to provide the tasks needed and work the complete specified schedule that will be developed by the provider and the applicant. His performance will be monitored and evaluated by the provider and the case worker.

The case worker must also explain to the applicant and the caregiver that the tasks listed as "C" (caregiver) under the service arrangement on Form 2060, Needs Assessment Questionnaire and Task/Hour Guide, must remain as caregiver tasks if the caregiver is hired as the paid attendant. Those tasks may not be purchased tasks as long as this caregiver is the paid attendant. If circumstances change and the attendant can no longer perform or is no longer willing to perform either the purchased tasks or the caregiver tasks, then the provider will be requested to hire a new attendant for those tasks. The caregiver will be designated as someone not to be hired for those tasks on Form 2101, Authorization for Community Care Services.

In situations as described in Section 2433, Determining Unmet Need in the Service Arrangement Column, where the caregiver has recently quit employment to provide care, note the tasks the caregiver will continue to provide voluntarily and mark them as "C" in the service arrangement column of Form 2060. Other needed tasks may be purchased.

For ongoing cases, a caregiver who had been listed as working full time and quits a job to provide care for the individual may also be considered as a potential attendant. The case worker must obtain verification the caregiver quit employment within 30 days prior to the requested change. Any tasks previously identified as performed by the caregiver may not be purchased tasks.

2514 Who Cannot Be Hired as the Paid Attendant

Revision 17-1; Effective March 15, 2017

The Texas Health and Human Services Commission (HHSC) is not responsible for selecting and hiring the individual's paid attendant. The only role HHSC plays in the hiring process is notifying the provider when a

particular person must **not** be hired.

Based on the following chart, if a person is identified as someone who must not be hired as the paid attendant, the case worker documents this information in the Comments section on the initial and all subsequent submissions of Form 2101, Authorization for Community Care Services. The case worker enters "Do Not Hire" and the name of the individual on the form. The following chart lists the persons who must not be hired and must be specified as "Do Not Hire."

Do Not Hire:	If the individual:
Abused, Neglected, Exploited, as Substantiated by Adult Protective Services	has abused, neglected or exploited the individual or others.
Parent of a Minor Child	is the legal or foster parent of the minor child receiving Community Attendant Services (CAS). There is no prohibition against hiring the parent of an adult child to be the paid attendant.
Spouse in Primary Home Care (PHC) or CAS	is the spouse of the PHC or CAS individual.
Unwilling Household Member	is **not** willing to help the individual with any of the tasks the individual needs.
Caregiver Support	caregiver needs relief from providing continuous care and the authorization for purchased services is based on caregiver support.
Individual Designated	is a particular person the applicant/individual does **not** want hired as the paid attendant.
Caregiver/Paid Attendant at Reassessment	is no longer able or willing to provide tasks previously designated as caregiver tasks. The caregiver may not be hired for those tasks. (See Section 2664, Redetermination of Unmet Need.)

Beyond these limitations, the case worker will not specify who cannot be hired as the paid attendant.

2520 Freedom of Choice

Revision 17-1; Effective March 15, 2017

2521 Freedom of Choice in Living Arrangements

Revision 17-1; Effective March 15, 2017

The applicant has freedom of choice when it comes to his living arrangements. Case workers are, however, required to consider if the individual's needs can be met in the environment chosen by applicant.

Consider the individual's ability to understand whether the services the Texas Health and Human Services Commission (HHSC) can provide are adequate to meet his needs. If the individual has medical needs that cannot be addressed with personal care and housekeeping services, or if the environment poses a threat to health and safety, discuss these issues with the individual and the responsible person.

Explain the limitations of Community Care Services Eligibility (CCSE) services and determine how the individual's special needs will be met. Explore the possibility of alternative living arrangements, if feasible and necessary. If the individual insists on remaining in his current residence, despite the fact that his needs may not be met in that environment, assess his mental capacity for making an informed choice and whether he

understands the consequences of that choice. See Section 2550, Identifying Individuals at Risk, for additional information.

If he is capable of informed consent, respect his choice and develop a service plan accordingly. If he appears incapable of making an informed choice or if abuse, neglect or exploitation is suspected, make a referral to Adult Protective Services.

2522 Service Delivery in Alternate Locations

Revision 17-1; Effective March 15, 2017

It is acceptable to allow delivery of services intended for the home environment to be provided in alternate locations. Hours diverted to provide services to the individual in alternate locations may not be added back into the service plan. For example, an individual's service authorization includes an hour each day for feeding/eating. The individual will also need this help during a visit to his sister who lives 20 miles away, which will add an additional hour to the time needed to provide this assistance. The individual opts to divert an hour allocated for laundry to feeding/eating in order to make the visit. This hour cannot be added back into the service plan in order to provide the amount of time required to do the laundry.

Do not anticipate the need for additional hours based on delivery of services outside the home and build that time into the service plan. It is also unacceptable for additional hours to be approved because the extra time expenditure does not allow the attendant enough time to do some other task. Hours authorized will be based solely on services that are assumed to be provided within the home environment.

When individuals receive services outside the home, providers must document in the comments section of Form 3054, Service Delivery Record, the specific services provided and in which location. Documentation must also be available to substantiate the individual requested these services. The actual transportation, as well as transportation cost, is the responsibility of the individual.

2523 Freedom of Choice in Agency Selection

Revision 17-1; Effective March 15, 2017

Once it appears that the applicant will meet the eligibility criteria for Community Care Services Eligibility (CCSE)services, offer the applicant the choice of selecting an agency contracted to deliver the requested service in the applicant's area. Either the applicant or the responsible person may make the selection. The selection must be documented on an agency choice list or other document in the case record.

If the applicant requests time to consider his choice or to consult with family members or other resources, leave the applicant a return envelope or make arrangements to pick up the agency choice list when the decision is made.

If the applicant refuses to make a choice from all of the contracted agencies in the service area, an agency may be selected for the applicant as a last resort. The selection is assigned from a regional agency rotation log. The rotation log must be maintained and kept up to date.

2530 Other Resource Services

Revision 17-1; Effective March 15, 2017

When determining unmet need, also identify and examine other agencies' services that the individual now receives or is eligible to receive. This prevents service duplication and ensures all service resources have been pursued. Refer to Appendix XV, Services Available from Other State Agencies, for information about services

that may benefit the individual. Document the use of other service resources on Form 2059-W, Summary of Individual's Need for Service Worksheet, Item 7. If possible, document information about other service resources in the Service Authorization System Online (SASO) "Support Assisting Client window". If that is not feasible, document using the WordPad function. See Section 7330, Narrative Documentation for SASO Wizards, for specific instructions.

All other services available to the individual must be considered and used before services are authorized by the Texas Health and Human Services Commission (HHSC).

2531 Veterans Affairs Aid and Attendance and Housebound Benefits

Revision 18-1; Effective June 15, 2018

Some individuals receive Aid and Attendance (A&A) or housebound benefits (HB) from Veterans Affairs (VA). These benefits must be considered the primary source of funds to pay for in-home services.

HHSC has an information sharing program between HHSC, the Texas Veterans Commission (TVC), and the Veterans Land Board (VLB) for the purposes of coordinating and collecting information about the use and analysis among state agencies of data received from the Public Assistance Reporting Information System (PARIS) VA match. The PARIS system is a federal-state partnership that provides states with detailed information and data to assist in maintaining program integrity and detecting improper payments.

This information sharing program helps identify HHSC recipients who may be eligible for veteran's benefits. HHSC creates a file of active recipients in the Supplemental Nutrition Assistance Program (SNAP), Temporary Assistance for Needy Families (TANF), and Medicaid programs. The file of active recipients is sent to the Defense Manpower Data Center (DMDC) on a quarterly basis for PARIS matching. DMDC returns a file of the matched recipients with veterans benefit information back to HHSC. This file is shared with the TVC and VLB to contact veterans who may be eligible for benefits or may be eligible for increased benefits and report those benefits back to HHSC.

HHSC will receive reports regarding A&A and HB that may affect the level of service currently authorized for personal attendant services (PAS). HHSC will verify the information on any individuals currently receiving Community Attendant Services (CAS), Primary Home Care (PHC), Family Care (FC), Home and Community-based Services (HCS), Community Living Assistance and Support Services (CLASS), Deaf Blind with Multiple Disabilities (DBMD), Texas Home Living (TxHmL), or STAR+PLUS Home and Community Based Services (HCBS) program. Since financial eligibility for CAS is determined by HHSC, any changes to eligibility status will be processed by HHSC.

Actions Required Upon Receipt of the Report

When the report is received, the region must distribute the information to the assigned case workers to contact the individual and verify the change in VA benefits. For individuals receiving A&A or HB, the case worker must discuss and document how the individual is using the benefits. A list of some of the items/services that can be purchased using A&A or HB funds includes:

- medical supplies;
- medical equipment;
- nursing services;
- therapy;
- skilled services;
- medications; or
- other medically necessary items.

If all the A&A or HB funds are being used to purchase items that help the individual remain independent and in the community, the case worker documents the information and no funds are applied to the service plan.

The individual may also use the funds to purchase:

- PAS; or
- home health aide services.

If the individual is using the funds to purchase PAS or home health aide services, this must be considered when developing the plan of care. For FC, PHC and CAS, this would be noted on Form 2060, Needs Assessment Questionnaire and Task/Hour Guide, as services delivered by another agency. If the individual is able to purchase all the services required, then there is no unmet need and the individual would not be eligible for PAS. If the individual can only purchase part of the required services, or if the funds are not used to purchase services, then the amount of the A&A or HB funds is applied to the purchase of attendant care per Form 2060 instructions.

If the funds are not used to purchase services that help the individual remain independent and in the community, apply the funds to the purchase of non-skilled attendant care. Calculate the number of hours of non-skilled attendant care that could be paid for with the individual's unused portion of A&A or HB. To do this, divide the unused portion of the monthly benefit by the maximum non-priority attendant care limit rate without regard to service authorized. If the person meets the priority status criteria, use the maximum priority status attendant care limit rate. Subtract the resulting amount from the person's authorization. If the number of hours required by the individual's unmet need is more than the benefits he can purchase, authorize the additional needed hours of PAS. Begin these calculations by using the actual number of hours required by the individual's unmet need, even if this exceeds the maximum HHSC can purchase.

These procedures apply only to the purchase of PAS. Do not reduce the amount of other services because the individual receives VA benefits.

Example: An individual whose unmet need requires 20 hours per week of PHC receives A&A benefits. Dividing the amount of this individual's A&A benefits by the current maximum attendant care limit rate yields 46 hours per month.

46 ÷ 4.33 = 10.6 hours per week

20 − 10.6 = 9.4 hours per week

This individual may be authorized 9 1/2 hours per week.

Explain this procedure to the individual. If the authorized hours cannot cover all of the purchased tasks that have been identified on Form 2060, then the individual and case worker should jointly decide which PAS tasks will be purchased and authorize only those tasks on Form 2101, Authorization for Community Care Services. Update the Service Arrangement Column of Form 2060 to match the tasks/hours authorized on Form 2101.

Reporting Requirements

Regional management will be required to report the amount of savings generated by the application of VA funds. For example, an individual requires 20 hours per week of PAS, but is now receiving A&A funds. The A&A funds can purchase five hours per week reducing the weekly service plan to 15 authorized hours per week. The cost of the five hours per week is reported as a savings for HHSC.

2532 Skilled Home Health Services

Revision 17-1; Effective March 15, 2017

If an individual is receiving or is eligible to receive Medicare/Medicaid skilled home health (SHH) attendant care services, the tasks provided or potentially provided must be considered as resources available to the individual when determining unmet need. SHH is ordered for an individual by his physician and is provided over a short period of time in conjunction with illness.

Use regional procedures to refer any applicant/individual who requests or appears in need of SHH services.

It is possible to authorize other Community Care Services Eligibility (CCSE) services, including personal attendant services (PAS), at the same time SHH attendant care is being utilized and both services may even be provided on the same day. If an individual is receiving SHH attendant care, determine exactly which services are being delivered and ensure they will not be duplicated by any CCSE service that may be needed by the individual. If SHH provided attendant care on some but not all of the days of a week, PAS may be authorized to provide attendant care on the other days, if needed. If SHH is providing all the personal care needed by the individual but housekeeping services are needed, Family Care or Home-Delivered Meals may be suitable options to consider.

If SHH is providing only skilled nursing services by a registered nurse or licensed vocational nurse, the service would not be duplicated by any other CCSE service that might be authorized, and is not a consideration in determining unmet need. Consider how long SHH has been in use and how long it will continue as the CCSE service plan is developed with the individual. If duplication of tasks would occur by authorizing a CCSE service, denial and/or a later revision to the service plan may be necessary.

2533 Hospice Services

Revision 17-1; Effective March 15, 2017

When Medicaid recipients elect the Medicaid Hospice Program, they waive their rights to other programs with Medicaid services related to treatment of the terminal illness(es). These waived services are limited to services also provided under Medicare. Recipients do not waive their rights to HHSC services unrelated to the treatment of the terminal illness(es). Therefore, participation of the individual in a hospice program does not affect eligibility for Community Care Services Eligibility (CCSE) programs.

If an individual chooses to receive hospice services and some of the individual's needs will not be adequately met by the hospice agency, assess the individual and authorize services for the individual's remaining needs on the same basis as any other individual.

For more detailed information about the Hospice program, see Section 2745, Individuals Who Need Hospice Services.

2534 Mutually Exclusive Services

Revision 17-1; Effective March 15, 2017

To determine unmet need for a particular Community Care Services Eligibility (CCSE) service, or determine if an individual can receive other HHSC services, ask the individual or family members if the individual is receiving another HHSC service. Check the Service Authorization System Online (SASO) and the Client Assignment and Registration (CARE) system for services and refer to Appendix XX, Mutually Exclusive Services. See Section 4000, Specific CCSE services.

2534.1 Services Through the Texas Home Living Waiver

Revision 18-1; Effective June 15, 2018

Due to the limited services provided through the Texas Home Living (TxHmL) waiver, some Community Care Services Eligibility (CCSE) services are not mutually exclusive and can be received at the same time as Texas Home Living (TxHmL). See Appendix XX, Mutually Exclusive Services

Case workers must review the services received through TxHmL before authorizing CCSE services to assure there is no duplication of tasks and there is an unmet need for the service. Individuals must meet the eligibility requirements for the specific CCSE service requested. The case worker must document there is no duplication.

2534.2 Targeted Case Management and Other HHSC Services or the STAR+PLUS Program

Revision 18-1; Effective June 15, 2018

Local Authorities (LAs) provide service coordination through Targeted Case Management (TCM) to Individuals with Intellectual and Developmental Disabilities (IDD) in the HHSC LA priority population.

TCM authorizations are processed through the Service Authorization System Online (SASO). TCM services are identified in SASO as Service Group 14, Service Code 12A or 12C. TCM can be authorized along with Home and Community-based Services (HCS), Texas Home Living (TxHmL) or as a general revenue (GR) service.

TCM and Other HHSC Services

Other HHSC waiver services (excluding HCS and TxHmL) are mutually exclusive with TCM. An individual receiving any of the following waiver programs cannot receive TCM at the same time:

- Community Living Assistance and Support Services (CLASS)
- Deaf Blind with Multiple Disabilities (DBMD) Waiver

If an individual on TCM is applying for one of these waivers, then the SASO Service Codes 40, 40A and 60, for assessments, pre-assessments and prescriptions, are the only service codes allowed to overlap with TCM service authorizations.

Since the waiver programs identified above provide more comprehensive services to the individual, they will take precedence over TCM services in order to maximize the benefit to the individual. The HHSC case worker must contact the LA to coordinate closing TCM for the waiver service to begin. Individuals receiving the STAR+PLUS program may receive TCM. These services are not mutually exclusive.

The Program for All-Inclusive Care for the Elderly (PACE) is not a waiver program but an all-inclusive program. PACE is mutually exclusive with all other services including TCM. See Appendix XX, Mutually Exclusive Services

TCM and Other HHSC Services

Determining whether an individual who receives TCM services can receive other HHSC services, including Community Care Services Eligibility (CCSE) services, depends on whether he is receiving TCM services through HCS, TxHmL or as a GR service.

Once the case worker identifies an individual is receiving TCM, he or a regional designee must check the Client Assignment and REgistration (CARE) system to determine if the individual is receiving HCS or TxHmL. If the individual is receiving HCS or TxHmL, the case worker must refer to Appendix XX, to determine if the individual can receive other HHSC services, as some services are mutually exclusive and others are not.

If the individual is receiving HCS or TxHmL and the requested CCSE service is mutually exclusive, then the case worker will contact the individual to allow a choice of services and document the individual's choice. If the individual elects to continue receiving HCS or TxHmL, then the request for CCSE services is denied. If the individual elects to receive the CCSE service, then the case worker must contact the LA to coordinate closing services.

If the individual is not receiving HCS or TxHmL and is receiving TCM as a GR service, then he can receive other CCSE services.

2535 Involvement of Volunteer Resources

Revision 17-1; Effective March 15, 2017

Some services needed by aged and disabled individuals may be performed by volunteers. When developing an individual's service plan, consider whether volunteers from community resources might meet some of the individual's needs.

Volunteer help may include:

- shopping and paying bills;
- transportation;
- telephone reassurance;
- friendly visits;
- recreation activities, such as reading aloud, games, help with sewing, knitting, art or other handwork; or
- writing letters.

Some organizations may contribute group volunteer efforts to accomplish major tasks for functionally disabled individuals. These tasks might include:

- clothing care and distribution;
- yard work;
- hauling trash;
- cleaning windows;
- critical home repair;
- construction of ramps and assistive devices in the house;
- provision of medical equipment or apparatus;
- facilitation of support groups for caregivers; and
- transportation for elderly and disabled shut-ins.

Before completing a plan that includes volunteers, discuss the idea fully with the individual and his family or caregiver. If an individual is served completely through planned volunteer services, the case worker may keep the case open as "case management only" as long as the individual's condition warrants regular monitoring. In the case narrative, document all volunteer resource development and use.

2536 Program of All-Inclusive Care for the Elderly

Revision 18-1; Effective June 15, 2018

The Program of All-Inclusive Care for the Elderly (PACE) is an all-inclusive program that provides all required services for an individual enrolled in the program.

PACE Referral

- PACE services are available in designated areas of El Paso, Lubbock and Amarillo/Canyon.
- Bienvivir Senior Health Services has two sites in El Paso that provide PACE services to participants. For referrals of potential participants, contact the Intake Department at Bienvivir Senior Health Services by telephone at 915-599-8812.
- The Basics at Jan Werner has a site in Amarillo that provides PACE services to participants. For referrals of potential participants, contact The Basics at Jan Werner by telephone at 806-374-5516.

PACE Eligibility

To be eligible for PACE, the individual must:

- be at least 55 years old;
- be certified as nursing home eligible;
- meet medical necessity criteria for nursing facility care;
- choose PACE services; and
- reside in a designated catchment area.

PACE Services

The PACE interdisciplinary team provides preventative, rehabilitative, curative and supportive services in day health centers, homes, hospitals and nursing homes. Required services include all Medicare and Medicaid covered services and any other services the multidisciplinary team identifies as a need.

The PACE Integrated Model of Care includes any health-related service needed, including but not limited to:

- in-home services;
- day health care;
- primary care;
- acute hospital care;
- lab, x-ray and ambulance services;
- skilled nursing facility care;
- medical specialty services;
- all in-patient and out-patient medical care;
- specialty services such as dentistry and podiatry;
- social services;
- meals; and
- transportation.

Texas Health and Human Services Commission (HHSC) intake screeners in the catchment areas must be aware of the PACE service and referral procedures for the service. Intake screeners must provide information about PACE to individuals during the intake and referral process when the individual requesting services is determined to be 55 years of age or older and resides in a PACE service area. Individuals in the PACE catchment areas may request services through the local HHSC intake office or through the PACE service site.

Since PACE is an all-inclusive program, it is mutually exclusive with all other HHSC programs and STAR+PLUS programs. See Appendix XX, Mutually Exclusive Services

2540 Priority Status

Revision 22-3; Effective Sept. 1, 2022

A recipient priority status is assigned if an applicant or recipient is unable to perform one or more of the following ‘priority tasks’ without hands-on assistance from another person:

- feeding, eating;
- toileting;
- transfer; or
- meal preparation.

Assign priority status if at least one priority task is purchased and the recipient's:

- functional score for that task is 3; and
- support score for that task is 4.

The service arrangement column on Form 2060, Needs Assessment Questionnaire and Task/Hour Guide, must be completed for each task in which the recipient's impairment score is 1, 2 or 3. The support score column must be completed for each priority tasks in which the recipient scores 3 and the service is being purchased.

If the attendant does not show up during a normally scheduled service shift, the recipient's health, safety or well-being may or may not be jeopardized. Always assess the potential impact on the recipient's health, safety or well-being when determining the effects of an attendant not providing service.

Do not designate a recipient as having priority status if the failure of the attendant to report to work would not result in any risk to the recipient's health, safety or well-being. If the recipient appears to be at risk (scores a 3 on a priority task with little or no caregiver support), document the reason(s) why a support score of 4 was not assigned.

In determining whether health, safety or well-being is endangered, consider the worst result that might follow from the attendant not providing service.

Example: A recipient may have a friend who visits daily when they can, but the friend is regularly out of town on business. Determine the consequences of the attendant not showing up on a day when the recipient's friend is out of town.

Consider each recipient's condition and situation. One recipient may be able to miss a meal during a scheduled service shift because their caregiver will be home later to prepare the meal. Another recipient may not be able to miss a scheduled meal without risk to their health because of their nutritional needs or no caregiver to prepare the meal later. Contact the regional nurse if assistance is needed in assessing the risk that would result from an attendant not working during a scheduled shift.

Priority recipients must be advised of the importance of being available in their homes during the hours designated in the service plan. Advise the recipient to contact the provider in advance if the recipient knows they will not be at home during a normally scheduled shift. If information is received that a priority recipient will not be home, inform the provider.

Inform a priority recipient that the provider may monitor the attendant's work performance by making frequent calls or home visits. If a priority recipient objects to this increased monitoring of the attendant, the recipient has the option of withdrawing from priority status.

For priority cases, note in the comments section of Form 2101, Authorization for Community Care Services, this is a priority case. Use verbal referral procedures for new priority recipients negotiated with the provider.

Providers may not allow a service interruption for a recipient designated as priority status unless the:

- service interruption is caused by suspension of services;
- recipient is not at home when the attendant is scheduled to provide services; or
- recipient requests that services not be provided on specific days.

The provider must notify CCSE staff within seven calendar days of a priority recipient not receiving scheduled services. This notification is for CCSE staff's information only; no response is required. Do not approve or

disapprove service interruptions for priority recipients.

Recipients can refuse priority status. If a recipient refuses priority status, document in the case record the recipient's decision and the reason for it.

Because the unit rate for priority recipients is higher than the rate for non-priority, the maximum allowable service authorization is less for priority recipients. A priority recipient receiving the maximum hours per week may not be able to receive another Community Care Services Eligibility service for which they may be eligible. This could exceed the total expenditures allowed by the average daily nursing facility rate. A priority recipient can exercise the option to receive less than the maximum hours in order to receive another needed service or they can decline priority status. CCSE staff must give the recipient the choice and explain the options, including the advantages or disadvantages of each. Document the recipient's decision in the case record.

Related Policy

Support Score and Establishing Priority, 2534
Priority Status Individuals, 2540
Negotiated Referrals, 2631
Priority Status Determination, 4624
Suspension of Services and Interdisciplinary Team Procedures, 4677
Cost Limit for Purchased Services, Appendix II

2550 Identifying Individuals at Risk

Revision 17-1; Effective March 15, 2017

An individual whose unmet medical or functional need constitutes a potential hazard to his health or safety may need individualized case management and monitoring procedures to minimize immediate dangers and to prevent deterioration of his condition. The case worker may identify the unique problems of these individuals at the time of assessment and reassessment, or regional nurses may note them during utilization review visits. Provider staff may also alert the case worker. Address these problems in the individual's service plan and document the information on Form 2060, Needs Assessment Questionnaire and Task/Hour Guide, or on Form 2059-W, Summary of Individual's Need for Service Worksheet. This information is entered into Form 2059, Summary of Client's Need for Service, in the Service Authorization System. Consult with the unit supervisor and the regional nurse about threats to the individual's health and safety and about unmet medical and functional need issues. Use a team approach to develop service and monitoring plans whenever necessary and feasible.

A "critical level of risk" exists when an individual has certain medical, physical and social characteristics that endanger his health and safety in his current living arrangement. Factors that contribute to critical risk are the individual's level of functional impairment, his medical condition, the quality and strength of his caregiver arrangement, and the physical and social conditions of his immediate environment.

The following characteristics are indicators of potential critical-risk situations. If two or more of these are present in an individual or in his situation, the case worker must decide whether he should be handled as an individual at risk.

- The individual has a score of 40 or higher on Form 2060.
- No caregiver is available to provide needed assistance or the individual's caregiver may:
  - be unable or unwilling to provide the necessary care; or
  - exhibit abusive, neglectful behavior.
- The individual may not have sufficient mental clarity to make an informed choice and understand the consequences of that choice (scores of 2 or 3 on Item 23, Form 2060).
- The individual may be immobile or nonambulatory or may need total assistance with feeding, toileting or medication and exhibit inability to maintain his personal safety.

- The individual may have complex health problems that create the need for skilled nursing assistance with personal care tasks, specialized technical skills in daily management of personal care or total assistance with several personal care tasks.
- The individual's home may be insufficient to provide a safe environment.

Document the critical-risk decision and the reasons for it on Form 2084, Risk Management Team Meeting Summary, and in the case narrative if more space is needed.

2551 Case Worker Actions for Individuals at Risk

Revision 18-2; Effective November 19, 2018

The case worker must discuss the individual's needs and the critical conditions with the unit supervisor and any other person who may have identified the problems. The case worker and unit supervisor determine whether a risk management team meeting is necessary. If necessary, the case worker will:

- organize and coordinate a team meeting. Include, as needed, the provider supervisor, the unit supervisor and the regional nurse. If the situation indicates possible abuse, neglect or exploitation, report this to Adult Protective Services staff at the Department of Family and Protective Services.
- discuss with the team the specific circumstances that place the individual at risk, the options for dealing with those circumstances and the individual's capacity to consent. Determine whether a team visit to the individual's home is necessary.
- discuss and agree on how often and by whom monitoring contacts will be made. Document the monitoring plan in the case narrative or according to regional requirements.
- use information from team members and document the individual's circumstances or condition on Form 2084, Risk Management Team Meeting Summary. Have available team members sign the form. Keep the original in the case record and provide copies to team members.
- coordinate the team visit to the individual's home, if necessary. (All team members may not need to attend.) Discuss with the individual, his family and caregiver:
    - specific circumstances that place the individual at risk,
    - options for dealing with those circumstances, and
    - the proposed monitoring plan and the limitations of Community Care Services Eligibility (CCSE) services.
- discuss Attachment 2307-A, Family Care, Community Attendant Services and Primary Home Care Rights and Responsibilities, with the individual, his family members and caregivers. Make certain they understand the proposed service plan and the limitations of CCSE services. If the individual has not previously signed Form 2307, Rights and Responsibilities, have him, a family member or caregiver sign the form. If no one is willing to sign the form, record the refusal on the form and file it in the case record.
- monitor the individual according to the monitoring plan, documenting contacts in the case narrative until the circumstances or problems that caused the individual to be at critical risk are as stabilized as possible, or until the individual's circumstances or degree of risk changes. Coordinate monitoring contacts with provider staff and with the regional nurse.
- conduct functional reassessments every 12 months, or more often if needed, depending on the individual's situation or as indicated in the monitoring plan.

If the team members disagree about whether an individual is at risk, the person who first identified the critical-risk indicators should document in the case record the:

- individual's situation that puts him at risk;
- notification of other appropriate parties, including the case worker's supervisor; and
- responses to the notification.

If service plan disagreements cannot be resolved through team discussions, the unit supervisor consults with the lead regional nurse and, if necessary, the program director. Any difficulties with providers that cannot be

resolved through discussion should be reported to the contract manager. If the problem cannot be resolved in the discussion process, the regional director makes the final decision.

If, during the service planning process, staff become aware the individual's mental and physical health needs are not likely to be adequately met by authorized HHSC services, inform the individual and his family about alternative living arrangements and nursing home care, if appropriate. Document this conference and the individual's response in the case narrative or on Form 2084. The individual and his family decide whether he is to remain in his present living arrangement, using the available services. The individual is free to refuse any or all services offered.

2600, Authorizing and Reassessing Services

2610 Application Processing and Notification

Revision 17-1; Effective March 15, 2017

40 Texas Administrative Code §48.3901(d) — Eligibility for CCSE services for income-eligible applicants is determined within 30 calendar days after a signed application is received. For categorically-eligible applicants, eligibility must be determined within 30 calendar days after either the consumer's assessment or face-to-face contact with the worker, whichever occurs first. If the applicant withdraws from the program before an assessment is completed or a face-to-face interview is conducted, no further action is necessary.

2611 Processing Time Frames

Revision 17-1; Effective March 15, 2017

Program Standard: *The case worker is required to determine eligibility for Community Care Services Eligibility (CCSE) services for income-eligible applicants as soon as possible, but within 30 calendar days after a signed application is received. The case worker must determine eligibility for categorically eligible applicants as soon as possible, but within 30 calendar days after either the individual's assessment or face-to-face contact with the case worker, whichever occurs first.*

This standard is applied to all applications, except for Community Attendant Services (CAS), using the date shown in "Date Eligibility Rules Processed" on the Service Authorization System Online Wizards (SASOW) Form 2064, Eligibility Worksheet, as the end point of measurement. The 30-day processing deadline cannot be used to unnecessarily delay a decision if all information is available before the 30th calendar day.

Proceed with the eligibility determination process if the individual fails to cooperate but has received facility-initiated Day Activity and Health Services (DAHS) as a Medicaid individual. See the procedures in Section 4231.2, Intake Response.

2611.1 Processing Time Frames for Community Attendant Services

Revision 17-1; Effective March 15, 2017

Applications for Community Attendant Services (CAS) must be referred to Medicaid for the Elderly and People with Disabilities (MEPD) staff for a financial eligibility determination. Because the MEPD process can take up to 45 days for regular referrals and 90 days if a disability determination is required, this may delay Community Care Services Eligibility (CCSE) certification beyond the 30-day time frame.

MEPD will notify the Texas Health and Human Services Commission (HHSC) case worker of the eligibility decision through the MEPD to HHS Communication Tool. However, if a decision is not received, the HHSC

case worker must check the Texas Integrated and Eligibility Redesign System (TIERS) for an MEPD eligibility decision on or before the 25th day from the application date and perform weekly checks until the eligibility decision is received. The TIERS checks must be documented in the case record.

When the eligibility decision notification is received either through TIERS or the MEPD to HHS Communication Tool, the case worker has **seven** business days to:

- complete data entry in the Service Authorization System Online Wizards (SASOW); and
- send the referral packet to the Home and Community Support Services Agency (HCSSA) to begin pre-initiation activities.

The seven business days are measured from the date HHSC receives the eligibility decision from MEPD or the date eligibility is verified through TIERS. The case worker must print a copy of the eligibility notice or TIERS screen and file it in the case record.

The HHSC case worker must advise MEPD **only** if the applicant is not approved for CAS (i.e., no practitioner's statement or other circumstances preventing services delivery). In this circumstance, the case worker must send Form H1746-A, MEPD Referral Cover Sheet, to MEPD within two business days of determining the individual is not eligible for CAS, advising that the applicant has not met the functional eligibility requirements. Form H1746-A is sent to MEPD at the same time Form 2065-A, Notification of Community Care Services, is sent to the individual notifying him of CAS ineligibility.

The case worker is not required to notify MEPD when CAS services are authorized.

See Section 4653, Referral to the Provider, and Section 4660, Service Authorization, for additional procedures for authorizing CAS services.

Case workers always have seven business days after confirmation of MEPD eligibility to send the referral to the provider. This applies even when verification of MEPD certification is received near the end of the 30-day period allowed for completing CCSE applications.

2612 Notification of Eligibility Decision

Revision 17-1; Effective March 15, 2017

An applicant/individual certified for one Community Care Services Eligibility (CCSE) service but determined ineligible for another must be notified in writing of both decisions. An applicant/individual certified for personal attendant services and/or Home-Delivered Meals must also be notified in writing of the units per week he is eligible to receive services. If certified for Day Activity and Health Services (DAHS), the applicant/individual must be notified in writing of the number of days per week the DAHS authorization covers. The written notice for all services must contain the case worker's name, telephone number and appeal procedures.

When notifying the applicant of eligibility, specify on Form 2065-A, Notification of Community Care Services:

- the CCSE services for which the applicant is eligible or ineligible, and
- if determined eligible:
    - the number of hours of services the applicant is authorized to receive or the number of days or half days the applicant is authorized to attend a DAHS facility;
    - if applicable, that the Family Care or Primary Home Care applicant is eligible for priority status; and
    - the initial and ongoing copayments the Residential Care individual is to pay to the facility.

The case worker may notify an individual verbally of continued eligibility if the individual continues to qualify for the same service(s) and the number of hours/units of service remains the same. Document in the individual's

case record the date the case worker verbally informed the individual of his continued eligibility.

See Section 2662, Redetermination of Financial Eligibility, and Section 2660, Reassessments and Recertification Procedures, for time limits that apply when eligibility is redetermined.

2613 Case Record Documentation

Revision 21-4; Effective December 1, 2021

To document the eligibility decision, the applicant's case record must contain signed and dated copies of the following forms:

- Form 2064, Eligibility Worksheet, except if;
  - the application is denied before a financial eligibility determination is made; and
- Form 2060, Needs Assessment Questionnaire and Task/Hour Guide, except if the;
  - applicant requested only Day Activity and Health Services (DAHS), which does not require a Form 2060 score;
  - applicant withdrew the application before the case worker completed Form 2060;
  - application is denied for a reason other than:
    - no unmet need;
    - insufficient functional impairment; or
    - low hours for Family Care or Primary Home Care.

Note: Ensure each person enrolled in a Title XX program who is not categorically financially eligible receives a privacy notice, Form 0401, Notice of Privacy Practices or Form 0403, Explanation to Health Information Privacy Rights, as appropriate.

Related Policy

Privacy Notice, 1147

2620 Service Authorizations

Revision 21-2; Effective June 1, 2021

After developing the service plan with an eligible person, enter information in the Service Authorization System Online Wizards (SASOW) to authorize services.

Service plans may include one or more purchased services. If authorizing more than one service, ensure the tasks are not duplicative and the service combinations do not exceed the allowable costs specified in Appendix II, Cost Limit for Purchased Services.

Example: Before authorizing 10 units of Day Activity and Health Services (DAHS) per week for a person who will also be receiving an in-home service, determine if it is feasible for the person to take part in DAHS five full days per week.

Based on the urgency of the person's need, negotiate with the provider for the earliest possible date that services can begin. Remember that services can and may need to begin on the weekend if discharging a person from a hospital or other institution on a Friday afternoon and needs services immediately. Enter the negotiated beginning date of coverage.

Use the comments section of Form 2101, Authorization for Community Care Services, to give specific instructions to the provider about the person's service arrangement. These include the number of days the person

requests services, specific service schedules that are required or strongly preferred by the person, specific instructions about unique personal problems or the person's home, or information about people who should not be hired as the paid attendant.

For all personal attendant services (PAS), send the provider the initial packet which must include a cover sheet, the Long-term Care Services Intake System (NTK) generated Form 2110, Community Care Intake, and a copy of the following SASOW generated forms:

- Form 2059, Summary of Client's Need for Service;
- Provider Referral Supplement;
- Form 2060, Needs Assessment Questionnaire and Task/Hour Guide;
- Task/Hour Guide; and
- Form 2101, Authorization for Community Care Services.

Note: In the SASOW, the following forms are generated as two forms:

- Form 2059 is generated as Form 2059 and the Provider Referral Supplement.
- Form 2060 is generated as Form 2060 and the Task/Hour Guide.

For Family Care, the Form 2101 is an authorization to begin services.

For CAS and PHC, the Form 2101 is a referral and authorization for services is left pending for receipt of Form 3052, Practitioner's Statement of Medical Need.

Providers must follow the instructions on Form 2101. If a provider does not, try to resolve the problem through discussion with the provider's supervisors. If this fails, document and report the problem to your supervisor and follow the procedures specified in Section 2700, Service Monitoring, Changes and Transfers.

Related Policy

Content of Referral Packets, Appendix XIII

2630 Referrals to the Provider

Revision 17-1; Effective March 15, 2017

Refer to Section 4000, Specific CCSE Services, for specific procedures for each service for sending referrals to providers. See Appendix XIII, Content of Referral Packets, for referral-packet contents sent to providers for each service.

2631 Negotiated Referrals

Revision 17-11; Effective November 20, 2017

Program Standard: *Individuals must be referred no later than the next business day after the day the individual is visited and/or it is determined that a negotiated verbal referral is necessary. Form 2101, Authorization for Community Care Services, must be sent within five business days from the date the individual was determined eligible for a negotiated verbal referral. Use the comment section of the form to document verbal referrals, dates and other relevant information. The case worker must document in the case file the date Form 2101 was sent to the provider either in the narrative or by including the fax confirmation.*

Regardless of the response criteria established for the applicant at intake, the case worker must reassess the individual's need for service initiation during the assessment process. In particular, assess the continued

provision of any assistance with the individual's personal care needs by individuals and/or other providers.

If it is determined that the individual's unmet needs for personal care are, or will be, such that services must begin sooner than the time usually required when using the routine written referral process, contact the provider and negotiate a start date according to the individual's need for service initiation. The need for a verbal referral will vary from individual to individual. Consult with the unit supervisor if an individual's particular circumstances are such that it is uncertain whether to use the negotiated referral process.

2632 Routine Referrals

Revision 17-11; Effective November 20, 2017

Program Standard: *For applicants who do not require negotiated referrals, authorize services by sending Form 2101, Authorization for Community Care Services, within five business days from the date the applicant is determined eligible. The case worker must document in the case file the date Form 2101 was sent to the provider either in the narrative or by including the fax confirmation.*

If a provider is operating at capacity, or if all budgeted service slots are filled when an eligible individual is referred for services, enter the individual's name on the appropriate interest list. Individuals must be served as indicated in Section 2230, Interest List Procedures. For services other than Day Activity and Health Services (DAHS), Community Attendant Services (CAS) and Primary Home Care (PHC), the provider must return Form 2101 by the 21st calendar day from the date of the referral. If Form 2101 or some other kind of notification is not received, contact the provider to find out the reason for the delay and the status of the referral.

If the provider is unable or fails to provide services within the negotiated time, refer the individual to another provider. If another provider cannot provide the services as needed, resolve the problem through conference with the supervisor. For special referral procedures for PHC, CAS and DAHS, see Section 4000, Specific CCSE Services.

2640 Provider Requirements for Hiring a Paid Attendant

Revision 20-3; Effective September 1, 2020

Criminal background checks are required for all facilities and service providers who provide care to the aged and disabled. Except in emergency situations, providers are required to obtain a criminal history check before offering permanent employment to unlicensed employees having direct contact with recipients who receive:

- Day Activity and Health Services;
- Residential Care;
- Primary Home Care;
- Adult Foster Care; or
- Client-Managed Attendant Care.

A person must be barred from employment if they have been convicted of a criminal offense where an administrative review is not available. A person may request an administrative review for some criminal offenses that could bar employment.

If asked by anyone, including the recipient, about the results of the criminal history check, explain that:

- all providers must conduct criminal history checks on attendants;
- the Texas Health and Human Services Commission (HHSC) is monitoring compliance with the law; and
- confidentiality requirements prevent sharing information obtained as a result of a criminal history check with anyone except the employee.

2650 Changes in Service Plans

Revision 17-1; Effective March 15, 2017

2651 Disagreements about Service Plans

Revision 17-1; Effective March 15, 2017

If a disagreement arises between provider staff and Texas Health and Human Services Commission (HHSC) staff about an individual's service plan, resolve the problem through discussion and negotiation. Use an interdisciplinary meeting, if necessary. Ensure that services are not delayed unnecessarily because of these disagreements.

HHSC regional nurses make final decisions in disagreements with providers about an individual's medical need for Community Attendant Services and Day Activity and Health Services.

In all other instances, the Community Care Services Eligibility (CCSE) supervisor attempts to resolve the disagreement with the provider's supervisor. If supervisory staff of both providers are unable to resolve the disagreement, the CCSE program manager resolves the disagreement.

2652 Changing the Service Schedule Between Reassessments

Revision 22-3; Effective Sept. 1, 2022

Use the chart below to determine which changes must be included on Form 2101, Authorization for Community Care Services, if a schedule change results in a change in hours or priority status.

Type of Recipient	Specific Instructions
Ongoing Primary Home Care or Community Attendant Services with chronic medical conditions, and transfer case	Specify the effective date as the beginning date of the service plan change on Form 2101, Item 4. If the change results in: • an increase in hours, the "Begin" date on Form 2101 must be at least seven days from the Form 2101 date, unless another date is negotiated; or • a decrease in hours, the "Begin" date on Form 2101 must be at least 12 days from the Form 2101 date. **Note:** For a decrease in hours, the "Begin" date on Form 2101 must match the effective date on Form 2065-A, Notification of Community Care Services.

Type of Recipient	Specific Instructions
Community Attendant Services	If a change is being conducted with an annual reassessment, enter the "Begin" date as indicated below and leave the authorization "Pending." The HHSC regional nurse will authorize Form 2101. If a decrease in service is being implemented between assessment periods, the "Begin" date should be 12 days in the future to allow advance notice of the reduction in service. The "Begin" date must match the effective date on Form 2065-A. For an increase in hours, the "Begin" date should be dated seven days in the future to allow the provider time to implement the change, unless a different date has been negotiated.
Family Care and Family Care transfer case	For a decrease in hours the "Begin" date should be 12 days in the future to allow advance notice of the reduction in service. For an increase in hours, the "Begin" date should be dated seven days in the future to allow the provider time to implement the change, unless a different date has been negotiated.
Primary Home Care, Community Attendant Services or Family Care	Transfer to Priority Status: Use verbal referral procedures for new priority recipients.

Complete Form 2067, Case Information, for personal attendant services for all other changes not related to a change in hours.

Related Policy

Form 2101 Coverage Dates for Title XIX Services, Appendix XXIII

2653 Provider Flexibility

Revision 17-1; Effective March 15, 2017

Providers are, as much as possible, expected to follow instructions given on Form 2101, Authorization for Community Care Services. However, there are times when changes in tasks or schedules will be necessary in order to meet the individual's needs. In these situations, it is not necessary for the provider to notify the case worker as long as the units delivered and billed for a calendar month do not exceed 4.33 times the adjusted weekly hours identified on Form 2060, Needs Assessment Questionnaire and Task/Hour Guide.

Example – An individual who regularly receives 15 hours of service per week is sick for two days and declines services due to illness. During those two days, a total of five hours of personal care services would have been delivered had the individual been able to receive services. Because the individual may have an increased need for services following the illness, those five hours may be made up if it would be to the benefit of the individual. Because the number of hours delivered does not exceed the number of hours authorized, the provider does not need to notify the case worker.

This ongoing flexibility is intended to allow services to meet the individual's needs, considering his desires and changes in his condition. The flexibility is not intended to be for the convenience of the provider or to be applied

retroactively to justify an attendant absence or interruption of services.

If a provider makes changes to tasks/schedules inappropriately or against the individual's wishes, try to resolve the problem through discussions with a provider supervisor. If this fails, report the problem to the case worker's supervisor and follow procedures specified in Section 2700, Service Monitoring, Changes and Transfers.

2660 Reassessments and Recertification Procedures

Revision 18-1; Effective June 15, 2018

Conduct reassessments and (if applicable) referrals of individuals to Community Care Services Eligibility (CCSE) services within:

- 24 months of the last financial redetermination, and
- 12 months of the last functional assessment.

Annual reassessments are required for all CCSE services. See Section 2663.1, Annual Home Visit Required for Individuals Receiving PAS, and Section 2663.2, Determining When a Home Visit is Necessary for Other Services, to determine if a home visit is required for the reassessment.

When the reassessment is conducted in the individual's home, the case worker must schedule the visit with the individual or his authorized representative at a time that is convenient to the individual. Schedule the appointment by telephone or in writing using Form 2068, Application, Redetermination or Monitoring for Community Care Services. If the appointment cannot be kept for some reason, inform the individual or his authorized representative in advance that the appointment will have to be rescheduled. Do not visit the individual without advance notice of the visit.

During the reassessment, the case worker must:

- redetermine functional eligibility on Form 2060, Needs Assessment Questionnaire and Task/Hour Guide, as required by the specific program;
- redetermine unmet need, as outlined in Section 2433, Determining Unmet Need in the Service Arrangement Column;
- present the Consumer Directed Services (CDS) option and have the individual sign Form 1581, Consumer Directed Services (CDS) Option Overview; and
- present Form H0025, HHSC Application for Voter Registration, and offer the opportunity to register to vote

To comply with the National Voter Registration Act of 1993, the individual must be offered the opportunity to register to vote at the time of application and at each annual redetermination. Provide assistance to any individual who requests assistance in completing Form H0025, Review Form H0025 for completeness in the individual's presence. The individual may:

- mail Form H0025; or
- return the form to the case worker's office for appropriate mailing to the county registrar's office.

2661 Individual Unavailable for Reassessment

Revision 17-1; Effective March 15, 2017

In some situations, the case worker will use his judgment to determine how long a case should remain open when the individual is unavailable for a reassessment. As a general rule, if the individual continues to be unavailable for more than 30 days, it should be determined if the unavailability is temporary. If an individual is repeatedly unavailable after an appointment has been scheduled, refer to the procedures in Section 2830, Refusal

to Comply with Service Delivery Provisions. If the individual is unavailable because of temporary nursing home admission, use the time limits and procedures in Section 2822, Service Suspension by Case Workers.

2661.1 Delay in Home Visits Due to Individual Illness

Revision 17-1; Effective March 15, 2017

While it is important that required home visits are performed on a timely basis, due to the increase in serious transmittable diseases in the general population, there may be circumstances that could place staff at risk for contracting contagious illnesses.

In order to ensure the health and welfare of staff members who could come in contact with individuals reporting a contagious illness, case workers may delay home visits under the following circumstances.

If a case worker contacts an applicant/individual to schedule a home visit (initial, reassessment or monitoring visit) and the individual states he has a contagious illness such as influenza, the case worker must document the contact and the reason for the delay of the home visit, including the stated illness. If possible, the case worker should schedule a future date for the visit when the individual thinks he will be better. If unable to schedule the visit for a future date, the case worker must contact the individual at least weekly until the home visit can be made. Each contact must be documented in the case record. This documentation will be considered as an acceptable reason for delaying a required home visit.

2662 Redetermination of Financial Eligibility

Revision 18-1; Effective June 15, 2018

Program Standard: *The case worker must redetermine financial eligibility within 24 months of the previous determination of financial eligibility.*

The financial reassessment must be completed by the last day of the 24th calendar month from the previous financial redetermination. To redetermine financial eligibility for income-eligible individuals, use the policies and procedures in Section 3000, Eligibility for Services. The case worker must:

- compare income and resources reported this year with what was previously reported;
- discuss with the individual any discrepancies between the two; and
- verify the existence and amounts of new income or resources if these additional assets bring the individual within proximity to eligibility limits.

Case workers must be diligent in ensuring that individuals receiving personal attendant services (PAS) are served by Title XIX PAS whenever possible. If the financial situation of an ongoing Family Care (FC) individual has changed in a way that might make him eligible for Community Attendant Services (CAS), a referral should be made to Medicaid for the Elderly and People with Disabilities (MEPD) at the next financial reassessment

Example: An FC individual was denied CAS eligibility at the time of application because of resources that exceeded the $2,000 eligibility limit. However, the individual now reports a total of $1,200 in resources and all other CAS eligibility criteria (for example, a need for a personal care task) are met. At the financial reassessment, a referral to MEPD must be made.

2662.1 Financial Reassessments for Community Attendant Services (CAS)

Revision 21-3; Effective September 1, 2021

MEPD staff must redetermine financial eligibility for CAS annually.

Renewal packets are mailed 60-90 days prior to the annual renewal date. Complete and return Form H1200, Application for Assistance – Your Texas Benefits, along with any required verification documents, within 30 days. If Form H1200 and the required verification are not received by the due date, benefits will be denied.

During regular monitoring visits, remind CAS recipients of the importance of completing and returning the renewal form within the 30-day timeframe so they can continue to receive services. Ensure recipients are aware they can complete an annual renewal online through YourTexasBenefits.com or over the phone by calling 211.

Some CAS recipients may receive Form H1200-SR, Streamlined Redetermination for Medicaid for the Elderly and People with Disabilities, instead of Form H1200. The cover letter for Form H1200-SR will advise the recipient that no action is needed if there are no changes to the reported information and the renewal form does not need to be returned.

Recipients who are receiving CAS and SNAP or TANF benefits will also receive Form H1010, Texas Works Application for Assistance - Your Texas Benefits. Remind CAS recipients that, in addition to completing Form H1200 to renew CAS benefits, Form H1010 must be completed and returned to continue to receive SNAP or TANF benefits.

If verification of ongoing functional eligibility is requested by MEPD at the annual redetermination, send a copy of the Service Authorization System Online (SASO) Service Authorization screenshot to show the recipient remains active on CAS. Use Form H1746-A, MEPD Referral Cover Sheet, to fax the information to the Document Processing Center (DPC).

Related Policy

Guidelines for Completing Form H1746-A. MEPD Referral Cover Sheet, Appendix V

2663 Reassessment of Functional Need

Revision 17-1; Effective March 15, 2017

Program Standard: *The case worker reassesses the individual's need within 12 months of the previous assessment. The functional assessment must be completed by the last day of the 12th calendar month from the previous functional assessment.*

To reassess functional need, use the policies and procedures in Section 2430, Functional Assessment, and in the instructions for Form 2060, Needs Assessment Questionnaire and Task/Hour Guide.

- For services requiring a functional needs Form 2060 score for eligibility, the case worker must complete or update the score in Part A of Form 2060 at each annual reassessment.
- For individuals who receive Day Activity and Health Services (DAHS) or Consumer Managed Personal Attendant Services (CMPAS) as the only service, a Form 2060 score is not required.
- For Family Care (FC), Community Attendant Services (CAS) and Primary Home Care (PHC), the case worker must review Part B and Part C of Form 2060 at least annually during the interview with the individual.

2663.1 Annual Home Visit Required for Individuals Receiving PAS

Revision 17-6; Effective June 28, 2017

Program Standard: *A home visit must be conducted with all individuals receiving Community Attendant Services (CAS) for all annual reassessments and 90 day monitoring contacts. A home visit must be conducted with all individuals receiving Primary Home Care (PHC) and Family Care (FC) at least once every 24 months at the same time the financial redetermination is conducted.*

During the home visit, the case worker provides oversight of the individual's health and safety. The case worker must evaluate the individual's ability to cope with the activities of everyday living in the home environment and identify when changes to the service plan or the addition of other services provided by the Texas Health and Human Services Commission (HHSC) may be of benefit.

For CAS, it is recommended the case worker complete the annual functional reassessment during the last 90-day monitor for the year prior to the annual being due. If the annual functional reassessment is not completed during the last 90-day monitoring visit prior to the annual being due, then an additional home visit is required to complete the reassessment. An exception to having to make a home visit is when Form 2060, Needs Assessment Questionnaire and Task/Hour Guide, has been completed within the last 60 days due to an interim change, the case worker may conduct the annual reassessment by telephone.

For all CCSE services, if an individual requests a change at the annual reassessment, the change must be worked within five days or by the annual reassessment due date, whichever is earlier.

For CAS, Form 2101, Authorization for Community Care Services, will continue to be sent within five business days of the home visit due to the nurse approval requirements for the program.

All annual reassessments must be recorded on Form 2314, Satisfaction and Service Monitoring, and in the Service Authorization System Online Wizards (SASOW). It must include the individual as the primary contact and the location as a home visit.

2663.2 Determining When a Home Visit is Necessary for Other Services

Revision 17-1; Effective March 15, 2017

For services other than Community Attendant Services, determine if the reassessment should be done in a face-to-face home visit or by telephone interview, based on the service received and the individual's circumstances. See Section 4000, Specific CCSE Services, for home visit requirements for each specific service.

Individual circumstances that may include the need for a face-to-face reassessment include but are not limited to:

- a service other than Emergency Response Services or Home-Delivered Meals is being added to the service plan;
- individuals with no telephone or who cannot communicate by telephone because of cognitive or physical impairments and/or lack a knowledgeable source to contact;
- Community Care Services Eligibility (CCSE) individuals who are receiving services from Adult Protective Services (APS) or have a history of self-neglect;
- individuals who have experienced multiple changes in a short time frame, such as major changes in health, living arrangements or caregiver arrangements, and the case worker is unable to obtain an accurate assessment that reflects all of the changes by telephone;
- case transfers to case workers or newly hired case workers, unless the losing and gaining case workers discuss and agree on the individual's condition;
- individuals with weak, unreliable or no caregiver support systems;
- individuals who have a history of refusal to comply with service provisions;
- individuals whose health and safety are at risk; or
- individuals who choose to live in a home with dilapidated, unsanitary or hazardous living conditions.

Case worker circumstances may warrant that a home visit be made, such as case worker trainees assigned to a caseload.

2664 Redetermination of Unmet Need

Revision 17-1; Effective March 15, 2017

The unmet need policy applies to ongoing cases as well as to applications. At each reassessment, the case worker must evaluate whether the Community Care Services Eligibility (CCSE) services already being purchased are meeting needs that would go unmet if no services were purchased. During the annual functional assessment or for each request for a change in service plan or hours, review each task on Form 2060, Needs Assessment Questionnaire and Task/Hour Guide.

In the Service Arrangement column, determine if needs are being met through other sources or if the individual continues to have a need for the task to be purchased. If there are no tasks to be purchased, the individual no longer has an unmet need and is no longer eligible. If unmet need exists, continue with the development of an appropriate service plan.

In situations in which the individual's caregiver also serves as the paid attendant, carefully review the tasks marked "C" on the Service Arrangement Column on the previous Form 2060. These are the tasks that the caregiver agreed to perform voluntarily at the last assessment. These tasks may not be purchased. If the caregiver states that he/she is no longer able or no longer willing to provide the tasks, then advise the caregiver that the provider will be notified to hire a new paid attendant for those tasks. Document any changes in caregivers or caregiver tasks on Form 2060 and Form 2059-W, Summary of Individual's Need for Service Worksheet. The information on Form 2059-W is entered in the Service Authorization System Online Wizards (SASOW) for Form 2059, Summary of Client's Need for Service.

In reassessment decisions, apply policy about duplicate services.

2670 Notifications at Reassessment

Revision 18-2; Effective November 19, 2018

40 Texas Administrative Code §48.3902 – To continue receiving services, the client must meet the CCSE eligibility requirements at the time of recertification of financial eligibility and reassessment of needs.

Program Standard: *Notify the individual in writing, using Form 2065-A, Notification of Community Care Services, of changes in the individual's service plan, to include: addition of service(s), increase in hours, decrease in copayment, or loss of priority status based on the individual's request.*

Form 2065-A must be sent within two workdays of the decision if the change involves:

- denial of priority status if the applicant requests it;
- an increase in units;
- a decrease in the copayment; or
- adding a new service.

For Community Attendant Services (CAS) case actions initiated by the Medicaid for the Elderly and People with Disabilities (MEPD) specialist, the Community Care Services Eligibility (CCSE) case worker is only required to check the notice forwarded by MEPD for accuracy and file it in the case record. The case worker's only liability for any MEPD-issued Form 2065-A is to report the error to the MEPD specialist via Form 2067, Case Information.

Program Standard: *Notify the individual in writing of any reduction, termination in services, loss of priority status or increase in copayment at least 12 days before the effective date of the decision.*

If an individual loses eligibility, Form 2065-A must be sent with 12 days advance notice. **Exception:** Advance notice is not required if the individual loses Medicaid eligibility such as Supplemental Security Income (SSI) or Temporary Assistance for Needy Families (TANF).

Program Standard: *Notify the applicant/individual or his authorized representative of his rights and responsibilities and of HHSC service limitations.*

The case worker gives Form 2307, Rights and Responsibilities, to the Adult Foster Care (AFC) individual/responsible person before AFC is authorized or reauthorized. The form is given to the CCSE individual/responsible person at the initial face-to-face visit. (For individuals receiving only Day Activity and Health Services (DAHS) or Home-Delivered Meals (HDM), the initial Form 2307 may be reviewed over the telephone.)

The case worker also gives Attachment 2307-A, Family Care, Community Attendant Services and Primary Home Care Rights and Responsibilities, when the applicant/individual requests attendant care and when the individual moves into a new home. At least annually, the case worker discusses all parts of Form 2307 with the individual/responsible person to ensure that he understands the form's content.

2680 Recertification

Revision 21-4; Effective December 1, 2021

When the reassessment is complete, send the following forms to the provider:

- Form 2101, Authorization for Community Care Services, for all Day Activity and Health Services, Primary Home Care, Home-Delivered Meals, Family Care and Residential Care cases when there is a change in the service plan.
- Form 2101, for all Community Attendant Services (CAS) cases, even if there is not a change in the service plan.
- Form 2065-A, Notification of Community Care Services, for all cases when there is a change in the service plan. It is not necessary to send notification if the only change is a transfer from one provider to another.

For Adult Foster Care (AFC), send the following:

- Form 2065-A, for all cases when there is a change in the service plan. It is not necessary to send notification if the only change is a transfer from one provider to another.
- Form 2101, for all cases even if there is not a change.
- Form 2327, Individual/Member and Provider Agreement, update as needed.
- Form 2330, Assessment and Service Plan Approval for Adult Foster Care, even if there is not a change.
- Attachment 2307-F, AFC Rights and Responsibilities, only if the recipient has moved to another home.

Related Policy

Content of Referral Packets, Appendix XIII
Effective Dates, 2811

2700, Service Monitoring, Changes and Transfers

2710 Monitoring Visits and Contacts

Revision 17-1; Effective March 15, 2017

Program Standard: *The case worker must monitor the individual's situation, the service(s) the individual receives and the adequacy of the service plan, in accordance with the requirements of the specific service he receives. Monitoring of the service plan includes checking for the appropriate priority level, ensuring the individual has the appropriate Community Care Services Eligibility and ensuring the hours/units authorized meet the individual's needs.*

2710.1 Monitoring Initiation of Services

Revision 18-1; Effective June 15, 2018

In most situations, the three-day and 30-day initiation of service monitoring visits are not required for Community Care for Aged and Disabled (CCAD) cases. Telephone or face-to-face monitoring visits to ensure service initiation are required for two groups of individuals:

- those with priority status (three-day and 30-day); and
- those who are using the Consumer Directed Services (CDS) option for service delivery (30-day only). See Section 6332.3, Monitoring CDS Service Initiation.

For these two groups, the case worker must:

- contact the provider if they determine that services have not been initiated;
- determine the reason for the delay;
- determine when services will begin;
- monitor the progress of service initiation; and
- complete a service satisfaction monitoring contact within 30 days of the first monitoring contact.

Case workers should be aware of service initiation issues and complete optional three-day or 30-day contacts if it is deemed appropriate based on the:

- individual's medical condition to ensure his health and safety;
- dependability of the individual's family/friends resource system;
- impact of environmental circumstances (for example, unsafe or unsanitary conditions that could become a barrier to service delivery); or
- provider's ability to deliver services within the specified timelines.

Although not required, case workers should verify service initiation by:

- contacting the individual by telephone or home visit;
- contacting the provider contracted to deliver services;
- reviewing notifications of service initiations from providers, including Form 2067, Case Information, or Form 2101, Authorization for Community Care Services;
- considering other reliable verbal or written information received that verifies service initiation; or
- providing the individual with notice to contact the case worker if services are not initiated within a designated time frame.

2710.2 Monitoring Ongoing Services

Revision 22-3; Effective Sept. 1, 2022

In addition to the initial three-day or 30-day monitoring contact, the minimum requirements for additional recipient contacts are:

- For all recipients, except those receiving Community Attendant Services (CAS), monitor services every six months. Contact the recipient:
  - by the last day of the sixth month from the initial assessment date for the initial six-month monitor; and
  - by the last day of the sixth month from the previous monitoring contact for ongoing six-month monitors.
- For a priority recipient (other than CAS) and if required by the region, make a face-to-face visit within six months of the last monitoring contact date. **Example**: If the last monitoring contact was made on March 15, the next contact is due on or before Sept. 14.

  Note: There are other possible circumstances that may require a home visit.

- For CAS recipients, the required 90-day monitoring visit must be completed with a face-to-face home visit. The 90-day monitoring visit meets the requirement of the six-month monitor.
- For Adult Foster Care recipients, after the first three monthly monitoring contacts (30 days, 60 days and 90 days), regular six-month monitors must be completed. The first six-month contact is required three months after the 90-day contact.

More contacts or home visits are required if recipient circumstances warrant. Some recipients may need additional monitoring or problems may arise that require additional contacts. Recipients with weak or informal support systems may need to be seen more frequently. Home visits may be required to ensure the recipient's safety and well-being are not compromised.

Develop a monitoring plan that considers:

- the recipient's functional needs;
- the capabilities of family or friends' resource and support systems; and
- the impact of the recipient's environmental circumstances.

If a home visit is required, inform recipients in advance by phone or in writing, using Form 2068, Application, Redetermination, or Monitoring for Community Care Services, unless there is indication of abuse, neglect or fraud.

Related Policy

Determining When a Home Visit is Necessary for Other Services, 2663.2
Monitoring Community Attendant Services Individuals, 2711
Adult Foster Care, 4100

2710.3 Service Plan Changes at the Monitoring Contact

Revision 17-1; Effective March 15, 2017

Reduce hours or terminate services at annual reassessment or any other time the individual:

- requests a reduction or termination;
- gains a resource resulting in fewer unmet needs and the need to reduce service hours; or
- is performing all or some activities of daily living due to long-term improvement in functional condition.

The case worker uses his judgment to determine if the individual's long-term improvement is expected to last through the current authorization period or beyond before reducing or terminating services. See Section 2721.6, Long-term Versus Short-term Changes in the Individual's Condition, for additional details in making that determination.

The individual and provider may agree to change the number of personal attendant service (PAS) hours to be provided based on the individual's needs without prior approval from the case worker. The amount of service provided should be sufficient to meet the individual's needs depending on the loss or gain in the individual's functional ability to perform activities of daily living.

Case worker approval or denial is required for all requests to increase PAS service hours previously authorized or to add or delete priority status.

2710.4 Monitoring Documentation Requirements

Revision 20-2; Effective June 1, 2020

The primary purpose of each monitoring contact, whether a home visit or a phone call, is to determine the adequacy of the current service plan and actual service delivery.

Form 2314, Satisfaction and Service Monitoring, must be used for all required monitoring contacts, including three-day, 30-day, 60-day, 90-day, six months, and annual.

Note: All other contacts must be documented on Form 2058, Case Activity Record or other case narratives as determined by the region.

During each monitoring visit, assess the quality of services and whether the services continue to meet the needs of the recipient by determining that:

- services are delivered according to the service plan and as agreed to by the recipient and the provider agency;
- the attendant comes and leaves as negotiated by the recipient, attendant and provider agency;
- the recipient is satisfied with each of the services being delivered; or
- there is a need to change the priority status, increase hours or change other services.

Ask enough questions during each contact to ensure the recipient’s current responses, together with the written case record, address each of the criteria listed above. See Appendix XVI, Monitoring Questions, for examples of specific questions that may be appropriate.

At every contact, document each of the following:

- Eligibility — Does the recipient continue to meet all eligibility requirements for the authorized services?
- Condition or Status — Has there been any change in the recipient's condition or situation that affects service delivery or adequacy of the service plan, such as priority status or the need for more hours or other services?
- Quality of Services — Have services been delivered according to the service plan? Does the attendant perform the required tasks and arrive and leave as scheduled? Is the recipient satisfied with the services that have been delivered?
- Adequacy of Service Plan — Does the service plan need to be changed?

Changes in services may be requested by the recipient or the provider agency. Document **all** requests for changes on Form 2067, Case Information, or Form 2058, Case Activity Record and include the date the request was received. If the recipient requests a change during the monitoring contact, document the request, and the action to be taken, on Form 2314.

Enter **all** required monitoring contacts in the Service Authorization System Online (SASO) Monitoring Wizard. A copy of the SASO automated Form 2314 must be filed in the case record.

Related Policy

Service Authorization System Online (SASO) Wizards and Use Requirements, Section 7300

2710.5 Actions Required After Monitoring

Revision 17-9; Effective September 15, 2017

Case workers report and discuss with the provider any problems or deficiencies in service provision and strive to resolve the problems. See Section 2736.1, Reporting Service Delivery Issues, for detailed instructions for handling service delivery issues.

2711 Monitoring Community Attendant Services Individuals

Revision 17-1; Effective March 15, 2017

Individuals receiving Community Attendant Services (CAS) are eligible for personal attendant services (PAS) under the provisions of §1929(b) of the Social Security Act. The act requires the case worker to monitor the home and community care provided under the State plan and specified in the "ICCP" (Individual Community Care Plan). This monitoring must involve visiting each individual's home or community setting where care is being provided not less often than once every 90 days.

An HHSC case worker must meet this requirement by conducting a face-to-face visit with the individual receiving CAS in the individual's home or community setting where CAS services or State Plan services included in the individual's Individual Service Plan (ISP) are being provided. This face-to-face visit must occur not less often than once every 90 days. The 90 day visit will be for the purpose of monitoring the individual's satisfaction of services.

The Texas Health and Human Services Commission (HHSC) is required to make every reasonable attempt to complete the CAS monitoring, as the Social Security Act requires. In order to meet the reasonable attempt requirement, case workers must adhere to the following guidelines:

- The 90-day monitoring must be completed at least every 90 days with the individual or primary caregiver in the location where services are delivered.
- All attempts to contact the individual must be documented in the case record to support the efforts to meet the federal requirement. A 90-day monitoring contact may not be made with an employee of the provider serving the individual.
- If the 90-day monitoring visit becomes delinquent, it must still be completed at the earliest possible opportunity. The case record must contain ongoing documentation of attempts to contact the individual until the monitoring is actually completed.
- In cases where the individual is in a nursing facility, hospital or out of the service area, the 90-day monitor must be conducted within 14 calendar days of learning the individual has returned to the home. Documentation of the individual's inaccessibility must be contained in the case record.

Federal law specifically requires visits every 90 days, not every three months. This 90-day deadline will usually be one or two days short of three calendar months. **Example:** If a CAS case is monitored March 15, the next monitoring visit must be on or before June 13 (the 90th day after March 15). See Appendix XVIII, Time Calculation.

For CAS cases, the case worker sets the initial 90-day home visit schedule from the date within 90 days of the initial start of care (SOC), as determined by the regional nurse and documented on Form 2101, Authorization for Community Care Services, in the Service Authorization System Online (SASO). The case worker is not required to conduct a 90-day monitor home visit prior to the SOC date determined by the regional nurse. Once the initial SOC has been determined, the case worker sets subsequent 90-day monitors using the Deadline Calculation Chart within Appendix XVIII to calculate when the next 90-day monitoring visit is due. It is recommended that

case workers conduct the annual reassessment simultaneously with the 90-day monitor due prior to the first annual reassessment to align future 90-day monitors due at the annual reassessment.

All 90-day monitors must be recorded on Form 2314, Satisfaction and Service Monitoring, in the Service Authorization System Online (SASO) Monitoring Wizard. Use the coding for entry into the SAS Monitoring Wizard. See Section 7300, Service Authorization System (SAS) Wizards and Use Requirements, or the SASO Help File for assistance in completing the SASO monitoring visit.

Inform the Medicaid for the Elderly and People with Disabilities (MEPD) specialist of any changes that may affect the eligibility of a CAS individual.

2712 Six-Month Monitoring Contacts

Revision 17-1; Effective March 15, 2017

When a six-month monitoring contact is required but a home visit is not required by the region, the contact may be completed by telephone. If the individual does not have a telephone or cannot communicate by telephone, and a caregiver or relative can tell the case worker about the individual's condition, service needs and the adequacy of service delivery, the contact may be with a caregiver or responsible relative. If contact cannot be made by telephone with the individual, caregiver or responsible relative, a face-to-face visit is required. The first attempted contact should be at least seven days before the contact due date. All attempts to contact the individual must be documented in the case record.

Before a face-to-face or telephone contact is made with someone other than the individual, make at least two attempted contacts with the individual. Document all attempts in the case record. For a priority status individual, two attempted contacts are defined as:

- at least one attempted face-to-face contact with the individual, his caregiver or his authorized representative if circumstances require a home visit; and
- another attempted face-to-face contact with the individual or his authorized representative if the region requires a home visit or a telephone contact with the individual, caregiver or his authorized representative.

During each six-month monitoring contact, ask about the:

- current condition and situation of the individual; and
- appropriate delivery of services.

Determine if any changes are needed in the service plan. The case worker may have to make a face-to-face contact if the:

- telephone contact indicates a significant change and the case worker cannot adequately assess the situation without a home visit (see Section 2721, Functional Changes);
- contact indicates a need to add a service or increase hours (see Section 2663.2, Determining When a Home Visit is Necessary for Other Services); or
- individual indicates dissatisfaction with services and the case worker cannot adequately assess the situation without a home visit.

A face-to-face contact is not required if the individual requests a decrease in hours, unless eligibility could be affected.

2720 Interim Changes

Revision 17-1; Effective March 15, 2017

2721 Service Plan Changes

Revision 17-1; Effective March 15, 2017

Changes to the service plan may be necessitated by changes in the individual's functional abilities or personal circumstances, including:

- hospitalizations;
- severe acute illnesses or accidents, or recoveries from major illness or accidents;
- loss of or changes in caregivers; and
- moves or changes in living arrangements.

2721.1 Individual Responsibility to Report Changes

Revision 17-1; Effective March 15, 2017

Discuss with the individual the importance of reporting changes and explain the consequences of failing to do so. If the individual receives Primary Home Care (PHC), Community Attendant Services (CAS), Family Care (FC) or Home-Delivered Meals (HDM), explain the need to notify the provider if the individual will not:

- be home when services are scheduled, or
- need services when scheduled. This is particularly important for personal attendant services individuals with priority status.

2721.2 Provider Responsibility to Report Changes

Revision 17-1; Effective March 15, 2017

Attendants are also responsible for reporting to supervisors any changes in the individual's status or environment that threaten the individual's health or safety or that may affect his service plan. The provider supervisor reports these changes to the case worker. Examples of these changes include hospitalizations, episodes of illness, changes in functional abilities, skin problems, bruises, mental instability that endangers the individual or others, onset of incontinence, unusual complaints of pain, unusual behaviors, or unusual changes in food intake.

The attendant also reports changes that may affect social resource systems, family relationships and assistance programs Examples include changes or problems in housing, household make-up, loss or change in caregiver arrangements or loss of benefits. If necessary, refer the individual to Adult Protective Services.

If a provider fails to report changes that affect an individual's service plan, the problem must be discussed with provider staff. If the problem continues, document the instances and discuss them with the Community Care Services Eligibility (CCSE) supervisor, who notifies the contract manager and program manager.

2721.3 Determining if a Home Visit is Necessary

Revision 17-1; Effective March 15, 2017

The case worker will use his judgment to decide if he has enough information to respond to the reported change without visiting the individual. If in doubt, a home visit should be made. Consider the following when making that determination:

- Is the case worker already very familiar with the individual's situation?
- Does the information available about the change and its impact seem clear and appear reliable?

- Is the reported change relatively simple or more complex? **Examples:** Several changes at once or sudden and severe deterioration.
- Is there disagreement between what others say the individual now needs and what the individual is saying he needs?

Make a home visit and complete a functional reassessment if the individual needs or requests a new service and his current Form 2060, Needs Assessment Questionnaire and Task/Hour Guide, score is below the minimum score for that service.

Reduce hours or terminate services at annual reassessment, or any time before the annual review, when the individual:

- requests a reduction or termination,
- gains a resource resulting in few unmet needs and the need to reduce service hours, or
- performs all or some activities of daily living due to long-term improvement in functional condition resulting in the need to reduce or terminate services.

2721.4 Revising the Service Plan

Revision 17-1; Effective March 15, 2017

Program Standard: *The case worker must revise the service plan, which is priority level, need for more/less hours or tasks, within 14 calendar days of learning of a change in the individual's status/condition, or must document why no changes to the service plan are needed. If the case worker becomes aware of the need for a service plan change as a result of conducting an annual reassessment, the change must be completed as part of that reassessment. If the individual is released for another CCSE service, the case worker will refer to Section 2611, Processing Time Frames.*

Contact the individual and determine whether a new assessment, a revised service plan or a revised monitoring plan is needed, based on the individual's new condition or situation. Assess the needs of the individual and develop or revise the individual's service plan, including:

- Form 2060, Needs Assessment Questionnaire and Task/Hour Guide (update if not being completely recreated);
- personal assistance services tasks;
- priority level; and
- number of hours/units of service the individual is authorized to receive per week.

2721.5 Long-term Versus Short-term Changes in the Individual's Condition

Revision 17-1; Effective March 15, 2017

The case worker uses his judgment to determine if the change in the individual's condition is expected to last through the current authorization period or beyond before reducing or terminating services. Do not reduce or terminate services if it is determined the individual is experiencing temporary improvement in functional condition.

If it is determined the individual's condition has temporarily improved because the individual is performing tasks previously done by the attendant, the individual and provider may agree to fewer hours per week. Send the provider Form 2067, Case Information, to inform the provider that fewer service hours may be provided if the individual agrees to the reduction. In this situation, the case worker would not update the Service Authorization

System Online (SASO) record or send Form 2065-A, Notification of Community Care Services, to the individual for a reduction of hours.

If a change in the individual's condition impedes his functional ability to perform activities of daily living, it may be necessary to add additional hours or tasks to the service plan. Case worker approval or denial is required for all requests to increase personal attendant services hours previously authorized or to add or delete priority status. The amount of service provided must be sufficient to meet the individual's needs.

2721.6 Authorizing and Documenting Changes

Revision 17-1; Effective March 15, 2017

All requests for changes in services, whether received from the individual or the provider, must be documented in the case record. Documentation may be on Form 2067, Case Information, or recorded in the case record narrative. Form 2058, Case Activity Record, may be used as well as other case narratives. Form 2314, Satisfaction and Service Monitoring, may also be used, but is not required for changes.

Make all necessary changes in the service arrangement column on Form 2060, Needs Assessment Questionnaire and Task/Hour Guide. To authorize changes in priority level and/or hours, update and submit Form 2101, Authorization for Community Care Services. Send Form 2065-A, Notification of Community Care Services, to the individual if the:

- Primary Home Care, Community Attendant Services, Family Care hours increase or decrease;
- individual gains or loses priority status;
- number of home delivered meals per week changes; or
- authorized units of Day Activity and Health Services change.

Document the outcome of the request for the change in the case record. If it is determined that no revision is needed in the service plan, document the decision and the reasons in the case record. If the provider or regional nurse requested the change, use Form 2067.

2722 Individual Moves and Case Transfers

Revision 17-1; Effective March 15, 2017

At times, an individual's move requires transferring the individual's case to a new case worker within the same region or a different region.

When an individual moves to an area served by a different case worker within the same region or outside the region, the case remains open and the existing service plan stays in effect until a new plan is implemented. Every effort should be made to minimize gaps in coverage for the individual. Although the old plan remains in effect until amended, actual services may in some cases have to be temporarily suspended. For example, the new area/region does not have space in a Residential Care (RC) or Day Activity and Health Services (DAHS) facility. The case worker who is notified of the move should initiate the action for the transfer.

2722.1 Procedures If the Losing Case Worker Initiates Action

Revision 17-8; Effective September 1, 2017

If the current case worker (losing case worker) is contacted by the individual (or individual's representatives) and **the individual has not already moved**, it is that case worker's responsibility to:

- contact the office in the new location and get the name, address and telephone number of the gaining case worker to give to the individual.
- contact the gaining case worker by telephone and discuss the case. Provide the gaining case worker with the individual number so the case worker can access the Service Authorization System Services (SASO) for current individual information.
- have the gaining case worker fax a provider choice list, if the current provider does not provide services in the new area. If the same provider will be serving the individual in the new location, the losing case worker keeps Form 2101, Authorization for Community Care Services, open and the gaining case worker makes any needed changes. If moving to another region, the provider number will be different even if the individual is staying with the same agency.
- provide the individual with the case worker and provider information. Have the individual select a new provider and relay that information to the gaining case worker with a projected date of transfer.
- forward the case record to the gaining case worker within three workdays of confirming the move.
- send Form H1746-A, MEPD Referral Cover Sheet, if applicable, advising of the transfer and the new address so that the MEPD case can also be updated. Advise staff for any other services the individual is receiving that the individual has moved (for example, Supplemental Nutrition Assistance Program).

2722.2 Procedures If the Gaining Case Worker Initiates Action

Revision 17-3; Effective May 15, 2017

It is the gaining case worker's responsibility to:

- update Form 2101, Authorization for Community Care Services, by entering in the comments section that this is a transfer case. Include the negotiated start date and the losing provider's end date.
- mail Form 2101, Form 2059, Summary of Client's Need for Service, and the Provider Referral Supplement to the new provider agency.
- advise the losing case worker that Form 2101 has been updated. He must print a copy of Form 2101 and send it to the losing provider.
- update any current Community Care Interest List entries for the individual for the new area.
- send Form H1746-A, MEPD Referral Cover Sheet, for all Community Attendant Services (CAS) individuals to the Medicaid for the Elderly and People with Disabilities (MEPD) specialist advising that the individual has moved to the service area and has a continued need for service. The old and new addresses should be provided, so the CAS case can be requested from the current MEPD worker.
- contact the individual within 14 days to assess the individual's new living arrangements and need for service plan changes. If needed, schedule a home visit. (See Section 2663.2, Determining When a Home Visit is Necessary for Other Services, to determine if a home visit is necessary.)

2722.3 Additional Procedures

Revision 17-1; Effective March 15, 2017

The regional nurse does not need to give prior approval unless a reassessment is being conducted at the same time the transfer is being done, and then a copy of Form 2101, Authorization for Community Care Services, needs to be forwarded to the regional nurse with the transfer agency information.

The provider does not have to obtain new physician's orders for prior approval from the regional nurse for a transferring case.

2723 Freedom of Choice

Revision 17-3; Effective May 15, 2017

In areas where there is more than one provider for a specific service, allow the individual the freedom to choose/change providers without restriction.

When an individual requests to change providers, the case worker must first determine the individual's reason for dissatisfaction and whether the individual's satisfaction can be met without the provider change. The case worker completes the following steps within fourteen days of the individual's request:

1. Ask the individual or his representative to select a new provider, and document the choice.
2. Contact the gaining provider before the transfer occurs to determine when services can begin.
3. Update the information on Form 2059, Summary of Client's Need for Service.
4. Update Form 2101, Authorization for Community Care Services, by entering:
    - the nine-digit vendor provider number; and
    - a statement in the comments section that this is an individual-requested change of providers and the effective date of the change.
5. Send the new provider Form 2110, Form 2059 and Form 2101.
6. For non-Community Attendant Services (CAS) cases, send the current (losing) provider a copy of Form 2101 that reflects the effective date of the transfer.
7. On CAS cases where the change is being made in conjunction with an annual reassessment, the regional nurse will:
    - update Form 2101 upon receipt; and
    - send the updated form that shows the effective date of the transfer to the new provider.

The case worker will send the current (losing) provider a copy of the updated form that reflects the effective date of the transfer.

In situations in which the individual has been suspended due to health and safety reasons and services will continue with a new provider, the HHSC case worker must determine how much information to share with the new provider regarding the previous actions. See Section 2840.1, Sharing Information with New Providers Regarding Health and Safety Issues.

2724 Medicaid Coverage for Individuals Denied SSI

Revision 17-1; Effective March 15, 2017

In almost all instances, receipt of Supplemental Security Income (SSI) entitles an individual to Medicaid. In most instances, loss of SSI eligibility also means loss of Medicaid benefits. There are several exceptions to this, however, particularly when someone loses SSI eligibility because of income from Social Security benefits. If a CCSE individual receives both SSI and Social Security benefits and the SSI is denied because of income associated with Social Security, encourage the individual to apply to the Medicaid for the Elderly and People with Disabilities (MEPD) specialist for an eligibility determination. Send a referral to the MEPD specialist if the individual is interested.

2725 Certificates of Insurance Coverage

Revision 17-1; Effective March 15, 2017

Public Law 104-191, the Health Insurance Portability and Accountability Act of 1996 (HIPAA), requires that health insurers, including Medicaid, furnish certificates of creditable coverage whenever an individual ceases coverage under a plan or policy. The purpose of the certificate is to provide evidence that the individual had prior creditable health insurance coverage that counts toward reducing or eliminating pre-existing condition exclusions under any subsequent health insurance coverage the individual may obtain.

This legislation will affect community care individuals who are Medicaid recipients. Information regarding certificates of coverage is provided to CCSE applicants and individuals on Page 2 of Form 2065-A, Notification of Community Care Services.

Texas Medicaid & Healthcare Partnership (TMHP) is the contractor that produces these certificates for denied Medicaid individuals. If an individual has questions about the certificate or needs a replacement certificate, he should write or call TMHP.

2730 Special Procedures for Helping Individuals Enter or Leave a Nursing Facility, Institution, or Hospice

Revision 17-1; Effective March 15, 2017

2731 Individuals Entering a Nursing Facility

Revision 17-1; Effective March 15, 2017

Some individuals living in their own homes may need counseling about the available options for receiving long-term care, including nursing facility placement. Caregivers of individuals who have heavy care needs may experience severe stress or be unable to continue the duty for weeks and months without reprieve. Individuals may be at risk if they remain in their current environments. Assess these situations from the standpoints of both the individual's safety and the caregiver's ability to withstand the stress of constant care. Offer them the opportunity to consider nursing facility care.

If an individual wants to enter a nursing facility, help him make his plans. If the individual is not a Medicaid recipient, refer him to Medicaid for the Elderly and People with Disabilities (MEPD) staff to start the financial application process as quickly as possible.

If an individual lacks family or a responsible person to help him with all the final activities involved in moving into a nursing facility, help him by involving his friends and other volunteers.

Nursing Facility Care for Individuals Under Age 22

State Law (Chapter 242, Health and Safety Code) requires that the Community Resource Coordination Group (CRCG) be notified no later than the third day after the date a Community Care for the Aged and Disabled child under age 22 with a developmental disability is initially placed in an institution.

The name and telephone number of the CRCG contact person may be obtained by calling the CRCG State Office at 512-206-4564. A CRCG list is also available via the Internet at:

https://crcg.hhs.texas.gov/faq.html.

If notice is received of an initial placement of a child in an institution, contact the person making the placement to ensure that family members of the family are aware of:

- service and support that could provide alternative to placement of the child in the institution, and
- available placement options.

2732 Closing Service Authorizations for Individuals Entering or Leaving a Nursing Facility

Revision 17-1; Effective March 15, 2017

2732.1 Individuals Entering a Nursing Facility

Revision 17-1; Effective March 15, 2017

A batch process is in place that closes the service authorization records for Community Care individuals who have entered a nursing facility. When Form 3618, Resident Transaction Notice, is submitted by the nursing facility, all Service Authorization System Online (SASO) authorization records, except Service Code 20-Emergency Response Services, are closed by an automated batch process that occurs five times a week.

The batch process uses the date in Item 11 (Date of Above Transaction) on Form 3618 as the end date of the service authorization. A daily report is generated and posted to the Claims Management Project Documents website.

Regional Claims Management System (CMS) coordinators must access the reports and notify case workers when they have individuals whose service authorization records are closed by the batch process. Case workers must monitor these cases for 30 days until it is determined whether the individual's nursing facility stay will be long term. If the individual will be remaining in the facility, the case worker closes the remaining Service Code 20 record, if applicable.

2732.2 Individuals Leaving a Nursing Facility

Revision 17-1; Effective March 15, 2017

For individuals being discharged from a nursing facility who are to begin receiving Community Care services, Provider Claims Services has established a hotline number to call to close the nursing facility authorization. The hotline number is 512-438-2200. Select Option 1.

The case worker should call the hotline directly to request the nursing facility record in the Service Authorization System Online(SASO) be closed so Community Care services can be authorized. The case worker will no longer contact the regional Claims Management Services (CMS) coordinator for this action. The case worker must confirm the individual has been discharged from the facility and Community Care services are negotiated to begin on or after the date of discharge.

When calling the hotline, the case worker must identify himself as a Texas Health and Human Services Commission (HHSC) employee and report that the individual has discharged from the nursing facility and provide the discharge date. The Provider Claims Services representative will close all Group 1 Service Authorizations and Enrollment in SASO, including the Service Code 60. The case worker documents the contact in the case record.

2732.3 Individuals Denied a Determination of Medical Necessity

Revision 17-1; Effective March 15, 2017

When a Medicaid nursing facility resident is denied a determination of medical necessity, Texas Medicaid & Healthcare Partnership (TMHP) sends a denial letter to the individual and the individual's physician. The facility and the Medicaid for the Elderly and People with Disabilities (MEPD) specialist are notified via TMHP's weekly status report.

If the individual requests CCSE services, respond to this request by following the usual intake procedures, including interviewing and assessing needs. If the individual is determined eligible to receive CCSE services but prefers to receive services outside the intake unit's geographical area, the intake unit staff refers the case to the

appropriate case worker or region. When CCSE staff receive an out-of-town referral or inquiry, they help with alternate placement activities.

2732.4 Promoting Independence Initiative

Revision 17-1; Effective March 15, 2017

Promoting Independence (PI) Initiative, enacted by House Bill 1867 of the 79th Session of the Texas Legislature, is intended to ensure a system of services and supports that fosters independence and productivity, and provides meaningful opportunities for the elderly and people with disabilities to live in their home communities.

Money Follows the Person (MFP) is available for persons requiring waiver services. It allows Medicaid funds that are being used to pay for the individual's care in a nursing facility to be transferred to pay for Medicaid waiver services in the community. Individuals identified as using MFP-funded services do not use regional interest list allocations.

MFP does not apply to non-waiver community care services.

For additional information, see the appropriate program handbook for the desired community care or waiver service.

2733 Individuals Receiving Services through Local Authorities

Revision 17-1; Effective March 15, 2017

Local Authorities (LAs) specialize in working with persons who have intellectual developmental disabilities (IDDs), intellectual disabilities (IDs) or persons with mental illness, especially those who are in crisis situations. Close coordination with LA is vital to ensure the safety and well-being of the individual and others. Contact the local LA agency to determine what procedures to follow to obtain permission from the individual to discuss his case with LA staff.

The liaison case workers at the LA community center are responsible for helping individuals with IDD/ID with the process of admission to or discharge from state supported living centers or intermediate care facilities for individuals with an intellectual disability or related condition (ICF/IID). Refer to the appropriate liaison worker any persons requesting or requiring entry into these facilities. Liaison case workers also have primary case management responsibility for individuals with IDD/ID who return to the community from state supported living centers. Contact liaison workers for specific information about their responsibilities and about the availability of LA resources for individuals with IDD/ID.

Persons discharged from state hospitals are referred to the appropriate LA community center or outreach program for follow-up. LA case management services are available to them if they meet eligibility and priority criteria. Contact the liaison worker for specific eligibility information. These individuals may also apply personally for CCSE services.

If there is no LA case worker assigned to the individual's case, contact the local LA agency to discuss the individual's condition. Refer the individual to them for services, assistance and/or case management, if appropriate. Include the LA case worker in the development of the individual's CCSE service plan and clearly define the case worker's roles and responsibilities in managing the case. Encourage the LA case worker to offer support counseling and training to the:

- individual;
- the individual's caregiver; and
- provider of services.

Keep the LA case worker informed of changes in:

- the individual's environment (such as hospitalizations, residence, household composition);
- the individual's physical/mental condition;
- medications or lack of medication; and
- the service plan.

Document in the case record contacts with LA staff, including any agreements reached.

Refer to Appendix XV, Services Available from Other State Agencies, for a list of the services that may be available through the LA agency.

Note: Refer to Section 1140, Disclosure of Information, regarding disclosure of information and national standards created under the Health Insurance Portability and Accountability Act to protect the confidentiality of individually identifiable health information.

2734 TDC Individuals Leaving TDC

Revision 17-1; Effective March 15, 2017

Texas Department of Corrections (TDC) staff are responsible for discharge planning for elderly or disabled persons being released from TDC. TDC tries to make a referral at least 30 days before the inmate is to be released from prison. TDC is represented in the community by the Board of Pardons and Parole (BPP). BPP supervises the individual in the community and provides or arranges for other services he may need. Follow the usual case management procedures to certify the individual eligible for services, to refer his case for service, and to monitor or evaluate any services authorized.

2735 Individuals Who Need Hospice Services

Revision 17-1; Effective March 15, 2017

Medicare and Medicaid hospice services are available to terminally ill Medicare/Medicaid eligibles who file an election statement with a particular hospice. Hospice applicants must be certified as terminally ill (six months or less to live) by a physician. For dually eligible individuals who elect hospice care, coverage is concurrent for the Medicare and Medicaid programs. Hospice care is also available on a private-pay basis.

Hospice staff contact the case worker by telephone concerning the start and cancel dates for hospice care. Hospice staff will no longer send a copy of Form 3071, Individual Election/Cancellation/Update, to HHSC staff. Individuals may elect or cancel hospice care at any time.

Individuals electing hospice may be eligible for services through HHSC as long as there is no duplication in the services delivered. A Medicaid recipient, age 21 and older, who elects Medicaid hospice, waives his rights to other programs with Medicaid services related to the treatment of the terminal illness. The Medicaid recipient does not waive his rights to services offered by HHSC that are unrelated to the treatment of the terminal illness. Individuals under 21 years of age who elect hospice do not waive rights to Medicaid services related or unrelated to the terminal illness.

HHSC case workers must follow up with the individual receiving services to determine what hospice will provide and adjust the individual’s service plan to assure no duplication of services. Case workers must respond to a notification of hospice election within the time frames of a change request.

The unmet need policy in Section 2433, Determining Unmet Need in the Service Arrangement Column, does apply to hospice individuals. Coordinate any CCSE service plan with the hospice provider to prevent duplication

and to assure adequate services to the individual. If an individual's need for help with a particular task is adequately met by the hospice provider, do not authorize purchased services for that task.

If the need for help will not be met by the hospice provider, or if the need will be only partly met, authorize services on the same basis used for any other individual.

Case workers may receive a request to initiate a CCSE service for an individual who is already receiving that service from a hospice. In this case, it must be determined whether the hospice will continue to provide the needed care. Authorize the CCSE service if the hospice service will end on a particular date, or if the hospice provider will provide the service only until the CCSE service can begin. Coordinate service initiation and ending dates with the hospice provider in order to prevent a break in services. When a CCSE individual enters a nursing home under hospice, terminate CCSE services effective the date the individual entered the facility. If the individual receives hospice care at home, making reduction or termination of CCSE services necessary, give the individual the usual 12-day advance notice before the effective date of the reduction or termination.

If an HHSC individual with Medicaid for the Elderly and People with Disabilities (MEPD) eligibility determination (Community Attendant Medicaid Hospice Program Services) enters a nursing facility under Medicaid hospice, the HHSC case worker notifies the MEPD staff of the Hospice nursing facility entry and closure of the HHSC case by sending Form H1746-A, MEPD Referral Cover Sheet.

In relevant situations, consider hospice services as a resource available to CCSE applicants and individuals. Monitor CCSE individuals on an ongoing basis to determine whether they need or are receiving hospice services.

Note: Refer to Section 1140, Disclosure of Information, regarding disclosure of information and national standards created under the Health Insurance Portability and Accountability Act to protect the confidentiality of individually identifiable health information.

2736 Complaints, Grievances or Suggestions

Revision 17-1; Effective March 15, 2017

The applicant or individual has the right to lodge a complaint, voice a grievance or recommend changes in policy or service without restraint, interference, coercion, discrimination or reprisal. Staff must:

- acknowledge the complaint, grievance or recommendation within 14 days of the date the Texas Health and Human Services Commission (HHSC) receives it; and
- resolve it within 60 days of that date.

2736.1 Reporting Service Delivery Issues

Revision 17-9; Effective September 15, 2017

Program provider service delivery issues may be reported to the Health and Human Services (HHS) Office of the Ombudsman. These reports may be generated by:

- the individual/individual's representative;
- Texas Health and Human Services Commission (HHSC) staff, including issues discovered by the case worker, or reports received during monitoring contacts; and
- other individuals, including the individual's family/friends.

Service delivery issues include any dissatisfaction expressed by the individual regarding a service delivery provider. The individual may express dissatisfaction about:

- the quality of a service provided (care, treatment or services received);
- aspects of interpersonal relationships, such as rudeness; or
- the service provider's failure to:
    - respect the individual's rights;
    - follow terms of the contract or applicable rules; or
    - provide services which may or may not have had an adverse effect on the individual.

This list is not all inclusive.

Complaints of a regulatory nature about nursing facilities, home and community support service agencies, intermediate care facilities, assisted living facilities, day activity and health services, prescribed pediatric extended care centers, and Home and Community-based Services and Texas Home Living providers should be reported to Consumer Rights and Services at 1-800-458-9858 or crscomplaints@hhsc.state.tx.us to generate an investigation by Regulatory Services.

Within five working days of receiving a report or becoming aware of service delivery issues, the case worker must respond to the individual and the provider either by phone or face-to-face contact to discuss the issues. The case worker must inform the provider of the service delivery issues and discuss resolutions. The case worker convenes an interdisciplinary team (IDT) meeting, if appropriate. The case worker coordinates with the individual and provider to implement actions required to resolve the issues. The case worker must document the receipt of the report and contacts with the individual and the provider in the case record. The case worker must document any barriers or hindrance by either party that interferes with resolution of the issues. The resolution of the issues and/or attempts to resolve the issue must be documented.

If service delivery issues cannot be resolved within 10 working days of the initial receipt of a report or becoming aware of service delivery issues, the case worker must:

- report the service delivery issues to the HHS Office of the Ombudsman at 1-877-787-8999;
- inform the individual of his right to call the HHS Office of the Ombudsman to register a complaint regarding the provider, including a Consumer Directed Services agency (CDSA); and
- inform the individual of his right to choose another provider.

The case worker must make the report to the HHS Office of the Ombudsman within three working days after the 10-working-day resolution period ends.

In situations where service delivery issues may compromise the individual's health and safety, the case worker must report as soon as possible but no later than 24 hours of receiving the report or becoming aware of service delivery issues. The case worker must also contact Adult Protective Services (APS) or Child Protective Services (CPS) within 24 hours if there is an immediate or imminent threat to the health and safety of the individual. The case worker must continue to work with the individual and provider to resolve the issues within the 10-working-day time frame.

The case worker must identify the specific service the provider is delivering when calling to report a complaint. For example, the case worker identifies the provider as a "Primary Home Care provider" when making a referral that involves Primary Home Care service delivery issues. The case worker must provide specific information related to the service delivery issue, including actions taken to resolve the issues and why the actions did not resolve the issues.

2740 Fraud Detection and Documentation

Revision 17-1; Effective March 15, 2017

2741 Provider Fraud

Revision 17-1; Effective March 15, 2017

The Texas Health and Human Services Commission (HHSC) endorses the concept that people who provide services are essentially honest and are entitled to the same protection under the law as all other individuals. However, when there is an indication of potential fraud, the allegations must be investigated.

To determine the existence of fraud, the following must be established:

- Intentional misstatement or concealment by the provider created a false impression.
- HHSC paid the provider based on the false impression, when the payment would not have been made if the truth had been known.

Examples of provider fraud include (list is not all-inclusive):

- billing for services which were not provided,
- provision of services which are not medically necessary,
- filing false claims,
- continuing inappropriate billing after provider education visits,
- billing for services provided by inappropriate persons,
- practicing without a proper license or obtaining a license under false pretenses,
- using improper billing practices, and
- violating the contract or provider agreement.

2742 Responding to Allegations of Provider Fraud

Revision 17-1; Effective March 15, 2017

When an allegation of provider fraud is received, staff should follow these procedures:

- During the first contact, staff receiving the complaint should obtain facts relating to the specific case in as much detail as possible. This includes:
  - who engaged or participated in the alleged fraudulent conduct,
  - what the suspected violation was,
  - when the conduct occurred (dates or time periods),
  - where the conduct occurred,
  - how the fraudulent action was performed, and
  - the names of witnesses and how they can be contacted.
- Staff should try to obtain the complainant's name, address, home telephone number and telephone number where the complainant can be reached during the day. Staff should advise informants who wish to remain anonymous that the Texas Health and Human Services Commission (HHSC) needs a way to contact them during the investigation.
- Staff must not make any agreements or commitments to anyone regarding the investigation or any possible adverse action.

2743 Individual Fraud

Revision 17-1; Effective March 15, 2017

Individuals receiving Long Term Care Services are perceived honest and entitled to the same protection under the law as all other individuals. However, when there is indication of potential fraud, the allegations must be investigated.

To determine the existence of fraud, the following must be established:

- Intentional misstatement or concealment by the individual or authorized representative created a false impression.
- The Texas Health and Human Services Commission or contracted provider delivered services based on the false impression, when the services would not have been provided if the truth had been known.

Examples of individual fraud include (list is not all-inclusive):

- knowingly providing false information regarding an applicant's financial, medical or functional status in order to be determined eligible for assistance;
- withholding or concealing information pertaining to the applicant's financial, medical or functional status which may cause the applicant to be ineligible for services;
- receiving services which the individual knows to be medically unnecessary; and/or
- knowingly receiving services from individuals who do not have a proper license or who obtained a license under false pretenses.

2744 Responding to Allegations of Individual Fraud

Revision 17-1; Effective March 15, 2017

When potential individual fraud is discovered, staff should follow these procedures:

1. Record all pertinent facts relating to the specific case in as much detail as possible. This includes:
    - who engaged or participated in the alleged fraudulent conduct,
    - what the suspected violation was,
    - when the conduct occurred (dates or time periods),
    - where the conduct occurred,
    - how the fraudulent action was performed, and
    - the names of individuals with knowledge of the situation and how they can be contacted.
2. If fraud is alleged by a third party, staff should try to obtain the complainant's name, address, home telephone number and telephone number where the complainant can be reached during the day. Staff should advise informants who wish to remain anonymous that the Texas Health and Human Services Commission (HHSC) needs a way to contact them during the investigation.
3. Staff must not make any agreements or commitments to anyone regarding the investigation or any possible adverse action.

Restitution **must not** be requested in cases where fraud is being pursued. Restitution is securing payment from an individual when fraud **is not indicated**. Once restitution is requested, you cannot refer the case for fraud.

2745 Reporting Suspected Fraud in the Consumer Directed Services Option

Revision 17-1; Effective March 15, 2017

Following are established procedures for reporting suspected fraud in the Consumer Directed Services (CDS) option to the Office of Inspector General (OIG). This applies when there is suspected fraud committed by the individual receiving services, the CDS employer or the CDS employee. This does not apply to provider fraud.

When the HHSC case worker suspects fraud was committed by the individual receiving services, the CDS employer or the CDS employee, or is made aware of suspected fraud from an entity other than the Financial Management Services Agency (FMSA), the case worker must report the suspected fraud to the OIG. The case worker can submit the referral using the OIG website, https://oig.hhsc.state.tx.us/wafrep/, or by calling 1-800-436-6184. The case worker must inform the OIG the individual is using the CDS option.

If the case worker does not receive a referral number after submitting the information on the OIG website, it means the referral may not have transmitted successfully. The case worker must call 1-800-436-6184 to confirm the OIG received the referral and ask for the referral tracking number. The case worker must document the suspected fraud and referral information on Form 2058, Case Activity Record.

Once the case worker submits the fraud referral to the OIG, the case worker must inform the FMSA about the suspected fraud and that a referral was made to the OIG using Form 2067, Case Information. The case worker must also send a secure email to CDS Operations staff, cds@hhs.texas.gov, at state office containing the following information for tracking purposes:

- Name of the FMSA;
- Name of the person(s) suspected of committing fraud (include as much identifying information as possible, such as Social Security number, Medicaid number, date of birth, address and phone number);
- Brief summary of the fraud allegation, including dates and estimated cost as a result of the violation;
- Date the fraud allegation was reported to the OIG and the OIG referral tracking number;
- Program or service impacted; and
- Contact information for the HHSC case worker who submitted the referral and the HHSC office where the case worker is located.

When an FMSA suspects fraud was committed by the individual receiving services, the CDS employer or the CDS employee, the FMSA will make a referral to the OIG. The FMSA will inform HHSC CDS Operations staff at state office that the FMSA submitted a fraud referral to the OIG for tracking purposes.

The FMSA will also inform the HHSC case worker that a fraud referral was submitted to the OIG using Form 2067. The case worker must file Form 2067 received from the FMSA in the individual's case file. No further action is needed by the case worker regarding the fraud referral once the FMSA notifies HHSC the referral was made to the OIG.

2750 Fraud Referral

Revision 17-1; Effective March 15, 2017

2751 Development of the Fraud Referral Packet

Revision 17-1; Effective March 15, 2017

Consult the unit supervisor for guidance in determining the appropriateness of the referral and the information being provided. If it is decided that a referral is to be submitted, complete the online reporting document, Form H4834, Individual or Recipient Provider Fraud Referral/Status Report, available at oig.hhsc.state.tx.us/wafrep. The online reporting system will prompt the user to enter:

- the name of the person providing information;
- additional contact person information, if available;
- the name of the person completing the form, if different from the person providing the information;
- law enforcement information, if available (indicate if law enforcement was notified);
- witness information, if available;
- the name of the person or facility being reported; and
- detailed information about the waste, abuse or fraud concern, including:
    - provider identification. Include the name, provider type and specialty, business address, residence address and provider numbers.
    - identification of the alleged illegal act. Include specific data regarding potential witnesses, addresses, work and home telephone numbers. Also include names, mail codes and telephone numbers of all staff who can provide information.

- identification of policy, regulation or procedural violations. Cite the appropriate numerical reference and manual title, the department rule or policy clearance letter. The reference should include the specific chapter, subchapter, page number and effective date of the manual or publication.
- source. Indicate who or what initiated the allegation.
- other pertinent documentation related to the case.

Once all of the information has been entered, the system will allow users to print the information to be included in the referral packet.

2752 Expedited Referrals

Revision 17-1; Effective March 15, 2017

If staff have reason to believe that the conduct of the suspected provider, individual or authorized representative is serious enough to require immediate action, it may be appropriate to expedite the referral. As with routine referrals, the unit supervisor must first be consulted. An expedited referral should be made when a delay would:

- probably result in the loss, destruction or altering of valuable evidence;
- probably result in harm to an individual;
- probably result in significant monetary loss to the Texas Health and Human Services Commission (HHSC) that would probably not be recoverable; or
- hinder an investigation or criminal prosecution of the alleged offense.

In these situations, the case is immediately referred to the HHSC Medicaid Program Integrity Unit at 512-436-6184 before the referral packet is produced. The HHSC representative will instruct staff as to what portions of the required information should be completed and sent.

2753 Referral of Potential Fraud

Revision 17-1; Effective March 15, 2017

If the unit supervisor determines that the criteria for fraud exists, a fraud referral to the Texas Health and Human Services Commission (HHSC) Medicaid Program Integrity Unit is initiated (even if the potential fraud does not affect Title XIX funds). Mail the referral packet to:

Office of Inspector General
Mail Code 1361
P.O. Box 13247
Austin, TX 78708-5200

HHSC is responsible for ensuring that all pertinent information is obtained and may subsequently request additional information. Providing requested material to the HHSC does not constitute a confidentiality violation. Staff in that division conduct an analysis and collect data to create a complete picture of the alleged incident.

After referring the case to HHSC, no other action is necessary. Continue to maintain the case as usual. HHSC staff should preserve a professional working relationship with the provider, individual or authorized representative while the fraud referral is being investigated. However, for the duration of the investigation, staff must not discuss the alleged violation with unauthorized personnel. This prevents the possibility of interference with the investigation.

2800, Notifications, Suspensions, Denials and Terminations

2810 Individual Notification Procedures

Revision 17-1; Effective March 15, 2017

Program Standard: *Notify the individual in writing using Form 2065-A, Notification of Community Care Services, of all eligibility/ineligibility decisions or any changes in the individual's service plan, to include: addition of service(s), increase or decrease in hours, increase or decrease in copayment, or loss of priority status based on the individual's request within two business days of the decision.*

When notifying the applicant of eligibility, specify on Form 2065-A:

- the Community Care Services Eligibility (CCSE)services for which the applicant is eligible or ineligible; and
- if determined eligible:
    - the number of hours of services the applicant is authorized to receive or the number of days or half days the applicant is authorized to attend a Day Activity and Health Services (DAHS) facility;
    - if applicable, that the Family Care, Primary Home Care or Community Attendant Services applicant is eligible for priority status;
    - the initial and ongoing room and board payments for Residential Care and Adult Foster Care; and
    - the initial and ongoing copayments the Residential Care individual is to pay to the facility.

An applicant/individual certified for one CCSE service but determined ineligible for another must be notified in writing of both decisions. An applicant/individual certified for personal attendant services and/or Home-Delivered Meals must also be notified in writing of the hours per week or meals per week he is eligible to receive. If certified for DAHS, the applicant/individual must be notified in writing of the number of days per week the DAHS authorization covers. The written notice for all services must contain the case worker's name, telephone number and appeal procedures.

For ongoing individuals, on Form 2065-A, record the:

- action taken and the effective date; and
- name of the CCSE service(s) on which the action is based.

If the notification is an adverse action, the notice must also state the:

- reason for the adverse action; and
- *Case Worker CCSE Handbook* reference on which the adverse action is based.

See the Form 2065-A Attachment for handbook and rule references.

The case worker may notify an individual verbally of continued eligibility if the individual continues to qualify for the same service(s) and the number of hours/units of service remains the same. Document in the individual's case record the date the case worker verbally informed the individual of his continued eligibility.

2811 Effective Dates

Revision 17-1; Effective March 15, 2017

The Texas Health and Human Services Commission (HHSC) case worker notifies the applicant or individual in writing of any action that denies, suspends, reduces or terminates services. The HHSC case worker sends the notice of adverse action to the individual 12 calendar days before the effective date of the action, except in situations in which services have been suspended due to threats to health and safety. In those situations, the HHSC case worker sends the written notice of adverse action without advance notice if the crisis cannot be resolved.

An applicant or individual has the right to appeal any decision that denies, reduces or terminates his services and request a fair hearing in accordance with Title I, Texas Administrative Code (TAC) §357.

For information about calculating effective dates of reduction or termination of services, see Appendix IX, Notification/Effective Date of Decision, and Appendix XVIII, Time Calculation.

In general, the effective date of the reduction in services is 12 calendar days after the Form 2065-A, Notification of Community Care Services, date. The effective date of an increase in hours is seven calendar days after the Form 2101, Authorization for Community Care Services, date. For an adverse action, if the day after the effective date is a Saturday, Sunday or legal holiday, the period is extended to include the next day that is not a Saturday, Sunday or legal holiday. (See Appendix XVIII.)

The date at the top of Form 2065-A is the date the HHSC case worker completes the form. Since offices have different mail pickup times, staff are not required to consider the mail date when completing the form. Staff must ensure applicants and individuals are notified within the required time frames.

Services will be reduced or terminated at annual reassessment, or any other time the case worker becomes aware before the annual review, when the individual:

- requests a reduction or termination;
- gains a resource resulting in fewer unmet needs and the need to reduce service hours; or
- is performing all or some activities of daily living due to long-term improvement in functional condition resulting in the need to reduce or terminate services.

An applicant or client may request an appeal of any decision that denies, reduces, or terminates his benefits. The effective date of the action depends on the situation, as shown in the following table:

If . . .	Then . . .
Termination or reduction is because client lost his eligibility as an income eligible, failed to qualify as an income-eligible after a verbal referral, failed to meet the client needs assessment score or medical criteria for the service, repeatedly (more than three times), directly or knowingly and passively condoned the behavior of someone in his home and thus, refused to follow the service delivery provisions, experienced a change in his need for the specific service, or failed to pay fees for services,	The action is effective 12 days from the date of the notice unless the action is appealed. In the event of appeal, services continue until the hearings officer gives a decision. The cost of providing services during this period is subject to recovery by the department from the client. Services to clients in Residential Care facilities are terminated five days after the hearings officer gives his decision.
Termination is because client lacks TANF, SSI, Medicaid, or Supplemental Nutrition Assistance Program eligibility,	Services continue only to the end of the month that the client is determined ineligible, even if the action is appealed.
Termination is because client lacks physician's orders for the service,	Services continue only through the date the previous orders end, even if the action is appealed.
Termination or reduction is because of budgetary constraints or changes in federal law or state regulations, and services are reduced or terminated for an entire categorical client group,	Services continue only through the date of termination of a categorical client group, even if appealed.

If . . .	Then . . .
Termination is because the client or someone in his home threatens the health or safety of others, or because the client threatens his own health or safety.	Services may be terminated immediately under the following conditions: • a client receiving Residential Care, Adult Foster Care, DAHS, or special services to persons with disabilities threatens his own health or safety or that of others, or • someone in the client's home or an individual receiving Emergency Response Services, Home-Delivered Meals, waiver services, Family Care, Primary Home Care, or special services to persons with disabilities threatens the Texas Health and Human Services Commission (HHSC) staff or provider's health or safety.

2812 Changes in the Individual's Need for Services

Revision 17-1; Effective March 15, 2017

Case workers determine if the individual's long-term improvement is expected to last through the current authorization period or beyond, before reducing or terminating services.

If it is determined that the individual's condition has temporarily improved because the individual is performing tasks previously done by the attendant, the individual and provider may agree to fewer hours per week.

Do not reduce or terminate services if it is determined the individual is experiencing temporary improvement in functional condition. If the individual feels he temporarily needs fewer hours, send the provider Form 2067, Case Information, informing the provider that fewer service hours may be provided if the individual agrees to the reduction. If the individual is experiencing temporary functional improvement, the case worker would not change the task/hour guide or authorization, or send Form 2065-A, Notification of Community Care Services, to the individual for reduction of hours.

The individual and provider may agree to change the delivery schedule for personal attendant services (PAS) hours based on the individual's needs without prior approval from the case worker.

Case worker approval or denial is required for all requests to increase PAS hours previously authorized or to add or delete priority status. In these situations, terminate or reduce services 12 calendar days after the Form 2065-A completion date.

2813 Situations in Which the 12-Day Adverse Action Period May Be Reduced

Revision 17-1; Effective March 15, 2017

There may be situations when an individual wants to waive or shorten the 12-day notice period before services are reduced or terminated. Some examples of applicable situations include the following:

- A Family Care individual is being removed from an interest list for Title XX Day Activity and Health Services (DAHS) and wants to withdraw or have services reduced in less than 12 days in order to attend

DAHS immediately; or
- Community Care for Aged and Disabled individuals who prefer to receive 1915(c) waiver services may also wish to have the change take place in less than 12 calendar days.

If the individual indicates a desire to waive or reduce the 12-day advance notice, be very cautious and remember that an individual may change his mind. In most instances, the provider can be verbally notified to stop service and still maintain the formal effective date 12 calendar days in the future.

If the individual still wants to waive or shorten the 12-day advance notice, complete Form 2065-A, Notification of Community Care Services, with the effective date being the date the individual wants services to end or be reduced. Explain in the comments section that the individual is voluntarily waiving or reducing his right to the 12-day advance notice. The individual must:

- sign this statement; and
- be given the original and one copy of the notice.

2814 Transfers Between Primary Home Care, Community Attendant Services and Family Care

Revision 18-1; Effective June 15, 2018

Send Form 2065-A, Notification of Community Care Services, when an individual is transferred from any of the three programs listed to any of the other three programs listed: Primary Home Care (PHC), Community Attendant Services (CAS), or Family Care (FC). Do not send another form to terminate the previous service. Specify on the form the:

- name and amount of the previous service,
- name and amount of the new service,
- effective date of the transfer, and
- reason for the transfer.

Indicate in the comments section that the individual should not notice any difference in the amount or type of services received because of this transfer.

Example:
The service you were receiving, Primary Home Care, 16 hours a week, will change to Family Care, 16 hours a week, effective June 1, 2010.

Comments: Primary Home Care will terminate because you lost financial eligibility for that program. You should not notice any difference in the amount or type of services you will receive because of this transfer.

Although Form 2065-A must be sent when an individual transfers between PHC, CAS and FC, the effective date is either the negotiated date or the date following the Medicaid end date.

See Section 4600, Primary Home Care and Community Attendant Services, for additional transfer procedures.

Refer to Appendix IX, Notification/Effective Date of Decision, and Appendix XVIII, Time Calculation, for other exceptions to the 12-day notice requirement. The effective date of the transfer does have to be at least 12 days following the date of notification if the number of hours is decreased.

2820 Service Suspensions

Revision 17-1; Effective March 15, 2017

Services may be suspended by the provider or by the case worker.

2821 Service Suspension by Providers

Revision 17-1; Effective March 15, 2017

Providers may suspend services to individuals before the service approval period ends. See Section 4000, Specific CCSE Services, for information about suspension of each specific service.

On the day of suspension or by the first Texas Health and Human Services Commission workday following suspension, the provider must contact the case worker to explain the reason for suspending services. The Emergency Response Services provider must submit written notification (Form 2067, Case Information, optional) within five workdays of the oral notification or suspension of services.

If an individual meets the criteria for Adult Protective Services, refer him accordingly. Refer other individuals to other appropriate service resources as needed.

The case worker documents in the case record the incident that caused the suspension and the date of the incident. The results of any related interdisciplinary team meetings must be included in the documentation. After evaluating suspensions to determine whether services should be terminated and the case closed, the case worker takes the appropriate action. In some situations, the problems that caused the suspension can be resolved. If they are resolved:

- send Form 2067 to the provider documenting the problem resolution; and
- reach an agreement with the provider about the date on which services will be reinstated.

2822 Service Suspension by Case Workers

Revision 17-1; Effective March 15, 2017

40 Texas Administrative Code §48.3903 Denial, Reduction, and Termination of Benefits

(c) A client is not eligible for CCSE services when:

(1) he dies;
(2) he is admitted to an institution;
(3) his physician requests service termination (Medicaid services only); or
(4) he requests service termination or repeatedly refuses to accept help, except in an involuntary protective services case, or he refuses to comply with his service plan.

2822.1 Hospital and Nursing Facility Stays

Revision 20-3; Effective September 1, 2020

Suspend services when available information confirms that a nursing home or hospital stay will be longer than 30 days. Use Form 2067, Case Information, to notify the provider to suspend services effective the date of nursing home or hospital entry. It is not necessary to send updates to the provider.

Continue to monitor the situation. If the person has not returned home by the 30th day, contact the person or authorized representative (AR) to see if a discharge date is planned. If the person has a planned discharge date within the next 30 days, leave the case open and monitor on the planned discharge date.

Terminate services, using the date of admission as the effective date of termination, if information shows that the nursing facility or hospital stay will be longer than 30 days. **Exception:** The effective date of termination for Residential Care should be the 30th day after admission to the nursing facility or 60 days after admission to a hospital.

Consult with the person, family and others associated with the person to determine the length of stay. Be cautious about terminating Title XX services, especially if the region has an interest list for those services.

Emergency Response Services (ERS) may remain open until the decision is made to terminate all services because the nursing facility stay has become permanent. See Section 4300, Emergency Response Services, for suspension of ERS by the ERS provider.

The following situations should always be considered short-term and services should be suspended for up to 30 days, rather than terminated:

- admission to a swing bed facility (by regulation, swing bed nursing home stays are limited to 30 days); and
- admission to a hospital for mental illness treatment.

Services may be suspended indefinitely if the person is admitted to a rehabilitation hospital or to a rehabilitation floor or wing of a medical hospital.

2830 Refusal to Comply with Service Delivery Provisions

Revision 17-1; Effective March 15, 2017

Refer to 40 Texas Administrative Code §48.3903 Denial, Reduction, and Termination of Benefits

Examples of refusal to comply with the service delivery provisions include, but are not limited to, the following:

- The individual is often away from his residence when service is scheduled and he repeatedly fails to notify the provider that he will be gone, even though he has been counseled about this problem and its implications.
- The individual or someone in the individual's home regularly will not permit the in-home provider to perform one or more of the tasks in the service plan or the individual receives personal attendant services and refuses to allow the provider to perform the authorized tasks.
- Despite several provider efforts to find and place an acceptable attendant in the home, the individual refuses to accept in-home services because of dissatisfaction with a particular attendant.
- The individual or someone in the individual's home regularly behaves in a way that is so offensive to staff that they refuse to serve him, and the individual knowingly and passively condones the person's behavior, and staff are unable to provide services. (Examples of offensive behavior include sexual harassment, sexual misconduct and racial discrimination.)

If the provider notifies the Texas Health and Human Services Commission about a service delivery compliance problem, contact the individual or the responsible party. Attempt to resolve the problem in a way that is satisfactory to the individual and the parties involved. A joint staffing may be conducted at the individual's home to try to resolve the situation.

2830.1 Individuals Who Refuse to Comply with Electronic Visit Verification Requirements

Revision 17-1; Effective March 15, 2017

Individuals requesting or receiving attendant services from a Home and Community Support Services Agency (HCSSA) are required to participate in Electronic Visit Verification (EVV) by allowing the attendant to use their home landline to report the start of work and the end of work. If an individual does not have a home landline, or if the individual will not allow the attendant to use the home landline, the individual must agree to an alternate device installation in the home. Failure to cooperate with EVV requirements can result in suspension or termination of services.

It is the case worker's responsibility to review the information on the rights and responsibilities form and adequately explain the EVV requirements to the applicant or individual receiving services. It is important to communicate that an individual's failure to cooperate with EVV requirements can result in the suspension or termination of services. The case worker must explain the following points:

- EVV is a telephone and computer-based system that electronically verifies service visits occur and documents the precise time service provision begins and ends. The purpose of EVV is to verify that individuals are receiving the services authorized for their support and for which the state is being billed.
- EVV will not change the services the individual receives.
- EVV is mandatory for all HCSSAs and individuals receiving services from an attendant, unless the individual receives services through the CDS option.
- The attendant will need the individual's permission to use the home landline toll-free number at the start and at the end of work. Under no circumstances should the individual call the toll-free number on behalf of the attendant. If the individual is asked to do this, they should report it to the provider agency.
- If the individual does not have a home landline or does not want the attendant to use his telephone, an alternative device can be placed in the home, which is used only to verify the attendant's start and end of work. This device must remain in the home at all times. If the individual notices the removal of the device, they should report it to the provider agency.
- If the individual notices any other possible EVV violation such as an instance in which the attendant leaves the home without providing services after calling the toll-free number upon arrival , they should report it to the provider agency.
- If the individual has additional questions, the case manager refers him to the selected HCSSA or Financial Management Services Agency (FMSA) for additional information on how EVV works.

For individuals using the CDS option, the case worker must explain that the individual receiving services, or a designated representative (DR), is the employer of record and can choose to use the EVV system or use paper time sheets. The three choices are:

- Full Participation-Phone and Computer: The CDS employee(s) use the telephone portion of EVV, and the employer of record uses the computer portion of the system to perform visit maintenance.
- Partial Participation-Phone Only: This option allows the employer of record to participate in EVV, but provides some help from the FMSA with visit maintenance. The CDS employee calls in when he or she starts work and calls out when they end work. The employer uses a paper time sheet to document service delivery. The FMSA performs visit maintenance to make sure the EVV system matches the paper time sheets approved by the CDS employer.
- No EVV Participation: If the employer of record does not have access to a computer, assistive devices or other supports, or feels he cannot fully participate in EVV, he may choose to use a paper time sheet to document service delivery.

The FMSA will require the employer of record to complete Form 1722, Employer's Selection for Electronic Visit Verification (EVV), to indicate his choice.

If an individual is refusing to cooperate with EVV requirements, it is considered as a refusal to comply with service delivery provisions and policies in Section 2831, Suspensions Due to Refusal to Comply with Service Delivery Provisions, are applicable. Some individuals whose provider is required to participate in EVV are not allowing the attendant to use their home phone and are also refusing to allow a Fixed Visit Verification (FVV) device to be placed in their home.

Providers are required to participate in EVV for services delivered by an attendant. Individuals who refuse to allow the attendant to record hours worked through EVV, either through the use of their home phone or a FVV device, are non-compliant with their service delivery plan. These individuals are essentially not allowing the provider to carry out services in accordance with provider requirements.

2831 Suspensions Due to Refusal to Comply with Service Delivery Provisions

Revision 17-10; Effective October 6, 2017

The provider or case worker may suspend services until an interdisciplinary team (IDT) meeting is scheduled and the situation is discussed. After the IDT meeting, the case worker must send the individual a letter within five working days stating services can be terminated if he does not comply with service delivery provisions and stating specifically what the individual must do to continue services.

If the situation is not resolved and the individual continues to refuse to comply, the case worker convenes a second IDT and sends the individual a second notice stating continued refusal to comply with service delivery provisions will result in the termination of services.

If the situation continues not to be resolved and a third situation arises, the case worker convenes a third IDT and must send a third and final letter to the individual stating continued refusal to comply with service delivery provisions will result in the termination of services.

If the situation continues, the case worker may terminate services by sending Form 2065-A, Notification of Community Care Services. See Section 2810, Individual Notification Procedures. Denials based on refusal to comply with service delivery provisions must be approved by the supervisor. Document the conference and approval in the case narrative.

There is no time period during which the instances of refusing to comply must occur.

2832 Documentation of Compliance Issues

Revision 17-1; Effective March 15, 2017

Documentation in the case narrative is required in all situations involving the individual's refusal to comply with service delivery provisions. Opinions or evaluative conclusions are not appropriate documentation to substantiate a denial of services. Documentation should stress a factual statement of actions constituting noncompliance.

Determine and document whether the individual is aware of and able to understand the consequences of his or other's actions. If the individual is not aware of his behavior or the behavior of someone in his home, discuss the issues with him.

Determine if the person seems to be abusing, neglecting or exploiting the individual, and refer the individual to Adult Protective Services (APS), if necessary. Continue services pending the APS investigation. APS may take appropriate action, such as obtaining a guardian, to resolve the problem if the individual is abused, neglected or exploited.

Document the date and content of each discussion with the:

- individual;
- interested family member;
- provider; and

- unit supervisor.

2833 Reauthorization of Services After Termination for Refusal to Comply

Revision 17-1; Effective March 15, 2017

If an individual's services have been terminated because of his refusal to comply with service delivery provisions that involve a provider, confer with the unit supervisor prior to referral to another. It may be necessary to discuss the individual's particular compliance issues before reauthorizing services. The unit supervisor must approve the referral. Note the approval in the comments section of Form 2101, Authorization for Community Care Services.

Follow these steps when an applicant who had been authorized services in the past, but whose services were terminated due to his failure to comply with service delivery provisions, reapplies:

1. Before contacting the applicant, review with the supervisor circumstances of the previous denial and the steps to be taken with the applicant. Document the review in the case record.
2. Review with the individual/responsible party:
    - the reason for the previous termination,
    - the responsibility of the individual/responsible representative to notify the provider and Texas Health and Human Services Commission (HHSC) about problems related to the service delivery provisions and the importance of good communication, and
    - each task to be authorized, emphasizing the only tasks to be performed by the attendant are those authorized by HHSC.
3. Authorize services if the individual agrees to follow the service delivery provisions.
4. Record the conversation with the individual in the case record narrative.
5. Contact the individual or provider weekly for one month to assess the individual's compliance with service delivery provisions. If the individual continues to have problems complying with service delivery provisions, contact the individual and emphasize the need for him to comply.
6. If the provider complains about the individual refusing to follow his service delivery provisions, contact the individual monthly after the first month of service. Discontinue monthly contacts when complaints cease.
7. Terminate services if the individual refuses more than three times to comply with service delivery provisions.

2840 Threats to Health or Safety

Revision 17-1; Effective March 15, 2017

Occasionally, an individual or someone in his home might exhibit behavior that constitutes a threat to the health or safety of another person. Examples include, but are not limited to:

- exhibiting weapons;
- making direct spoken threats of physical harm, force or death;
- physically attacking a person with or without a weapon;
- threatening use of force by self or someone else;
- using or selling illegal drugs; and
- displaying dirty needles or the smell of toxic fumes from the manufacture and/or sale of illegal drugs in the individual's home environment.

If, during the initial contact or any other contact by the case worker or provider staff, an individual or someone in his home exhibits threatening behavior or makes comments that are threatening, hostile or of a nature that would cause concern for the individual, provider or Texas Health and Human Services Commission (HHSC)

employee, the case worker must immediately notify management. Regional management must review these situations on a case-by-case basis and determine the most appropriate action to be taken. If the applicant's safety may be at risk, the case worker must follow current policy regarding notification to the Department of Family and Protective Services Adult Protective Services (APS). If the case worker believes there is a potential threat to others, regional management should determine the best method for notifying the provider and addressing the individual's needs without placing staff members at risk.

If an individual threatens his own health or safety by threatening or attempting suicide or self-injury and is at immediate risk, place a 911 call to report the emergency. A referral to APS must also be made. If the applicant or individual seems to be abused, neglected or exploited by the person who threatens the health or safety of others, refer the individual to APS.

In most cases where there is a potential for danger, services should be suspended immediately.

The case worker must send Form 2065-A, Notification of Community Care Services, by the next working day after receiving notice from the provider that services have been suspended for failure to comply or threats to health and safety. The notice must reference 40 Texas Administrative Code §48.3903, state the last day services are delivered, and include a clear statement in the comments explaining why services have been suspended.

Within three working days after the case worker becomes aware of the suspension, the case worker must arrange an interdisciplinary team (IDT) meeting to try to resolve the issue with the provider and the individual. Depending on the severity of the reason for the suspension, some IDT meetings may be conducted by telephone or some may require a face-to-face contact.

The case worker may conduct the IDT meeting by telephone or a face-to-face contact for all suspension reasons listed in this section. Case workers are required to discuss the specific case with their supervisors to determine the best approach for conducting the IDT. Case workers must document the rationale for conducting the IDT by telephone.

During the IDT meeting, the case worker, provider staff, the individual and the individual’s representative, if any, must evaluate the issue and discuss the program requirements for continued services. The IDT should identify any solutions to resolve the issue, including the individual’s understanding of the issue and what must be done to resolve the issue. The case worker must document the requirements for continued services. See Section 2831, Suspensions Due to Refusal to Comply with Service Delivery Provisions, and Section 2832, Documentation of Compliance Issues, for additional guidelines.

If the issue leading to suspension is resolved during the IDT, the provider must, within two business days after the IDT meeting, either implement the recommendations of the IDT or discharge the individual and refer the individual to the case worker for referral to another provider. The case worker must notify the individual orally or in writing of the reinstatement of services. If services continue, assess if the individual meets the guidelines for an individual at risk and if so, follow procedures outlined in Section 2550, Identifying Individuals at Risk. If the issue is not resolved and services cannot be continued, the case worker begins the termination process.

2840.1 Monitoring or Annual Home Visit Delay Due to Unsafe Environmental Circumstances

Revision 17-1; Effective March 15, 2017

The Texas Health and Human Services Commission (HHSC) case worker is required to make every reasonable attempt to complete the Community Attendant Services (CAS), Primary Home Care (PHC) and Family Care (FC) service monitoring or annual reassessment visit. All attempts to contact the individual must be documented in the case record to support the efforts to meet the requirements. In some situations, the case worker is unable to make the face-to-face home visit due to a dangerous environmental situation beyond the case worker or individual’s control. These situations may include but are not limited to:

- current police activity (i.e., a car chase, weapons drawn, drug raids);
- gathering of people on the streets demonstrating threatening or intimidating behavior directed at the case worker; and
- illegal activities in close proximity (e.g., next door to the individual's home) occurring at the time the case worker attempts the home visit.

When such situations occur and the case worker feels threatened, he or she can make the home visit at another time. The case worker must immediately notify regional management of his inability to conduct the home visit. The case worker must schedule another service monitoring or annual reassessment visit at the earliest possible opportunity. The case record must contain ongoing documentation of attempts to complete the visit and the reason for the delay until the monitoring visit has been completed.

If, during the home visit an individual or someone in his home exhibits threatening behavior or makes comments that are threatening or hostile, the case worker can end the service monitor or annual reassessment and reschedule for a later time. The case worker must immediately notify regional management of his or her inability to conduct the home visit. The case worker will refer to Section 2840, Threats to Health or Safety, to suspend or terminate services. If the threatening behavior is resolved, the case worker must schedule another service monitoring or annual reassessment visit at the earliest possible opportunity. The case record must contain documentation of all attempts to complete the visit, along with any reasons for delays until the monitoring visit has been completed.

2840.2 Chronic Contagion/Infestation Conditions

Revision 17-1; Effective March 15, 2017

While the chronic contagious medical condition or infestation of the individual's home may not pose an immediate danger to the health and safety of the individual, provider agency staff or case worker, either situation may adversely affect the health of all such persons involved in supporting the individual's services and may pose a risk of exposing other individuals to the contagious medical condition or environmental infestation. Examples of unresolved chronic adverse medical or environmental related condition(s) may include the presence of bed bugs, fleas, ticks, lice or scabies.

The case worker must assess the individual's ability to comply with the request to eradicate contagions or infestations and should exhaust all efforts in arranging for assistance to eradicate contagions or infestations, based upon the assessment of the individual's capabilities. The case worker should identify available local resources which may provide the needed assistance in meeting the individual's specific needs in relation to resolving the risks associated with the spread of the contagion or environmental infestation to others.

As stated in Section 2831, Suspensions Due to Refusal to Comply with Service Delivery Provisions, the provider or case worker may suspend services until an interdisciplinary team (IDT) meeting is scheduled and the situation is discussed. Efforts to identify local resources and natural supports to assist the individual if any such resources and supports exist, should be well documented as part of the IDT meeting. Any specific actions and responsibilities required of the individual and other persons and an agreed-upon time frame for completion of the eradication should be documented. Information from a pest control professional must be the basis in the establishment of a timeline expectation for eradication, as each situation will be unique. The specific actions and responsibilities required of the individual or other persons, such as family members or friends, who have agreed to provide support as part of the eradication plan should be documented as service provision requirements.

If the eradiation plan is not followed and the situation is unresolved, the case worker refers to Section 2830, Refusal to Comply with Service Delivery Provisions, and Section 2831 for guidance in instances in which the individual is non-compliant with service delivery provisions.

The case worker follows policy in 40 Texas Administrative Code §48.3903, (f) Denial, Reduction or Terminations of Benefits, to provide adequate notice of possible termination of services if the individual fails to

cooperate with service delivery provisions.

2840.3 Active Tuberculosis (TB) Diagnosis

Revision 18-3; Effective December 14, 2018

An applicant or individual with a TB diagnosis cannot have services denied or terminated as a consequence of his/her disease.

The regional HHSC staff will contact their regional health department to ensure staff are linked to the right TB personnel to address TB cases on a case-by-case basis. The HHSC unit case worker may confer with their unit supervisor for help with processing the case and may use the following web address to contact their regional health department: http://www.dshs.texas.gov/regions/. If the HHSC case worker/supervisor is unable to contact the local regional health department or needs more information, they may contact the Texas Department of State Health Services (DSHS) TB and Hansen's Disease Program staff who are linked to TB personnel in the county in which the patient resides. The telephone number is 512-533-3000 for general information and 512-533-3144 for the nurse administrator. Upon receiving the physician's report, DSHS assigns a representative to monitor the case through "directly observed therapy." This process involves observation of the individual taking his/her medication; it may also involve health-related training and the provision of additional care of the individual.

For cases with active TB, a team meeting should be set up to include the regional nurse, case worker, provider and the local DSHS representative handling the case. These individuals will ensure coordination of care and determine if special precautions need to be taken.

It is possible that DSHS will instruct HHSC to suspend the case while the TB remains active; if so, it will provide care for the individual during this period. Most individuals become negative for TB within a few weeks of drug therapy.

Note: Refer to Section 1140, Disclosure of Information, regarding disclosure of information and national standards created under the Health Insurance Portability and Accountability Act to protect the confidentiality of individually identifiable health information.

2840.4 Sharing Information with New Providers Regarding Health and Safety Issues

Revision 17-1; Effective March 15, 2017

When services have been suspended due to health and safety reasons, HHSC staff are required to convene an interdisciplinary team (IDT) meeting to resolve the issues. If the issues cannot be resolved, the provider may report it will no longer serve the individual due to health and safety concerns.

In some situations, HHSC may terminate the individual's services due to health and safety issues. In other situations, HHSC may initiate services with a new provider. If the HHSC case worker makes a referral to a new provider, he must determine how much information to share with the new provider regarding the previous actions.

The HHSC case worker must share sufficient information with the new provider to avoid putting the provider at risk. This allows the provider to adequately plan for safely delivering services to the individual, including selecting the appropriate service delivery staff and preparing the staff to handle situations that may arise. Providing information may avoid the issues that previously caused the termination or suspension.

Case workers must use good judgment in determining what information to share and, if in doubt, consult with their supervisors for guidance.

2841 Reinstatement of Services Terminated for Threats to Health or Safety

Revision 17-6; Effective June 28, 2017

An applicant whose services were terminated in the past due to his or someone in his home being a threat to the health or safety of the client, department staff, or provider agency staff may be authorized services if the applicant signs Form H0003, Agreement to Release Your Facts, authorizing release of information, and:

(1) The applicant/person in home who posed the threat has been treated or is receiving treatment by a licensed or certified physician, psychiatrist, or psychologist and can furnish a letter saying that he is no longer a threat to himself or others; or
(2)The applicant/person in home allows a collateral contact with his physician, psychiatrist, or psychologist and the contact indicates that the applicant is no longer a threat to himself or others; or
(3)The person in the home who posed the threat no longer poses the threat.

Complete the eligibility determination in the Service Authorization System Wizards within 30 calendar days after the date the signed application is received by the department. (See Section 2344, Individual Rights and Responsibilities.)

2841.1 Sharing Information on Previous Actions for Reinstatement

Revision 17-1; Effective March 15, 2017

If an individual who has been previously terminated from services due to health and safety reasons reapplies for services and meets the requirements in Section 2841, Reinstatement of Services Terminated for Threats to Health and Safety, information may need to be shared with a newly selected provider.

If the HHSC case worker makes a referral to a new provider, he must determine how much information to share with the new provider regarding the previous actions that resulted in termination of services. The case worker must share sufficient information with the new provider to avoid putting the provider at risk and allow the provider to adequately plan for safely delivering services to the individual. This includes selecting the appropriate service delivery staff and preparing the staff to handle situations that may arise. Providing information may avoid the issues that previously caused the termination or suspension.

Case workers must use good judgment in determining what information to share and, if in doubt, consult with their supervisors for guidance.

2900, Appeals and Fair Hearings

2910 Individual's Right to Appeal and Request a Fair Hearing

Revision 17-1; Effective March 15, 2017

40 Texas Administrative Code §48.3903

(a) An applicant or client may request an appeal of any decision that denies, reduces, or terminates his benefits.
(b) A client is entitled to be notified 10 days before any reduction or termination of his services, or to have the notification mailed 12 days before the date of reduction or termination. If a client threatens his own health or safety or that of others, purchased services may be terminated without advance notice.

Inform the applicant/individual in writing by sending Form 2065-A, Notification of Community Care Services, about his right to request a fair hearing if services are denied, reduced or terminated. An individual may appeal his dissatisfaction concerning

- ineligibility for services;
- the tasks within a service;
- the amount (number of units) of service the individual will receive;
- the amount of the copayment for Residential Care; or
- the denial or termination of the priority status.

An individual also may appeal when the individual requests a new service, or requests an increase in the number of tasks or units of service, and the request is not acted on within required time limits.

To request a hearing, an individual may return Form 2065-A with a check mark in the appropriate box, or the individual may make an oral or written request for a fair hearing.

An individual must request a fair hearing within 90 days from the date of the action he wants to appeal. To continue receiving benefits until the hearings officer gives a decision, the individual must request the fair hearing before the effective date shown on Page 1 of Form 2065-A. In situations where services were terminated because of threats to the health or safety of another person, the individual is not entitled to continued services even if appealed before the effective date shown on Page 1 of Form 2065-A. (See Section 2811, Effective Dates, and Appendix IX, Notification/Effective Date of Decision, for guidance on effective date of termination in which the individual is not entitled to continued benefits.)

When a fair hearing is requested after the 90 day time period, HHSC staff may not prevent an applicant or individual from filing an appeal because they believe the appeal was not requested within the required number of days. If a fair hearing request is received after 90 days from the date of the notice, the case worker must follow current procedures to file the appeal. The hearings office will make the decision regarding the individual's right to appeal.

The hearings officer is the final authority regarding the timeliness of appeal requests and accepts appeals filed after the time limit in order to determine whether there was good cause for the delay in filing.

2911 Notice to the Provider for Continuing Services

Revision 17-1; Effective March 15, 2017

If the individual appeals before the effective date on Page 1 of Form 2065-A, Notification of Community Care Services, the case worker must continue services at the current level pending the hearings officer's decision, unless denial is based on threats to health and safety. (See Section 2840, Threats to Health and Safety). Within three business days after receipt of the request for a fair hearing, the case worker must complete a new Form 2101, Authorization for Community Care Services, in the Service Authorization System Online (SASO) reinstating services at the current level. The case worker sends Form 2101 to the provider notifying them to provide services at the current level until the hearings officer's decision is rendered. The "Begin Date" of services is the day after the termination date or reduction date on the previous Form 2101. The case worker also sends Form 2067, Case Information, informing the provider to reinstate services pending the hearings officer's decision.

Example 1: At the annual reassessment, the case worker determines the Primary Home Care personal attendant services (PAS) hours must be reduced from 20 hours per week to 15 hours per week. The case worker sends Form 2065-A to the individual and Form 2101 to the Home and Community Support Services Agency (HCSSA) as notification of the reduction in hours. The individual appeals before the effective date of the case action. The case worker authorizes PAS at 20 hours per week until the hearings officer's decision is rendered.

When all services are terminated, such as at the annual reassessment when the individual does not meet eligibility criteria, case workers must continue services at the current level when the individual files an appeal before the effective date.

Example 2: At the annual reassessment, a Family Care individual is terminated due to scoring 21 on Form 2060, Needs Assessment Questionnaire and Task/Hour Guide. The case worker sends Form 2065-A to the individual and Form 2101 to the provider as notification of the termination of services. The individual appeals before the effective date of the case action. The case worker authorizes services at the same level as the previous Form 2101 authorization.

When the individual submits a clear, written statement requesting services stop during the appeal process, the case worker sends Form 2067 to the provider with an effective date to stop service delivery. The case worker does not send the individual another Form 2065-A.

HHSC does not continue services during the appeal process if Medicaid eligibility has been terminated, unless Medicaid eligibility is reinstated during the appeal period. Refer to Section 3441, Loss of Categorical Status or Financial Eligibility, and Section 2932, Coordination of Fair Hearings with MEPD Utilizing OES CRU, for procedures related to Medicaid terminations and continuation of services.

2912 Special Procedures for Denials of Community Attendant Services (CAS) Individuals

Revision 17-1; Effective March 15, 2017

Denials of CAS individuals must be coordinated with both the HHSC regional nurse and with the Medicaid for the Elderly and People with Disabilities (MEPD) specialist. If the HHSC case worker denies the individual based on functional need, Form H1746-A, MEPD Referral Cover Sheet, must be sent to advise MEPD of the denial.

If the individual appeals the denial, another Form H1746-A must be sent to MEPD advising that services will be reinstated pending the fair hearings officer's decision. MEPD must also be notified on Form H1746-A when a decision is rendered.

If the change that prompted the request for an appeal on a Community Attendant Services decision occurred in the course of an annual reassessment, use Form 2067, Case Information, to notify the provider and the HHSC regional nurse. The HHSC regional nurse submits Form 2101, Authorization for Community Care Services, to reinstate services.

2913 Coordinating with Utilization Review for Fair Hearing Requests as a Result of Utilization Review Findings

Revision 17-1; Effective March 15, 2017

HHSC case workers must notify the utilization review (UR) nurse and UR regional manager when an applicant or individual has requested a fair hearing as a result of UR findings for concurrent reviews.

Case workers must follow normal time frames and procedures for implementing UR findings following receipt of a UR tool indicating a case action is required. When the action is completed for an addition/increase in services or termination/decrease in services, the case worker must send a notice to the applicant or individual notifying him of the case action. The applicant or individual has the option to appeal the case action indicated on the notice. Case workers must follow current policies and procedures regarding continuation of services pending an appeal.

If the applicant or individual requests a fair hearing, the case worker must inform the UR nurse who completed the review and UR regional manager via email that a fair hearing has been requested as a result of the UR findings. The case worker will complete Form H4800, HHSC Fair Hearing Request Summary, and send the form to the Hearing Division and supervisor within three days of the request for a hearing.

On Form H4800, the case worker will list the UR nurse, Agency Representative, UR regional manager, and Agency Representative Supervisor. The case worker may be listed. The case worker must confirm the correct UR nurse and UR regional manager to list on the form. The case worker includes the UR nurse whose name is located in Section A of the UR tool. The case worker identifies the name of the UR regional manager by calling the UR nurse or calling the Utilization Management and Review (UMR) manager identified on the UMR website.

The designated data entry representative (DER) will be responsible for uploading the case worker's fair hearing evidence packet in the Texas Integrated Eligibility Redesign System (TIERS) Fair Hearings and Appeals system. The evidence packet submitted by the case worker will include the applicable notification form. If available, the case worker includes the signed notification form returned by the applicant or individual. The case worker does not include any other documentation in the evidence packet.

The UR nurse and UR regional manager will develop the fair hearing evidence packet to support the decision made by UR to change the services planned or delivered to the applicant or individual. The evidence packet will include a summary of the UR findings and applicable Texas Administrative Code (TAC) rules and policy. The UR representative will upload the evidence packet in TIERS.

Form H4800-A, Fair Hearing Request Summary (Addendum), must be included as the cover sheet for each fair hearing evidence packet. The DER and UR representative must upload the fair hearing evidence packets in TIERS no later than **10 calendar days** prior to the fair hearing date. The case worker and UR nurse must forward a copy of the fair hearing evidence packets to the applicant or individual no later than **10 calendar days** prior to the fair hearing date.

The UR nurse, UR regional manager (optional) and case worker will participate in the fair hearing to admit the fair hearing packets into evidence and provide testimony regarding the case action.

2913.1 Concurrent Utilization Review When a Fair Hearing is Pending or a Decision Has Been Rendered

Revision 17-1; Effective March 15, 2017

When a case record is selected for concurrent review and a fair hearing is pending, the case worker must inform the Utilization Review (UR) nurse that a fair hearing is pending. The case worker does not submit the case record for concurrent review. UR will then replace the case with another randomly selected case record for concurrent review.

When a case record is selected for concurrent review and a fair hearing decision has been rendered during the current plan year, the case worker must inform the UR nurse of the fair hearing decision details by providing the UR nurse with a copy of the final order submitted by the hearings officer. The case worker must provide specific information to the UR nurse about the service(s) appealed and the actions the case worker took to implement the hearings officer's decision. The case worker submits the case record for concurrent review following current procedures. The case worker will follow current policy and procedures for implementing UR findings.

2914 Withdrawal of an Appeal

Revision 17-1; Effective March 15, 2017

An appellant or appellant representative may request to withdraw his appeal orally by calling the hearings office. An oral request to withdraw may be accepted by the hearings officer's administrative assistant or the hearings officer. HHSC staff should advise the appellant or appellant representative to speak directly to the administrative assistant or hearings officer. If the appellant or appellant representative contacts HHSC staff regarding the withdrawal, HHSC staff must contact the hearings office via conference call with the appellant or appellant representative on the line so the appellant or appellant representative may inform the hearings office of the withdrawal. If the appellant or appellant representative sends a written request to withdraw to HHSC staff, HHSC staff must forward this written request to the hearings office. A fair hearing will not be dismissed based on an HHSC decision to change the adverse action. All requests to withdraw the hearing must originate from the appellant or appellant representative.

If the appellant or appellant representative requests to withdraw his appeal within 14 calendar days of the fair hearing date, the hearings officer will notify HHSC by phone or email and open the conference line to inform participants of the cancellation. If the appellant or appellant representative requests to withdraw his appeal more than 14 calendar days prior to the fair hearing date, the hearings officer will indicate the withdrawal in the Texas Integrated Eligibility Redesign System (TIERS) and a written notice will be sent to participants informing them of the fair hearing cancellation.

2920 Request for Increase in Services During an Appeal

Revision 17-1; Effective March 15, 2017

When services are reduced or terminated, such as at the annual reassessment, and the individual files an appeal before the effective date of the reduction or termination, the case worker must continue services at the current level until the hearings officer's decision is rendered. If the individual requests increased services pending the hearings officer's decision, the case worker cannot process the request. Within 14 calendar days of the request, the case worker must send the individual Form 2065-A, Notification of Community Care Services, explaining the request for increased services is denied pending the hearings officer's decision and may be reviewed for authorization once the hearings officer's decision is rendered, if the individual is determined eligible.

2930 Fair Hearing Procedures

Revision 17-1; Effective March 15, 2017

All fair hearings are processed through the Fair and Fraud Hearings section of the Appeals Division of the Texas Health and Human Services Commission (HHSC). The appeals division receives appeal requests from applicants and individuals contesting actions taken regarding benefits and services of various programs. These include the Supplemental Nutrition Assistance Program (formerly known as the Food Stamp Program), Temporary Assistance for Needy Families, all Medicaid-funded services, and other agency programs that are required by state or federal law, or rules, to provide the right to a fair hearing. Hearings officers conduct hearings, consider evidence and issue decisions in accordance with rules, regulations and state and federal law.

See the HHSC *Fair and Fraud Hearings Handbook* for specific information regarding the HHSC rules and requirements governing the fair hearings process.

2931 Processing Fair Hearing Requests Using TIERS

Revision 17-1; Effective March 15, 2017

When a request for a fair hearing is received from an applicant or individual orally or in writing, the Texas Health and Human Services Commission (HHSC) must refer the request to the hearings officer within five calendar days from the date of the request. Information is not mailed to the hearings officer, but is entered into

the Texas Integrated Eligibility Redesign System (TIERS) Fair Hearings and Appeals system by the designated data entry representative.

Upon receipt of the fair hearing request, the case worker completes Form H4800, Fair Hearing Request Summary.

The case worker sends Form H4800 to the Hearing Division and the supervisor within three calendar days of the request for a hearing. The three-day time frame allows the data entry representative two days to enter the information into the TIERS system. See the Form H4800 Instructions for specific directions for completion and transmittal.

Designated Data Entry Representative Procedures

Within two calendar days of receipt of Form H4800, the data entry representative enters the information into the Fair Hearings and Appeals system in TIERS. When the entry of all the information is completed, the system assigns the appeal identification (ID) number. The data entry representative will note the appeal ID number on the bottom of the form and in the designated space on the front of the form and send a copy back to the case worker and supervisor.

HHSC Fair Hearings and Appeals Procedures

The TIERS system will generate a hearing packet which includes Form H4803, Notice of Hearing, and Form H4800. The case worker and supervisor will receive a copy of Form H4800 and the letter identifying the hearings officer assigned and information on the time and location for the hearing. It is the supervisor's responsibility to ensure that the case worker or a designated representative participates in the hearing and is sufficiently prepared and knowledgeable about the case to represent the agency during the fair hearing process.

If Form H4800 has already been submitted into TIERS and there are subsequent changes such as address changes, participant updates, withdrawal forms or supporting documents needed for a fair hearing, the case worker completes Form H4800-A, Fair Hearing Request Summary (Addendum), with the updated information and submits it to the data entry representative.

The data entry representative must check TIERS for the fair hearings officer assigned to the case. If a fair hearings officer is not yet assigned, the data entry representative must wait until one is assigned to send the additional information. When sending information, the data entry representative completes the following activities according to the situation:

- When Form H4800-A is completed informing the fair hearings officer of address changes, participant updates and withdrawal forms, the data entry representative sends Form H4800-A directly to the hearings officer’s email address. The case worker must enter the appeal ID number in the subject line.
- When the data entry representative submits *supporting documentation* for an appeal, he uploads the information directly into TIERS and sends the hearings officer an email with Form H4800-A attached. The case worker must enter the appeal ID number in the subject line. The email must also inform the hearings officer that supporting documentation listed in Section 2 of Form H4800-A has been uploaded in TIERS. The case worker and data entry representative must follow current time frames and procedures to ensure supporting documentation is uploaded into TIERS no later than 10 calendar days prior to the fair hearing date.

2932 Coordination of Fair Hearings with MEPD Utilizing OES CRU

Revision 17-1; Effective March 15, 2017

The Texas Health and Human Services Commission (HHSC) Office of Eligibility Services (OES) Centralized Representation Unit (CRU) handles all hearings for Medicaid for the Elderly and People with Disabilities (MEPD) and Texas Works staff. CRU replaces the MEPD specialist in specific steps related to denial of MEPD applications and ongoing cases. CRU:

- represents HHSC OES in fair hearings;
- completes and implements all MEPD case actions based on fair hearing decisions; and
- coordinates actions required with regional MEPD staff and HHSC staff.

The case worker must coordinate all appeals with CRU in which MEPD staff determine financial eligibility. The case worker must remember CRU replaces the local MEPD specialist in the following steps and that notices must not be sent to the local MEPD specialist, except as specified. All correspondence on appeals will go to the CRU supervisor and CRU administrative assistant.

Applicants/individuals may appeal a decision orally, in person or in writing. The case worker is responsible for completing Form H4800, Fair Hearing Request Summary, to file the appeal through the Texas Integrated Eligibility Redesign System (TIERS) when an applicant/individual requests a fair hearing. The method in which the form is completed depends on the action being appealed. HHSC staff must determine if the appealed action is:

- a waiver/service denial (excludes denials based on MEPD denials); or
- an MEPD financial denial (denials based on an MEPD denial action).

If the appealed action is related to Community Care Services Eligibility (CCSE) criteria other than an MEPD financial denial action, the case worker completes Form H4800 and enters his name as the "Agency Representative." In the "Additional Witnesses" field, HHSC staff enter "CRU Supervisor" (enter the actual name), and "CRU Administrative Assistant" (enter the actual name). The CRU supervisor and administrative assistant names **must** be entered by using the "MOR Search" function. This will ensure that all the correct information is populated in TIERS and both the CRU supervisor and the administrative assistant receive the notice of the appeal.

If the appealed action is an MEPD financial denial, the case worker completes Form H4800 and enters "CRU Supervisor" (enter the actual name) as the "Agency Representative." This information **must** be entered through the "MOR Search" function for CRU to receive the hearing information. List the HHSC case worker, supervisor and titles in the "Additional Witnesses" section. The name of the local MEPD specialist is not entered by staff on Form H4800 for MEPD financial appeals. HHSC staff must include the title, such as HHSC case worker or HHSC supervisor. Enter the HHSC staff email address. Enter the CRU administrative assistant (enter the actual name) in "Additional Witnesses" using the "MOR Search" function.

When Form H4800 is sent to the Hearing Division, the case worker sends an email notification regarding the request for an appeal to the HHSC Office of Eligibility Services (OES) Fair Hearings mailbox, oesfairhear@hhsc.state.tx.us. In the subject line of the email, include the following: Request for Continued Benefits-MEPD Appeal ID-XXXXXXX. In an attachment to the email, HHSC staff must also include a copy of the HHSC notification form sent to the applicant or individual. The email must include the:

- applicant's/individual's name;
- Medicaid number (if available);
- type of service (CCSE Community Attendant Services); and
- specific information requesting the MEPD financial case remain active/open during the appeal, if the applicant/individual appealed in a timely manner.

For example, the financial case or application may need to remain open pending an appeal decision regarding medical or functional eligibility. The case worker must notify CRU to keep the MEPD case open pending the fair hearing decision.

Upon receipt of notification of an appeal, CRU requests the MEPD evidence packet from the local MEPD specialist and completes any necessary actions required during the appeal process. The CRU supervisor assigns CRU staff to represent MEPD at the hearing, if required, and takes steps to ensure the appropriate MEPD financial case action is taken once a hearings officer's decision is rendered.

When a hearing decision based on program criteria is rendered by the hearings officer, the case worker (staff name entered as "Agency Representative") will be notified via email of the decision by the hearings officer. Based on the hearing decision, the case worker determines the appropriate action according to program specific time frames. The case worker may need to coordinate effective dates of reinstatement with CRU and must email the CRU supervisor and administrative assistant for the coordination. The case worker reports the implementation of the hearing decision through TIERS on Form H4807, Action Taken on Hearing Decision, according to current procedures.

The local MEPD specialist will continue to notify the case worker if an appeal is filed by MEPD regarding a financial eligibility decision, and refer the MEPD case to CRU to handle during the appeal process. Once the appeal decision regarding the MEPD financial case is rendered by the hearings officer, CRU will notify HHSC staff via email of the hearing decision, including decisions that are sustained, reversed or withdrawn. Based on the hearing decision, the case worker determines the appropriate action for the service. The email sent by CRU will include:

- the applicant's/individual's name;
- Medicaid number;
- a copy of the hearing decision; and
- effective or denial date of Medicaid eligibility.

The case worker must not put an applicant/individual back on a specific interest list while an MEPD denial is in the appeal process. The case worker must take appropriate action to certify or deny the case, or resume services once the MEPD hearing decision is rendered. The individual may choose to be added back to the interest list once the case worker denies the service.

2933 Submitting the Appeals Evidence Packet

Revision 17-1; Effective March 15, 2017

When an applicant or individual requests a fair hearing, the burden of proof to uphold the Texas Health and Human Services Commission (HHSC) decision rests with HHSC. The hearings officer is a neutral party and is restricted by law from presenting the agency's case. It is **crucial** that staff complete and organize all fair hearing packets in order to support the agency decision.

The Texas Integrated Eligibility Redesign System (TIERS) generates a hearing packet that includes Form H4803, Notice of Hearing, and Form H4800, Fair Hearing Request Summary. The case worker and his/her supervisor receive a copy of Form H4800 and the letter identifying the hearings officer assigned, and the time and location of the hearing. Staff or the designated representative participating in the hearing must be sufficiently prepared and knowledgeable about the case to represent the agency during the fair hearing process.

Each entity involved in the fair hearing is responsible for preparing its packet and forwarding the packet to both the:

- hearings officer identified on Form H4800; and
- appellant.

All documentation must be neatly and logically organized, and all pages numbered. Staff use Form H4800-A, Fair Hearing Request Summary (Addendum), to submit all supporting documentation to the hearings officer. The appeal identification number assigned by TIERS must be written on the top of Form H4800-A.

Provide the names, titles, addresses and telephone numbers of all persons or designees who will attend the hearing. Depending on the issue being appealed, the region may elect to send additional staff (e.g., the regional nurse, regional attorney, etc.); however, it is mandatory that the following staff attend:

- Texas Medicaid & Healthcare Partnership (TMHP), for medical necessity/level of care (MN/LOC) denials;
- Medicaid for the Elderly and People with Disabilities (MEPD) or Centralized Representation Unit (CRU), for financial denials;
- case worker or designee, for all case decisions; and/or
- Utilization Review nurse to the appeal action, if applicable.

All related documentation necessary to support the agency's decision must be sent by the data entry representative (DER) to the fair hearings officer as soon as possible, but no later than ***10 calendar days*** before the hearing. Examples of additional information and who is responsible for submitting that information to the state fair hearings officer and appellant include, but are not exclusively limited to:

- the case worker or designee:
  - Texas Administrative Code or policy handbook references related to the case action;
  - summary of events;
  - a copy of any individual service plans, Form 2060, Needs Assessment Questionnaire and Task/Hour Guide, or other official documentation forms including form instructions;
  - other documentation supportive of the decision, such as records of telephone calls, visit summaries, etc.;
  - any relevant Utilization Review findings; and
  - a signed copy of the denial notification form (if available, use the signed form returned by the applicant/individual when the appeal was filed);
- MEPD:
  - documentation supportive of the financial decision, including official documentation forms, telephone calls, etc.; and
  - a copy of the original signed denial form returned by the member, if available (if unavailable, send unsigned copy);
- TMHP:
  - a copy of the MN/LOC assessment; and
  - other documentation supporting the decision.

Uploading the Appeals Evidence Packet into TIERS

All evidence packets must be scanned into the TIERS Appeals application using the process described below. The regional data entry representative (DER) uses Form H4800-A to submit all supporting documentation (also referred to as the "appeals packet") to the fair hearings officer. The appeal identification number assigned by TIERS must be written on the top of Form H4800-A. The DER must upload the fair hearing evidence packet in TIERS no later than ***10 calendar days*** prior to the fair hearing date.

The case worker must provide the information to the DER no later than ***12 calendar days*** prior to the fair hearing date, to allow enough time for the evidence packet to be submitted timely. The case worker must:

- go to the multi-function HHSC WorkCenter and scan in the documentation;
- save the document by either allowing the default document name or entering a name of the user's choosing;
- retrieve the scanned document and attach it to an email; and
- send the document to the regional DER.

No later than ***10 calendar days*** prior to the fair hearing date, the case worker must forward a copy of the fair hearing evidence packet to the applicant or individual requesting the fair hearing.

Within two business days after receipt, the DER must:

- save the attachment to the appropriate network drive, as assigned by regional management;
- go into the TIERS portal (without launching TIERS) and select the "Appeals" tab;
- ensure the appeal has been entered in TIERS (this requirement must be met before the next step can be completed);
- select "Hearing Evidence Packets Upload" and enter the appeal identification;
- select "Document Type: Agency Evidence Packet" (items entered in any other selection will not be included in the evidence packet);
- select "Validate";
- check the details to ensure the right person has been selected;
- browse for the document; and
- select "Upload."

Users who make mistakes that cannot be reversed may contact the state office Document Maintenance manager to assist in correcting the error and uploading the appropriate information.

2934 Presentation of Evidence at the Fair Hearing

Revision 17-1; Effective March 15, 2017

Staff listed on Form H4800, Fair Hearing Request Summary, will receive Form H4803, Notice of Hearing, notifying participants when the hearing will be held. HHSC staff must adequately prepare both the fair hearing packet and presentation of evidence at the fair hearing. The burden of proof to uphold the agency's decision rests with the agency. The hearings officer is a neutral party and is restricted by law from presenting the agency's case.

Documentation contained in the fair hearing packet will not be considered in the decision unless the packet is offered into evidence. To accomplish this requirement, the agency representative must present the packet, **ask that it be submitted as evidence** and summarize what the packet contains.

Example: "I want to offer the following packet as evidence in the appeal filed on the behalf of Joe Smith. Pages 1-10 contain information relating to the completion of Form 2060, Needs Assessment Questionnaire and Task/Hour Guide. Pages 11-15 contain policy from the *Community Care for Aged and Disabled Handbook*, which relate directly to the issue in question. Pages 16-20 contain documents signed by the applicant related to individual rights. Page 21 contains Form 2065-A, Notification of Community Care Services, which was mailed to the applicant on March 2, 2010."

The hearings officer usually can only consider the specific information offered in evidence when making the hearing decision. For example, the case worker may clearly explain how the applicant must score 24 points on Form 2060 to be eligible for Primary Home Care. However, if documentation backing up that explanation (Handbook policy, Form 2060 Instructions and appropriate appendices) is not contained in the packet, the explanation will not be considered.

Oral testimony may be considered only if read into the record and if the appellant agrees to allow it.

The hearings officer will ask the appellant if he received the evidence packet. If not, the hearings officer will attempt to determine why. If no effort was made to send a packet to the appellant, the packet may not be admitted and the appropriate agency representative will have to read information into the record in order to have it considered.

The hearings officer will then ask for objections and allow all admissible documents into evidence. Any documents admitted by the hearings officer may be considered when a decision is rendered. Specific items of importance on a page or policy section must be emphasized as the case is presented to ensure the case has been

clearly presented. If any documents are not admitted, the hearings officer will explain the reasons for excluding the material.

2935 Action Taken after the Hearing Decision

Revision 17-1; Effective March 15, 2017

2935.1 Action Taken on the Hearing Decision for Reductions

Revision 17-1; Effective March 15, 2017

After the hearing is held, the Texas Health and Human Services Commission (HHSC) hearings officer will send a decision letter, Form H4807, Action Taken on Hearing Decision, to the appellant and send copies to the case worker and the supervisor. If the HHSC decision is sustained, then the case worker takes the appropriate action. If services continued during the appeal period, then the case worker completes a new Form 2101, Authorization for Community Care Services, and sends it to the provider with the reduced service amounts. The action must be completed within **10 calendar days** after the hearings officer's decision. It is not necessary to send the individual another Form 2065-A, Notification of Community Care Services, since the individual has already been notified of the change.

If the hearings officer reverses the decision, the hearings officer also sends HHSC Form H4807 and specifies the corrective action to be taken and a 10-day time frame for the completion of the action. The case worker continues authorization at the higher level of services. The case worker sends the individual Form 2065-A showing the new level of services. A new Form 2101 is not required, since the provider is already delivering services at the higher level. The case worker actions required by the hearings officer must be reported back through the Texas Integrated Eligibility Redesign System (TIERS) within the 10-day time frame designated by the hearings officer. Form H4807 is no longer completed and mailed back to the hearings officer. All communication will be through TIERS.

2935.2 Action Taken after the Hearing Decision of Terminations

Revision 17-1; Effective March 15, 2017

Once the hearings officer's decision is rendered and if the individual is determined eligible to continue receiving services, the case worker sends Form 2065-A, Notification of Community Care Services, to the individual to notify him that the hearings officer's decision overturned the termination and his eligibility is continued. The case worker includes the following statement in the comments: "The hearings officer has overturned the termination decision and you have been determined eligible for continued services effective (the begin date)." The case worker sends the provider an updated Form 2101, Authorization of Community Care Services, reinstating services.

If the hearings officer sustains the termination decision and services were not continued, then no further case worker action is required on the case. If the hearings officer sustains the termination decision and services were continued, the case worker must terminate services in Service Authorization System and send the provider Form 2101 ending services within 10 calendar days after the hearings officer decision, or in accordance with instructions provided by the hearings officer. The case worker does not send another Form 2065-A to the individual to provide notification that the individual is not eligible based on the hearings officer's decision. The case worker orally notifies the individual of the termination of services and the effective date and documents the contact in the case record.

2935.3 Fair Hearings Officer Orders a New Assessment

Revision 17-1; Effective March 15, 2017

If the hearings officer's final decision orders completion of a new Form 2060, Needs Assessment Questionnaire and Task/Hour Guide, the hearing is closed as a result of this ruling. The case worker must notify the individual of the results of the new assessment on Form 2065-A, Notification of Community Care Services. The individual may appeal the results of the new assessment. If the individual chooses to appeal, the case worker must indicate in Section 8, Summary of Agency Action of Form H4800, HHSC Action Taken on Hearing Decision, and also during the fair hearing that the new assessment was ordered from a previous fair hearing decision. If the individual requests an appeal of the new assessment, HHSC continues services until the second fair hearing decision is implemented.

2935.4 Reporting the Action Through TIERS

Revision 17-1; Effective March 15, 2017

The case worker completes Form H4807, Action Taken on Hearing Decision, recording case actions taken and sends it to the supervisor and the designated data entry representative. The case worker must send Form H4807 within the time frames to allow at least two days for the data entry representative to enter the information into the system. If the action cannot be taken by the time frame designated by the hearings officer, the case worker must complete Section B on Form H4807 and send to the supervisor and data entry representative providing the reason for the delay. Acceptable reasons are listed on the form and the begin delay date and end delay date must be included. See the form instructions for detailed information on completing Form H4807.

2936 Fair Hearing Exception Process

Revision 17-1; Effective March 15, 2017

When a fair hearing decision is rendered, staff must implement the decision of the fair hearings officer within the applicable time frames, including the restoration of any benefits or services.

Staff who disagree with the result of a fair hearing must follow regional procedures in referring the issue to the regional director. Staff use Form 1590, Request for a Fair Hearing Exception, to initiate a fair hearing exception request. The form documents the region's request for a review of a fair hearing decision.

If he agrees with the region's request, the regional director forwards Form 1590 to the Community Services Policy (CSP) unit manager. The CSP unit manager must receive the form by the fifth calendar day following the date on the hearing decision. A copy of the form is kept in regional files, not in the case record.

Upon reviewing the region's exception request, the CSP unit manager will decide whether to forward the exception request for consideration by HHSC. If the CSP unit manager (or designee):

- concurs with the regional assertion that policy was misapplied, the form is forwarded to the Fair and Fraud Hearings Section.
- determines a clear error of law or fact was made by the hearings officer, he requests that HHSC review the case action and, if they are in agreement, issues a revised hearing decision.
- does not concur with the regional request, the request will not be forwarded to HHSC.

If the CSP unit manager forwards the exception request for consideration by HHSC, then the HHSC case worker or designee must mail Form 1015 or Form 1015-S, Fair Hearing Exception Letter, and a copy of the exception request to the applicant or individual. The case worker or designee must place the letter and exception request in the outgoing mail by the close of the next business day following receipt of the notification from the CSP unit manager. A copy of the letter and exception request must be placed in the case record.

The region will be notified of the decision whether the request was or was not forwarded to HHSC. Even if an exception request is being filed, the hearings officer's decision must be implemented within the required time frames.

3000, Eligibility for Services

3100, Eligibility Determination Procedures

3110 Eligibility for CCSE Services

Revision 17-1; Effective March 15, 2017

40 Texas Administrative Code (TAC) §48.2901(a). To receive Community Care Services Eligibility (CCSE), a client must meet income, resource, age, and need criteria.

40 TAC §48.2910(b). Clients who live in nursing homes are not eligible to receive CCSE services.

An applicant or individual who lives in Texas may qualify to receive most CCSE services regardless of citizenship or the duration of residency. However, individuals may not receive Community Attendant Services or waiver services without verification of citizenship and identity.

Provider agencies must accept HHSC' decision about which individuals are eligible. For eligibility requirements for specific CCSE services, see Section 4000, Specific CCSE Services.

Note: Refer to Appendix XV, Services Available from Other State Agencies, for information about services that may benefit the applicant/individual.

3111 Age Limits

Revision 17-1; Effective March 15, 2017

40 Texas Administrative Code §48.2906, Age Limits

(a) A person must be 18 years of age or older, or an emancipated minor, to receive Community Care Services Eligibility (CCSE) services, except:

(1) a person of any age may receive CCSE Medicaid-funded day activity and health services;
(2) a person of any age who is not eligible for the Texas Health Steps program may receive CCSE Medicaid-funded community attendant services.

Although age limits do not apply to Title XIX Day Activity and Health Services (DAHS), licensure prohibits service providers to deliver DAHS services in facilities that are not licensed to serve individuals under age 18. There are currently no facilities licensed in Texas that can serve non-adults.

3120 Loss of Eligibility

Revision 17-1; Effective March 15, 2017

40 Texas Administrative Code §48.3903(c). The client is not eligible for CCSE services when

(1) he dies;
(2) he is admitted to an institution;

(3) his physician requests service termination (Medicaid services only); or
(4) he requests service termination or repeatedly refuses to accept help, except in an involuntary protective services case, or he refuses to comply with his service plan.

The case worker must notify the provider as soon as an individual has died or is entering a nursing home. Terminate services effective the date of death or entry into the nursing home. The provider cannot bill for attempting to deliver services after the effective date of the termination.

3200, Resource Eligibility Criteria

3210 Resource Limits

Revision 17-1; Effective March 15, 2017

40 Texas Administrative Code §48.2922. An individual applicant or client is not eligible for CCSE services if the value of nonexempt resources owned by him exceeds $5,000. A couple is not eligible for CCSE services if the value of nonexempt resources they own exceeds $6,000.

The individual limit applies to individuals who are single, even if they live with relatives. The individual limit also applies to individuals whose spouses live in different households. The couple limit applies to married individuals who live in the same household, even if the spouses are ineligible.

Include in the individual's resources those resources the individual owns even if the resources are managed and controlled by someone else acting on the individual's behalf. Also include funds that are not in the individual's name if those funds clearly belong to the individual and are available for use. Determine ownership based on the individual's statement unless contradictory evidence from another source exists.

3220 Types of Resources

Revision 17-1; Effective March 15, 2017

40 Texas Administrative Code §48.2923. In determining eligibility for CCSE services, the department considers the following to be resources:

(1) Liquid resources including cash on hand, CDs, checking or savings accounts, money market funds, revocable trust funds, saving certificates, stocks, or bonds. Liquid resources also include the individual's or couple's portion of money in a checking or savings account or a money market fund held jointly with another person.

(A) Jointly held liquid resources are the resources of the applicant/client if he has unrestricted access to the funds, regardless of the source. The applicant/client may move his portion of jointly held funds in a joint account to a new account. Although the new account may be jointly owned, all funds in the new account are considered to be his.
(B) Money received as a nonrecurring lump sum payment is not considered a resource until 30 days from the date of receipt. Lump sum payments include, but are not limited to, income tax refunds; earned income tax credits or rebates; one-time bonuses from mineral rights; retroactive lump sum Social Security, SSI, or railroad retirement benefits; lump sum insurance settlements; one time gifts, awards, or prizes; and refunds from rental or utility deposits. The applicant/client is responsible for reporting the receipt of a lump sum payment.

(2) Nonliquid resources including nonexempt licensed or unlicensed vehicles; buildings and land not designated as homestead that are not producing income, or are producing income less than 6% of the equity value; and any other property not specifically excluded.

Evaluate nonliquid resources according to the equity value. Equity value is the market value of the resource minus any recorded encumbrances.

Money received from the sale of a countable or excluded resource, other than a homestead, is not counted as a resource until the first day of the month following a full month after it was sold. **Example:** The resource is sold on June 15; proceeds are not counted until Aug. 1.

Annuities

A revocable annuity is a countable resource. If an individual has an annuity, the case worker must review the contract or agreement terms to determine if the principal is an available resource. Refer the annuity document to the regional attorney if there is a question as to whether or not the annuity is revocable.

Irrevocable annuities are not countable resources for Community Care for Aged and Disabled individuals. However, the purchase of an annuity may affect the individual's eligibility for institutional care or waiver services. If the individual is concerned about the effect the annuity may have on future eligibility for services, refer the individual to consult with a Medicaid for the Elderly and People with Disabilities specialist.

Guardianships and Power of Attorney

If the individual is a guardian for a person other than his spouse, do not include in his resources any separately identifiable funds belonging to the other person but accessible to the individual as that person's guardian.

A person who has a financial power of attorney for another is acting solely as a fiduciary agent. The fiduciary agent acts in a financial capacity, whether formal or informal, regardless of title (for example, representative payee, guardian or conservator); therefore, assets belonging to the other individual should not be considered as part of the individual's available assets.

Assets held by a fiduciary agent for an individual are considered available to the individual, unless otherwise excludable.

3230 Resource Exclusions

Revision 17-8; Effective September 1, 2017

In determining eligibility for CCSE services, the department does not consider the following to be resources. They are considered to be excluded for eligibility purposes. Any item not listed as an exclusion is considered a resource.

(1) Homestead — Any structure used by the client as a residence, including other buildings and contiguous land. Mobile homes, houseboats, and motor homes are considered structures. Vacant property is not a homestead. Contiguous land means land adjacent to the home, including any land separated only by roads, rivers, and streams. Land is contiguous as long as it is not separated by property owned by another person. The homestead is excluded as a resource regardless of its location, even if the client no longer lives there (unless he has purchased another residence). If he owns two houses, his homestead is the property that he uses as a residence. Only one homestead may be excluded for each client or couple.
If the individual lives in a house, but also has a mobile home, houseboat or motor home on the property, these are all excluded as part of the homestead.

(2) Personal property — Household goods and personal effects.
(3) Property essential to employment — Tools and equipment required for employment or self-employment.
(4) Prepaid burials — Prepaid burial arrangements, burial insurance, and burial plots.
(5) The cash surrender value of all life insurance.

(6) Vehicles — One passenger car or other vehicle, such as a van or truck, used for transportation; or one unlicensed vehicle.

(A) A second vehicle may be excluded if it is:

(I) specially equipped to enable a person with a disability to drive, or
(II) essential to the employment or self-employment of the family.

(B) Any additional vehicles, licensed or unlicensed, are considered resources.

An inoperable junk vehicle can be assigned a value of $100, if the individual's resources are less than:

- $4,900 for a single person, or
- $5,900 for a couple.

The case worker must verify the value of an inoperable vehicle when the individual's resources are within $100 of the CCSE resource limit ($5,000 for a single person or $6,000 for a couple).

(7) Income-producing property — Property that annually produces net income equal to or greater than 6% of the property's equity value. The equity value is the current market value of the property less any recorded encumbrances. (See Section 3231, Rate of Return on Income-Producing Property.)
(8) Installment contracts from mortgages, notes, or loans — The value of installment contracts for the sale of land, other property, or repayment of loans, if the contract or agreement is producing income according to the fair market value at the time of the agreement. An installment is a mortgage or similar contract in which the buyer promises to pay a fixed amount over a period of time until the principal of the note is paid. Even though the seller retains legal title, the property is not considered a countable resource as long as the buyer is fulfilling the contractual obligation. The payment is considered income.
(9) Disaster assistance — Government payments granted for the rebuilding of homes destroyed or damaged in a disaster.

Reverse mortgages are treated as loans. The money received is not considered to be income. However, it is a resource the month after receipt.

(10) Energy assistance — Payments or allowances for energy assistance made under any federal, state, or local law.
(11) Supplemental Nutrition Assistance Program (SNAP) allotments — The value of SNAP allotments and USDA-donated foods.
(12) Inaccessible resources — The cash value of resources that are inaccessible to the client. Examples are irrevocable trust funds, property in probate, and pension funds. Real property that the client or family is making a good faith effort to sell is exempt. The client or family must ask a fair price for the property, according to its current market value. Property is also exempt if it is jointly owned and the other co-owners refuse to sell.

- If jointly owned property is not excluded, the market value of the individual's share of the property is countable. However, if the value will not affect eligibility, enter the full value of undivided property and document that the property is jointly owned.
- An IRA should be treated as a pension fund, and therefore not considered as a resource for eligibility determination.

(13) Mineral rights — The value of mineral rights.
(14) Life estates and remainder interests — A life estate is the right an individual has to property during the individual's lifetime. A remainder interest is the right of ownership to the property when the life estate holder dies.
(15) Replacement value of excluded resources — The replacement value of an excluded resource if it is lost, damaged, or stolen. The cash received from an insurance company for replacing the resource is not considered for three months if the resource is personal property or six months if it is real property. Any cash not spent

within the specified period is considered a resource.
(16) Monthly gross income — All income received monthly. Monthly gross income is counted as income in the month received and excluded as a resource in that month.

- Do not deduct income from resources unless the countable resources exceed $5,000 ($6,000 for a couple).
- If resources exceed the $5,000/$6,000 limit, determine whether the monthly income is actually included in the checking or savings account or cash on hand.
- If cash on hand is money remaining from the current month's income, it may be deducted unless this would duplicate deduction of the same money as a checking or savings account deposit.
- If resources exceed the $5,000/$6,000 limit, deduct the amount of income the individual may have received at the end of the month intended for the next month. Example: Next month's Social Security check arrives early (the last day(s) of the month) and is deposited into the individual's checking or savings account.
- If income is deducted and the individual receives Veterans Affairs (VA) aid-and-attendance or homebound benefits, deduct the full amount of VA payment even though aid-and-attendance is excluded from income.

(17) Sale of a homestead — Proceeds from the sale of a homestead up to six months after they become available to the seller. The six months gives the client time to acquire another homestead. If he does so, any balance from the original sale must be considered as an available resource. If, before the end of the six-month period, the client declares that he has no intention of acquiring another homestead, the proceeds from the sale must be counted as an available resource.
(18) Agent Orange Settlement Payments — Payments from the Agent Orange Settlement Fund or any other fund established in settlement of the Agent Orange product liability litigation.
(19) Radiation exposure compensation — Payments received under the Radiation Exposure Compensation Act (P.L. 101-246).
(20) Funds from the Transition to Life in the Community Program.
(21) Livestock.
(22) Earned income tax credit (EITC) refunds from the Internal Revenue Service.

3231 Rate of Return on Income-Producing Property

Revision 17-1; Effective March 15, 2017

To determine whether the property is producing enough income to be excluded as a resource:

Step	Procedure
1	Determine the current market value, or the amount the property would bring on the open market. The current market value may be based on an estimate by a knowledgeable source such as a realtor or bank official.
2	Determine the total amount owed on the property (encumbrances) by viewing a copy of the loan agreement, purchase contract, or contract with the creditor.
3	Calculate the equity value by subtracting the encumbrances from the current market value.
4	Multiply the equity value by 6% to determine the required gross yearly revenue that must be produced to exempt the property.
5	Calculate the net yearly income the property produces from rents, leases, etc. by subtracting from the gross yearly income any expenses such as taxes, insurance, costs of repairs and maintenance, and interest on the property's mortgage. (Expenses for capital improvement and depreciation are not deductible.)
6	Compare the required gross yearly revenue calculated in step 4 (yearly income that must be produced) with the net yearly income from step 5 (actual yearly income produced) to determine whether the net income equals or exceeds 6% of the equity value. If the property is not producing income equal to or greater than 6% of the equity value, consider the equity value of the property a resource.

3300, Income Eligibility

3310 Income and Income Eligibles

Revision 21-3; Effective September 1, 2021

To be eligible for CCSE services, the person must either be:

1. categorically eligible by receiving
   - Supplemental Security Income (SSI);
   - Temporary Assistance for Needy Families (TANF);
   - Supplemental Nutrition Assistance Program (SNAP);
   - Medicaid, Specified Low-Income Medicare Beneficiary (SLMB) or Qualified Medicare Beneficiary (QMB) benefits; or
2. income eligible. The person's and their spouse's countable income must be equal to or less than the income limit set by the U.S. Department of Health and Human Services (HHS).

Categorical Eligibility for Title XIX Services

A person with full Medicaid is financially eligible for Title XIX services. These people are referred to as categorically eligible.

Use the Texas Integrated Eligibility Redesign System (TIERS) to determine the eligibility status of a person applying for Title XIX CCSE programs.

Related Policy

TIERS Inquiries, 7110
SAVERR/TIERS Type Program Chart, Appendix XIV

Categorical Eligibility for Title XX Services

Recipients of some non-Medicaid programs are financially eligible for Title XX benefits based on existing program eligibility. These people are referred to as having categorical eligibility for Title XX services.

Financial Eligibility Determination for Title XX Services

CCSE staff determine financial eligibility for applicants for Title XX programs unless financial eligibility has already been determined based on existing program eligibility. These people are referred to as income eligibles.

Related Policy

Determination of Countable Income, 3320
Budgeting Countable Income, 3330
Computation of Gross Income, 3340
TIERS Inquiries, 7110

Financial Eligibility for Community Attendant Services (CAS)

Financial eligibility for CAS is determined by both Medicaid for the Elderly and People with Disabilities (MEPD) and Texas Works (TW) staff. CCSE staff must not deny CAS, STAR+PLUS Home and Community

Based Services (HCBS) or 1915(c) Medicaid waiver cases based on income or resources, even if the applicant's assets appear to substantially exceed the eligibility limits.

Effect of Living Arrangement on Financial Eligibility for Title XX Programs

If both spouses apply for services and only one spouse receives SSI, TANF, Medical Assistance Only or another program that provides categorical eligibility for CCSE services, compare the total income of both spouses with the couple's income limit to determine the second spouse's eligibility.

If a married person does not live with their spouse, use the individual income limit. Do not consider the income of the spouse unless that income (or part of it) is given to the person. Income diverted from a spouse in a nursing home to the person at home is included in the person's income calculation. If income diverted from a spouse in a nursing home makes a person ineligible, explain to the person that they can request the amount of income they keep from the institutionalized spouse may be reduced. If the amount they keep is reduced, they will be required to pay more to the nursing home. The person must contact MEPD to request this change. Explain that the person may need to reapply for CCSE, if the situation changes.

A CAS, PHC or Title XIX Day Activity and Health Services recipient who requests a Title XX service, is categorically eligible for Title XX services based on the current Medicaid eligibility certification.

Related Policy

Income and Resource Limits, Appendix XI

3320 Determination of Countable Income

Revision 17-1; Effective March 15, 2017

40 Texas Administrative Code (TAC) §48.2903, Determination of Countable Income. Countable income is determined by totaling gross income from all the following sources, less all applicable exclusions and exemptions. Applicable exclusions/exemptions are specified in 40 TAC §48.2904 and 40 TAC §48.2905 of this title (relating to Income from Excludable Sources and Income from Exempt Sources.)

(1) Total gross earnings — This includes money, wages, commissions, tips, piece-rate payments, cash bonuses, or salary received for work performed as an employee. This also encompasses pay for members of the armed forces (including allotments from any armed forces pay received by a member of the family group from a person not living in the household).
(2) Self-employment income (including farm income) — For earned income to be considered self-employment, either the individual or spouse must be actively involved or materially participating in producing the income.
(3) Social security and railroad retirement benefits.
(4) Dividends — This consists of dividends from stocks or membership in associations, and periodic receipts from estates of trust funds. These payments are averaged over a 12-month period.
(5) Rental income — This includes payments to the individual from the rent of housing, store, or other property, as well as from boarders or lodgers.
(6) Net income derived from oil, gas, or mineral rights — This can include both lease and royalty payments. These payments are averaged over a 12-month period.

(Reminder: Refer to Section 3330, Budgeting Countable Income, to determine if this income can be excluded as infrequent and irregular or as a lump sum payment.)

(7) Income from mortgages or contracts.
(8) Public assistance or welfare payments — Temporary Assistance to Needy Families, Supplemental Security Income, and general assistance (cash payments from a county or city) are included.

(9) Veterans' pensions and compensation checks — This may include money paid periodically by the Veterans Administration to disabled members of the armed forces or to survivors of deceased veterans, subsistence allowances paid to veterans for education and on-the-job training, and refunds paid to ex-servicemen as GI insurance premiums.
(10) Educational loans, grants, fellowships, and scholarships.
(11) Unemployment compensation — Unemployment compensation may be received from government employment insurance agencies or private companies during periods of unemployment, and includes any strike benefits received from union funds.
(12) Workers compensation and disability payments — This includes compensation received periodically from private or public insurance companies for injuries incurred at work.
(13) Alimony.
(14) Regular monthly cash support payments from friends or relatives.
(15) Pensions, annuities, and irrevocable trust funds — Payments may be paid to a retired person or his survivors by a former employer or by a union, either directly or through an insurance company. Periodic payments from annuities, insurance, irrevocable trust fund payments, and civil service pensions are included.
(16) Income from the client's share of a life estate.

3330 Budgeting Countable Income

Revision 17-1; Effective March 15, 2017

The sources of income that may be included in the income eligibility budget fall into one of three categories: countable, excludable and exempt. Countable income is addressed in Section 3320, Determination of Countable Income. Treatment of the excludable and exempt income varies, as illustrated below.

3330.1 Excludable Income

Revision 17-1; Effective March 15, 2017

40 Texas Administrative Code §48.2904, Income from Excludable Sources. Income may be fully or partially countable, or may be excluded from the current eligibility budget. Excludable income will continue to be monitored by the caseworker at each financial review to determine how eligibility is affected. Excludable sources of income include:

(1) deductions from earned income, including social security payments, Medicare premium payments, bonds, pensions, and union dues;
(2) the first $65 of a client's (or couple's) net earned income, plus 1/2 of the remainder;
(3) loans, grants, scholarships, and fellowship funds obtained and used under conditions that preclude their use for current living costs. Any portion used to pay any other expense (room, board, books, etc.) cannot be excluded;
(4) Veterans Administration aid-and-attendance benefits, homebound elderly benefits, and payments to certain eligible veterans for purchase of medications;
(5) infrequent or irregular income (income received less frequently than once a month) that averages $20 per month or less;
(6) 1/3 of the total amount of child support payments for an eligible child; and
(7) allowable exclusions from self-employment income, as indicated on the following chart.

Expense	Excludability
Money paid to or for employees not living in the home	Excludable
Money paid to or for employees living in the home	Excludable
Federal, state, or local income taxes	Excludable
Sales tax	Excludable

Expense	Excludability
Property tax	Excludable
Rental of business property	Excludable
Utilities for business property	Excludable
Stock/inventory, raw materials	Excludable
Supplies	Excludable
Fuel expenses for the business	Excludable
Insurance premiums	Excludable
Linen service	Excludable
Interest for business loans or property	Excludable
Lodging when traveling (when not counted as shelter)	Excludable
Own meals when traveling for business	Excludable
Net loss for same determination period	Excludable
Additional expenses related to self-employment (advertising, co-op, license fees, journals, etc.)	Excludable
Additional farming-related expenses (feed, seed, plants, seedlings, farm supplies, breeding fees, fertilizer and lime, crop insurance, crop storage, fees for livestock testing, etc.)	Excludable for self-employment farming Excludable for unearned income farming only if part of the lease agreement
Depreciation related to self-employment	Excludable
Cost of doing business in the home (separately identifiable from home expenses), including utilities. For rooms designated for business purposes in a single residence, expenses are compared to the total number of rooms in the house. Bathrooms are not counted as rooms; basements and attics are counted only if they have been converted into living spaces.	Excludable
Purchase and cleaning of uniforms	Not excludable
Capital asset purchases	Not excludable
Capital asset improvements	Not excludable
Payment on principal of loan for income producing property	Not excludable
Travel to/from place of business	Not excludable
Net loss from previous determination period	Not excludable
Depreciation related to unearned income (e.g., rental income)	Not excludable

Mandatory deductions from unearned income may also be excluded from the eligibility budget. Documentation in the case record must clearly state that the deduction is mandatory and whether/when the mandatory deductions will end.

For earned income to be considered self-employment, either the individual or spouse must be actively involved or materially participating in producing the income. A business owner is determined to be materially participating if he meets any one of the following criteria:

- The owner engages in periodic advice and consultation with the tenant, inspection of the production activities, and furnishing of machinery, equipment, livestock, and production expenses.

- The owner makes management decisions that affect the success of the enterprise.
- The owner performs a specified amount of physical labor to produce the commodities raised.
- The owner does not meet the full requirements above, but his involvement in crop production is nevertheless significant.

A blind or disabled student under 22 years of age who regularly attends school, college, a university or a course of vocational or technical training can have limited **earnings** that are not counted toward the income eligibility budget. (This exclusion does not apply to unearned income.)

The maximum amount of the income exclusion varies from year to year and is determined annually by the Social Security Administration (SSA). Exclusion amounts can be determined online at www.ssa.gov/OACT/COLA/studentEIE.html.

Section 2002 of the American Recovery and Reinvestment Act of 2009 (ARRA) authorizes additional unemployment compensation benefits of $25 per week for individuals receiving unemployment benefits. The additional $25 unemployment compensation benefits received as a result of ARRA are not countable income for either eligibility or co-payment purposes. As the additional unemployment compensation may be included either with the regular payment or as an additional payment, a contact with the Texas Workforce Commission may be needed to determine if any of the payments are part of the ARRA additional compensation.

3330.2 Exempt Income

Revision 17-8; Effective September 1, 2017

There are numerous exemptions on countable income. These exemptions can be found in Appendix XXX, Income and Resource Exemptions for Determining Financial Eligibility.

Exempt income is not included in the income eligibility calculation. Once identified and documented, caseworkers will not be required to monitor exempt income at subsequent financial redetermination. Sources of exempt income include:

(1) interest income.
(2) cash received from the sale of a resource. This cash is a resource, not income.
(3) income of minor children who are supported by or dependent upon the client.
(4) refunds from the Internal Revenue Service for earned income tax credit.
(5) reimbursement from an insurance company for health insurance claims.
(6) any cash from a non-governmental medical or social services organization if the cash is:

- for medical or social services already received by the individual and approved by the organization, and which does not exceed the value of those services; or
- a payment restricted to the future purchase of a medical or social service.

(7) proceeds of either a commercial loan or an informal loan, for which repayment is required with or without interest. The proceeds (amount borrowed) are not counted as income in the month in which they are received, but are considered to be a resource in the following month(s). To claim exemption of the proceeds of a loan, a client must prove that he acknowledges an obligation to repay and that some plan for repayment exists. If these conditions can be verified, no written contract is required.
(8) the amount of the cost-of-living increase in any pension or benefit, received on or after January 1, 1985, that would cause the client to be ineligible for continued services. This exclusion applies only to community care clients who are already receiving services or case management and would become ineligible because of the increase. It does not apply to applicants.
(9) in-kind income, such as food, clothing, shelter, rent subsidies.
(10) one-time or lump-sum payments from any source.
(11) funds from the Transition to Life in the Community Program.

For a complete list of income exemptions, see Appendix XXX.

The term "lump sum," as listed in (10) above, can be defined as income that is not expected to recur with a predictable pattern of frequency.

Income received less than three times per year that does not meet the $20 monthly average requirement, as listed in (5) above, should be treated as a lump sum payment. If the lump sum could affect eligibility, the case should be monitored 30 days following receipt to ensure that resource eligibility is not affected.

3340 Computation of Gross Income

Revision 17-1; Effective March 15, 2017

If an individual receives gross income more often than monthly, compute the income as follows.

- Weekly income — multiply by 4.33
- Bi-weekly income — divide by 2 and multiply by 4.33
- Twice monthly income — multiply by 2.

3341 Income Averaging

Revision 17-1; Effective March 15, 2017

Calculate the income average of all income that may be received monthly, but is usually received less often. The case worker also may need to calculate the 12-month average income for monies received for seasonal employment, such as agricultural or construction work.

If an individual ends regular employment to accept seasonal employment but later returns to the regular job, calculate the income average from the combined sources over the 12-month period.

3400, Verification Procedures

3410 Verification of Public Assistance Status

Revision 17-1; Effective March 15, 2017

Within 24 months of the last financial review, verify the correct categorical financial status of current Temporary Assistance for Needy Families (TANF), Supplemental Security Income (SSI), Qualified Medicare Beneficiary (QMB), Specified Low-Income Medicare Beneficiary (SLMB), Qualifying Individuals (QI), Supplemental Nutrition Assistance Program, Medicaid Buy-In or Medicaid individuals and certify eligibility on this basis. Documentation on Form 2064, Eligibility Worksheet, or a printed copy of an HHSC computer inquiry placed in the individual's case folder will satisfy verification requirements for an individual receiving service(s) based on categorical financial status.

Refer to Section 7110, TIERS Inquiries, for a full listing of programs that provide categorical eligibility for Community Care for Aged and Disabled programs.

3420 Verification of Income and Resources

Revision 17-1; Effective March 15, 2017

Program Standard: The case worker must accurately establish the countable amount of income and resources to determine the income-eligible applicant's financial eligibility.

Determine the amount of countable assets for persons applying as income eligibles. Within 24 months of the last financial review, financial eligibility must also be redetermined for these individuals. An individual's declaration of income/resources for all programs is acceptable (excluding waiver services) unless:

- there is reason to doubt the reliability of the applicant's statement. The case worker has the option of requesting verification whenever any doubt exists.
- the applicant's declared resource amount is within $100 of the resource eligibility limit.
- the applicant's declared income amount is within $10 of the income eligibility limit.
- the applicant appears unsure about the amount of income or resources available. The case worker may accept a certain level of uncertainty. Example: The individual may state that he receives "about $350 per month." Since this is well below the income eligibility cap, the applicant's statement may be accepted even though the individual is not absolutely sure about the amount. However, if the applicant responded with "somewhere around $1,500," it would be necessary to verify the amount of income, given the uncertainty and the proximity to the eligibility limit.

If an individual meets the criteria in Section 3430, Eligibility Before Verification, refer the individual for services before verifying income and resources, and complete the verification within 30 days of the application.

Applicants are responsible for providing all information needed to establish eligibility. Ask the applicant or responsible party to provide the needed information to verify income and resources.

When information is requested from the applicant or responsible party, give a specific due date and explain the result of not providing the requested information. During a review, make the due date two weeks before the day the current certification period ends. This will allow a few more days to give the individual a second chance before terminating services effective the last day of certification. Follow up at least one time before denying the applicant for failure to cooperate.

During a financial review, if an individual reports closing a bank account or no longer having an account that was included in the last review, and adding the last known balance would bring the individual to within $100 of the resource eligibility limit, verify with the bank that the account has been closed.

If the information can be obtained by making a telephone call or mailing a verification form, attempt to obtain the information before denying the application. If the case worker cannot obtain the information and the applicant does not provide the information, deny the application. If the case worker cannot obtain information needed for a financial recertification and the individual does not provide the information, send Form 2065-A, Notification of Community Care Services, at least 12 days before termination becomes effective.

The case worker may, without verifying the income or resources, deny an application because the individual reports excess income or resources. Explain the reason for the denial to the individual or responsible party. Explain in the comments section of Form 2064, Eligibility Worksheet, that the denial was due to the individual's declaration of excess income or resources.

See Appendix XII, Examples of Methods to Verify Income and Resources, for examples of methods to verify income and resources. The case worker may use a verification source not listed in Appendix XII if it is determined the source is both knowledgeable and objective. A person is considered knowledgeable if that person routinely assesses values on that type of resource in the area where the resource is located. A person may not be considered objective if that person has a vested interest in the individual's eligibility.

Documentation on Form 2064 should contain enough information to determine what, when, where and how the applicant's/individual's income/resources were verified, so that they can be traced to the original source. For categorically eligible applicants and individuals (Temporary Assistance for Needy Families (TANF), Medical Assistance Only (MAO), Supplemental Security Income (SSI), Qualified Medicare Beneficiary (QMB),

Specified Low-Income Medicare Beneficiary (SLMB), Qualifying Individual (QI) and the Supplemental Nutrition Assistance Program), the case record must:

- show that categorical status was verified, or
- include a printed copy that shows the applicant's categorical status.

Form 2064 must show that verifications were received before the date eligibility rules were processed.

3421 Financial Documentation Requirements

Revision 17-1; Effective March 15, 2017

This chart is designed to assist in determining what is required for financial eligibility documentation.

If the individual's:	and	then:
income is not within $10 of the eligibility limit and/or resources are not within $100 of the eligibility limit	information gathered by the case worker matches information on the application form,	no verification is required. Enter the monthly dollar amount in SASOW and select the *client statement option*. No other documentation is required.
income is not within $10 of the eligibility limit and/or resources are not within $100 of the eligibility limit	information gathered by the case worker does not match information on the application form,	no verification is required. Enter the monthly dollar amount in SASOW and select the *client statement option*. No other documentation is required.
income is within $10 of the eligibility limit and/or resources are not within $100 of the eligibility limit	information gathered by the case worker matches information on the application form,	view verification containing all information listed in Column 3 of Appendix XII. Enter the monthly dollar amount and select the appropriate documentation source in SASOW/TIERS. No further documentation is required. If the case worker is not able to view adequate documentation, verification of income and resources is required.
income is within $10 of the eligibility limit and/or resources are not within $100 of the eligibility limit	information gathered by the case worker does not match information on the application form,	view verification containing all information listed in Column 3 of Appendix II. Enter the monthly dollar amount and select the appropriate documentation source in SASOW/TIERS. Explain the discrepancy in documentation.

If the individual's:	and	then:
income is within $10 of the eligibility limit and/or resources are within $100 of the eligibility limit	N/A	verification of income and resources is required.

3422 Exceptions to Verification Requirements

Revision 18-1; Effective June 15, 2018

Within 24 months of the initial financial determination, income-eligible individuals must complete a new Form H1200, Application for Assistance – Your Texas Benefits,/Form H1200-EZ, Application for Assistance — Aged and Disabled. Subsequent financial redeterminations will not require completion of Form H1200/Form H1200-EZ, unless the case worker has reason to believe the individual's financial eligibility may be in question.

Even though a new Form H1200/Form H1200-EZ is not needed, the case worker still must contact the individual and confirm that significant changes in income and resources have not occurred.

If there is a new source of income at a financial review or a new resource, then re-verify all of the individual's resources. If adding the individual's new assets to existing income/resources brings the total income within proximity of financial eligibility limits, re-verify all of the individual's resources.

Following these guidelines, at a review the case worker may need to verify both income and resources, income but not resources, resources but not income, or neither income nor resources.

If an individual loses categorical eligibility (for example, stops receiving Temporary Assistance for Needy Families or the Supplemental Nutrition Assistance Program) between reviews, that individual may be able to continue receiving services without a financial review until the next financial review is due (see Section 3441, Loss of Categorical Status). If the individual or case worker reports income and resources within eligibility limits (and no other information exists to contradict this report), the individual may continue to receive Title XX (block grant) services. In such a case, the case worker must verify both income and resources at the next financial review.

3430 Eligibility Before Verification

Revision 17-1; Effective March 15, 2017

40 Texas Administrative Code §48.3901(g). A Medicaid-certified applicant for CCSE-purchased services who requires a verbal referral is eligible to receive CCSE-purchased services when his eligibility for Medicaid is verified. A non-Medicaid certified applicant who meets the requirements for a verbal referral is eligible to receive CCSE purchased services while income and resources are verified. [See Section 1130, Definitions, and Section 2631, Negotiated Referrals.]

(1) To be eligible, this applicant must:

(A) be a new applicant for CCSE services;
(B) appear to be eligible based on the declaration of income and resources on his application for services or to

have possession of a current medical care identification card; and
(C) meet the age and need criteria for the CCSE service he requires.

(2) The eligibility period for non-Medicaid applicants begins on the date of application.
(3)To continue receiving services, a non-Medicaid applicant must provide within 30 days of the application date the information needed to verify the applicant's income and resource amounts.

If, pending financial eligibility verification, the non-Medicaid applicant appears eligible for immediate service initiation, use the following procedures, as appropriate.

1. Refer the applicant to the provider according to Section 2631.
2. On Form 2101, Authorization for Community Care Services, enter the earliest date negotiated with the provider as the date services begin.
3. If the applicant is determined ineligible within the 30-day verification period, or if the applicant does not provide the information needed to verify income and resource amounts by the 30th day, send Form 2065-A, Notification of Community Care Services, to the individual to terminate services 12 days after the Form 2065-A date. (Refer to Appendix IX, Notification/Effective Date of Decision.)

3440 Changes in Financial Circumstances

Revision 17-1; Effective March 15, 2017

40 Texas Administrative Code §48.3901(f). The client must report promptly any changes in income, resources, or family size; loss of assistance grant or Medicaid benefits; or other changes in functional ability or circumstances that affect eligibility. The client is subject to fraud prosecution if he willfully fails to report changes and continues to receive services for which he is not eligible.

Individuals must report promptly any changes in income or resources. Note in the case record, but do not verify, reports of changes in income or resources that do not affect eligibility. Newly acquired resources that may affect eligibility, such as an inheritance involving property, are disregarded for 30 days from the date received. After 30 days, determine the amount of resources and terminate the individual's eligibility if the amount exceeds the resource limit.

3441 Loss of Categorical Status or Financial Eligibility

Revision 17-1; Effective March 15, 2017

In situations in which a Community Care Services Eligibility (CCSE) individual temporarily loses categorical or financial eligibility, the case worker must contact the individual and/or the appropriate agency to determine the reason for the denial and determine if reinstatement is likely.

If the individual loses Medicaid eligibility because his Supplemental Security Income (SSI) is being denied, the case worker must contact the individual and/or the Social Security Administration (SSA) to determine the reason for the denial and if the individual may be reinstated without a break in coverage.

Case workers may receive a copy of a denial notice or the monthly Loss of Eligibility Report for eligibility for the following programs:

- Community Attendant Services (CAS)
- Medicaid Buy-In (MBI)
- Medicaid through Temporary Assistance for Needy Families (TANF)
- Categorical eligibility through the Supplemental Nutrition Assistance Program (SNAP)
- Qualified Medicare Beneficiary (QMB)
- Specified Low-Income Medicare Beneficiary (SLMB)

- Qualifying Individual (QI)
- Medicaid through Type Program (TP) 03 (Pickle), TP 18 (Disabled Adult Children), TP 19 (SSI Denied Children) or TP 22 (Widow/Widower).

Upon learning of the denial, the case worker must check the Texas Integrated Eligibility Redesign System (TIERS) to verify the denial and the reason. The case worker must contact the individual to discuss the situation and, if feasible, assist the individual with completing the actions necessary for reinstatement of eligibility. If the individual has been denied on failure to furnish information, the case worker must contact the individual as soon as possible to advise him of the loss of service and the necessity of providing the information required by Medicaid for the Elderly and People with Disabilities (MEPD) or TANF. The case worker may also contact the MEPD or TANF specialist involved, ask about the individual's current income and resource amounts, and whether reinstatement will be occurring.

3441.1 Procedures Pending Reinstatement

Revision 18-1; Effective June 15, 2018

If the case worker is advised by the Social Security Administration (SSA), Medicaid for the Elderly or People with Disabilities (MEPD) or Temporary Assistance for Needy Families (TANF) that the individual will be reinstated within a month or is working on reinstatement, the case worker explores transferring the individual to Family Care (FC), if enrollment is possible in the region.

If the individual has not responded to requests for information and continues to fail to furnish information to the appropriate agency by the agency's deadline, he is not eligible to transfer to FC and the case is denied.

During times of extreme budget limitations on a regional or statewide basis, no individual may bypass the FC interest list. In absence of these budget limitations, the following procedures may be used.

If the individual or case worker reports income and resources within eligibility limits (and no other information exists to contradict this report), the individual may continue to receive Title XX (block grant) services or be transferred from Primary Home Care (PHC) to FC. Note the individual's changed status and record the self-declared income and resources in the case record. Update the Service Authorization System Online (SASO) to show the individual as income eligible. It is not necessary to obtain Form H1200, Application for Assistance – Your Texas Benefits, or Form H1200-EZ, Application for Assistance – Aged and Disabled, from the individual or to verify income and resource amounts until the next financial review is due.

The case worker must process a change within 14 days resulting from the individual’s loss of Medicaid resulting in a need to transfer from PHC to FC. When applicable, submit Form 2101, Authorization for Community Care Services, to transfer an individual from PHC to FC. Use the comments section on Form 2101 to document the individual’s services being transferred from PHC to FC due to a loss of Medicaid. Enter the day after the last date of Medicaid coverage as the "from" date on Form 2101. (If the Medicaid denial is unknown until after the last day of Medicaid coverage, use the earliest date FC can begin as the "from" date.) In the event that the individual has been receiving a block grant service and will continue to receive the same service, the same authorization may be continued.

If transferring to FC is not an option due to regional constraints, the case worker may suspend services for 60 calendar days to allow a determination on the individual's Medicaid status to be made regarding the reinstatement of services. Within four business days of determining suspension is appropriate, the case worker sends the individual Form 2065-A, Notification of Community Care Services, checking the Notification of Ineligibility or Termination of Benefits, the date services end, and noting services are suspended pending reinstatement of Medicaid or financial eligibility (as applicable). The case worker also sends the provider Form 2067, Case Information, suspending services effective the date of Medicaid denial.

During the period in which services are temporarily suspended by Medicaid, all case actions, such as monitoring and annual visits, changes, and transfers will be suspended. However, the case worker must set a special review for the 60th day following the suspension to check if eligibility has been re-established.

At any time during the initial 60-day period the case worker learns that eligibility has been re-established, the case worker has 14 days to resume services. Case workers must call the provider to negotiate the earliest date for services to resume. Case workers follow up the telephone call with Form 2067 to the provider, noting reinstatement of services with the negotiated date. Case workers must make any 90-day monitoring or annual reassessment visits which would have occurred during the suspension. The case worker documents the reinstatement of eligibility and the reason in delay for monitoring or annual reassessment visits due to the suspension of services in the case record and sends the individual Form 2065-A with a statement that services have been reinstated.

If, on the 60th day eligibility has not been re-established, the case worker may extend the temporary suspension for an additional 30 days for a total of 90 calendar days if the case worker determines the individual may still have eligibility reinstated. This determination will be established based on research of MEPD case-specific information. At any time during the additional 30 days the case worker learns that eligibility has been reinstated, the case worker has 14 days to resume services. Case workers must send Form 2067 to the provider to have services resumed, and must make any 90-day monitoring or annual reassessment visits which would have occurred during the suspension. The case worker documents the reinstatement of eligibility and the reason in delay for monitoring or annual reassessment visits due to the suspension of services in the case record and sends the individual Form 2065-A with a statement that services have been reinstated.

If reinstatement of eligibility will not be granted, the case worker sends the individual Form 2065-A denying services. The date of denial will be based on the:

- Medicaid eligibility end date, as indicated in the Texas Integrated Eligibility Redesign System (TIERS); or
- denial date on Form H4808, Notice of Change in Applied Income/Notice of Denial of Medical Assistance, from MEPD.

Form 2101 must be sent to the provider on the same date, noting services are denied effective the date of the financial denial.

3441.2 Reinstatement Procedures After Denial

Revision 17-1; Effective March 15, 2017

If financial or categorical eligibility is re-established within 60 days of the denial date and the individual reapplies for services, the case worker may use the information currently on file to determine eligibility. Completing new forms will not be required, except for a new Form 2110, Community Care Intake, and Form 2101, Authorization for Community Care Services. The case worker must note in the Comments section of Form 2110 that reinstatement procedures are being used within 60 days of the denial date and may use the following forms currently on file:

- Form 2059, Summary of Client's Need for Service
- Form 2060, Needs Assessment Questionnaire and Task/Hour Guide
- Form 2307, Rights and Responsibilities
- Form 1584, Consumer Participation Choice

The case worker must contact the individual and review the functional assessment, including Form 2060 and Form 2059, to determine if there have been any changes in the individual's physical condition or needs. If Form 2060 is over one year old, if there have been changes in the individual's condition or needs or if the individual

has difficulty communicating by telephone, the case worker must make a home visit to review/revise the assessment. Initial eligibility time frames will apply.

The case worker must send an initial referral packet and initial Form 2101 referral to the selected provider. For Primary Home Care and Community Attendant Services, the provider must complete all pre-initiation activities, including obtaining a new Form 3052, Practitioner's Statement of Medical Need.

4000, Specific CCSE Services

4100, Adult Foster Care

4110 Description

Revision 17-1; Effective March 15, 2017

Adult Foster Care (AFC) provides a 24-hour living arrangement in a Texas Health and Human Services Commission (HHSC) contracted foster home for persons who, because of physical, mental or emotional limitations, are unable to continue independent functioning in their own homes. Services may include meal preparation, housekeeping, minimal help with personal care, help with activities of daily living and provision of or arrangement for transportation. The unit of service is one day.

Providers of AFC must live in the household and share a common living area with the individual. Detached living quarters do not constitute a common living area. The individual enrolled to provide AFC must be the primary caregiver. Providers may serve up to three adult individuals in an HHSC-enrolled AFC home without licensure as a personal care home.

4111 Four Bed Adult Foster Care Homes

Revision 17-1; Effective March 15, 2017

A Type C Assisted Living license is obtained if the provider wants to serve four individuals. The home cannot be approved for the fourth individual until the provider has applied for and received the Type C license. After the enrollment is complete, the provider may apply for a Type C license from the Texas Health and Human Services Commission Regulatory Services Division. The license must be renewed yearly and requires an annual fee.

4112 Small Group Homes

Revision 17-1; Effective March 15, 2017

Adult Foster Care (AFC) may also be provided in a small group home licensed by the Texas Health and Human Services Commission (HHSC) as Assisted Living Type A, Small, under the Minimum Licensing Standards for Assisted Living. The provider must submit a copy of the Assisted Living license to contract management staff before enrollment and upon renewal thereafter. The provider must report to contract management staff any problem(s) identified by Regulatory Services. HHSC regional contract managers enroll small group homes and providers must meet all applicable requirements in the Minimum Standards for AFC. Providers must serve no more than eight adult individuals in an enrolled small group home.

AFC provided in small group homes is subject to two sets of regulations: HHSC minimum standards for AFC and Licensing Standards for Assisted Living Facilities. The stricter requirements apply when requirements conflict; therefore, an enrolled AFC provider whose home is licensed as a small group home must comply with

the requirement that an attendant be present at all times when residents are in the facility. This requirement applies regardless of the number of individuals currently residing in the facility.

4113 Contract Manager and Case Worker Responsibilities

Revision 17-1; Effective March 15, 2017

4113.1 Contract Manager Responsibilities

Revision 17-1; Effective March 15, 2017

Texas Health and Human Services Commission regional contract managers are responsible for all requirements for adult foster care (AFC) providers and homes. The contract manager's responsibilities include:

- recruiting adult foster homes;
- processing AFC applications;
- orientating and training the provider;
- conducting fire and health inspections;
- disenrolling adult foster homes;
- approving private pay individuals;
- conducting administrative reviews;
- reassessing the provider and home; and
- processing payments.

4113.2 Case Worker Responsibilities

Revision 17-1; Effective March 15, 2017

Texas Health and Human Services Commission (HHSC) case workers are responsible for all requirements for adult foster care (AFC) applicants and individuals. The case worker's responsibilities include:

- completing the AFC applicant intake and assessment process;
- determining financial and functional eligibility for AFC;
- assessing appropriateness for AFC;
- providing information to interested applicants about potential adult foster homes and arranging visits to the homes;
- developing a service plan and completing the individual provider agreement;
- authorizing AFC services;
- monitoring the individual; and
- processing changes and conducting annual reassessments of the individual.

4120 Eligibility

Revision 17-1; Effective March 15, 2017

4121 Basic Eligibility

Revision 17-1; Effective March 15, 2017

To be eligible for adult foster care (AFC), applicants and individuals must meet basic eligibility requirements for Community Care Services Eligibility services as well as specific requirements related to AFC. These

requirements can be found in Section 3000, Eligibility for Services.

4122 Appropriate Characteristics for Adult Foster Care

Revision 17-1; Effective March 15, 2017

Applicants and ongoing individuals in adult foster care (AFC) must display appropriate characteristics for AFC placement.

AFC placement is not appropriate for all individuals. Form 2330, Assessment and Service Plan Approval for Adult Foster Care, must be completed for all applicants. If any inappropriate characteristics are identified, the applicant/individual is not appropriate for AFC and cannot be authorized for services.

A new Form 2330 must be completed at each annual review to ensure the individual's needs can be met within the foster care setting.

4123 Supervisory Approval

Revision 17-1; Effective March 15, 2017

It is the supervisor's responsibility to ensure that the applicant/individual meets the appropriate characteristics and their needs can be adequately met in adult foster care (AFC). The supervisor indicates on Form 2330, Assessment and Service Plan Approval for Adult Foster Care, whether AFC is approved or disapproved. Supervisory approval is required before AFC is authorized and also required to reauthorize.

See Section 3000, Eligibility for Services, for additional eligibility requirements.

4130 Adult Foster Care Intake and Assessment

Revision 17-1; Effective March 15, 2017

Adult Foster Care (AFC) is appropriate for individuals who, because of physical, mental or emotional limitations, are unable to continue independent functioning in their own homes and who need and desire the support and security of family living. AFC is also appropriate for individuals who do not need institutional care, but are unable to resume independent living or have no relatives who are able to provide a home.

4131 Response to Request for Services

Revision 17-1; Effective March 15, 2017

Upon receipt of an intake for adult foster care (AFC), the case worker arranges a home visit to conduct the assessment based on the intake priority. Refer to Section 2340, The Initial Interview and Application Process, for complete procedures. During the home visit, the case worker assesses the applicant for financial eligibility and functional eligibility, using Form 2060, Needs Assessment Questionnaire and Task/Hour Guide, and also completes Form 2330, Assessment and Service Plan Approval for Adult Foster Care, to determine whether the applicant is appropriate for AFC. Form 2330 lists the appropriate and inappropriate mental and physical characteristics for AFC individuals.

AFC is not appropriate and should not be authorized for a person who:

- requires considerable assistance with personal care due to physical or mental conditions;
- requires long-term care in a medical or psychiatric facility;

- is a danger to himself or others; or
- is bedfast.

4132 Individual Rights and Responsibilities

Revision 18-2; Effective November 19, 2018

The case worker must explain the room and board requirements in adult foster care (AFC) and ensure that the applicant understands that he must pay a portion of his monthly income for room and board. Review Form 2307, Rights and Responsibilities, and Attachment 2307-F, AFC Rights and Responsibilities, with the applicant. Make sure the individual understands his responsibilities as a resident in an AFC home.

4133 Assessing Potential Adult Foster Care Homes

Revision 17-1; Effective March 15, 2017

If the applicant displays the appropriate characteristics and appears to meet eligibility criteria, the case worker provides information about potential adult foster care (AFC) homes. The case worker can arrange visits to appropriate AFC homes or if the applicant is capable or has family/supports available, he may make the arrangements to visit potential AFC homes. In some situations, the case worker may need to assist the applicant in making the visit(s).

The purpose of the visits to potential AFC homes is to let the applicant assess the home and let the AFC provider assess if the applicant will be appropriate in the foster home. The case worker may contact the provider and share information about the applicant, including the applicant's particular needs and problems, to ensure that the potential provider is fully aware of the responsibilities involved in caring for the particular applicant and to prevent a potential mismatch of the applicant and provider.

4134 Placement on the Interest List

Revision 17-1; Effective March 15, 2017

If an intake is received for adult foster care (AFC) but no foster homes are available to provide care, place the individual's name on the interest list and determine if other services may be appropriate to meet the individual's needs while waiting for placement in AFC. Refer to Section 2930, Community Services Interest List (CSIL), for interest list procedures. The application process for AFC begins when the individual's name is released from the interest list.

4135 Adult Protective Services Individuals in Adult Foster Care

Revision 17-1; Effective March 15, 2017

4135.1 Placement of Adult Protective Services Individuals in Adult Foster Care

Revision 17-1; Effective March 15, 2017

In some areas, Adult Protective Services (APS) may use adult foster care (AFC) as a resource for placement of APS individuals. Approval by the contract manager is required before an APS individual moves into a Texas

Health and Human Services Commission enrolled AFC household. The purpose of the approval is to determine the:

- appropriateness of the individual's characteristics;
- capacity of the foster home to meet the individual's needs; and
- compatibility of service delivery to the APS individual and the delivery of services to the certified AFC individuals.

If it is determined by the contract manager that placement in foster care is inappropriate, the APS worker and the provider will help the individual make other living arrangements.

4135.2 Adult Protective Services Investigations of Adult Foster Care Providers

Revision 17-1; Effective March 15, 2017

Any time Texas Health and Human Services Commission (HHSC) staff suspect abuse, neglect or exploitation of an adult foster care (AFC) individual in a foster home, a report must be made immediately to Adult Protective Services (APS).

If reports are made to APS from outside sources, HHSC staff may not be notified of individual allegations against a service provider until after those allegations have been validated. However, APS staff may ask Community Care Services Eligibility (CCSE) staff to assist with the delivery of services during the course of their investigation if the alleged mistreatment poses an immediate threat to the safety of AFC residents.

The contract manager assigned to the facility handles disenrollment and corrective actions against the foster home, as appropriate. If the case worker is unable to find a suitable residence for the individual, the individual is referred to APS for assistance in moving from the foster home.

An individual who has the capacity to consent may decide not to move from the foster home, even though the allegation has been validated and the situation is likely to recur. In such an instance, the individual's AFC services will be denied and payments to the home will terminate. However, the individual may continue to reside in the home by making private pay arrangements with the provider.

If an individual who does not appear to have the capacity to consent refuses to move from a home operated by an individual identified as the perpetrator in a case of validated abuse, neglect or exploitation, make a referral to APS.

4136 Private Pay Individuals and Retroactive Payment Procedures

Revision 17-1; Effective March 15, 2017

4136.1 Private Pay Individuals in Adult Foster Care

Revision 17-1; Effective March 15, 2017

Some adult foster care (AFC) providers may wish to take private pay individuals. Approval by the contract manager is required before the private pay individual is accepted in the home. The AFC provider must contact the contract manager when considering admitting a private pay individual. The contract manager will furnish Form 2330, Assessment and Service Plan Approval for Adult Foster Care, to the AFC provider. The AFC provider must complete Form 2330 and return it to the contract manager to approve or disapprove the private pay individual. The purpose of the approval is to determine the:

- appropriateness of the individual's characteristics,
- capacity of the foster home to meet the individual's needs, and
- compatibility of service delivery to the private pay individual and the delivery of services to the certified AFC individual.

If it is determined by the contract manager that placement in foster care is inappropriate, the AFC provider cannot accept the individual.

Refer any issues regarding placements to the contract manager to resolve.

4136.2 Retroactive Payment Procedures

Revision 17-1; Effective March 15, 2017

If a private pay applicant already in the foster home applies for adult foster care (AFC) and meets all eligibility requirements, AFC can be approved retroactive to the date of intake.

AFC may be authorized retroactively with supervisory approval to the latter of the date of:

- request for services (intake date), or
- entry into the foster home.

Supervisory approval is required in all situations. If an applicant does not meet eligibility requirements including appropriate characteristics, then AFC is not authorized and it is the individual's responsibility to arrange for payment to the foster home or relocate.

4140 Adult Foster Care Case Worker Procedures

Revision 17-1; Effective March 15, 2017

4141 Eligibility Determination

Revision 17-1; Effective March 15, 2017

To determine eligibility for adult foster care (AFC), the case worker must:

- certify that the applicant meets financial and functional eligibility on Form 2064, Eligibility Worksheet;
- determine that the applicant has an agreement with an enrolled AFC home to potentially move into the home; and
- document on Form 2330, Assessment and Service Plan Approval for Adult Foster Care, that the applicant meets the appropriate criteria for AFC.

After eligibility is determined, the case worker submits the individual's case record to his supervisor for review and approval. Documentation in the case record must be complete to enable the supervisor to certify the individual's need for care and the appropriateness or inappropriateness of the placement arrangement.

4142 Supervisory Approval

Revision 17-1; Effective March 15, 2017

Upon receipt of the case record, the supervisor reviews:

- Form 2060, Needs Assessment Questionnaire and Task/Hour Guide, to verify the individual's functional need for care;
- Form 2330, Assessment and Service Plan Approval for Adult Foster Care, to verify the appropriateness of the applicant; and
- any additional documentation, including the case narrative to review the individual's care needs.

The supervisor may consult with the contract manager to evaluate the capacity of the foster care provider to meet the unique needs of the individual in the foster home setting.

The supervisor decides whether the foster home can meet the needs of the individual and if the individual is appropriate for adult foster care (AFC). If so, the supervisor approves AFC and the service plan by signing and dating Form 2330 or by giving verbal approval, which is documented by the case worker. If the service is not approved, the supervisor confers with the case worker about problems with the plan, as perceived through the record reviews. The case worker must find a more suitable arrangement or resolve the potential problems with the individual and the foster care provider to his supervisor's satisfaction. Refer the individual to Adult Protective Services (APS) if there is reason to suspect abuse, neglect or exploitation.

4143 Service Planning

Revision 17-1; Effective March 15, 2017

Upon approval for adult foster care (AFC), the supervisor and case worker discuss if the individual has any special needs that require additional monitoring in the foster home setting beyond the scheduled monitoring. If needed, a monitoring schedule is developed and documented in the case record.

The final care and monitoring plan for the individual should address his functional, medical, social and emotional needs and how they might be met in the selected foster care home. Assess whether other resources in the community should be used to meet specialized needs of the individual. Use of those resources should be documented in the care plan.

If there are health concerns regarding the individual, the regional nurse may be consulted and a recommendation may be made for the individual to have a physical/medical exam prior to moving into the AFC home.

Once the supervisor has approved the individual and potential placement in AFC, the case worker contacts the individual and the AFC provider to arrange for the initial visit and a negotiated move-in date for the individual.

4150 Finalizing the Care Plan – Required Initial Home Visit

Revision 17-1; Effective March 15, 2017

Program Standard: On or before the date the individual moves into the adult foster care (AFC) home, a meeting with the individual and the AFC provider is required to discuss the individual's care plan and to complete Form 2327, Individual/Member and Provider Agreement.

The individual's family members or responsible person may be included in the meeting and the meeting should preferably take place in the AFC home.

During the initial home visit, discuss the individual's needs and care plan as indicated on Form 2060, Needs Assessment Questionnaire and Task/Hour Guide, and Form 2330, Assessment and Service Plan Approval for Adult Foster Care. Reach an agreement about how the individual's needs should be met through daily care and activities.

Discuss the individual's care plan with the individual and family members/responsible party and reach understanding with them about how the foster care provider will meet his needs. This discussion should ensure

that the individual, his family/responsible party and the foster care provider are adequately prepared for a new individual in the home and that adjustments occur smoothly. Document the care plan and any special needs of the individual or special agreements between the individual and provider on Form 2327.

4151 Individual and Provider Agreement

Revision 21-4; Effective December 1, 2021

Document the service arrangements and the room and board payment agreement on Form 2327, Individual/Member and Provider Agreement when meeting with the applicant and the adult foster care provider.

Review all the information on the agreement with the applicant, family or responsible person, and the provider. Cover all conditions of the agreement and the following topics in the discussion:

- a full description of the care needs of the applicant, the services and the schedule of care, including if the applicant requires 24-hour supervision by the AFC provider;
- the beginning and end date of the agreement;
- a detailed description of the rights and responsibilities of the applicant and the provider;
- an explanation of the applicant's right to privacy and confidentiality;
- the monthly room and board amount the applicant agrees to pay the provider;
- an inventory of the applicant’s personal effects;
- the names, addresses and phone numbers of people to notify in an emergency, including the applicant's physician, family members or responsible person;
- any special habits and needs of the applicant and any special arrangements or agreements between the applicant and the provider;
- any other training needs of the provider and methods to get that training;
- the responsibility of both the applicant and the provider to notify CCSE staff and the contract manager of problems, such as illnesses, hospitalizations, acts of violence, accidents, complaints about abuse, neglect or exploitation; and
- other conditions that reflect changes in the applicant's condition and might affect the appropriateness of the foster home.

Discuss with the foster care provider the likelihood of problems arising after the applicant moves into the home, notification procedures and suitable actions to take to resolve problems. Also, discuss with the provider the impact of a new applicant on members of the foster care family and other people in the home. Anticipate problems that might arise and how to handle them. Outline the schedule of planned monitoring visits. The applicant and the provider must sign Form 2327 after discussing and agreeing to all the above topics.

4152 Personal Needs and Medical Expenses Allowance

Revision 17-1; Effective March 15, 2017

40 Texas Administrative Code §48.3906, Adult Foster Care Personal Needs and Medical Expenses Allowance. Adult foster care clients must be allowed to keep funds for personal needs and medical expenses as specified in paragraphs (1)-(3) of this section.

(a) Clients with Medicaid coverage must be allowed to keep at least $50 a month for personal needs.
(b) Clients without Medicaid coverage must be allowed to keep at least $85 a month for personal needs and medical expenses.
(c) All clients must be allowed to keep at least one-half of any cost-of-living adjustment received on or after January 1, 1993.

Ensure that the individual keeps sufficient funds each month for personal needs and medical expenses. The $50 and $85 amounts are minimum amounts. The individual may need to keep more depending on his particular circumstances. Help the individual determine how much he spends on prescription drugs and medical bills each month. When the room and board agreement is negotiated, also consider personal expenses such as replacement of clothing and toiletries.

4153 Room and Board Agreement

Revision 17-1; Effective March 15, 2017

Ensure that the individual and provider understand that the room and board arrangement with the provider is separate from the Texas Health and Human Services Commission (HHSC) payment for services. The individual pays the provider for room and board. Help the provider and the individual negotiate the room and board agreement. The amount paid may be influenced by prevailing rates in the community. The room and board agreement and any other monetary arrangements are entered on Form 2327, Individual/Member and Provider Agreement.

If the individual is moving into the adult foster care home mid-month, prorate the amount of room and board for the month and advise the individual and provider of the prorated amount. The ongoing amount of room and board is negotiated with the individual and provider and both amounts are recorded on Form 2327.

4153.1 Changes in the Room and Board Agreement

Revision 17-1; Effective March 15, 2017

If the individual has a change in income or expenses, he or the provider may request a change in the amount of room and board payment. Changes in the room and board payment are negotiated between the individual and the provider and are documented on Form 2327-A, Room and Board Amendment to the Individual/Member and Provider Agreement.

4154 Leave Away from the Foster Home and Bedhold Charges

Revision 17-1; Effective March 15, 2017

40 Texas Administrative Code (TAC) §48.3904(f). The Texas Department of Human Services pays the daily rate for up to 14 days of leave for each 12-consecutive-month period when an authorized client is away from the foster home. Payment for leave in excess of 14 days per year is the responsibility of the client. Any bedhold charges are between the client and provider because they have negotiated a monthly room and board agreement. Bedhold charges, however, may not exceed the daily room and board rate.

§48.3904(g). The adult foster care provider is responsible for notifying the case worker by the next workday when a client is away from the foster home for personal leave or hospitalization.

During the initial home visit, the case worker reviews the information regarding the individual's responsibility to pay a bedhold charge when away from the home. Ensure that the individual understands that if he uses more than 14 days of leave during a 12-month period, he is responsible for paying the provider the full daily rate.

4155 Authorization of Adult Foster Care

Revision 17-1; Effective March 15, 2017

After all procedures are completed, the case worker sends the individual Form 2065-A, Notification of Community Care Services. The case worker authorizes adult foster care on Form 2101, Authorization for Community Care Services, in the Service Authorization System wizards and sends the provider a copy of Form 2101.

4156 Adult Foster Care and Day Activity and Health Services

Revision 17-1; Effective March 15, 2017

Some services cannot be authorized at the same time as Adult Foster Care (AFC). Refer to the chart in Appendix XX, Mutually Exclusive Services. Day Activity and Health Services (DAHS) may be authorized for AFC individuals under the following conditions. The AFC individual:

- requests to attend DAHS for socialization; or
- has a medical need that cannot be met by the AFC provider.

Documentation in the case record must clearly specify that at least one of the above conditions is met. See Section 4221, Medical Criteria, for the DAHS eligibility requirements for a medical need.

DAHS may be authorized for the maximum of 10 units per week; however, the authorization must be related to the individual's need and not authorized for the convenience of the AFC provider.

40 Texas Administrative Code §48.8907(a), Resident care and services. The adult foster care provider must:

(1) provide services to residents according to the individual service plan and the client/provider agreement;
(2) meet all requirements and conditions stated on the client/provider agreement, approval of foster care, and client service plan;
(3) ensure that an approved substitute provider is present in the home if at least one resident remains in the home when the provider plans to be absent from the home for more than three hours in a 24-hour period. Residents whose care plans specify the need for 24-hour supervision may not be left without the supervision of an approved substitute provider for any period of time.

If an individual is authorized to attend DAHS but is ill or prefers not to attend on a particular day, it is the AFC provider's responsibility to provide supervision in the AFC home for the individual.

4160 Monitoring

Revision 17-1; Effective March 15, 2017

Program Standard: Monitoring contacts are required monthly for the first three months the individual is in the foster home. Two of the monitoring contacts may be made by telephone if appropriate for the individual. At least one of the contacts must be a home visit to the individual in the foster home and the individual must be interviewed privately.

4161 60-Day and 90-Day Monitoring Contacts

Revision 17-1; Effective March 15, 2017

Monitoring contacts must be completed during the first three months after the individual is certified for adult foster care. Two of the monitoring contacts may be made by telephone. At least one of the three monitoring contacts must be made in person with the individual in the foster home. The individual must be seen alone so that he can freely discuss any problems with the provider or the home. It is the case worker's responsibility to

assist in resolving any problems noted. Contact the contract manager if there are problems with the home or the provider.

4162 Six-Month Monitoring Contact

Revision 17-1; Effective March 15, 2017

After the first three months, the individual must be monitored at regularly scheduled six-month intervals, unless the case worker and supervisor have determined that the individual requires more frequent monitoring. The first six-month monitoring contact occurs three months after the 90-day monitoring contact.

Regular monitoring visits should assess the individual's needs and whether the provider is addressing and meeting those needs. Report to the contract manager if the adult foster care provider is not addressing or meeting those needs. The individual's physical and medical condition should be carefully monitored to determine whether initial problems are resolved and/or whether new problems are arising due to decreased functional capacity or illness. Regional nurses should be used in this assessment/monitoring process as needed.

All monitoring contacts must be recorded on Form 2314, Satisfaction and Service Monitoring, in the Service Authorization System monitoring wizard.

4170 Significant Changes

Revision 17-1; Effective March 15, 2017

It is the responsibility of the case worker and the adult foster care (AFC) provider to ensure that the AFC individual is in an appropriate setting to meet his needs. When the AFC individual has a change in functional need, health problems or changes in behavior, it is the responsibility of the AFC provider to notify the case worker.

Within 14 days or sooner, as appropriate, the case worker must follow-up with the individual and provider to determine if changes to the care arrangement are needed. The case worker may consult with the supervisor to determine how quickly a response is needed to the situation.

Give particular attention to individuals who reflect dramatic changes in functional need, medical problems or behaviors that are inappropriate for foster care. Alert family members and/or the responsible party or guardian to the situation. Discuss with them and the individual the potential for the individual to remain in the foster home. If an individual has a guardian appointed by the courts, the guardian acts on the individual's behalf. If the individual has had a decline in his medical condition or functional ability, consult the regional nurse and request that the nurse make a visit to the individual for a medical assessment.

4171 Changes in the Service Plan

Revision 17-1; Effective March 15, 2017

Document the changes in an individual's condition on Form 2060, Needs Assessment Questionnaire and Task/Hour Guide, and Form 2330, Assessment and Service Plan Approval for Adult Foster Care, noting changes in the individual's functional ability and appropriateness for adult foster care (AFC) placement. Discuss the changes with the supervisor, regional nurse (if needed), AFC provider and family members. Refer to Section 2550, Identifying Individuals at Risk, if the individual's health and safety are at risk and additional service planning is needed. If AFC continues to be appropriate for the individual, document the needed changes in the service plan on Form 2327, Individual/Member and Provider Agreement.

4172 Adult Foster Care No Longer Appropriate

Revision 17-1; Effective March 15, 2017

If after a review of Form 2060, Needs Assessment Questionnaire and Task/Hour Guide, and Form 2330, Assessment and Service Plan Approval for Adult Foster Care, the individual's needs can no longer be met or the individual is no longer appropriate for adult foster care, discuss alternative living arrangements with the individual and family/responsible party. Long-range care plans should be discussed frankly with the individual, family members and the foster care provider to ensure that all are aware of the capabilities and limitations of adult foster care services for individuals with deteriorating medical or functional conditions. Individuals who become inappropriate for foster care must be advised of other available options. Help individuals and their family members in this decision process and with transfer activities when necessary. If the provider decides that the individual is not appropriate for care in his home, the provider contacts the case worker to request that the individual be transferred to another placement. The case worker is responsible for preparing the individual for the move and transition.

4173 Termination of Adult Foster Care Services

Revision 17-1; Effective March 15, 2017

Once an individual is identified as inappropriate for foster care, the case worker must negotiate a time frame with the individual, family/responsible party and the adult foster care (AFC) provider for the individual to move. The time frame is determined on a case-by-case basis depending on the urgency and severity of the situation and how quickly an appropriate placement can be arranged. If the individual has been a threat to the health and safety of other individuals or has exhibited inappropriate behaviors so that the provider is asking the individual to move immediately, then the case worker must make every effort to locate another living arrangement as soon as possible. If other living arrangements are not readily available for the individual, refer to Adult Protective Services (APS) to assist in locating appropriate placement for the individual.

If the individual will not be transferring to another AFC setting, send the individual Form 2065-A, Notification of Community Care Services, with the negotiated move date as the end date of services. Unless the individual's service is being terminated due to threat to health and safety (see Section 2811, Effective Dates for Service Reduction and Termination), give the individual at least 12 days notice. Terminate AFC services on Form 2101, Authorization for Community Care Services.

If there is resistance to the move from the individual, family or the provider, an additional staffing with the individual, family/responsible party and provider may be required to resolve the problem. Request that the supervisor and contract manager attend the staffing, if necessary. Advise the individual and provider that AFC services will terminate on the date specified on Form 2065-A. The provider has the right to begin eviction proceedings as specified in the provider's resident rights and responsibilities. Ensure that the individual and responsible party understand the consequences of eviction. If the provider must use eviction procedures and the individual has refused to make other living arrangements, refer the individual to APS.

If the individual and provider decide that the individual will remain in the home as a private pay individual, then the contract manager must give approval. Make sure the individual and provider understand that there are no case management services or payment arrangements from the Texas Health and Human Services Commission for a private pay individual.

4180 Annual Reassessment

Revision 17-1; Effective March 15, 2017

Reassess the adult foster care (AFC) individual every 12 months as outlined in Section 2660, Reassessments and Recertification Procedures. Form 2330, Assessment and Service Plan Approval for Adult Foster Care, must be completed annually and signed by the supervisor. Carefully review the appropriate and inappropriate characteristics on Form 2330 and be alert for changes that indicate that the individual is no longer appropriate for AFC or that his medical/functional needs can no longer be met. If the individual's condition is deteriorating, but not to the point that AFC is currently inappropriate, discuss with the individual that a move may be necessary in the future.

Reevaluate the service plan at each reassessment and update according to the individual's new/changed needs. Discuss changes in the individual's need level and in the service plan with the foster care provider and obtain supervisory approval.

Reauthorize AFC on Form 2101, Authorization for Community Care Services.

4200, Day Activity and Health Services

4210 Description

Revision 22-3; Effective Sept. 1, 2022

Day Activity and Health Services (DAHS) include nursing and personal care services, physical rehabilitative services, nutrition services, transportation services and other supportive services. These services are provided at facilities licensed and certified by the Texas Health and Human Services Commission(HHSC). Except for holidays, these facilities must have services available at least 10 hours a day, Monday through Friday.

The method of payment is a unit of authorized service and is defined as half a day. One unit of service constitutes three hours but less than six hours of covered services provided by the DAHS facility. Six hours or more of service constitutes two units of service. Time spent in approved transportation provided by the DAHS facility shall be counted in the unit of service.

Services must be provided according to the recipient's service plan. Discuss with the recipient, their family or authorized representative regarding the recipient’s condition, program plan and staff administering the plan.

Recipients must be given the opportunity to receive medical attention and help in getting health services not available from the provider.

The facility must be used only for authorized purposes.

Related Policy

Day Activity and Health Services Provider Manual

4211 Nursing and Personal Care

Revision 17-1; Effective March 15, 2017

Services include:

- evaluating and observing an individual's status and instituting appropriate nursing intervention, when needed, to stabilize his condition or prevent complications;
- helping the individual order, maintain, or administer prescribed medication;
- promoting and participating in the individual's education and counseling. Participation is based on his health needs and illness status, involving the individual and other individuals for a better understanding

and implementation of immediate and long-term health goals;
- helping with personal care tasks, including the restoration or maintenance of the individual's ability to perform personal care skills; and/or
- assessing and evaluating the individual's health status.

4212 Physical Rehabilitation

Revision 17-1; Effective March 15, 2017

Services include:

- restorative nursing, including the use of nursing knowledge and skills to help the individual achieve his maximum degree of functioning;
- group and individual exercises, including range-of-motion exercises; and
- transportation to and from a facility approved to provide therapies, if specialized services are needed on the days the individual attends the Day Activity and Health Services (DAHS) facility.

4213 Nutrition

Revision 17-1; Effective March 15, 2017

Services include:

- one hot meal, served between 11 a.m. and 1 p.m. (the meal should supply one-third of the recommended daily allowance (RDA) for adults as recommended by the U.S. Department of Agriculture);
- special diets required by the individual's plan of care;
- supplementary mid-morning and mid-afternoon snacks; and
- dietary counseling and nutrition education for the individual and family.

4214 Transportation

Revision 17-1; Effective March 15, 2017

If needed, the Day Activity and Health Services (DAHS) facility ensures transportation to and from the facility.

4215 Other Supportive Services

Revision 17-1; Effective March 15, 2017

Services include:

- cultural enrichment or educational activities;
- social activities, on-site or in the community; and
- recreational therapy in a program planned to meet the individual's social needs and interests.

4220 Eligibility

Revision 22-3; Effective Sept. 1, 2022

The provision of Community Care Services Eligibility (CCSE) services is not allowed for people who live in an institutional setting. An institutional setting is defined as a skilled nursing facility or an intermediate care

facility, including an intermediate care facility for persons who have an intellectual disability.

One unit of DAHS is at least three hours but less than six hours per week. A person who needs less than one unit (three hours) of service per week is not eligible. DAHS cannot be authorized for more than 10 units per week.

To be eligible for DAHS, an applicant or recipient must have:

- Medicaid or be income and resource eligible;
- an unmet need for DAHS;
- a chronic medical diagnosis and physician's orders for DAHS; and
- one or more functional limitations and the potential for receiving therapeutic benefits from DAHS.

Related Policy

Resource Limits, 3210
Income and Income Eligible, 3310

4221 Financial Eligibility Criteria

Revision 17-1; Effective March 15, 2017

Medicaid recipients are financially eligible for Title XIX Day Activity and Health Services (DAHS). Applicants who are not Medicaid recipients but who are categorically eligible or within the Community Care Services Eligibility (CCSE) income and resource limits are financially eligible for Title XX DAHS. Applicants are not eligible if they are receiving another CCSE service that duplicates DAHS. See Section 3000, Eligibility for Services, for the policies concerning income and resources.

4222 Medical Eligibility Criteria

Revision 22-3; Effective Sept. 1, 2022

A person must have the following to meet the medical eligibility criteria for DAHS:

- An identified chronic medical condition and physician's orders certifying that the applicant has a need for DAHS.
- One or more function limitation(s) and the potential to benefit therapeutically from DAHS, as determined by a health assessment of the applicant's medical needs. The health assessment will identify the functional need or needs and the therapeutic benefit the applicant will receive from personal care, habilitative or restorative activities by participation in DAHS.

The provider agency completes Form 3055, Physician's Orders (DAHS), and Form 3050, DAHS Health Assessment/Individual Service Plan, for new enrollments, for transfers to a different DAHS provider agency, and if the recipient's condition changes.

Note: A physician cannot be reimbursed for completing Form 3055 if they received Medicaid reimbursement for the diagnosis and treatment of the person's illness that makes them eligible for DAHS.

Related Policy

Service Plan Changes Reported by the Facility, 4261
DAHS Transfers, 4262
Facility Response for Facility-Initiated Referrals, 4234
Facility Response to CCSE Staff Referrals, 4235

4223 Unmet Need Criteria

Revision 17-1; Effective March 15, 2017

Applicants must have an unmet need for services and are not eligible for Day Activity and Health Services (DAHS) if they are receiving another CCSE service that duplicates DAHS. DAHS may be received with some other services as long as there is not a duplication of services.

4223.1 DAHS in Conjunction with Other Services

Revision 18-1; Effective June 15, 2018

Day Activity and Health Services (DAHS) may be received in conjunction with some other services, including the following:

- Individuals who receive personal care and supervision through Adult Foster Care (AFC) services may receive 10 units per week of DAHS to benefit medically from the other services provided by the DAHS program. Documentation of the medical benefit must be included in the case record. See Section 4156, Adult Foster Care and Day Activity and Health Services, for additional information.
- A Consumer Managed Personal Attendant Services (CMPAS) individual may receive up to 10 units of DAHS per week.
- Residential Care (RC) individuals may receive DAHS only if the services provided by the DAHS facility are medical services that cannot be provided by the RC facility. An RC individual may receive no more than one unit per day of DAHS, which is the time needed for the DAHS facility to provide medical services.
- An individual in the following waiver programs can access DAHS if the individual meets the DAHS eligibility criteria:
    - Home and Community-based Services (HCS), if age 18 or older;
    - Community Living Assistance and Support Services (CLASS), if age 18 or older;
    - Deaf Blind with Multiple Disabilities (DBMD); and
    - Texas Home Living (TxHmL).

See Appendix XX, Mutually Exclusive Services, for complete information regarding which Long-term Services and Supports may be received in conjunction with others. Staff must also ensure that individuals with active Medicaid coverage are not certified for Title XX DAHS.

4224 DAHS Licensure Age Requirements

Revision 17-1; Effective March 15, 2017

Day Activity and Health Services (DAHS) facilities licensed as adult day care centers are unable to serve individuals under age 18. An individual under age 18 requesting DAHS must be advised that even if eligibility criteria for DAHS are met, he may not be able to access the service unless a facility is licensed to serve children and has a separate facility not accessible to adults. The case worker should refer the applicant to alternative services, such as:

- after school and/or summer programs offered by independent school districts;
- Texas Workforce Commission providers that offer day care services;
- local day care centers;
- faith-based local organizations; or
- other organizations that provide assistance to children with specific physical or medical conditions.

4230 DAHS Approval

Revision 17-1; Effective March 15, 2017

Determination and redetermination of eligibility for Day Activity and Health Services (DAHS) involves the cooperative efforts of the regional nurse, the case worker, the facility nurse and the individual's physician.

4231 Intake

Revision 17-1; Effective March 15, 2017

Intake into Day Activity and Health Services (DAHS) begins when the case worker receives a request for services. Requests for DAHS services may be made by:

- the individual,
- his physician,
- his authorized representative, or
- an interested party.

A DAHS facility may also request services for an individual who is already attending the DAHS facility if the applicant is:

- Medicaid eligible, and
- not a DAHS individual.

4231.1 Facility-Initiated Referrals

Revision 22-3; Effective Sept. 1, 2022

Facility-initiated referrals only apply to Title XIX DAHS services. Only Medicaid eligible applicants are eligible for facility-initiated referrals. The facility may admit and begin services for a Medicaid recipient before receiving approval from HHSC if it is willing to risk the loss of revenue if the applicant is determined ineligible. The applicant cannot be currently receiving DAHS at any other facility that has a DAHS contract.

Applicants have freedom of choice in the selection of qualified providers. CCSE staff and the regional nurse must coordinate transfers from one DAHS facility to another to prevent duplication of services or gaps in coverage.

For the facility-initiated referral, the facility must:

- have obtained verbal or written physician orders;
- verbally notify CCSE staff or the intake unit and request DAHS services for the applicant; and
- follow up the verbal notification in writing within seven calendar days by sending Form 2067, Case Information, to CCSE staff.

The date of the verbal notification is the date of request for DAHS.

4231.2 Intake Response

Revision 17-1; Effective March 15, 2017

Within 14 calendar days of receipt of the intake, the case worker must contact the applicant either by telephone or face-to-face contact to complete the application for Day Activity and Health Services (DAHS). Time frames for responding to other requests for services (intakes) are based on the priority of the intake. See Section 2320, Case Worker Response, for priorities and time frames. A home visit is required only at the applicant's request.

Prior to the contact, the case worker checks the Texas Integrated Eligibility Redesign System (TIERS) to determine if the applicant is Medicaid eligible or categorically eligible. The case worker also checks the Service Authorization System Online (SASO) to determine the applicant is not a current DAHS individual.

If the applicant is not Medicaid eligible, determine if the applicant will meet the criteria for Title XX Services and if Title XX Services are available. See Section 2230, Interest List Procedures.

If the applicant is not Medicaid eligible and the intake is a facility-initiated referral, notify the facility by telephone and follow up with Form 2067, Case Information, letting the facility know the applicant is not Medicaid eligible and is not eligible for the facility-initiated referral.

If the applicant is already a DAHS individual at another facility, notify the facility by telephone and follow up with Form 2067, letting the facility know the applicant is already an individual, is not eligible for the facility-initiated referral and must follow the transfer procedures as outlined in Section 4262, DAHS Transfers.

4231.3 Initial Interview

Revision 17-1; Effective March 15, 2017

The case worker contacts the applicant either by telephone or face-to-face to complete the assessment interview. During the interview, the case worker discusses services available through Day Activity and Health Services (DAHS) and determines if the applicant appears to have a medical diagnosis and a functional disability related to the medical diagnosis, an unmet need for services or is receiving other services that duplicate DAHS.

During the assessment, the case worker:

- completes Form 2307, Rights and Responsibilities, and if the contact is by telephone, mails Form 2307 to the individual for signature;
- completes Form 2059-W, Summary of Individual's Need for Service Worksheet, to be entered into the Service Authorization System;
- assesses the number of units (one unit equals at least three hours but less than six hours) the applicant prefers and needs per week;
- assesses the applicant for any other needed services; and
- obtains an Application for Assistance form (see Section 2333, Applications), if the applicant is not Medicaid or categorically eligible.

The date of assessment begins the 30-day time frame for the case worker to complete the application process.

4231.4 Response to Individuals Who Are No Longer Attending DAHS

Revision 17-1; Effective March 15, 2017

If the applicant has stopped attending Day Activity and Health Services (DAHS) before the application process is complete, the applicant does not have to complete an application or Form 2307, Rights and Responsibilities, if he was Medicaid-eligible when DAHS was received. Attempt to contact the individual by telephone, mail or home visit to:

- determine if he is receiving DAHS at another facility or receiving other Community Care Services Eligibility (CCSE) services that may duplicate DAHS;

- verify his attendance at the facility; and
- complete Form 2059-W, Summary of Individual's Need for Service Worksheet, to be entered into the Service Authorization System.

If unable to locate the individual or if the individual refuses to provide any information, verify through automation records the individual's effective date of Medicaid coverage and whether the individual is receiving other CCSE services that may duplicate DAHS. See Section 2433, Determining Unmet Need in the Service Arrangement Column, to determine CCSE services that duplicate each other. Complete and send to the facility:

- Form 2101, Authorization for Community Care Services, if the individual is eligible; or
- Form 2065-A, Notification of Community Care Services, if the individual is ineligible.

Send Form 2065-A to the applicant.

See Section 4233, Initial Eligibility Determination and Referral.

Note: Coordinate with the local Area Agency on Aging to ensure there is no service duplication.

4232 Freedom of Choice

Revision 22-3; Effective Sept. 1, 2022

When referring a person to a DAHS facility, describe the facility to the person and the type of service available. If possible, the person should visit the facility before services begin. Based on federal requirements for services funded under Medicaid, the person maintains freedom of choice among the DAHS facilities that serve their area. If the person meets all DAHS eligibility requirements, they have freedom of choice to choose a DAHS facility, regardless of any relationship to the provider.

A DAHS facility must serve eligible people, unless a facility is at licensed capacity.

Refer people to DAHS facilities based on the following priorities:

- person's choice;
- physician's choice, if stated;
- rotation of eligible providers.

After the person has selected a facility, contact the facility to determine if there are openings. If the facility is operating at capacity, contact the person and arrange another satisfactory placement.

DAHS facility staff maintain an interest list for Title XIX and private-pay people. Medicaid regulations prohibit HHSC from maintaining an interest list for any Title XIX service.

HHSC regional staff maintain the interest list for Title XX applicants.

Related Policy

Interest List Procedures, 2230

4233 Initial Eligibility Determination and Referral

Revision 21-4; Effective December 1, 2021

Title XX DAHS

After the initial assessment, determine the following:

- the applicant meets the financial eligibility criteria;
- the applicant has an unmet need for Day Activity and Health Services (DAHS); and
- there is no duplication of other services.

CCSE staff complete the referral Form 2101, Authorization for Community Care Services; and send the referral packet to the DAHS facility within five business days.

The referral packet must include:

- a cover sheet;
- the Long-term Care Services Intake System (NTK) generated Form 2110, Community Care Intake; and
- a copy of the following Service Authorization System Online Wizards (SASOW) generated forms:
  - Form 2059, Summary of Client's Need for Service;
  - Provider Referral Supplement; and
  - Form 2101.

If it is determined the applicant is not eligible for DAHS, send Form 2065-A, Notification of Community Care Services, to the applicant.

Title XIX DAHS

Title XIX DAHS referrals are initiated by the facility after an applicant begins attending the DAHS facility. When completing the referral packet, indicate in the comments section of Form 2101 that the applicant is being referred for facility-initiated DAHS. If the applicant no longer attends the DAHS facility, enter the date the applicant stopped as the "end" date on Form 2101 and note in the comments section the applicant is no longer attending DAHS.

If it is determined the applicant is not eligible for facility-initiated DAHS:

- send Form 2065-A to the applicant;
- send a copy of Form 2065-A to the DAHS facility; and
- notify the facility by phone of the denial.

If the applicant qualifies for Title XX DAHS, send the referral packet and notify the facility the applicant is eligible for Title XX DAHS instead of facility-initiated DAHS.

Related Policy

Content of Referral Packets, Appendix XIII

4234 Facility Response for Facility-Initiated Referrals

Revision 22-3; Effective Sept. 1, 2022

For facility-initiated referrals, the DAHS facility must submit a full prior approval packet to the HHSC regional nurse within **30 calendar days** after the date of the initial physician's orders (verbal or written) by submitting:

- referral Form 2101, Authorization for Community Care Services;
- Form 3050, DAHS Health Assessment/Individual Service Plan; and
- Form 3055, Physician's Orders (DAHS).

4234.1 Regional Nurse Responsibilities for Facility-Initiated Referrals

Revision 21-4; Effective December 1, 2021

The Day Activity and Health Services (DAHS) facility must request written prior approval for all applicants from the regional nurse within 30 calendar days after the date of the physician's orders.

The regional nurse authorizes services and sends Form 2101, Authorization for Community Care Services, to the facility and CCSE staff within five business days if:

- the DAHS facility submits the prior approval packet to the regional nurse within 30 calendar days of the initial physician's orders; and
- the applicant meets all eligibility requirements.

The effective date is the date of the physician's orders on Form 3055, Physician's Orders (DAHS).

Example: The facility receives Form 3055 on April 5 with a physician's signature date of April 1. The facility receives Form 2101 and the referral packet from CCSE staff on April 20. The facility submits the prior approval packet to the regional nurse on April 22 and the nurse receives the packet on April 24. This is within 30 calendar days of the physician's orders and the applicant meets all eligibility requirements, so the regional nurse authorizes services effective April 1.

If the DAHS facility fails to submit the prior approval packet or additional documentation within the required time frame, the additional documentation is not adequate, or CCSE staff determine the applicant ineligible, the regional nurse cancels the DAHS facility-initiated prior approval and the DAHS facility is not reimbursed for services. If the applicant meets all eligibility requirements, the regional nurse authorizes services by sending Form 2101 to the facility and CCSE staff.

The nurse may send Form 2101 to CCSE staff by secure email as determined by regional procedures. If the region elects to have the regional nurse notify CCSE staff by email, the nurse must include the applicant's name, identification number and date of authorization in the email. The unit supervisor or other appointed HHSC staff will also receive the notice. CCSE staff must go into the Service Authorization System Online (SASO) and print a copy of the authorization Form 2101 and a copy of the email for the case record.

The effective date is the earliest of the following dates on the prior approval packet:

- postage meter date (if not cancelled by the U.S. Postal Service);
- U.S. Postal Service date; or
- HHSC stamp-in date.

The facility is not reimbursed for any services delivered before the authorization date.

Example: The facility obtains verbal physician's orders and requests services through HHSC on April 1. The facility sends Form 3055 to the physician for completion and signature. CCSE staff complete the assessment on April 13 and Form 2101 and sends the referral packet to the facility. On May 2, the facility receives Form 3055 and mails the prior approval packet to the regional nurse. The regional nurse receives the packet on May 4, which is more than 30 days from the physician's verbal orders. The regional nurse establishes eligibility and authorizes services effective May 2, which is the U.S. Postal Service date on the envelope mailed from the facility.

Critical Omissions for Facility-Initiated Referrals

If there are critical omissions, the regional nurse sends Form 3070, Day Activity and Health Services Notification of Critical Omissions, to the facility within five business days of receipt of the prior approval packet

and sends a copy to CCSE staff. The facility must send corrections to the regional nurse within 14 days. If the corrections are received within the time frame and the applicant meets eligibility requirements, the regional nurse authorizes services effective the date of the physician's orders on Form 3055. If the facility fails to meet this time frame, the date of prior approval can be no earlier than the postmark or HHSC-stamped date on the corrected documentation.

Related Policy

Critical Omissions, 4236

4234.2 Case Worker Responsibilities for Facility-Initiated Referrals

Revision 17-1; Effective March 15, 2017

It is the case worker's responsibility to determine the applicant's eligibility within 30 calendar days from the assessment date and to track if Form 2101, Authorization for Community Care Services, has been completed by the Texas Health and Human Services Commission (HHSC) regional nurse. If, on the 30th day the case worker has not received Form 2101 or received notice of critical omissions, the case worker contacts the regional nurse to inquire if the required information has been received. The case worker must document the contact and the regional nurse's response. The case worker will take one of the following actions:

- If the regional nurse has received the prior approval packet and services will be authorized, the regional nurse advises the case worker of the anticipated authorization date and sends Form 2101 to the facility and the case worker.
- If the regional nurse has sent the prior approval packet back to the facility for critical omissions, the case worker allows another 30 calendar days for the facility to send corrections and receive approval. If Form 2101 has not been received at the end of the 30 days, the case worker contacts the regional nurse for the status and anticipated dates of approval or denial.
- If the regional nurse has **not** received the prior approval packet or the critical omissions corrections, the case worker must deny the application and notify the applicant, the facility and the regional nurse of the denial, using Form 2065-A, Notification of Community Care Services. The facility will **not** be reimbursed for the services delivered.

The applicant may reapply for services, but new physician's orders and a new assessment must be completed.

4235 Facility Response to CCSE Staff Referrals

Revision 22-3; Effective Sept. 1, 2022

For referrals initiated by CCSE staff, the DAHS facility must respond within 14 days of receipt of the referral Form 2101, Authorization for Community Care Services.

Within 14 days of the receipt of the referral Form 2101, the DAHS facility sends the prior approval packet to the HHSC regional nurse. The prior approval packet consists of:

- referral Form 2101;
- Form 3050, DAHS Health Assessment/Individual Service Plan; and
- Form 3055, Physician's Orders (DAHS).

If the DAHS facility notifies CCSE staff that the health assessment or the physician's orders will be delayed beyond 14 days, evaluate the cause of the delay. Consult the recipient to determine if they should be referred to another provider of their choice. If CCSE staff determine a new referral is needed, verbally notify the original

provider and the HHSC regional nurse. Send Form 2067, Case Information, to the original provider to confirm the withdrawal.

Related Policy

Initial Eligibility Determination and Referral, 4233

4235.1 Regional Nurse Responsibilities for CCSE Referrals

Revision 21-4; Effective December 1, 2021

When the regional nurse receives the required forms from the facility, the regional nurse reviews Form 2101, Authorization for Community Care Services, Form 3050, DAHS Health Assessment/Individual Service Plan, and Form 3055, Physician's Orders (DAHS), to determine if the applicant meets the Day Activity and Health Services (DAHS) medical eligibility criteria. If there are critical omissions or errors in the required documentation, the regional nurse must follow the critical omissions procedures.

The regional nurse must keep the envelope that the prior approval material is mailed in. If more than one prior approval packet is included in the envelope, the regional nurse or designee must list the name of each applicant that a prior approval packet had in the envelope.

The regional nurse grants approval if the:

- applicant meets the eligibility criteria; and
- there are no critical omissions or errors in the documentation from the facility.

The regional nurse generates and sends the authorization, Form 2101 to the facility and CCSE staff within five business days of receipt of the prior approval request. This provides notification of approval or denial of the applicant.

The region has the option of allowing the regional nurse to send notification of the authorization to CCSE staff by secure email, rather than sending the paper copy. Each region may determine which method best suits its needs. The regional nurse will continue to send a paper copy to the provider.

If the region elects to have the regional nurse notify CCSE staff by email, the nurse must include the applicant's name, identification number and date of authorization in the email. The unit supervisor or other appointed HHSC staff will also receive the notice. CCSE staff must go into the Service Authorization System Online (SASO) and print a copy of the authorization Form 2101 and a copy of the email for the case record.

Related Policy

Medical Eligibility Criteria, 4222
Facility Response to Case Worker Referrals, 4235
Critical Omissions, 4236

4235.2 Effective Dates for Initial Cases

Revision 17-1; Effective March 15, 2017

The regional nurse establishes the beginning date of Day Activity and Health Services (DAHS) coverage based on whether the individual is referred by the case worker or by the facility as a facility-initiated referral, and if there are critical omissions/errors in the required documentation.

For case worker referrals, the regional nurse establishes the Begin Date of coverage on Form 2101, Authorization for Community Care Services, as the date it is expected to be mailed to the facility. If this date is not feasible, the regional nurse negotiates the Begin Date of coverage on Form 2101 with the case worker and the facility, according to the individual's needs and the individual's unique circumstances.

The regional nurse establishes the beginning date of coverage on Form 2101 for a facility-initiated referral using the date of the physician orders. If there are corrections for critical omissions/errors in the required documentation, the regional nurse follows procedures in Section 4236, Critical Omissions, and establishes the effective date as the:

- date of the physician orders, if corrections are received within 14 days of the date the regional nurse sends Form 3070, Day Activity and Health Services Notification of Critical Omissions; or
- date the corrections are received, if the corrections are not received within 14 days.

4235.3 Case Worker Responsibilities for Case Worker Referrals

Revision 17-1; Effective March 15, 2017

Within two business days of receipt of Form 2101, Authorization for Community Care Services, from the regional nurse, the case worker sends Form 2065-A, Notification of Community Care Services, to the individual notifying the individual of eligibility or ineligibility.

If the individual was a facility-initiated referral, a copy of Form 2065-A is also sent to the facility. The effective date on Form 2065-A must match the effective date on Form 2101 from the regional nurse.

4236 Critical Omissions

Revision 22-3; Effective Sept. 1, 2022

If the required documentation contains errors or omissions, the HHSC regional nurse:

- Completes Form 3070, Day Activity and Health Services Notification of Critical Omissions; and
- sends it to the facility along with the rejected prior approval packet.

Corrections of critical omissions or errors in DAHS facility documentation must be received by HHSC within 14 calendar days after the HHSC regional nurse mails Form 3070, Day Activity and Health Services Notification of Critical Omissions, to the facility.

If the facility fails to submit the required documentation timely, contact the applicant within three business days after being notified by the HHSC regional nurse. Explain that a referral can be made to another DAHS facility due to the delay, if the applicant, their family or their authorized representative prefers this option.

The regional nurse uses the earliest of the following dates to establish the date that prior approval material and corrections of critical omissions or errors are received from the facility:

- postage meter date (if not canceled by the U.S. Postal Service);
- U.S. Postal Service date; or
- HHSC stamp-in date.

The facility has 14 calendar days to correct critical omissions or errors. If the facility returns the packet before the 14th calendar day but all identified omissions or errors are not corrected, the facility has the rest of the 14 calendar days to resubmit additional corrections.

The regional nurse verbally notifies the facility that:

- the corrected packet does not address all errors noted on Form 3070, and
- additional corrections must be submitted on or before the 14th calendar day to avoid a gap in payment.

The regional nurse documents this verbal notification (date, name of contact, etc.) in the case record.

4240 Facility Initiation of Services

Revision 17-1; Effective March 15, 2017

The facility must complete and return HHSC's authorization for community services form to the case worker within 14 days from the begin date on HHSC's authorization for community care services form. The Day Activity and Health Services (DAHS) facility must indicate the date services were initiated, the schedule for delivering services, and the total units authorized for the individual.

The 14-day period (for the facility to return Form 2101, Authorization for Community Care Services) encourages the facility to start services promptly. The 14-day period does not apply if an individual is already attending a DAHS facility when the facility refers him to the case worker (for example, a facility-initiated referral). For facility-initiated referrals, the facility returns Form 2101 as soon as possible after receiving it from the case worker.

4250 Monitoring

Revision 17-1; Effective March 15, 2017

Monitor the services based on the priority assigned to the individual's case. For priority levels, see:

- Section 2540, Priority Status Individuals;
- Section 2710, Monitoring Visits and Contacts;
- Section 2711, Monitoring Visits for Community Attendant Services (CAS) Individuals; and
- Section 2712, Six-Month Monitoring Contacts.

Timelines for Day Activity and Health Services (DAHS)-only cases are measured differently than other situations because there is no Form 2060, Needs Assessment Questionnaire and Task/Hour Guide, date from which to count. Measure DAHS-only timelines from the:

- initial contact date (for initial certifications); or
- the previous date on Form 2314, Satisfaction and Service Monitoring, (for recertifications).

The regional nurse also monitors DAHS through utilization review.

4260 Changes

Revision 17-1; Effective March 15, 2017

The Day Activity and Health Services (DAHS) facility must inform the case worker of changes in the individual's status, condition and when the individual is suspended from attending DAHS.

4261 Service Plan Changes Reported by the Facility

Revision 22-3; Effective Sept. 1, 2022

The DAHS facility must verbally notify CCSE staff of any changes in the recipient's status or condition. This may require a change in their plan of care, units of service or service termination. If so, they must follow up with written notification within seven days.

CCSE staff approve changes in the plan of care which may affect eligibility or units of service.

Within 14 calendar days of receipt of Form 2067, Case Information:

- review the request for a change which may affect eligibility or units of service;
- contact the recipient to confirm they are in agreement with the proposed change; and
- respond to the written request.

If CCSE staff and the recipient agree with the facility's request, complete and send Form 2101, Authorization for Community Care Services. If CCSE staff and the recipient agree to terminate or reduce services, follow adverse action procedures.

If CCSE staff or the recipient disagree with the request, send Form 2067 to the facility to explain the reason for not making the change.

Related Policy

Individual Notification Procedures, 2810
Effective Dates, 2811
Form 2101 Coverage Dates for Title XIX Services, Appendix XXIII

4261.1 Individual Absences

Revision 17-1; Effective March 15, 2017

If a Day Activity and Health Services (DAHS) participant is absent from the facility for 15 consecutive days, the DAHS facility must verbally notify the Texas Health and Human Services Commission (HHSC) of the suspension no later than the first workday after services are suspended and then send Form 2067, Case Information, within seven workdays after the incident was reported verbally.

If an individual is absent from a regularly scheduled program, the DAHS facility must contact the individual or someone knowledgeable about his condition the same day that the absence occurs. If the DAHS facility is unable to contact the individual or someone knowledgeable about his condition, the DAHS staff must document this in the individual's record. DAHS facilities are not required to notify the case worker of daily absences from the facility.

4262 DAHS Transfers

Revision 17-1; Effective March 15, 2017

Only the individual may initiate a Day Activity and Health Services (DAHS) facility transfer; the change cannot be requested by facility staff.

When an individual decides to transfer to a new DAHS facility (including a facility in a different region), the individual must contact the HHSC case worker before making the move. The individual may make the request to the case worker orally or in writing. If a request for a DAHS transfer is received from anyone other than the individual, the case worker must contact the individual to ensure he desires the change. Services at the new facility may begin no earlier than one day after the individual receives services from the previous facility.

Within 14 days of the request from a current individual to transfer to another facility, follow these procedures:

- Negotiate with both facilities the date the current facility will stop providing services and the date the new facility will start services, ensuring there is no gap or overlap in services.
- Update Form 2101, Authorization for Community Care Services, by entering:
  - the nine-digit vendor number;
  - the effective date of the transfer; and
  - a statement in the comments section that this is an individual transfer.
- Send Form 2101 to the gaining DAHS facility to begin services.
- Send Form 2101 to the losing facility to terminate services.

It is critical for the case worker to coordinate individual transfers from one facility to another to ensure that no duplication of service or gaps in dates of coverage exist. Facility-initiated referrals are for applicants only and may not be used for individuals currently receiving DAHS services.

4263 Suspensions

Revision 22-3; Effective Sept. 1, 2022

The provider agency must suspend services if:

- the recipient permanently leaves the state or moves outside the geographic area served by the program;
- the recipient dies;
- the recipient is admitted to an institution which is defined as a:
  - hospital;
  - nursing facility;
  - state school;
  - state hospital; or
  - intermediate care facility serving people with an intellectual disability or related conditions;
- the recipient requests that services end;
- HHSC denies the recipient's Medicaid eligibility (not applicable to Title XX DAHS services); or
- the recipient exhibits reckless behavior, which may result in imminent danger to the health and safety of the recipient or others.

The provider agency must notify CCSE staff by fax of any suspension by the next business day. The faxed notice of a suspension must include:

- the date of service suspension;
- the reason(s) for the suspension;
- the duration of the suspension, if known; and
- an explanation of the provider agency's attempts to resolve the problem that caused the suspension, including the reasons why the problem was not resolved.

CCSE staff confirm the reason for the suspension and take appropriate action. If the suspension results in case closure or termination of DAHS, coordinate closure and the termination date with the provider to allow time for the recipient to receive notification of the right to appeal.

Related Policy

Service Suspensions, 2820
Service Suspension by Provider, 2821
Service Suspension by Caseworker, 2822
Hospital and Nursing Facility Stays, 2822.1
Refusal to Comply with Service Delivery Provisions, 2830

Suspensions Due to Refusal to Comply with Service Delivery Provisions, 2831
Threats to Health or Safety, 2840

4264 Ensuring Health and Safety at DAHS Facilities

Revision 22-3; Effective Sept. 1, 2022

If a recipient exhibits reckless behavior while at a DAHS facility that may result in imminent danger to the health and safety of DAHS recipients or staff, the DAHS facility must take immediate action to protect recipients and staff in the facility. This may require removing the recipient from the facility or away from others and contacting local authorities such as police, sheriff's department or mental health authorities, to ensure everyone's safety. The facility may make a referral for appropriate crisis intervention services to the Texas Department of Family and Protective Services (DFPS) Adult Protective Services (APS). The facility must immediately suspend services to the recipient.

The DAHS facility must verbally notify CCSE staff of the reason for the immediate suspension by the following HHSC business day and follow up with written notification to HHSC within seven HHSC business days of the verbal notification. Upon notification, CCSE staff must follow the threats to health or safety policy, including notifying CCSE management of the incident and conferring to ensure all appropriate actions are taken to maintain a safe environment in the facility.

Arrange an interdisciplinary team meeting at the earliest opportunity to determine if the issue can be resolved and services can be continued. If the threat to health and safety was serious enough, services may be terminated immediately.

If the recipient reapplies for services at a later date, they must provide information or authorize collateral contacts to verify they are no longer a threat.

Related Policy

Effective Dates, 2811
Threats to Health or Safety, 2840
Reinstatement of Services Terminated for Threats to Health or Safety, 2841

4270 Reassessment

Revision 22-3; Effective Sept. 1, 2022

CCSE staff must reassess a DAHS recipient's eligibility at least every 12 months. The DAHS facility does not need to obtain new physician's orders for recipients receiving ongoing DAHS.

Timelines for DAHS-only cases are measured differently than other case situations because there is no Form 2060, Needs Assessment Questionnaire and Task/Hour Guide, date from which to count. Measure DAHS-only reassessment timelines from the:

- initial contact date (for initial certifications); or
- the previous date on Form 2314, Satisfaction and Service Monitoring, (for recertifications).

When reassessing a DAHS recipient's eligibility, examine the history of attendance. Reauthorize only the number of units the recipient is likely to use. Explore the reasons for underutilization by discussing the situation with the recipient, facility staff and the recipient's family.

If underutilization has been sporadic due to temporary factors such as acute illness or hospitalization, no change in service authorization may be needed. However, if underutilization has occurred consistently during the previous six months, discuss changing the service plan with the recipient and their family. The number of units authorized per week may need to be decreased.

A review of the service plan may be appropriate during the 12-month period if a change in units of service is required.

If CCSE staff determine a recipient continues to be eligible for DAHS but the number of units are changing, submit Form 2101, Authorization for Community Care Services, to the facility. If the facility does not agree with the service plan change, the facility representative must contact CCSE staff before the effective date of the change to resolve the disagreement.

If CCSE staff determine the recipient no longer qualifies for DAHS, send Form 2065-A, Notification of Community Care Services, to the recipient and terminate services. Update and send Form 2101 to terminate services.

Related Policy

Effective Dates, 2811
Renewal of Prior Approval, 4271
Notification/Effective Date of Decision, Appendix IX
Form 2101 Coverage Dates for Title XIX Services, Appendix XXIII

4271 Renewal of Prior Approval

Revision 17-1; Effective March 15, 2017

Although the coverage period is open-ended in the Service Authorization System, the case worker must conduct a reassessment/redetermination of the individual and send the facility Form 2101, Authorization for Community Care Services, confirming eligibility status if the number of units changes or if services are terminated. Use the following procedures for renewal of prior approval, including late renewals.

If the case worker . . .	Then . . .
reassesses/redetermines the individual eligible for services **and** there are no changes to the service plan,	verbally notify the individual that services will continue at the same level. Do not send any forms to the Day Activity and Health Services facility if there are no changes.
reassesses/redetermines the individual eligible for services **and** there are changes to the service plan (units),	• send the individual Form 2065-A, Notification of Community Care Services, to notify him of the change in the service plan; and • send the facility an updated and signed Form 2101 to notify it of the change. The effective date for a decrease is 12 days following the Form 2065-A date. The effective date for an increase is seven days following the Form 2101 date.

If the case worker . . .	Then . . .
reassesses/redetermines the individual ineligible for services,	• send the individual Form 2065-A to notify him of the termination; and • send the facility an updated and signed Form 2101 as notification of the termination. See Appendix IX, Notification/Effective Date of Decision, to determine the effective date.

4300, Emergency Response Services

4310 Introduction

Revision 17-1; Effective March 15, 2017

Emergency response services (ERS) are provided through an electronic monitoring system. This system is for use by functionally impaired adults who live alone or who are functionally isolated in the community. In an emergency, the individual can press a call button to signal for help. The electronic monitoring system, which has a 24-hour, seven-day-a-week monitoring capability, helps ensure that the appropriate person or service agency responds to an alarm call from an individual.

ERS can be delivered to individuals with a landline telephone or in some areas may be available to individuals with cellular phone service or Voice Over Internet Protocol (VOIP). The provider agency choice list designates which ERS providers in the contracted service area are able to accommodate applicants who elect to receive ERS without a landline telephone. The rates for the service are the same regardless of the ERS delivery mechanism (e.g., cellular, landline, VOIP).

4311 Program Definitions

Revision 17-1; Effective March 15, 2017

The following words and terms, when used in this chapter, shall have the following meanings, unless the context clearly indicates otherwise:

Alarm call — A signal transmitted from the equipment to the provider's response center indicating that the individual needs immediate assistance.

Call button — An electronic device that, when pressed, triggers an alarm to the response center to alert the provider that an individual needs immediate assistance. The device may be held in the hand, worn around the neck, hung on a garment or kept within the individual's reach.

Installer — A volunteer, a subcontractor or an employee of a provider who connects, maintains or repairs the equipment.

Monitor — A volunteer, subcontractor or an employee of a provider who monitors Emergency Response Services (ERS) and ensures that an alarm call is responded to immediately.

Responder — A person designated by an individual to respond to an emergency call activated by the individual. A responder may be a relative, neighbor or a volunteer.

Response center — The site where a provider's ERS monitoring system is located.

Subcontractor — An organization or individual who delivers a component of ERS for the provider for a fee and is not an employee or volunteer of the provider.

4312 Eligibility and Referral Procedures

Revision 17-1; Effective March 15, 2017

4312.1 Eligibility

Revision 17-1; Effective March 15, 2017

40 Texas Administrative Code (TAC) §48.2928. To be eligible for emergency response services, a client must:

(1) meet the functional need criteria as set by the department. The department uses a standardized assessment instrument to measure the client's ability to perform activities of daily living. This yields a score, which is a measure of the client's level of functional need. The department sets the minimum required score for a client to be eligible, which the department may periodically adjust commensurate with available funding. The department will seek stakeholder input before making any change in the minimum required score for functional eligibility; and

(2) meet the requirements:

(A) live alone, be alone routinely for eight or more hours each day, or live with an incapacitated individual who could not call for help or otherwise assist the client in an emergency;
(B) be mentally alert enough to operate the equipment properly, in the judgment of the DHS case worker;
(C) have a telephone with a private line, if the system requires a private line to function properly;
(D) be willing to sign a release statement that allows the responder to make a forced entry into the client's home if he is asked to respond to an activated alarm call and has no other means of entering the home to respond; and
(E) live in a place other than a skilled institution, assisted living facility, foster care setting, or any other setting where 24-hour supervision is available.

The eight hours mentioned in requirement (1) of the rule does not have to be continuous, provided the individual is alone at least eight hours in each 24-hour period. Even if the individual has an attendant, consider the individual alone.

If the provider is unable to complete installation, inform the individual that installation of ERS equipment is pending for the reasons stated by the provider. If the individual is unable or unwilling to make the needed modifications, explore other community resources to determine if these could be used to complete the needed modifications. If none are available, services may then be denied using termination code "other." Document the reason in the case record.

See 3000, Eligibility for Services, for additional eligibility requirements.

40 TAC §48.3903(d). The client is not eligible for emergency response services if:

(1) he abuses the service by activating:

(A) four false alarms which result in a response by fire department, police/sheriff, or ambulance personnel within a six-month period; or

(B) twenty false alarms of any kind within a six-month period;

(2) he is admitted to a skilled institution, personal care home, foster care setting, or any other setting where 24 hour supervision is available;

(3) in the case worker's judgment, he is no longer mentally alert enough to operate the equipment properly. Situations include, but are not limited to:

(A) he damages the equipment,

(B) he disconnects the equipment and has received two warnings that are documented in the case record,

(C) he refuses to participate in the monthly systems checks; or

(4) he is away from the home or is unable to participate in the service delivery for a period of three consecutive months or more.

4312.2 Referral Process

Revision 18-2; Effective November 19, 2018

A provider must accept all HHSC referrals. A case worker makes a routine referral on Form 2101, Authorization for Community Care Services, or makes a negotiated referral by phone and Form 2101.

The case worker gives eligible applicants an explanation of the service. He explains that applicants/individuals are required to:

- participate in the service delivery requirements; and
- the case worker reviews Attachment 2307-B, ERS Eligibility Criteria and Responsibilities, with the individual, which includes a statement allowing the responder to enter the participant's home, by force if necessary, to assist the participant.

The case worker follows procedures as outlined in 3000, Eligibility for Services.

4313 Case Management Duties Related to Emergency Response Services (ERS)

Revision 17-1; Effective March 15, 2017

If the applicant/individual appears to be in need of ERS and wants to receive ERS, the case worker determines if the applicant/individual meets the general criteria for participating in ERS.

If eligible for ERS, the case worker shares the regional list of all ERS providers and encourages the applicant to choose the most economical alternative for service provision. The applicant/individual selects a provider from the list of providers. If the applicant/individual has no preference, the case worker refers the applicant to the provider with the lowest rate. If more than one provider has the same lowest rate, the case worker makes the referral by rotation of providers. If the individual is currently receiving services from a provider that does not have the lowest rate, but is not satisfied with that provider, the case worker should encourage the individual to choose another provider. The individual should not be encouraged to choose another provider just because it has a lower rate.

The case worker may assist the individual or the provider in identifying potential responders, and in periodically updating the information the provider maintains in its files on responders and other emergency numbers. The case worker must not be an emergency responder for the individual.

HHSC rules require the ERS provider to notify the case worker no later than the next HHSC workday of alarms, other individual emergencies or changes in the individual's behavior or condition that preclude ERS.

At least annually, the case worker must review the list of responders provided to the provider to ensure the list is current. During the course of the services, the case worker and the provider have the joint responsibility of keeping each other informed of changes or problems.

Report to the contract manager any provider tendency or pattern of designation of emergency personnel as respondents. Advise the individual that he is responsible for any charges assessed by emergency personnel if they are summoned to the individual's home for a non-medical emergency.

4320 Service Delivery Requirements

Revision 17-1; Effective March 15, 2017

4321 Service Initiation

Revision 21-2; Effective June 1, 2021

When an Emergency Response Service (ERS) provider receives a copy of Form 2101, Authorization for Community Care Services, and the provider packet, they will initiate services.

After receiving the packet, the ERS provider will:

- contact the participant to make an appointment to install the emergency response home unit equipment; and
- prepare a participant file, which includes applicable provider agency forms.

Note: In addition to requesting the applicant's or recipient's information, the provider will also complete a home entry release statement, ownership of equipment statement, and complaint procedure form.

If a different service initiation date is required, the provider must contact Community Care Services Eligibility (CCSE) staff to negotiate the new service initiation date by which services must begin.

Evaluate if an alternative service or other resources are available to meet the person's needs. Instruct the provider to retain the authorization and initiate services as soon as possible or request the return of the written referral packet.

Related Policy

Content of Referral Packets, Appendix XIII

4322 Reserved for Future Use

Revision 22-2; Effective June 1, 2022

4323 Reserved for Future Use

Revision 22-2; Effective June 1, 2022

4324 Provider Follow-Up Procedures

Revision 17-1; Effective March 15, 2017

The provider notifies the case worker of service initiation as outlined in 4321, Service Initiation.

The provider maintains ongoing communication with the case workers and the regional contract manager. He discusses individual-specific issues with the case worker, and contract management issues (overall service delivery, policies and procedures) with the regional contract manager.

4325 Selection of Providers and Provider Changes

Revision 22-2; Effective June 1, 2022

Each region maintains a list of all Emergency Response Services (ERS) providers. The list includes:

- vendor number;
- geographic areas served; and
- rate(s).

This information is given to the recipient to assist in making an informed choice. The recipient must select an ERS provider from the regional list. If the recipient does not have a preference, refer the recipient to the provider with the lowest rate. If there is more than one provider with the same lowest rate, refer to the next provider on a rotating basis.

The recipient must contact CCSE staff to request a provider change. CCSE staff determine:

- the issue or reason for the change request;
- if the issue can be addressed without changing providers; and
- if the provider will agree to the transfer.

Before processing a transfer, try to resolve the recipient’s concerns with the current provider.

If the issue with the provider is based on the recipient's failure to comply with the service plan, convene an interdisciplinary team (IDT) meeting to discuss the issues. If services are not terminated due to the recipient’s failure to comply with the service plan, authorize a transfer if necessary to address the recipient's concerns or if the recipient insists on changing providers.

Have the recipient select another provider and process the transfer. Coordinate the date the current provider will end services and the date the new provider will begin services. An ERS provider may receive payment for the month of service regardless of the number of days services were provided in the month services were terminated. During a transfer of ERS services, make every effort to end the service of the first provider on the last day of the month and begin service of the second provider on the first day of the following month. Coordination of the end and begin dates reduces the need for payment of services to a second ERS provider for the same calendar month.

Related Policy

Suspension and Termination of Services, 4340

4330 Service Delivery

Revision 17-1; Effective March 15, 2017

4331 Reserved for Future Use

Revision 22-2; Effective June 1, 2022

4332 System Checks

Revision 22-2; Effective June 1, 2022

An ERS recipient must be able to participate in monthly system checks. The monthly system check is to ensure that the recipient can successfully make an alarm call and that the equipment works properly.

If a provider is unable to complete a system check during a calendar month, they must notify CCSE staff in writing.

Once notified that the provider is unable to complete a system check, convene an IDT to evaluate the situation. Determine if the recipient continues to be appropriate for the service. If continuing services, complete and return Form 2067, Case Information. If terminating services, complete Form 2101, Authorization for Community Care Services.

Allow the authorization for ERS to remain effective if the recipient is still eligible for the service, but is unable to participate in a monthly system check.

Ensure the recipient's authorization does not exceed three consecutive billing months during which the recipient is unable to participate in the monthly system checks.

4333 Equipment Malfunction

Revision 22-2; Effective June 1, 2022

A provider must contact the recipient by the next day after learning of any equipment failure. They must replace the equipment if the recipient is available within one working day or by the end of the third day if the recipient is not available the first working day.

The provider must ensure the equipment is functioning properly and that each recipient receives services during the entire authorization period.

The following people may report equipment malfunctions to the provider:

- recipient;
- recipient's family members;
- recipient's responders;
- CCSE staff; and
- monitors.

Providers:

- Send the installer to the recipient's home to repair or replace the equipment as equipment malfunctions are reported.
- Keep a record of each equipment malfunction in the provider's files.
- Must visit a recipient's home to check the equipment within five working days after the equipment has registered five or more "low battery" signals in a 72-hour period.
    - They must replace a defective battery during the visit.
- Must respond to "low battery" signals received from the recipient's equipment.
    - Provider staff must contact the recipient by phone after receiving a "low battery" signal to determine if the "low battery" could be caused by an accident, such as the unit having been unplugged.
    - If the "low battery" signals continue, the provider must send a staff member to check, and repair or replace the recipient's ERS equipment within five working days after the receipt of the fifth "low battery" signal.

4340 Suspension and Termination of Services

Revision 22-2; Effective June 1, 2022

An interdisciplinary team (IDT) meeting may be called by CCSE staff or provider staff if monthly system checks are unsuccessful or a recipient or someone in their home engages in illegal discrimination against a provider staff or HHSC staff. If services should continue, send Form 2067, Case Information, to notify the provider. If services will be terminated because of the IDT, send Form 2101, Authorization for Community Care Services, to terminate services.

Report any changes involving the recipient to the provider. (Example: hospitalization, change of residence, or visits with relatives.)

A provider may leave ERS equipment in a recipient's home and continue service delivery when the recipient has temporarily entered an institution. The provider must suspend services if the recipient has been in the institution for more than 120 consecutive days. The provider is eligible for payment if the system checks are conducted during the 120-day period.

The provider must request termination of services when the recipient is no longer competent enough to operate the equipment properly. Situations include, but are not limited to, when the recipients:

- damages the equipment;
- disconnects the equipment and has received two warnings that are documented in the case record; or
- refuses to participate in the monthly system checks.

Providers:

- Must document the inability to test the home unit in the recipient’s case file.
- Request the installer remove the equipment from the recipient’s home after CCSE staff authorize service termination.
- May leave ERS equipment in a recipient’s home and continue services until the end of the month the service authorization expires.
- Receives payment for the month the service authorization ends, if:
    - monitoring continues until the equipment is picked up; and
    - the equipment is tested during the same calendar month or at the time of pickup.
- May be paid for the last month of service if ERS is terminated, regardless of how many days of service were provided in that month, if the provider has complied with ERS requirements.

The recipient is not liable for payment for lost or damaged equipment.

4341 Interdisciplinary Team (IDT) Meeting

Revision 22-2; Effective June 1, 2022

CCSE staff or the provider staff will convene an IDT meeting as needed. A meeting should be called for situations where the provider is unable to resolve issues with the recipient. CCSE staff must participate in the IDT meeting to assist in resolving issues. The IDT meeting could result in continuation or discontinuation of services. If applicable, policy relating to failure to comply with the service plan must be considered.

4350 Reserved for Future Use

Revision 22-2; Effective June 1, 2022

4351 Advertising and Solicitation

Revision 17-1; Effective March 15, 2017

HHSC may investigate complaints of solicitation or coercion of individuals. Validated complaints may lead to adverse actions or termination of contracts. The ERS provider is in violation of the ERS contract if the provider employs a person:

- who is paid money each time he recruits a new Medicaid recipient; or
- whose sole responsibility is recruitment, regardless of how he is compensated.

The ERS provider may have an employee who is responsible for recruitment in addition to other assignments, as long as he is paid a regular salary and does not receive bonuses or anything that could be construed as a bonus for recruitment of Medicaid recipients.

4352 Disclosure of Previous Employment and Certification

Revision 17-1; Effective March 15, 2017

If a former or current HHSC employee or former or current council member or their relatives are an officer, director, owner or employee, the commissioner of HHSC or designee must approve the contract or contract renewal.

4353 Reserved for Future Use

Revision 22-2; Effective June 1, 2022

4360 Reassessment

Revision 17-1; Effective March 15, 2017

Reassess for eligibility within 12 months of the last functional assessment for services. Call or make a home visit to re-determine the individual's eligibility for ERS. During the home visit, ask the individual to explain how to

initiate an alarm call. Evaluate whether the individual continues to be sufficiently mentally alert to operate the equipment. (See 4312.1, Eligibility.)

If the individual continues to be eligible and there are no changes, do not send anything to the provider. If services are terminated, coordinate the effective date of termination to match on Form 2065-A, Notification of Community Care Services, and Form 2101, Authorization for Community Care Services, to allow the individual 12 days prior notice.

4400, Family Care Services

4410 Primary Home Care Program

Revision 17-1; Effective March 15, 2017

The Primary Home Care Program (PHCP) is the personal attendant services (PAS) umbrella program under Chapter 47 of the Texas Administrative Code (TAC), which includes the following services:

- Primary Home Care (PHC);
- Community Attendant Services (CAS); and
- Family Care (FC).

FC provides in-home PAS to individuals eligible under Title XX of the Federal Social Security Act (relating to block grants to states for social services). Providers delivering PAS must meet all the requirements in Texas Administrative Code §47.11, Contracting Requirements.

With the exception of this section and Section 4610, Primary Home Care Program, all non-Chapter 47 rule references within the *Community Care Services Eligibility Handbook* to "Primary Home Care" or "PHC" refer to the service, not the umbrella program.

For information on the Title XIX PHCP programs, see Section 4600, Primary Home Care and Community Attendant Services.

4411 Family Care Services Description

Revision 17-1; Effective March 15, 2017

Family Care (FC) provides assistance with activities of daily living to eligible individuals who have functional limitations caused by age, disabilities or medical problems. Services are limited to 50 hours per week (42 hours per week for a priority individual). Services include help with personal care, household tasks, meal preparation and escort.

FC is a non-skilled, non-technical service delivered by an attendant employed by the provider. The attendant must be age 18 or older. Providers must comply with the requirements in the contract with the Texas Health and Human Services Commission and in the *Contracting to Provide Primary Home Care Services Handbook*.

4412 Allowable Tasks

Revision 18-1; Effective June 15, 2018

Personal attendant services (PAS) that may be delivered under Family Care (FC) include the tasks defined in 40 Texas Administrative Code §47.41, Allowable Tasks.

For information on Escort Services, refer to 40 TAC §48.2919(a) and (b), Time Allocation for Escort Services.

Refer to the examples given in Section 4621, Allowable Tasks, for more information on calculating time for escort. Escort may include accompanying the individual on non-medical trips such as the grocery store, paying bills, pharmacy, hair stylist/barber or social events. The time used to provide the escort task must not exceed the total time purchased for attendant care. No additional time for escort is allocated to the individual's service plan. The individual may elect to receive escort in place of assistance with household or personal care on a day that best meets his/her needs. This service does not include the direct transportation of the individual by the attendant.

Because shopping is an authorized task, it may entail the provider paying mileage to the attendant to perform the task. The individual cannot be charged for transportation costs incurred in performance of this task by either the attendant or the provider.

To facilitate safe individual ambulation or movement, arranging furniture may be provided (Example: Individuals who use wheelchairs, walkers or crutches or for blind individuals). The provider supervisor addresses this activity during orientation for an attendant who provides services to this type of individual.

Refer to Page 3 & 4 of Form 2060, Needs Assessment Questionnaire and Task/Hour Guide, for further definition of activities that may be provided within each task.

4413 Excluded Services

Revision 17-1; Effective March 15, 2017

Family Care (FC) does not include services that must be provided by a person with professional or technical training. Examples include but are not limited to the following:

- insertion and irrigation of catheters;
- irrigation of body cavities;
- application of sterile dressings involving prescription medications and aseptic techniques;
- tube feedings;
- injections;
- administration of medication; and
- any other skilled or technical services identified by the department.

Services that maintain an entire family or household are also excluded unless the entire household receives FC services. Examples:

- cleaning floor and furniture in areas that the individual does not occupy or use;
- preparing meals for the entire family or household;
- laundering clothing or bedding that the individual does not use; and
- shopping for groceries or household items the individual does not need for health and maintenance.

An attendant may shop for items the individual needs and that the rest of the household also uses.

4420 Eligibility

Revision 17-8; Effective September 1, 2017

To be eligible for family care, the applicant/individual must:

- meet the income and resource guidelines established by the department in 40 Texas Administrative Code §§48.2902, 48.2903, 48.2922, and 48.2923 (relating to Income and Income Eligibles, Determination of

Countable Income, Resource Limits, and Countable Resources);
- meet the minimum functional need criteria as set by the department. The department uses a standardized assessment instrument to measure the individual's ability to perform activities of daily living. This yields a score, which is a measure of the individual's level of functional need. The department sets the minimum required score for an individual to be eligible, which the department may periodically adjust commensurate with available funding. The department will seek stakeholder input before making any change in the minimum required score for functional eligibility; and
- be ineligible to receive attendant care services funded through Medicaid.

The applicant/individual must require at least six hours of family care per week to be eligible, unless the applicant/individual:

- requires family care to provide respite to the caregiver;
- lives in the same household as another individual receiving family care, community attendant services, or primary home care;
- receives one or more of the following services (through the department or other resources):
  - congregate or home-delivered meals;
  - assistance with activities of daily living from a home health aide;
  - day activity and health services; or
  - special services to persons with disabilities in adult day care;
- receives aids-and-attendance benefits from the Veterans Administration; or
- is determined, based upon the functional assessment, to be at high risk of institutionalization without family care.

For eligibility policy not contained in this section, see:

- Section 3110, Eligibility for CCSE Services;
- Section 3111, Age Limits;
- Section 3200, Resource Eligibility Criteria; and
- Section 3300, Income Eligibility.

4421 Residence

Revision 17-1; Effective March 15, 2017

40 Texas Administrative Code §48.2918(b). To receive services, the applicant/client must reside in a place other than:

(1) a hospital;
(2) a skilled nursing facility;
(3) an intermediate care facility;
(4) an assisted living facility;
(5) a foster care setting;
(6) a jail or prison;
(7) a state school;
(8) a state hospital; or
(9) any other setting where sources outside the primary home care program are available to provide personal care.

Family Care (FC) cannot be authorized if the individual lives in a home licensed as a personal care home by the Texas Department of State Health Services. If the home is not a licensed personal care home, services may be authorized as follows:

- If three or fewer persons live in the home, the proprietor can be the personal attendant services (PAS) attendant for the individual(s) who resides there. The individual may not receive both PAS and Adult Foster Care.
- If the home provides only room and board to four or more persons living in the home, it does not require licensure as a personal care home. PAS services can be authorized for individuals in this setting, but the proprietor, his agent or employee cannot be the attendant for individuals who reside in the home. The case worker must specify this on Form 2101, Authorization for Community Care Services.

FC can be provided to a private pay applicant/individual living in a residential care facility (whether or not contracted with HHSC) under the following conditions. The case worker:

- applies the unmet need policy on a task-by-task basis, not duplicating services. Facilities provide varying degrees of assistance, and tasks purchased should not be tasks provided by the facility.
- must closely monitor the case to determine if the individual is receiving additional services from the facility. Service plans must be adjusted to avoid duplication of services/tasks.

If the individual begins receiving Residential Care (RC) through HHSC, FC is terminated effective no later than the date RC services are started.

4430 Case Worker Procedures for Determining Eligibility

Revision 18-2; Effective November 19, 2018

See Section 2200, Intake Procedures, for intake, screening criteria and interest list procedures.

Upon receipt of a Family Care intake or release from the interest list, the case worker makes a home visit within the required time frames to begin the application process.

Conduct a home visit to determine whether the individual meets eligibility criteria as outlined in Section 4420, Eligibility. The applicant must provide information to determine financial eligibility as outlined in Section 3000, Eligibility for Services, and must be screened for eligibility for Community Attendant Services (CAS).

Give the following to all applicants:

- Form 2307, Rights and Responsibilities;
- Attachment 2307-A, Family Care, Community Attendant Services and Primary Home Care Rights and Responsibilities; and
- Attachment 2307-EVV, Electronic Visit Verification Rights and Responsibilities, when the applicant requests CAS, Primary Home Care of Family Care Services.

Explain that the case worker must approve increases in the number of hours of services the individual receives. Also inform the individual that he/she may select another provider if he is dissatisfied with the services or with the attendant providing the services.

4431 Family Care Financial Eligibility

Revision 17-1; Effective March 15, 2017

To be eligible for family care, the applicant/individual must:

- meet the income and resource guidelines established by the department in 40 Texas Administrative Code §§48.2902, 48.2903, 48.2922, and 48.2923 (relating to Income and Income Eligibles, Determination of Countable Income, Resource Limits, and Countable Resources);
- be ineligible to receive attendant care services funded through Medicaid.

The case worker must determine that an applicant for Family Care is not eligible for services through Primary Home Care (PHC) or Community Attendant Services (CAS). See Section 2340, The Initial Interview and Application Process, for information on the determination of financial eligibility and screening for eligibility for CAS.

See Section 3000, Eligibility for Services, and Appendix XII, Examples of Methods to Verify Income and Resources, for specific information on determining financial eligibility.

4432 Family Care Functional Eligibility

Revision 17-1; Effective March 15, 2017

40 Texas Administrative Code (TAC) §48.2911, Family Care

(a) To be eligible for family care, the applicant/client must:
(2) meet the minimum functional need criteria as set by the department. The department uses a standardized assessment instrument to measure the client's ability to perform activities of daily living. This yields a score, which is a measure of the client's level of functional need. The department sets the minimum required score for a client to be eligible, which the department may periodically adjust commensurate with available funding. The department will seek stakeholder input before making any change in the minimum required score for functional eligibility.

40 TAC §48.2907, Need

(a)The client needs assessment questionnaire is used to determine an individual's functional need for CCSE services.
(b) Regardless of a client's functional eligibility as determined by his score on the client needs assessment questionnaire, he receives CCSE services only if he has an unmet need for those services.

Applicants and individuals must score at least 24 on Form 2060, Needs Assessment Questionnaire and Task/Hour Guide, to be eligible for Family Care.

See Section 2400, Assessment Process, Section 2500, Service Planning, and Section 2600, Authorizing and Reassessing Services, for case worker procedures for full determination of functional eligibility and unmet need determination.

4433 Time Frames

Revision 17-1; Effective March 15, 2017

40 Texas Administrative Code §48.3901(d). Eligibility for CCSE services for income-eligible applicants is determined within 30 calendar days after a signed application is received.

The case worker must complete all eligibility determination within 30 calendar days from the assessment date and send the applicant Form 2065-A, Notification of Community Care Services, within two business days of the eligibility decision.

4440 Referral Process

Revision 21-4; Effective December 1, 2021

After completing the assessment, send the selected provider a referral packet.

The referral packet must include:

- a cover sheet;
- the Long-term Care Services Intake system (NTK) generated Form 2110, Community Care Intake; and
- copy of the following Service Authorization System Online Wizards (SASOW) generated forms:
  - Form 2059, Summary of Client's Need for Service;
  - Provider Referral Supplement;
  - Form 2060, Needs Assessment Questionnaire and Task/Hour Guide;
  - Task/Hour Guide; and
  - Form 2101, Authorization for Community Care Services.

All Form 2101 referrals to the provider, both initial and ongoing, must include the:

- authorized tasks;
- total number of authorized hours;
- number of days the applicant or recipient requests delivery of services; and
- relationship and name of any person designated as ‘do not hire.’

Document any of the following information in the comments section of the Form 2101:

- any special needs of the applicant or recipient that require a specific schedule and the reason;

  Example: “<Name of person> is diabetic and requires a specific eating schedule.” or “<Name of person> requires service delivery in the afternoon due to a sleeping condition.”

- the number of service days requested by the applicant or recipient based on the Form 2060;

  Example: "<Name of person> requests a five-day plan."

- the relationship and name of any person(s) designated as ‘do not hire;’

  Example: “Do not hire <spouse>, <name of spouse>, for any tasks.” or “Do not hire <daughter>, <name of daughter>, for shopping.”

Related Policy

Who Cannot Be Hired as the Paid Attendant, 2514
Referrals to the Provider, 2630
Content of Referral Packets, Appendix XIII

4440.1 Types of Referrals

Revision 17-1; Effective March 15, 2017

There are two methods of referral:

- For expedited referrals, the case worker makes the referral by oral notice and on Form 2101, Authorization for Community Care Services.
- For routine referrals, the case worker makes the referral on Form 2101.

Routine Referrals

Within five business days of the eligibility decision, the case worker mails the referral packet to the provider to authorize service delivery.

Expedited Referrals

In some instances, the individual's need for services, based on the case worker's judgment, is such that delivery of services must be facilitated. When weighing whether an expedited referral is warranted, consider:

- What was the individual's assigned intake priority? In most situations, cases which required an expedited response to a request for services also require an expedited referral.
- Is the applicant being authorized as having priority status? If so, that may indicate a need for an expedited referral.
- Could a delay in starting services constitute a threat to the individual's health, safety or well-being? If so, an expedited referral is needed.

The expedited referral process includes:

- upon making the eligibility decision, the case worker makes a verbal referral to the selected provider and negotiates a start of care date which must be less than 14 calendar days; and
- following up the verbal referral by sending a referral packet to the provider, including Form 2101, Authorization for Community Care Services, noting the time, date and staff person contacted, and the negotiated start date in the comments section.

4441 Provider Responsibilities after Receipt of Referral

Revision 17-1; Effective March 15, 2017

Upon receipt of the referral packet, the provider must conduct pre-initiation activities, develop a service plan and assign an attendant to perform services for the individual in accordance with 40 Texas Administrative Code §47.45. These activities must be completed within 14 days after one of the following dates, whichever is later:

- the referral date on Form 2101, Authorization for Community Care Services; or
- the date the provider receives Form 2101, unless the provider fails to stamp the receipt date on the form, in which case the referral date will be used to determine timeliness.

For expedited referrals, the provider must document the date, time and the name of the case worker who gives the verbal authorization. Provider staff contact the case worker if the packet is not in their office by the seventh day after the verbal referral.

The provider can request a corrected authorization if the information (for example, hours or dates of coverage) conflicts with what was given over the telephone. In these situations, correct and initial Form 2101 and mail a copy of it to the provider.

Within 14 days after initiating services, the provider must send notice of service initiation to the case worker. The provider may, but is not required, to use Form 2101 to notify the case worker of service initiation.

4441.1 Delay of Service Initiation

Revision 17-1; Effective March 15, 2017

40 Texas Administrative Code §47.61, Service Initiation.

(c) Delay in service initiation. A provider may delay service initiation only for reasons not directly caused by the provider, or reasons beyond its control, such as natural or other disasters. The provider must continue efforts to initiate services and set a date, if possible, for service initiation. The provider must document any failure to initiate services by the applicable due date in subsection (a) of this section, including:

(1) the reason for the delay, which must be beyond the provider's control;

(2) either the date the provider anticipates it will initiate services, or specific reasons why the provider cannot anticipate a service initiation date; and

(3) a description of the provider's ongoing efforts to initiate services.

(d) Documentation of service initiation. The provider must maintain documentation of service initiation in the individual's file.

4441.2 Initial Service Delivery Plan Variances

Revision 17-1; Effective March 15, 2017

Providers must follow the rules as specified in 40 Texas Administrative Code §47.45(b), Service delivery plan variances.

4442 Resolution of Service Plan Disagreement

Revision 17-1; Effective March 15, 2017

If a disagreement exists about the appropriateness of a referral or about service delivery issues involving the individual, the case worker and the provider staff attempt to resolve the disagreement. If the disagreement is not resolved at this level, supervisory staff of the two agencies attempt to resolve it. If supervisory staff of both agencies are unable to resolve a disagreement, the regional director or designee resolves it. Do not delay service initiation because of a disagreement. The regional nurse may always be consulted regarding health and safety issues or the appropriateness of the service plan.

4443 Change of Providers

Revision 17-3; Effective May 15, 2017

Monitor the individual after services are initiated and periodically thereafter to check on the adequacy of the service plan, the quality of service delivery and the individual's condition. Report to the unit supervisor any apparent deficiencies in the provider's delivery of Family Care (FC) services.

When an FC individual plans to change providers, the individual must first contact his case worker, who will:

- coordinate the transfer to prevent a gap in coverage; and
- attempt to resolve any problems the individual may be having with his current provider before processing the transfer.

Within 14 calendar days of notification that an ongoing FC individual is requesting a transfer to another provider, the case worker contacts the individual and the provider to determine:

- the individual's reason for dissatisfaction; and
- whether the individual's satisfaction can be accomplished without changing providers.

The case worker considers the following to identify the individual's reason for dissatisfaction:

- Timeliness of services
    - Are services being provided during the hours of the days the individual wants the services?

- Is a special attendant sent when a priority individual's special attendant is not able to work for the individual?
- Are services not being provided to a non-priority individual for more than 14 consecutive days or to a priority individual as scheduled, except if the reason for the break is based on:
  - the individual not being home when the attendant was scheduled to work;
  - the individual's request that services not be provided on a specific day(s); or
  - a reason for suspension of services, as listed in Section 4446, Suspension of Services and Interdisciplinary Team (IDT) Procedures?

    If a non-priority individual refuses to be without services for any length of time, the individual may transfer to another provider that may provide services when the individual prefers to receive them.

- When the individual is unavailable to receive services at the scheduled time, are services being delivered at an alternate time? For example, the individual has been discharged from a three-day hospital stay.
- Are services being provided as scheduled? Is it due to any of the following reasons?
  - The individual is often away from his residence when his service is scheduled and repeatedly fails to notify the agency that he will be gone, even if the case worker and provider have counseled him about this problem and its implications.
  - The individual or someone in the individual's home regularly will not permit the provider to perform one or more of the tasks in the service plan.
  - The individual refuses to accept services because of dissatisfaction with all attendants the provider sends.
  - The individual or someone in the individual's home regularly behaves in a way that is so offensive to staff employed by the provider that the provider refuses to serve the individual, and the individual knowingly and passively condones the person's behavior, and the staff are unable to provide services. Examples of offensive behavior include sexual harassment, sexual misconduct and racial discrimination.
- Does the attendant have a pattern of being late or not showing up for work?

- Accessibility of services
  - Is the individual able to speak with the provider when he wants to request a change in his service plan?
  - Is the provider readily responsive to the individual's request for change in the service plan?
  - Is the provider reluctant to speak with the individual because the individual has a history of harassing the provider or attendant?
  - Does the individual want to receive a task that is not purchased by the Texas Health and Human Services Commission?
- Quality of services
  - Is the attendant performing the tasks the individual wants?
  - Is the attendant able to perform the tasks the individual wants?
  - Is the attendant following the individual's instructions in performing tasks?
  - Are the individual's expectations of the attendant realistic?
- Individual's rights and responsibilities
  - Did the provider consider the individual's wishes when developing the service plan?
  - Does the provider respect the individual's right to privacy by informing the individual in advance when the attendant or the agency supervisor plan to visit the individual?
  - Does the individual feel that the provider communicates with him as an adult?
  - Does the individual feel that he can express his opinions or dissatisfactions without fear of losing his attendant or services?
  - Does the provider inform the non-priority individual, in advance, of the attendant's inability to work a particular day?

If the case worker determines that the individual's dissatisfaction is based on the individual's failure to comply with the service plan, the case worker contacts the individual or the party involved and attempts to resolve the problem in a way that is satisfactory to all parties involved. The case worker discusses the problem with the supervisor. An interdisciplinary team meeting may be conducted at the individual's home to try to resolve the situation. The case worker may terminate the individual's services if the individual refuses more than three times to comply with service delivery provisions by repeatedly and directly, or knowingly and passively, condoning the behavior of someone in his home.

By the 14th day, authorize the transfer if:

- it is determined that the individual's satisfaction cannot be met without changing providers and services do not have to be terminated based on failure to comply with the service plan; or
- the individual insists on transferring to another provider and it is determined that services do not have to be terminated based on failure to comply with the service plan.

Within 14 calendar days of receiving a request from the individual or the individual's representative to change providers, the case worker:

- asks the individual or the individual's representative to select a new provider and document the individual's choice of the new provider in the case record by:
    - coordinating with both providers the date the current provider will stop providing services and the date the new provider will start services;
    - updating any pertinent information on Form 2059, Summary of Client's Need for Service;
    - updating Form 2101, Authorization for Community Care Services, by entering the new nine-digit contract number in Item 2; and
    - documenting in the comments section that the individual is changing providers;
- sends the new provider the updated Form 2101 and Form 2059; and
- sends the current provider a copy of the updated Form 2101 that includes the effective date the individual changes providers.

4443.1 Service Interruptions

Revision 17-1; Effective March 15, 2017

Refer to 40 Texas Administrative Code §47.63(a), Service interruptions.

A service interruption occurs anytime service delivery is discontinued for 14 days or more for a reason that is not covered in Section 4446, Suspension of Services and Interdisciplinary Team (IDT) Procedures. The provider should make every effort to ensure that interruptions in service last less than 14 days, particularly if a break in service would jeopardize the individual's health or safety. When an interruption of services is unavoidable, the provider must document all service interruptions by the:

- 30th day after the beginning of the service interruption for priority individuals and

30th day that exceeds 14 days after the service interruption for non-priority individuals.

4444 Reporting Significant Changes

Revision 17-1; Effective March 15, 2017

The provider notifies the case worker or the case worker's office (by telephone or in person) about a change in the individual's condition or circumstances that may require a service plan change or service termination.

The provider must notify the case worker by the first Texas Health and Human Services Commission workday after provider staff notice the change and must follow up in writing, using Form 2067, Case Information, within seven days after verbal notification.

Any of the following changes in the individual's condition or circumstances may require a change in his service plan. (These are examples only; this list is not intended to be all inclusive.)

- The individual's health improves or deteriorates.
- The individual no longer needs services.
- The individual is discharged from a hospital.
- Problems exist with family relationships.
- The individual is evicted or otherwise loses his housing.
- The individual relocates.
- The individual is referred for home health services.
- Changes occur in the individual's household composition.

If the case worker receives a request for a change, respond to it within 14 days from the date the request is received. Review the individual's service plan to decide whether the change is necessary. If the case worker decides the change is not necessary, document the decision on Form 2067 and send it to the provider, keeping a copy in the case record.

Depending on the individual's new condition or situation, a new assessment or

Revision of the service plan (such as a change in priority status or a need for more hours) may be necessary. If appropriate, make changes to the service plan on Form 2101, Authorization for Community Care Services, according to Section 2720, Changes Reported in the Individual's Condition or Status during the Certification Period. Consult with the supervisor about the requested change, if necessary. If the report meets the criteria for Adult Protective Services (APS), refer the individual to that service. See Section 2220, Response to Requests for Service.

4445 Service Plan Changes

Revision 22-3; Effective Sept. 1, 2022

If a service plan change is authorized, mail two copies of Form 2101, Authorization for Community Care Services, and one copy of Form 2059, Summary of Client's Need for Service, to the provider. If a service plan change increases hours, the beginning date of coverage is seven days from the Form 2101 date, unless another date is negotiated. If a service plan change adds priority status, use verbal referral procedures for new priority recipients.

For a service decrease or termination, the provider must abide by CCSE staff's 12-day prior notice provided to the recipient before implementing the change. CCSE staff must advise the provider using the comments section on Form 2101, if applicable, not to implement an adverse action until after the 12-day notice. The recipient may appeal the decision and choose to continue to receive services pending the outcome of the appeal. These time frames apply only to those cases in which the provider has a current authorization for the recipient.

When the recipient requires an immediate change to the service plan, approve the change by phone or in person. Respond by the next business day when any of the following situations occur:

- The recipient has a major illness and no available caregiver.
- The recipient loses their caregiver suddenly, has no other available caregiver, and
    - is totally bedridden or unable to transfer from bed to chair without assistance;
    - cannot manage toileting tasks without personal assistance; or
    - needs meal preparation or feeding to ensure that they receive daily nourishment.

If necessary:

- verbally authorize a service plan change;
- initial the service arrangement column on Form 2060, Needs Assessment Questionnaire and Task/Hour Guide; and
- send two copies of Form 2101 to the provider within two business days of the verbal request.

Related Policy

Priority Status, 2540
Negotiated Referrals, 2631
Time Calculation, Appendix XVIII

4446 Suspension of Services and Interdisciplinary Team (IDT) Procedures

Revision 17-1; Effective March 15, 2017

The provider agency must suspend services if:

- the individual permanently leaves the state or moves to a county in which the provider agency does not contract with the Texas Health and Human Services Commission (HHSC) to provide services under the Primary Home Care Program (see Section 4677.1, Individual Temporarily Leaving Service Area);
- the individual moves to a location where services cannot be provided under the Primary Home Care Program;
- the individual dies;

Note: When notified of an active SSI/Medicaid individual's death, complete and send Form SSA-1610-U2, Public Assistance Agency Information Request, to report the death of the individual to the Social Security Administration. Keep a copy of Form SSA-1610-U2 and file in the case record.

- the individual is admitted to an institution. An institution is defined as a:
  - hospital;
  - nursing facility;
  - state school;
  - state hospital; or
  - intermediate care facility serving individuals with an intellectual disability or related conditions;
- the individual requests that services or specific tasks end;
- HHSC denies the individual's Medicaid eligibility (not applicable to family care services); or
- the individual or someone in the individual's home exhibits reckless behavior, which may result in imminent danger to the health and safety of the individual, the attendant, or another person. If this occurs, the provider agency must make an immediate referral to:
  - the Texas Department of Protective and Regulatory Services or other appropriate protective services agency;
  - local law enforcement, if appropriate; and
  - the individual's case worker.

Services may be suspended indefinitely if the individual is admitted to a rehabilitation hospital or to a rehabilitation floor or wing of a medical hospital.

The provider agency may also suspend services if:

- the individual or someone in the individual's home engages in discrimination against a provider agency or HHSC employee in violation of applicable law; or
- the individual refuses services for more than 30 consecutive days.

The provider agency must notify the case worker by fax of any suspension by the next working day. The faxed notice of a suspension must include:

- the date of service suspension;
- the reason(s) for the suspension;
- the duration of the suspension, if known; and
- an explanation of the provider agency's attempts to resolve the problem that caused the suspension, including the reasons why the problem was not resolved.

The provider agency must convene an interdisciplinary team (IDT) meeting to resume services.

The provider agency must resume services after suspension:

- upon the individual's return home, or the date the provider agency becomes aware of the individual's return home, if applicable;
- on the date specified in writing by the case worker;
- as a result of a recommendation by the IDT; or
- upon the provider agency's receipt of notification from the case worker that the provider agency must resume services pending the outcome of the appeal.

The provider agency must notify the case worker in writing of the date services resume and must send the notice within seven days of that date.

4447 Reassessment

Revision 21-1; Effective June 1, 2021

Functional Assessment

Functional eligibility must be redetermined for Family Care at least every 12 months. At each annual functional reassessment, review the screening exception criteria and determine if the recipient's circumstances have changed.

For example, if a person was placed on Family Care due to no personal care tasks, but at the annual reassessment now requires a personal care task, then refer the person to Primary Home Care (PHC) or Community Attendant Services (CAS).

If the recipient or provider reports interim changes between annual reassessments, apply the screening exception criteria at the next annual review.

If a recipient requests a change at the annual reassessment, the change must be worked within five days or by the annual reassessment due date, whichever is earlier.

Financial Assessment

Determine financial eligibility for Family Care at least every 24 months. If the person was previously determined ineligible for CAS due to resources, review the recipient's current financial information.

If the recipient appears to meet the financial requirements for CAS, send Form H1200, Application for Assistance – Your Texas Benefits, along with verifications of income and resources to MEPD for a CAS

financial determination.

If a recipient was determined eligible for Family Care due to receipt of QI-1 benefits, re-verify QI-1 benefits at each financial reassessment

Related Policy

Exception Criteria for Referrals to PHC or CAS, 2342.3
Exceptions to Verification Requirements, 3422
Content of Referral Packets, Appendix XIII

4448 Complaints

Revision 17-9; Effective September 15, 2017

An individual has the right to voice grievances or complaints concerning the Texas Health and Human Services Commission (HHSC) staff or purchased services without discrimination or retaliation. The individual has a right to report service delivery issues to the Health and Human Services Office of Ombudsman at 1-877-787-8999. If the case worker is aware of the issue, the case worker must work to resolve the individual's issues. See policy outlined in Section 2736.1, Reporting Service Delivery Issues, for detailed procedures in handling service delivery issues.

4500, Meals Services

4510 Description

Revision 17-1; Effective March 15, 2017

Home-Delivered Meals (HDM) provides hot, nutritious meals that are typically served in the individual's home. Meals may be delivered to alternate locations, provided the location is within the provider's normal service delivery area.

Example: An individual receives dialysis treatments on Mondays, Wednesdays and Fridays. Because the treatment center is within the provider's normal service delivery area, HDMs can be delivered to that location on the days the individual receives treatments.

When it is necessary for the individual to receive meals in an alternate location out of the service area on a regular basis, shelf-stable or frozen meals may be delivered to the individual's home for use in the other location. The case worker must check with the contract manager to ensure that the provider's contract allows delivery of shelf-stable/frozen meals.

Meals delivered by contracted providers are approved by a dietitian consultant who is either a registered dietitian licensed by the Texas State Board of Examiners of Dietitians or has a baccalaureate degree with major studies in food and nutrition, dietetics or food service management.

40 Texas Administrative Code (TAC) §55.15, Menus.

(a) A dietary consultant must approve each menu with a list of allowable substitutions as meeting one-third of the recommended daily dietary allowance. The approval must be dated before the date the meal is served. A provider agency may not deviate from the approved menu and its allowable substitutions, unless the provider agency is providing a therapeutic medical diet.
(b) Planned menus must provide foods with a variety of flavor, consistency, texture and temperature.
(c) A provider agency must maintain approved menus that meet the terms of the contract.

40 TAC §55.19, Modified Diets.

(a) A provider agency must keep documentation from the client's physician of the client's need for a therapeutic medical diet, according to the terms of the contract.
(b) A provider agency must determine the extent to which the provider agency can provide therapeutic medical meals.

In addition to healthy meals, monthly nutrition education is provided to HDM individuals.

40 TAC §55.11, Nutrition Education. A provider agency must provide nutrition education on a monthly basis, either verbally or in writing, to clients. An annual written plan for nutrition education must be developed, identifying subject matter, method of presentation, materials used, and source of the information presented. This plan must be maintained according to the terms of the contract.

4520 Eligibility

Revision 17-1; Effective March 15, 2017

Individuals who apply for or receive Title XX meals are not subject to an income and resource eligibility determination.

40 Texas Administrative Code §48.2912. To be eligible for home-delivered meals, applicants and clients must meet the functional need criteria as set by the department. The department uses a standardized assessment instrument to measure the client's ability to perform activities of daily living. This yields a score, which is a measure of the client's level of functional need. The department sets the minimum required score for a client to be eligible, which the department may periodically adjust commensurate with available funding. The department will seek stakeholder input before making any change in the minimum required score for functional eligibility.

An individual must score at least 20 on Form 2060, Needs Assessment Questionnaire and Task/Hour Guide, to be functionally eligible for Home-Delivered Meals.

4521 Home-Delivered Meals Interest List Procedures

Revision 17-1; Effective March 15, 2017

If all service authorization slots are filled at the time an individual requests home-delivered meals, consult the individual to decide whether his needs can be met through other services. If no other service is available or suitable, add the individual's name to the Home-Delivered Meals Interest List(s) by entering the information in the Community Services Interest List (CSIL) system. Individuals who request placement on an interest list must be Texas residents. Individuals are released from the interest list on a first-come, first-served basis; eligibility determinations are conducted as slots for service become available. See Section 2230, Interest List Procedures, for additional information.

If the individual is receiving meals through some other service, the case worker must explore if the meals are through a temporary service. There are several organizations within communities that offer temporary delivery of meals until another source is available. Meals received through the Area Agency on Aging (AAA) through Title III are limited and only meant to provide temporary assistance to individuals. Meals provided through other local organizations may also be temporary.

If an individual calls to request home-delivered meals through Title XX and is currently receiving meals, the intake person records the source of the current meals. The individual must not be screened out due to receiving meals from another source. The intake person completes the intake and either refers to a case worker for assessment, if the region has open enrollment, or places the individual's name on the interest list. If an ongoing

individual requests Title XX meals, the same policy applies. The applicant/individual may continue to receive temporary meals while on the interest list for Title XX home-delivered meals.

When the case worker receives the request for services or an individual's name is released from the interest list, the case worker must determine if the source of current meals is ongoing or temporary. If the applicant/individual states the meals are ongoing, the case worker must verify with the source and document that the meals are ongoing. The applicant/individual has a right to choose between Title XX home-delivered meals and the other source. The case worker must document the applicant's/individual's decision and follow procedures for approving or denying the request for services.

If the source is a temporary service, the applicant must be authorized for Title XX meals if all other eligibility requirements are met. Service initiation through Title XX meals must be coordinated with the termination of the temporary service and documented in the case record.

4530 Casework Procedures

Revision 17-1; Effective March 15, 2017

4531 Service Initiation

Revision 17-1; Effective March 15, 2017

Refer to 40 Texas Administrative Code §55.25, Service Initiation.

To refer individuals to providers for Home-Delivered Meals (HDM), complete Form 2101, Authorization for Community Care Services, and send the referral packet to the selected provider (see Appendix XIII, Content of Referral Packets). The provider must initiate services within 10 days from the date of referral and return Form 2101 to the case worker within 21 calendar days.

Inform the provider of any special circumstances that would be relevant to the individual's service provision. Whenever necessary for the individual's health, specify on Form 2101 that the provider must deliver meals that have been prepared without added salt as seasoning or flavoring. Ensure that the individual understands when the home-delivered meals will be delivered, his responsibility for receiving the meals and that he is not responsible for contributing or paying for them.

Reassess the individual's eligibility for services annually, within 12 months of the previous functional assessment.

Note: To ensure there is no service duplication of home-delivered meals, coordinate services with the local Area Agency on Aging.

4532 Individual Health and Safety

Revision 17-1; Effective March 15, 2017

A provider agency must have written procedures in place to ensure it investigates and reports to the appropriate persons or entities any significant changes in the individual’s physical or mental condition or environment. These procedures must require the following:

- The provider agency notifies an individual’s case worker, orally or by fax, within one working day after becoming aware of significant changes in the individual’s physical or mental condition or environment.

- If the provider agency notifies the case worker orally, the provider agency must send written notification to the case worker within five working days of the initial verbal notification.

A provider agency must inform the individual about safety, health, or fire hazards identified in the individual's home when the provider agency discovers these hazards. The provider agency must retain documentation of such communications in its files, according to the terms of the contract.

A provider agency must notify the Texas Health and Human Services Commission (HHSC) personnel, orally or by fax, within one working day after an incident that may prevent the provider agency from delivering meals to one or more individuals.

A reportable incident includes:

- weather-related emergency;
- fire; or
- other natural disaster.

The provider agency must report an incident to:

- the contract manager;
- the individual's case worker or supervisor.

If the provider agency notifies the case worker orally, the provider agency must send written notification to the contract manager or case worker, or both, within five working days of the initial notification.

If the individual delivering the meal reports to the provider any individual illnesses, potential threats to safety or observable changes in the individual's condition, the provider must notify the case worker about the report within 24 hours. The provider must also notify the case worker within 24 hours whenever the meal is found uneaten or untouched.

4532.1 Waivers for Alternate Meal Delivery Methods

Revision 17-1; Effective March 15, 2017

Home Delivered Meals (HDM) providers are generally expected to deliver five hot meals a week to each individual. Occasional exceptions to allow the use of "…frozen, chilled or shelf-stable meals for emergency or inclement weather situations, emergency situations and for situations approved by the contract manager on a case-by-case basis…", may be granted under Texas Administrative Code, Title 40, §55.21, concerning Frozen, Chilled or Shelf-Stable Meals.

HDM providers must submit a waiver request to the Texas Health and Human Services Commission (HHSC) contract manager if the provider determines that delivery of frozen or shelf-stable meals is required for certain individuals within the provider's contracted service area. Any waivers granted will be effective for a period not to exceed one fiscal year. The provider must not implement the waiver of the requirement for delivery of a hot meal five days a week prior to HHSC approval of the waiver request.

In order to be able to adequately inform individuals of the service delivery plan, case workers are expected to work closely enough with the contract manager to be aware of the delivery provisions of each HDM provider. Any inquiries by providers regarding the waiver must be referred to the contract manager.

4533 Suspension of Services

Revision 17-1; Effective March 15, 2017

Refer to 40 Texas Administrative Code §55.33, Suspension of Services.

The provider must notify the case worker on the day Home-Delivered Meals is suspended without the case worker's authorization. The provider must suspend services in any of the following situations when the:

- individual moves out of the geographical area served by the provider;
- individual enters an institution;
- individual requests that services be suspended or terminated;
- individual dies; or
- case worker directs the provider to suspend services.

Unless the interruption is the result of one of the above situations, the provider must obtain the case worker's approval for service interruptions of more than two consecutive days.

When the individual requests that services be suspended and specifies a date for services to resume, the provider is not required to notify the case worker.

4534 Termination of Services

Revision 17-1; Effective March 15, 2017

The case worker must send the provider authorization for community care services for Title XX services, indicating the date services are to be terminated.

Send a copy of Form 2065-A, Notification of Community Care Services, to the provider as notification of the termination and of the date the service will end. For detailed information regarding service termination, see Section 2800, Procedures for Denying or Reducing Services.

4600, Primary Home Care and Community Attendant Services

4610 Primary Home Care (PHC) and Community Attendant Services (CAS) Contracting

Revision 17-1; Effective March 15, 2017

PHC and CAS provide in-home personal attendant services (PAS) to individuals eligible under Title XIX Medicaid or under §1929(b)(2)(B) of the Social Security Act, respectively. Both programs require that recipients have a need for assistance with personal care tasks. Providers delivering PAS must meet all of the requirements in 40 Texas Administrative Code §47.11, Contracting Requirements.

For information on the Title XX PHCP program, see Section 4400, Family Care Services.

4620 Personal Attendant Services Description

Revision 17-1; Effective March 15, 2017

Primary Home Care and Community Attendant Services provide non-technical attendant services to eligible individuals who have a medical condition resulting in a functional limitation in performing personal care. Attendants help individuals with activities of daily living, such as bathing, grooming, meal preparation and housekeeping. Attendants are trained and supervised by non-medical personnel.

4621 Allowable Tasks

Revision 21-4; Effective December 1, 2021

Personal attendant services (PAS) that may be delivered under CAS and PHC include the following tasks.

Personal care tasks related to the care of the person's physical well-being, including:

- Bathing:
  - drawing water in sink, basin or tub;
  - hauling or heating water;
  - laying out supplies;
  - assisting in or out of tub or shower;
  - sponge bathing and drying;
  - bed bathing and drying;
  - tub bathing and drying; and
  - providing standby assistance for safety.
- Dressing:
  - dressing the person;
  - undressing the person; and
  - laying out clothes.
- Meal preparation:
  - cooking a full meal;
  - warming up prepared food;
  - planning meals;
  - helping prepare meals; and
  - cutting person's food for eating.
- Feeding or eating:
  - spoon-feeding;
  - bottle-feeding;
  - assisting with using eating and drinking utensils and adaptive devices, not including tube feeding; and
  - providing standby assistance or encouragement.
- Exercise:
  - walking with the person.
- Grooming:
  - shaving;
  - brushing teeth;
  - shaving underarms and legs, upon request;
  - caring for nails; and
  - laying out supplies.
- Routine hair or skin care:
  - washing hair;
  - drying hair;
  - assisting with setting, rolling, or braiding hair, not including styling, cutting, or chemical processing of hair;
  - combing or brushing hair;
  - applying nonprescription lotion to skin;
  - washing hands and face;
  - applying makeup; and
  - laying out supplies.
- Assistance with self-administration of medication:
  - reminding person to take a medication at the prescribed time;
  - opening and closing a medication container;

    - pouring a predetermined quantity of liquid to be ingested;
    - returning a medication to the proper storage area;
    - assisting in reordering medications from the pharmacy; and
    - administration of any medication when the person has the cognitive ability to direct the administration of their medication and would self-administer if not for a functional limitation.
- Toileting:
    - changing diapers;
    - changing colostomy bag or emptying catheter bag;
    - assisting on or off bedpan;
    - assisting with the use of a urinal;
    - assisting with feminine hygiene needs;
    - assisting with clothing during toileting;
    - assisting with toilet hygiene, including the use of toilet paper and washing hands;
    - changing external catheter;
    - preparing toileting supplies and equipment, not including preparing catheter equipment; and
    - providing standby assistance.
- Transfer:
    - non-ambulatory movement from one stationary position to another, not including carrying;
    - adjusting or changing the person's position in a bed or chair (positioning); and assisting in rising from a sitting to a standing position.
- Ambulation:
    - assisting in positioning for use of a walking apparatus;
    - assisting with putting on and removing leg braces and prostheses for ambulation;
    - assisting with ambulation or using steps;
    - assisting with wheelchair ambulation; and
    - providing standby assistance.

Home management tasks that support the person's health and safety, including:

- Cleaning:
    - cleaning up after the person's personal care tasks;
    - emptying and cleaning the person's bedside commode;
    - cleaning the person's bathroom;
    - changing the person's bed linens and making the person's bed;
    - cleaning floor of living areas used by person;
    - dusting areas used by person;
    - carrying out the trash and setting out garbage for pick up;
    - cleaning stovetop and counters;
    - washing the person's dishes; and
    - cleaning refrigerator and stove.
- Laundry:
    - doing hand wash;
    - gathering and sorting;
    - loading and unloading machines in residence;
    - using laundromat machines;
    - hanging clothes to dry; and
    - folding and putting away clothes.
- Shopping:
    - preparing a shopping list;
    - going to the store and purchasing or picking up items;
    - picking up medication; and
    - storing the person's purchased items.
- Escort:
    - accompanying the person outside the home to support the person in living in the community;

- arranging for transportation, not including direct person transportation;
- accompanying the person to a clinic, doctor's office, or location for medical diagnosis or treatment; and
- waiting in the doctor's office or clinic with person if necessary due to person's condition or distance from home.

CCSE staff must document a specific need for escort. If escort for medical trips occurs at least once a month, time may be allocated. To determine the weekly time allocation, divide the time by 4.33 to arrive at a weekly figure. If escort occurs more than once a week, include additional documentation explaining why the person needs escort this often. See Form 2060, Needs Assessment Questionnaire and Task/Hour Guide, for more information.

Since escort is always determined and entered on a weekly basis, use the following examples for escort services:

Example 1: A person has a doctor's appointment every week for one hour with their chiropractor and needs another hour transportation time to get to and from the doctor's office. The person needs two hours total escort weekly. Enter 120 minutes weekly for escort.

Example 2: A person has one appointment a month with their radiologist. The person needs four hours total for their monthly appointment. Formula: four hours x 60 minutes = 240 minutes. 240 minutes/4.33 = 55.43 minutes per week which rounds up to 60 minutes per week.

Monthly minutes must be divided by 4.33 (weeks per month) to obtain a weekly amount of minutes needed.

Example 3: Every month, a person sees their cardiologist two hours, general practitioner three hours, chiropractor three hours and psychologist two hours. These are all standing appointments the person sees monthly. Two hours + three hours + three hours + two hours = 10 hours monthly. 10 hours x 60 minutes = 600 minutes. 600 minutes/4.33 = 138.57 minutes per week which rounds up to 140 minutes per week. Enter 140 minutes per week.

While the Service Authorization System Online (SASO) automatically rounds up in five-minute increments, services are allotted and delivered in 30-minute increments so the person will actually receive 150 minutes or 2 ½ hours a week.

Example 4: The person sees a therapist every other Friday (bi-weekly) for 2 1/2 hours including travel time. 2 1/2 hours x 60 minutes = 150 minutes. 150 minutes x 2.17 Fridays per month = 325.50 minutes total per month. 325.50 minutes per month /4.33 weeks per month = 75.17 minutes per week which rounds up to 80 minutes. Enter 80 minutes per week.

Bi-weekly amounts must be multiplied by 2.17 to obtain a monthly amount, which can then be divided by 4.33 to obtain a weekly amount.

Example 5: The person has been in a car accident and has a large need for escort. They see a chiropractor three times a week for one hour each time, a physical therapist three times a week for an hour each time, a psychiatrist bi-weekly for two hours, a pain management specialist bi-weekly for two hours, a general practitioner two hours per month and a cardiologist once a month for three hours.

In this example, no action is needed for the chiropractor and physical therapist as their times are already in the weekly amounts. The conversions needed apply to the bi-weekly and monthly visits, which need to be converted to weekly amounts and then all added together.

Weekly: 6 hours x 60 minutes = 360 minutes

Bi-weekly: 4 hours x 60 minutes x 2.17 = 520.80/4.33 = 120.28 (per week)

Monthly: 5 hours x 60 minutes = 300 minutes/4.33 = 69.28 (per week)

360 + 120.28 +69.28 = 549.56 minutes per week, which rounds to 550 minutes per week.

Escort may also include accompanying the person on non-medical trips such as the grocery store, paying bills, pharmacy, hair stylist, barber or social events. No more time for escort for non-medical trips is allocated to the person's service plan on Form 2060. The person may elect to receive escort in place of assistance with household or personal care on a day that best meets their needs. The time used to provide the escort task must not exceed the total time purchased for attendant care.

This service does not include the direct transportation of the person by the attendant. Transportation is available through the Medical Transportation Program (MTP). Contact the regional MTP manager about the person's referral to this program.

Related Policy

Contracting to Provide Primary Home Care Services Handbook

4622 Excluded Tasks

Revision 17-1; Effective March 15, 2017

Services that must be provided by a person with professional or technical training may not be purchased through Title XIX personal attendant services. These excluded services include, but are not limited to:

- insertion and irrigation of catheters;
- irrigation of body cavities;
- application of sterile dressings involving prescription medications and aseptic techniques;
- tube feedings;
- injections;
- administration of medication; or
- any other skilled services identified by the Texas Health and Human Services Commission nurse.

Services that maintain an entire family or household, unless the entire household receives the service, are also excluded. Examples include:

- cleaning the floor and furniture in areas that the individual does not occupy or use;
- preparing meals for the entire family or household;
- laundering clothing or bedding that the individual does not use (for example, laundering clothing and bedding for the entire household rather than laundering only the individual's clothing and bed linens); or
- shopping for groceries or household items the individual does not need for health and maintenance. **Note**: An attendant may shop for items the individual needs and the rest of the household also uses.

4623 Personal Attendants

Revision 21-4; Effective December 1, 2021

The person's or provider's choice of attendants is not limited unless:

- CCSE staff specify a particular attendant should not be employed by the provider; or
- a supervisor, CCSE staff or regional nurse determines the attendant is not providing adequate care.

Personal attendant services tasks may be performed by an unlicensed person who is 18 or older and has demonstrated competency to perform the tasks assigned by the supervisor. Additionally, tasks may be performed by an unlicensed person who is:

- under 18 years old and a high school graduate; or
- enrolled in a vocational educational program and has demonstrated competency to perform the tasks assigned by the supervisor.

The attendant cannot be a legal or foster parent of a minor child who receives the service, or the service recipient's spouse.

Related Policy

Who Cannot Be Hired as the Paid Attendant, 2514

4624 Priority Status Determination

Revision 17-1; Effective March 15, 2017

Priority status is determined by evaluating the effect that going without certain critical purchased tasks would have on an individual.

An individual with priority status may receive no more than 42 hours of service per week. An individual without priority status may receive no more than 50 hours of service per week.

The community care case worker establishes a priority status for each individual based on the functional assessment. An individual is considered to have priority status if the following criteria are met:

- The individual is completely unable to perform one or more of the following activities without hands-on assistance from another person:
  A. transferring himself into or out of bed or a chair or on off a toilet;
  B. feeding himself;
  C. getting to or using the toilet;
  D. preparing a meal; or
  E. taking self-administered prescribed medications.
- During a normally scheduled service shift, no one is readily available who is capable and who is willing to provide the needed assistance other than the attendant.
- The community care case worker determines that there is a high likelihood the individual's health, safety, or well-being would be jeopardized if services were not provided on a single given shift.

Each eligible individual may receive up to 50 hours of personal attendant services per week (42 hours per week for an individual with priority status). For additional information regarding the determination of priority status, see Section 2540, Priority Status Individuals.

4630 Eligibility

Revision 17-1; Effective March 15, 2017

For eligibility policy not contained in this section, see:

- Section 3110, Eligibility for CCSE Services;
- Section 3111, Age Limits;
- Section 3200, Resource Eligibility Criteria; and
- Section 3300, Income Eligibility.

4631 Residence

Revision 17-1; Effective March 15, 2017

40 Texas Administrative Code §48.2918(b). To receive services, the applicant/client must reside in a place other than:

(1) a hospital;
(2) a skilled nursing facility;
(3) an intermediate care facility;
(4) an assisted living facility;
(5) a foster care setting;
(6) a jail or prison;
(7) a state school;
(8) a state hospital; or
(9) any other setting where sources outside the primary home care program are available to provide personal care.

Title XIX personal attendant services (PAS) cannot be authorized if the individual lives in a home licensed as a personal care home by the Texas Department of State Health Services. If the home is not a licensed personal care home, services may be authorized as follows:

- If three or fewer persons live in the home, the proprietor can be the PAS attendant for the individual(s) who resides there. The individual may not receive both PAS and Adult Foster Care.
- If the home provides only room and board to four or more persons living in the home, it does not require licensure as a personal care home. PAS services can be authorized for individuals in this setting, but the proprietor, his agent or employee cannot be the attendant for individuals who reside in the home. The case worker must specify this on Form 2101, Authorization for Community Care Services.

Title XIX PAS services can be provided to a private pay applicant/individual living in a residential care facility (whether or not contracted with HHSC) under the following conditions. The case worker:

- applies the unmet need policy on a task-by-task basis, not duplicating services. Facilities provide varying degrees of assistance and tasks purchased should not be a task provided by the facility.
- must closely monitor the case to determine if the individual is receiving additional services from the facility. Service plans must be adjusted to avoid duplication of services/tasks.

If the individual begins receiving Residential Care (RC) through HHSC, the Title XIX PAS service is terminated effective no later than the date RC services begin.

4632 Financial Eligibility

Revision 17-1; Effective March 15, 2017

40 Texas Administrative Code §48.2918(a). To be eligible for primary home care or community attendant (CA) services, the applicant/client must:

(1) be eligible for Medicaid in a community setting or be eligible under the provisions of the Social Security Act, §1929(b)(2)(B)

Before referring the individual to Primary Home Care (PHC), verify Medicaid eligibility for the month that financial/functional eligibility is determined.

To receive PHC services, applicants/individuals must be receiving benefits that include full Medicaid eligibility. Case workers must consult the Texas Integrated Eligibility Redesign System (TIERS) to determine if an applicant or individual is receiving full Medicaid benefits. Note: Residence outside an institution is also an

eligibility criterion so institutional type programs will not be eligible for PHC. See Section 7110, TIERS Inquiries, and Appendix XIV, SAVERR/TIERS Type Program Chart, for a description of all TIERS type programs.

Individuals obtain financial eligibility for Community Attendant Services (CAS) by applying to Medicaid for the Elderly and People with Disabilities. CAS eligibility can be confirmed by checking TIERS.

See Section 2347, Texas Medicaid Estate Recovery Program (MERP), when processing CAS applications.

4633 Functional Eligibility

Revision 17-8; Effective September 1, 2017

40 Texas Administrative Code (TAC) §48.2918(a). To be eligible for primary home care or community attendant (CA) services, the applicant/client must:

(2) meet the minimum functional need criteria as set by the department. The department uses a standardized assessment instrument to measure the client's ability to perform activities of daily living. This yields a score, which is a measure of the client's level of functional need. The department sets the minimum required score for a client to be eligible, which the department may periodically adjust commensurate with available funding. The department will seek stakeholder input before making any change in the minimum required score for functional eligibility.

Title XIX personal attendant services (PAS) eligibility only requires that an individual have a need for assistance with personal care. However, the provider is not allowed to provide services unless at least one personal task is authorized, scheduled and delivered by the provider.

Example: An applicant requests Primary Home Care (PHC) and scores 30 on Form 2060, Needs Assessment Questionnaire and Task/Hour Guide. However, the only personal care task the individual needs is meals service, which is being provided via congregate meals. Therefore, PHC services cannot be approved.

Applicants and individuals must score at least 24 on Form 2060, and require at least six hours of service per week. An individual requiring fewer than six hours of service per week may be eligible if the individual:

- requires primary home care or community attendant services to provide respite care to the caregiver;
- lives in the same household as another individual receiving primary home care, community attendant services, or family care;
- receives one or more of the following services (through the department or other resources):
  - congregate or home-delivered meals;
  - assistance with activities of daily living from a home health aide;
  - day activity and health services; or
  - special services to persons with disabilities in adult day care;
- receives aid-and-attendance benefits from the Veterans Affairs; or
- is determined, based upon the functional assessment, to be at high risk of institutionalization without primary home care or community attendant care services.

See Section 4651, Assessing the Individual's Needs, for casework procedures involved in establishing functional need.

4634 Practitioner's Statement of Medical Need

Revision 17-1; Effective March 15, 2017

40 Texas Administrative Code §48.2918(a). To be eligible for primary home care or community attendant (CA) services, the applicant/individual must:

(3) have a medical need for assistance with personal care.
(A) The individual's medical condition must be the cause of the individual's functional impairment in performing personal care tasks.
(B) Persons diagnosed with mental illness, mental retardation, or both, are not considered to have established medical need based solely on such diagnosis. The diagnoses do not disqualify an individual for eligibility as long as the individual's functional impairment is related to a coexisting medical condition;
(4) have a signed and dated practitioner's statement that includes a statement that the individual has a current medical need for assistance with personal care tasks and other activities of daily living.

The need for Primary Home Care (PHC) and Community Attendant Services (CAS) must be documented by a practitioner's statement of medical need. As part of the determination of eligibility for Title XIX personal attendant services (PAS), case workers must verify that applicants have a medically related health problem that causes a functional limitation in performing personal care.

See Section 4661, Receipt of the Practitioner's Statement of Medical Need, for procedures to determine medical need.

4640 Retroactive Payments

Revision 17-1; Effective March 15, 2017

State law requires that home and community support services agencies that provide personal attendant services (PAS) be licensed by the Texas Health and Human Services Commission (HHSC). It is possible for a Medicaid-eligible person to begin receiving services before HHSC receives a referral for Primary Home Care (PHC). The information below states the procedures case workers, HHSC nurses and providers must use when processing an application for retroactive payment.

4641 Provider's Role

Revision 17-1; Effective March 15, 2017

A provider who delivers attendant care services to a non-Medicaid individual on a private pay basis risks losing revenue unless an agreement exists for the individual to pay the provider if he is not determined eligible. A provider may bill non-Medicaid individuals for services delivered before the time the individual is eligible for retroactive payment by the Texas Health and Human Services Commission (HHSC). However, federal requirements do not allow providers to bill Medicaid recipients for Medicaid reimbursable services.

40 Texas Administrative Code (TAC) §47.85(c)(1) ─ The provider agency may be reimbursed for services provided before the date a completed, signed, and dated copy of DHS' Application for Assistance Aged and Disabled form is received: (A) for up to three months for a person who does not have Medicaid eligibility at the time of the request for retroactive payment; and (B) for an indefinite period for a person who is Medicaid eligible at the time of the request for retroactive payment.

The three month prior period applies to non-Medicaid individuals who apply for Primary Home Care (PHC) services using retroactive payment procedures. The three month prior period does not apply to Medicaid recipients who request PHC services using retroactive payment procedures. For Medicaid recipients, HHSC can reimburse a provider for a retroactive payment period beyond three months as long as the services are Medicaid reimbursable and the individual was Medicaid eligible when the services were received. Medicaid recipients do not complete a written application (Form H1200, Application for Assistance – Your Texas Benefits) for retroactive or ongoing PHC services.

A request for retroactive payment can be made by the individual, provider or interested party by contacting Community Care Services Eligibility (CCSE) intake staff. CCSE staff who receive requests for retroactive payment use current intake procedures for a routine request for in-home care services. The beginning date of services cannot be prior to the practitioner's signature date on Form 3052, Practitioner's Statement of Medical Need.

40 TAC §47.85(e) Pre-initiation activities. The provider agency must complete the pre-initiation activities described in §47.45(a) of this chapter (relating to Pre-Initiation Activities).

(f) Intake referral. On the day that the provider agency completes the pre-initiation activities, the provider agency must contact the local DHS office by telephone and make an intake referral by providing DHS information on the person to start the eligibility process.
(g) Service initiation. The provider agency must not begin to provide services to the person before the date the provider agency completes the pre-initiation activities and processes the intake referral as described in subsections (e) and (f) of this section.

Within seven days after the date the provider processes the intake referral, the provider must submit the written request for retroactive payment to the case worker. The written request must include the:

- copy of the service plan;
- copy of Form 3052;
- retroactive payment information, including the:
  - name of the provider;
  - contact information for the individual;
  - date services were started;
  - tasks provided to the individual including both tasks allowed and not allowed by the PHC program;
  - actual service hours that were provided per week, including hours allotted to allowed tasks and tasks not allowed by the PHC program; and
  - cost per hour of service charged to the individual.

If the provider billed the individual for tasks that are not Medicaid reimbursable, the provider must inform the case worker so he will know how many hours to deduct from the payment made by HHSC to the provider.

4642 Case Worker's Role

Revision 17-1; Effective March 15, 2017

The case worker must respond to the request for services according to the time frames in Section 2320, Case Worker Response, and make the home visit to assess the applicant for ongoing services.

The case worker is not responsible for determining functional need during the retroactive period. Form 2060, Needs Assessment Questionnaire and Task/Hour Guide, is completed to determine ongoing functional eligibility but does not affect eligibility for retroactive payments. Also, the case worker does not apply the unmet need policy to the retroactive period. See Section 2433, Determining Unmet Need in the Service Arrangement Column.

4643 Applicant Approved for Retroactive Payment and Continued Services

Revision 17-1; Effective March 15, 2017

If the applicant is Medicaid eligible or was Medicaid eligible at service initiation, the Texas Health and Human Services Commission (HHSC) will only reimburse the provider for tasks/hours/costs within the scope of the

Primary Home Care (PHC) program. If the applicant is eligible for the retroactive payment period and for continued PHC services, the case worker must verify that the service plan developed by the provider contains the following information:

- individual is receiving at least one personal care task. If there are no personal care tasks, the provider will not be reimbursed for services;
- total amount of weekly service hours;
- the total amount of weekly services hours are within the maximum weekly hours (50 allowed in the PHC program);
- tasks provided are the type covered under the PHC program; and
- cost per hour of service is equal to the non-priority rate in the PHC program. Note: Provider agencies will not determine priority status nor will they be reimbursed at the higher priority status rate for the retroactive payment period.

Determine the amount of reimbursement the applicant is eligible to receive from the provider by multiplying the cost per hour of service found in the service plan developed by the provider times the total amount of hours of approved service provided to the applicant. Include this amount on Form 2065-A, Notification of Community Care Services, to advise the applicant and the provider of the dollar amount of retroactive payment the applicant should receive from the provider.

Note: Because the individual is receiving services up to the time of the service initiation date for continued PHC services, the case worker may not know the last day services were provided during the retroactive period. The reimbursement amount may vary from the actual amount due to the applicant depending on whether the applicant paid in full, or has not paid the provider for the most recent service provided during the retroactive period.

The provider will not be reimbursed for a retroactive payment period if:

- the applicant did not receive any personal care tasks from the provider;
- none of the tasks provided by the provider were within the scope of the program (Example: the individual received transportation, direct administration of medications or protective supervision assistance); or
- the applicant is determined ineligible for retroactive payment by HHSC.

The provider will not be reimbursed for amounts higher than the HHSC limits when the:

- service plan includes more than the maximum weekly hours allowed in PHC; or
- cost per hour of service is more than the non-priority rate.

The case worker must deduct time for any task(s) that cannot be purchased as part of PHC service from the total hours of services provided by the provider in order to determine how many hours (at the non-priority status rate) HHSC will reimburse the provider. If more than 50 hours per week were provided, the time for the non-allowable tasks should be deducted first and then the additional hours deducted to be within the 50 hour per week limit.

Send the provider a copy of the same Form 2065-A sent to the applicant to advise the provider of the amount to reimburse the applicant. Multiply the total service hours the applicant received by the cost per hour of services reported in the provider's service plan. Note: The dollar amounts used in the examples are fictitious. The current PHC rates may be verified at https://pfd.hhs.texas.gov/long-term-services-supports.

Example 1:

A provider documents in the service plan that an applicant received 52 hours of service at $12.00 an hour for one week of the retroactive period. Of the total 52 service hours reported to date, three hours were for transportation. Calculate the amount the provider is paid using the following example as a guide.

52 hours minus 3 hours — (deduct 3 hours since transportation is not an allowable task in PHC) = 49 hours

49 hours x $9.61 — (the non-priority participating rate in PHC) = $470.89

$470.89 is the amount HHSC will pay the provider.

Document 49 hours in Item 18, Units, on Form 2101, Authorization for Community Care Services, and send it to the provider.

49 hours x $12.00 an hour (estimated private-pay rate) = $588.00. This is the amount of Medicaid-reimbursable tasks the provider must reimburse the individual.

Document $588.00 on Form 2065-A and send it to the applicant to advise him of the amount he should be reimbursed from the provider. Send a copy of Form 2065-A to the provider to advise the provider of the amount it must reimburse the individual. The provider can privately bill the individual for three hours of services determined by the case worker not to be Medicaid-reimbursable tasks.

Example 2:

A provider documents in the service plan that an applicant received 55 hours of service at $10.00 an hour for one week of the retroactive period. All of the 55 service hours were performed on Medicaid-reimbursable tasks. Calculate the amount the provider is paid using the following example as a guide.

55 hours minus 5 hours — (deduct five hours which exceed the weekly limit allowed in PHC) = 50 hours

50 hours x $9.61 = $480.50

$480.50 is the amount HHSC will pay the provider.

Document 50 hours in Item 18, Units, on Form 2101 and send to the provider.

50 hours x $10.00 an hour = $500.00. This is the amount of Medicaid-reimbursable tasks the provider must reimburse the individual.

Document $500.00 on Form 2065-A and send it to the applicant to advise him of the amount he should be reimbursed from the provider. Send a copy of Form 2065-A to the provider to advise the provider of the amount it must reimburse the applicant.

Example 3:

A provider documents in the service plan that an applicant received 55 hours of service at $12.00 an hour for one week of the retroactive period. Of the total of 55 service hours provided, three hours were for transportation. Calculate the amount the provider is paid using the following example as a guide.

55 hours minus 3 hours for transportation — (a non-Medicaid reimbursable task) = 52 hours

52 hours minus 2 hours — (deduct two hours which exceed the weekly limit allowed in PHC) = 50 hours

50 hours × $9.61 = $480.50

$480.50 is the amount HHSC will pay the provider.

Document 50 hours in Item 18, Units, on Form 2101 and send it to the provider. Send the usual initial PHC packet to the provider for the continued service period.

50 hours x $12.00 an hour = $600.00. This is the amount of Medicaid-reimbursable tasks the provider must reimburse the applicant.

Document $600.00 on Form 2065-A and send it to the applicant to advise him of the amount he should be reimbursed from the provider. Send a copy of Form 2065-A to the provider to advise the provider of the amount it must reimburse the individual. The provider can privately bill the individual for the three hours for transportation since this is not a Medicaid-reimbursable task.

If a provider provides service to an individual during a retroactive period where all tasks/hours/costs are all within the scope of the PHC program, then the dollar amount due the individual and the provider will be the same.

Example: A provider documents in the service plan that the individual received 30 hours of allowable household and at least one personal care task per week and charged the individual $9.61 an hour non-priority participating PHC rate to provide the attendant care. Calculate 30 hours x $9.61 = $288.30. This is the amount HHSC pays the provider and is the same amount refunded by the provider to the applicant. In this example, advise both the provider and the applicant the same amount, using Form 2065-A.

Send the provider Form 2101 for the retroactive payment period with an end date the day before the beginning of the continued PHC services. Send a second Form 2101 authorizing ongoing services with the complete initial PHC packet.

4644 Applicant Approved for Retroactive Payment and Denied Continued Services by the Case Worker

Revision 17-1; Effective March 15, 2017

If the applicant is eligible for the retroactive period but is not financially or functionally eligible for continued Primary Home Care (PHC) services, the case worker must call the provider and notify the provider of the last day of the retroactive period and the ineligibility for ongoing services. Document the telephone call in the comments section of Form 2101, Authorization for Community Care Services, for the retroactive period.

The case worker must verify the following conditions are present in the service plan developed by the provider:

- applicant is receiving at least one personal care task;
- total amount of weekly service hours are within the maximum weekly hours (50 allowed in the PHC program); and
- the tasks provided are covered within the PHC program.

The provider will not be reimbursed if no personal care task(s) were provided. The amount of reimbursement will be reduced if the:

- service plan includes more than the 50 weekly maximum hours allowed in PHC;
- tasks provided are not the type of tasks covered by the PHC program; or
- cost per hour of service the provider billed the applicant is more than the Texas Health and Human Services Commission non-priority rate.

Within two business days of the decision of ongoing ineligibility, the case worker sends the applicant and the provider Form 2065-A, Notification of Community Care Services, which includes the:

- effective date of denial of continued services, and
- amount the provider should reimburse the applicant.

The case worker must complete and send Form 2101 to the provider for the retroactive payment period. Use the Form 2101 instructions to complete the items for the retroactive period with the following exceptions:

- Item 4 — "Begin" date is obtained from the applicant's service plan which was developed by the provider. The begin date cannot be prior to the practitioner's signature date on Form 3052, Practitioner's Statement of Medical Need.
- Item 5 — "End" date is the date the case worker determines the applicant ineligible for continued PHC services. The "End" date on Form 2101 must match the:
  - effective date of denial on Form 2065-A; and
  - verbal termination date for the retroactive period.
- Item 18 — Enter the amount of service hours minus any disallowed tasks/cost/hours for services that are not Medicaid reimbursable.
- Item 31 — Last name of Doctor of Medicine/Doctor of Osteopathic Medicine (MD/DO) = RETRO PAS
- Item 33 — MD/DO License Number
- Item 34 — Date of Orders

4645 Special Procedures for Community Attendant Services (CAS)

Revision 17-1; Effective March 15, 2017

Providers must be aware of the risk of losing revenue if attendant care services are delivered to a non-Medicaid individual. If the applicant is determined ineligible, retroactive payment will not be made by the Texas Health and Human Services Commission (HHSC).

The case worker proceeds with the referral to Medicaid for the Elderly and People with Disabilities (MEPD) upon receipt of Form H1200, Application for Assistance – Your Texas Benefits, following the CAS referral procedures.

When the eligibility decision is received from MEPD and the applicant is determined eligible, the case worker sends the HHSC nurse a copy of the pre-assessment packet from the provider and Form 3052, Practitioner's Statement of Medical Need, along with a "pending" Form 2101, Authorization for Community Care Services, for the retroactive period. The case worker enters " Retroactive Payment Applicant" in the comments section on Form 2101. The HHSC nurse may authorize services effective the start date of service delivery as long as it is within the three months prior to the medical effective date established by MEPD, and other conditions are met. The HHSC nurse also completes a second Form 2101 for ongoing services if the applicant is eligible for ongoing CAS. See Section 4662.1, Authorization for Routine Referrals, for procedures for ongoing authorization. The HHSC nurse sends a copy of Form 2101 for the retroactive period and a copy of Form 2101 for ongoing services to the provider and the case worker.

Within two business days of receipt of Form 2101, the case worker sends the applicant and the provider Form 2065-A, Notification of Community Care Services, for the retroactive period which includes the:

- effective dates of the retroactive period;
- total weekly hours of service approved; and
- amount to be reimbursed to the applicant.

The case worker sends a second Form 2065-A to the applicant advising of ongoing services, including the effective date and the total weekly hours.

4646 CAS Applicant Determined Ineligible by MEPD Staff

Revision 17-1; Effective March 15, 2017

If the Community Attendant Services (CAS) applicant is determined ineligible by Medicaid for the Elderly and People with Disabilities (MEPD) staff, the case worker must:

- immediately notify the provider that the applicant is not Medicaid eligible, advising of the date of Medicaid denial; and
- send the applicant and provider Form 2065-A, Notification of Community Care Services, advising the denial for retroactive payment and continued services.

Note: The provider will not be reimbursed for retroactive services by the Texas Health and Human Services Commission and the provider does not have to reimburse the applicant for privately paid services.

4647 Notifications

Revision 17-1; Effective March 15, 2017

For all decisions on retroactive payments, both the applicant and the provider must be sent Form 2065-A, Notification of Community Care Services. The applicant must also be notified of eligibility or ineligibility for ongoing services on Form 2065-A. The provider is sent Form 2101, Authorization for Community Care Services, authorizing the retroactive services and Form 2101 for ongoing services, if the applicant is eligible.

4647.1 Notifications to Providers

Revision 17-1; Effective March 15, 2017

For all decisions on retroactive payments, send the provider a copy of Form 2065-A, Notification of Community Care Services. For any service authorizations, send the provider Form 2101, Authorization for Community Care Services. If, during the retroactive determination process for Primary Home Care the applicant is determined ineligible for continued services, the case worker must call the provider immediately to advise of the applicant's ineligibility. The case worker documents the telephone call in the comments section of Form 2101, authorizing the retroactive period.

4647.2 Notifications to Applicants

Revision 17-1; Effective March 15, 2017

Applicants must be notified of all decisions on Form 2065-A, Notification of Community Care Services, within two business days of the date of the decision. If the applicant is determined eligible for retroactive and continued services, send two Form 2065-As. Form 2065-A for the retroactive period must contain the effective dates, type and amount of service authorized and the amount of reimbursement the applicant should receive for the services the provider delivered during the retroactive period. The second Form 2065-A advises the applicant of the eligibility for ongoing services, including the effective date, type and amount of service authorized.

If the applicant is denied for retroactive and continued services, document in the comments section of Form 2065-A that the applicant is ineligible for continued Primary Home Care or Community Attendant Services and is not eligible for retroactive payments from the provider for the months of the retroactive period (list the actual months). Retroactive payment applicants who appeal because payment was denied by the Texas Health and Human Services Commission are not entitled to payment for continued services pending outcome of the appeal.

4648 Reimbursement

Revision 17-1; Effective March 15, 2017

40 Texas Administrative Code §47.85(i), Charges to persons who receive services.

(1) The provider agency may charge a person for services for which the provider agency intends to request retroactive payment, unless the person is Medicaid eligible.
(2) The provider agency must reimburse the entire amount of all payments made by the person to the provider agency for eligible services, even if those payments exceed the amount DHS will reimburse for the services, if DHS determines that the person is eligible for the Primary Home Care Program.

If the Texas Health and Human Services Commission determines the applicant is eligible for Primary Home Care or Community Attendant Services, the provider must reimburse the entire amount of all payments made to the provider for eligible services during the three months preceding eligibility, regardless of whether or not those payments exceeded the amount the provider will be reimbursed for those services.

If an applicant has a question or does not agree with the amount of reimbursement from the provider, it is up to the applicant, caregiver, authorized representative or applicant's family to advise the case worker of any discrepancies between the:

- amount of money the case worker advised that the applicant would receive; and
- actual amount received from the provider.

Final resolution of any disagreements between the provider, individual and/or case worker over the amount of reimbursement due the individual is resolved by the case worker's supervisor. The supervisor may consult appropriate regional support staff in an effort to reach a final decision involving reimbursement disagreements.
Note: The provider must reimburse the individual within seven days of receiving payment from HHSC.

4650 Service Planning

Revision 17-1; Effective March 15, 2017

The case worker is responsible for all aspects of service planning for Primary Home Care (PHC), including:

- determining the applicant's eligibility for services, as described in Section 4630, Eligibility;
- developing a service plan based on the applicant's unmet need for service, as described in Section 2433, Determining Unmet Need in the Service Arrangement Column;
- authorizing services and referral to a provider, as described in Section 4660, Service Authorization; and
- providing ongoing case management for the individual.

The case worker follows the procedures for initial intakes in Section 2300, Responding to Requests for Service. The initial home visit and functional assessment are completed in accordance with Section 2400, Assessment Process. Note on the worksheet of Form 2059, Summary of Client's Need for Service, the applicant's reported medical diagnosis and functional limitations. If the individual reports only a diagnosis of mental health, intellectual disability (ID) or intellectual and developmental disability (IDD), discuss that he may not meet the medical eligibility criterion for PHC. Advise the applicant that the provider will contact his medical practitioner for additional medical information. In developing the service plan, ensure that the applicant needs at least one personal care task.

4651 Assessing the Individual's Needs

Revision 18-2; Effective November 19, 2018

In a face-to-face interview with the individual, conduct a functional assessment of the applicant, as described in Section 2430, Functional Assessment. The case worker may consult the Texas Health and Human Services Commission (HHSC) nurse about any issues that:

- may impact individual health and safety; or
- bring medical and functional eligibility into question.

If, during the process of developing the service plan, it is determined that a particular person should not be employed as the individual's attendant, the case worker documents this information on Form 2101, Authorization for Community Care Services. See Section 2514, Who Cannot Be Hired as the Paid Attendant, for additional information.

Review the service plan and explain the services to the individual. Let him know the number of hours and number of days services are to be delivered and the tasks he is authorized to receive. Inform the individual that to continue to qualify for services, he must need at least one personal care task. If the individual does not need a personal care task, Title XIX personal attendant services (PAS) cannot be authorized. The individual must also need at least six hours of services per week, unless he meets one of the criteria listed in Section 4633, Functional Eligibility. Assess the individual for Family Care Services if the criteria for Title XIX PAS are not met.

Give Form 2307, Rights and Responsibilities, and Attachment 2307-A, Family Care, Community Attendant Services and Primary Home Care Rights and Responsibilities, to all applicants. Explain that the case worker must approve changes in the service plan. Also, inform the individual that he may select another provider if he is dissatisfied with the services or attendant providing the services.

If the Primary Home Care applicant meets all eligibility criteria, send a referral packet to the provider within five business days from the face-to-face interview. This referral will prompt the provider to begin pre-initiation activities.

If the Community Attendant Services applicant meets all functional eligibility criteria, send the Application for Assistance form to Medicaid for the Elderly and People with Disabilities for the financial determination.

4651.1 Service Delivery Outside the Home

Revision 17-1; Effective March 15, 2017

Services may be authorized to be delivered in locations other than the individual's home.

For service delivery outside the individual’s home but within a provider agency’s contracted service delivery area:

- The provider agency may develop a service plan that includes services regularly delivered at a location other than the individual’s home. The service plan must not exceed the weekly hours authorized on Form 2101, Authorization for Community Care Services.
- The provider agency may deliver services outside the individual’s home when the service plan does not include the regular delivery of such services.

The provider agency:

- may deliver services outside the individual’s home only if the individual requests such services;
- is not required to pay for expenses incurred as a result of an attendant delivering services outside the individual’s home;
- must make a reasonable effort to deliver services at a location other than the individual’s home when requested by the individual;
- maintains written justification if the individual’s request was not granted; and
- documents in the individual’s record:
    - each instance when the individual requested services at a location other than the home;
    - whether the individual’s request was granted;
    - what services were provided; and

- where the services were delivered.

Texas Administrative Code §47.63, Service Delivery, provides the rules for Home and Community Support Services (HCSS) agencies to deliver services outside the home. The provider may develop a service plan that includes services regularly delivered at a location other than the individual's home or may deliver services at an alternate location at the individual's request. See Section 2522, Service Delivery in Alternate Locations, for additional case worker procedures.

Case workers should pay particular attention to this policy if they have disabled individuals who are working or attending school and need assistance in the workplace/school. The Social Security Administration has several programs to assist disabled persons with employment at www.socialsecurity.gov/pubs/10095.html.

Additionally, persons enrolled in the Medicaid Buy-In program will be working and may require service delivery in alternate locations.

While services may be delivered outside the home, only allowable tasks may be authorized and the provider is not required to pay for expenses incurred by attendants delivering services outside the home. Hours authorized are based solely on services that could be delivered in the home.

The case worker must send Form 2067, Case Information, to the provider with information about the individual's request for services in an alternate location and work with the individual and provider to arrange the services that will meet the individual's needs within the scope of the program.

4652 Types of Referrals

Revision 17-1; Effective March 15, 2017

There are two methods of referral:

- For expedited referrals, the case worker makes the referral by oral notice and on Form 2101, Authorization for Community Care Services.
- For routine referrals, the case worker makes the referral on Form 2101.

See Appendix IV, Workflow and Time Frames, for procedures for the different types of referrals.

4652.1 Routine Referrals for Primary Home Care

Revision 21-2; Effective June 1, 2021

For routine Primary Home Care (PHC) referrals, complete the following within five business days after the home visit:

- enter the assessment information in the Service Authorization System Online Wizards (SASOW); and
- send a referral packet to the provider.

The referral packet must include:

- a cover sheet;
- the Long-term Care Services Intake System (NTK) generated Form 2110, Community Care Intake; and
- a copy of the following SASOW generated forms:
  - Form 2059, Summary of Client's Need for Service;
  - Provider Referral Supplement;
  - Form 2060, Needs Assessment Questionnaire and Task/Hour Guide;
  - Task/Hour Guide; and

- referral Form 2101, Authorization for Community Care Services.

The referral packet notifies the provider to begin pre-initiation activities.

Refer PHC applicants that are mandatory STAR+PLUS members to the enrollment broker.

Related Policy

Requests for Services in STAR+PLUS Areas, 2221
Content of Referral Packets, Appendix XIII

4652.2 Expedited Referrals for Primary Home Care

Revision 18-1; Effective June 15, 2018

In some instances, the individual's need for services, based on the case worker's judgment, is such that delivery of services must be facilitated. When weighing whether an expedited referral is warranted, the case worker should consider the following:

- What was the individual's assigned intake priority? In most situations, cases that require an expedited response to a request for services also require an expedited referral.
- Is the applicant being authorized as having priority status? If so, that may indicate a need for an expedited referral.
- Could a delay in starting services constitute a threat to the individual's health, safety or well-being? If so, an expedited referral may be needed.

The expedited referral process includes the case worker:

- making an oral request by the next business day from the home visit that immediately begins pre-initiation activities and negotiating a date for the completion of pre-initiation activities, which must be less than 14 days;
- following up the oral request by sending a referral packet, including Form 2101, Authorization for Community Care Services, to the provider, noting the negotiated completion date in the comments section;
- negotiating a start of care date with the provider upon notification of a completed practitioner's statement, which must be in less than 14 calendar days; and
- authorizing services in the Service Authorization System no later than the fifth business day after a start date has been negotiated.

The provider may only call the case worker to provide information from Form 3052, Practitioner's Statement of Medical Need, and negotiate a start-of-care date in the case of an expedited referral. The start of care for the expedited referral must be earlier than the 14-day time frame for a routine referral and cannot be before the date the practitioner signed Form 3052. The provider must send the case worker Form 3052 within seven days.

4652.3 Initial Referrals for Community Attendant Services

Revision 21-2; Effective June 1, 2021

For CAS referrals, complete the following within seven business days after receiving the financial eligibility determination:

- enter the assessment information in the Service Authorization System Online Wizard (SASOW); and
- send the provider a referral packet.

The referral packet must include:

- a cover sheet;
- the Long-term Care Services Intake System (NTK) generated Form 2110, Community Care Intake; and
- a copy of the following SASOW generated forms:
  - Form 2059, Summary of Client's Need for Service;
  - Provider Referral Supplement;
  - Form 2060, Needs Assessment Questionnaire and Task/Hour Guide;
  - Task/Hour Guide; and
  - referral Form 2101, Authorization for Community Care Services.

Do not send a copy of the referral Form 2101 to the HHSC nurse on initial CAS cases. Send the referral packet to the provider and it is the provider's responsibility to send the required documents, including Form 3052, Practitioner's Statement of Medical Need, to the HHSC nurse.

Note: Providers have been requested to send Form 2101 with Form 3052 as a courtesy to assist with applicant identification, but this is not required.

Track the CAS referral. If the authorization Form 2101 is not received from the HHSC nurse within 30 calendar days after sending the referral Form 2101 to the provider, check with the HHSC nurse to see if the referral was received from the provider. If not, contact the provider and request Form 3052 be sent to the HHSC nurse. Document all contacts in the case record.

Related Policy

Screening for Primary Home Care and Community Attendant Services, 2342
Workflow and Time Frames, Appendix IV
Content of Referral Packets, Appendix XIII

4652.4 CAS Applicants Requiring Immediate Service Delivery

Revision 17-1; Effective March 15, 2017

While a Community Attendant Services (CAS) applicant's financial eligibility is pending, the case worker may refer the individual to Family Care (FC). Unless new intakes are being placed on the interest list by the region, a referral to FC is mandatory if the individual:

- had an intake priority of immediate or expedited; or
- has a health condition requiring immediate service delivery in order to ensure his health and safety.

4653 Referral to the Provider

Revision 21-4; Effective December 1, 2021

Send the referral packet to the provider selected by the applicant or recipient. The referral packet must contain adequate information for the provider to develop the service plan based on the assessment.

The referral packet must include:

- a cover sheet;
- the Long-term Care Services Intake system (NTK) generated Form 2110;
- Community Care Intake; and
- a copy of the following Service Authorization System Online Wizards (SASOW) generated forms:

- Form 2059, Summary of Client's Need for Service;
- Provider Referral Supplement;
- Form 2060, Needs Assessment Questionnaire and Task/Hour Guide;
- Task/Hour Guide; and
- referral Form 2101, Authorization for Community Care Services.

All Form 2101 referrals to the provider, both initial and ongoing, must include the:

- authorized tasks;
- total number of authorized hours;
- number of days the applicant or recipient requests services be delivered; and
- relationship and name of any person designated as 'do not hire.'

Document any of the following information in the comments section of the Form 2101:

- any special needs of the applicant or recipient that require a specific schedule and the reason;
  Example: "<Name of person> is diabetic and requires a specific eating schedule." or "<Name of person> requires service delivery in the afternoon due to a sleeping condition."
- the number of service days requested by the applicant or recipient based on the Form 2060;
  Example: "The <Name of person> requests a five-day plan."
- the relationship and name of any person(s) designated as 'do not hire.'
  Example: "Do not hire <spouse>, <name of spouse>, for any tasks." or "Do not hire <daughter>, <name of daughter>, for shopping."

Related Policy

Who Cannot Be Hired as the Paid Attendant, 2514
Service Authorizations, 2620
Referrals to the Provider, 2630
Contents of Referral Packets, Appendix XIII

4654 Pre-Initiation Activities

Revision 17-1; Effective March 15, 2017

The receipt of the referral packet, including Form 2101, Authorization for Community Care Services, prompts the provider to begin pre-initiation activities.

40 Texas Administrative Code (TAC) §47.45(c)(1-2) specifies that providers must complete pre-initiation activities:

- for routine referrals, within 14 days of the later of:
  - the referral date; or
  - date the provider receives Form 2101; or
- for expedited referrals, by the date negotiated between the case worker and provider.

Pre-initiation activities include the following:

The supervisor must develop a service delivery plan on a single document that records the following:

- the tasks which the individual is authorized to receive;
- the total weekly hours of service HHSC authorizes the individual to receive;
- the service schedule, which must include as necessary, based on an individual's needs, certain time periods for the delivery of specified tasks.

The provider must obtain a complete practitioner's statement and submit for HHSC's review, as described in TAC §47.47 (relating to Medical Need Determination). This does not apply to Family Care services. For routine referrals, the provider must:

- send a copy of the practitioner's statement to HHSC by facsimile or secured email; or
- mail a copy of the practitioner's statement to HHSC.

For expedited referrals:

- HHSC may send the authorization for community services form pending receipt of the practitioner's statement if the provider notifies HHSC that the provider has received a complete practitioner's statement that documents the individual's medical condition is the cause of the individual's functional impairment.
- Upon notification of a completed practitioner's statement, HHSC and the provider will negotiate a start-of-care date.
- The provider must send the complete practitioner's statement to HHSC within seven working days of service initiation.
- If a complete practitioner's statement is not sent to HHSC within seven business days of service initiation, the provider is not entitled to payment from HHSC until the date HHSC receives the completed practitioner's statement. In this circumstance, HHSC will change the service initiation date to the date HHSC receives the completed practitioner's statement.
- The signature date of the practitioner must be on or before the negotiated start-of-care date.

4654.1 Delays in Pre-Initiation Activities

Revision 17-1; Effective March 15, 2017

The provider must complete the pre-initiation activities within the required time frames as described in Section 4654, Pre-Initiation Activities, or document the reason(s) for a delay.

- A provider may delay meeting the due dates only for reasons beyond its control, such as natural or other disasters. The provider must continue efforts to complete pre-initiation activities and set a date, if possible, for completion of pre-initiation activities.
- The provider must document any failure to complete the pre-initiation activities for routine referrals by the due date, including:
  - the reason for the delay, which must be beyond the provider's control;
  - either the date the provider anticipates it will complete the pre-initiation activities or specific reasons why the provider cannot anticipate a completion date; and
  - a description of the provider's ongoing efforts to complete pre-initiation activities.
- The provider must notify the case worker of any failure to complete the pre-initiation activities for expedited referrals before the negotiated date for completion of pre-initiation activities. The case worker may refer the individual to another provider.

4655 Initial Service Delivery Plan Changes

Revision 17-1; Effective March 15, 2017

The provider must notify the case worker of a variance in the service delivery plan when the initial service delivery plan developed by the provider:

- has more hours than authorized on the authorization for community care services form; or
- has no personal care services, except for Family Care services.

If the provider does not agree with the service plan on Form 2101, Authorization for Community Care Services, after completing pre-initiation activities, the provider must send a notice to the case worker explaining why changes are needed in the initial service plan.

Upon receipt of the written notification, the case worker must contact the individual within two business days to review the service plan and resolve the reported request for a change in tasks or hours. If the individual consents to the initial service plan developed by the case worker, the case worker sends the provider Form 2067, Case Information, advising that the individual is in agreement with the developed service plan. If the individual states that a change is needed, review and update Form 2060, Needs Assessment Questionnaire and Task/Hour Guide, and include the changes on Form 2101 to the provider. Services must be authorized within five days of receipt of the practitioner's statement. If a notification is received after services are authorized, process as an interim change. See Section 4673, Interim Service Plan Changes.

If the individual refuses all personal care tasks on the service plan, advise the individual that he will not be eligible for Primary Home Care or Community Attendant Services. Transfer the individual to Family Care or place on the Family Care Interest List. See Section 2720, Interim Changes, for additional guidelines for service plan changes.

4660 Service Authorization

Revision 17-1; Effective March 15, 2017

4661 Receipt of the Practitioner's Statement of Medical Need

Revision 17-1; Effective March 15, 2017

Before services can be authorized, the provider must submit Form 3052, Practitioner's Statement of Medical Need, to the case worker (for Primary Home Care (PHC)) or to the Texas Health and Human Services Commission (HHSC) nurse (for Community Attendant Services (CAS)). A copy of the form must be retained in the case record.

4661.1 Review of the Practitioner's Statement

Revision 17-1; Effective March 15, 2017

Once the practitioner's statement is received from the provider, the case worker (for Primary Home Care (PHC)) or Texas Health and Human Services Commission (HHSC) nurse (for Community Attendant Services (CAS)) will review the practitioner's statement to ensure that everything needed for authorization is in place.

The case worker (for PHC) or the HHSC nurse (for CAS) must ensure that:

- the practitioner has completed the Statement of Medical Need and certified the individual has a medical need resulting in a functional limitation;
- at least one functional limitation related to a diagnosis has been checked;
- the form has been completed and there is no missing information;
- the practitioner has signed the form;
- the practitioner's license number has been entered; and
- the practitioner's contact information is included.

The practitioner's name and license number must be entered in the Service Authorization System.

The case worker or HHSC nurse will accept the practitioner's certification that the individual has an acceptable medical diagnosis when the "Statement of Medical Need" on Form 3052, Practitioner's Statement of Medical Need, is completed. The practitioner must also check at least one functional limitation related to the diagnosis(es) and the case worker or HHSC nurse accepts that the practitioner has checked an appropriate functional limitation.

Persons with only a diagnosis(es) of mental illness and/or intellectual disability (ID)/intellectual and developmental disability (IDD) are not considered to have established medical need based solely on those diagnoses. However, they may establish medical need through a related diagnosis that results in a functional limitation.

In this situation, the practitioner will not sign the "Statement of Medical Need" on Form 3052 and the provider will notify the case worker that a signed Form 3052 will not be sent. When the case worker does the initial assessment and the applicant/family is stating that the only diagnosis is mental illness or ID/IDD, the case worker may consult with the HHSC nurse before making the referral for PHC or CAS. If it is clear at the time of the initial assessment there is no other medical diagnosis or if a signed Form 3052 cannot be obtained, the applicant may be placed on the Family Care interest list, or if funds are available and there is no interest list, may be assessed for Family Care services.

4661.2 Required Corrections

Revision 18-1; Effective June 15, 2018

Some problems related to the practitioner's statement will require correction. The case worker or Texas Health and Human Services Commission (HHSC) nurse must review the practitioner's statement within two business days after receipt to determine if all information is correct or if it will require correction. If correction is required, action must be taken that same day. Depending on the type of error, HHSC will either return the practitioner's statement to the provider for correction or obtain the information via a telephone call, requesting faxed confirmation when necessary.

Obtain the information via a telephone call when:

- functional limitation is not checked;
- practitioner's signature is not on Form 3052, Practitioner's Statement of Medical Need;
- provider/financial management services agency (FSMA) did not complete Part II that the practitioner who signed the order is not excluded from participation in Medicare or Medicaid;
- Form 3052 does not include the credential of the medical practitioner who signed the form (MD for Doctor of Medicine, APN for Advanced Practice Nurse, DO for Doctor of Osteopathic Medicine, PA for Physician Assistant);
- Form 3052 does not include the license number or the individual National Provider Identifier (NPI) number of the practitioner who signed it;
- the provider must fax an updated copy of Form 3052 to the case worker or HHSC nurse because the practitioner's signature date is missing or illegible; or
- the provider must fax an updated copy of Form 3052 to the case worker or HHSC nurse when the provider's stamped date is used instead of the practitioner's date on Form 3052, which does not include the provider name, abbreviated name or initials; or
- the case worker or HHSC nurse requires additional information to authorize services.

The provider is given five business days to complete all corrections. If appropriate, expedited procedures may be used to refer the individual to another provider.

Form 3052 will not need to be corrected for missing medical diagnosis and ICD-10 codes if the functional limitation has been checked.

4661.3 Closing Initial Referrals for Delays in Securing a Signed Practitioner's Statement

Revision 17-1; Effective March 15, 2017

When contacts from the program provider and case worker have proven unsuccessful in obtaining a signed practitioner's statement, the case worker may close the initial referral for services within 90 calendar days from the date of the initial Form 2101, Authorization for Community Care Services.

In cases in which the individual or provider agency indicates to the case worker that an appointment has been made with an alternative physician for the purpose of obtaining the practitioner's statement, the case worker shall continue to monitor the initial referral for up to 90 additional days. The case worker closes the referral by sending Form 2065-A, Notification of Community Care Services, to the applicant if the physician's statement has not been obtained following the second 90-day extension period.

The case worker will place the individual on the Family Care interest list, and must advise Medicaid for the Elderly and People with Disabilities (MEPD) that the applicant was not approved for CAS. In this circumstance, the case worker must send Form H1746-A, MEPD Referral Cover Sheet, stating the applicant has not met the functional eligibility requirements.

4662 Authorization of Services

Revision 17-1; Effective March 15, 2017

4662.1 Authorization for Routine Referrals

Revision 17-1; Effective March 15, 2017

For Primary Home Care (PHC), within five business days of receipt of the completed practitioner's statement, the case worker must enter the information into the Service Authorization System Online (SASO) and send authorization Form 2101, Authorization for Community Care Services, to the provider. The "Begin Date" (Item 4) on Form 2101 is the same as the "Mail Date" (Item 1). Form 3052, Practitioner's Statement of Medical Need, must be date stamped on the date of receipt. The case worker files Form 3052 in the individual's record. Services cannot begin until the provider receives Form 2101 authorizing services. The provider has seven days to initiate services after receipt of Form 2101. The case worker sends Form 2065-A, Notification of Community Care Services, to the individual within two business days of the "Begin Date" on Form 2101.

For Community Attendant Services (CAS), within five business days of receipt of the completed practitioner's statement and Form 2101, the Texas Health and Human Services Commission (HHSC) nurse must enter the information into SASO and send authorization Form 2101 to the provider and send a copy to the case worker, or notify the case worker by electronic mail. If the region elects to have the regional nurse notify the case worker by email, the nurse must include the individual's name, identification number, type of case action (initial, annual reauthorization, etc.) and date of authorization in the email. The unit supervisor and/or other appointed HHSC staff will also receive the notice. The case worker must go into SASO and print a copy of Form 2101 from SAS and a copy of the email for the case record.

The "Begin Date" (Item 4) on Form 2101 is same as the "Mail Date" (Item 1). Form 3052 must be date stamped on the date of receipt. The HHSC nurse sends Form 3052 by mail, fax or electronic scan to the HHSC case worker for retention in the individual's case record. The case worker must file the form in the case record and retain the form according to established form retention schedules. Services cannot begin until the provider

receives Form 2101 authorizing services. The provider has seven days to initiate services after receipt of Form 2101.

The case worker sends Form 2065-A to the individual within two business days of receipt of Form 2101 from the HHSC nurse. Form 2101 must be date stamped when it is received in the case worker's office.

4662.2 Authorization for Expedited Referrals

Revision 17-1; Effective March 15, 2017

When the provider orally notifies the case worker that the practitioner's statement has been received, the case worker must ask for the functional limitations, the practitioner's name and license number, and the signature date. The case worker and provider negotiate a begin date for services. The case worker enters the information in the Service Authorization System Online (SASO) and generates Form 2101, Authorization for Community Care Services, within five calendar days, entering the negotiated date as the begin date. In "Comments," the case worker enters the information on the oral notification, including the provider representative and date of negotiation. Form 2101 must be sent to the provider within five calendar days of the negotiation. The case worker sends Form 2065-A, Notification of Community Care Services, to the individual within two business days.

Each region must ensure there is always a case worker available to negotiate a start of care date on expedited referrals.

The provider must send the completed practitioner's statement to the Texas Health and Human Services Commission (HHSC) within seven business days of service initiation. If a completed practitioner's statement is not sent to HHSC within seven business days of service initiation, the provider is not entitled to payment from HHSC until the date HHSC receives the completed practitioner's statement. In this circumstance, the case worker changes the service initiation date in SASO to the date HHSC receives the completed practitioner's statement and sends the provider a corrected Form 2101.

4663 Effective Dates

Revision 17-1; Effective March 15, 2017

The case worker (for Primary Home Care) or Texas Health and Human Services Commission nurse (for Community Attendant Services) establishes the beginning date of coverage for initial cases on Form 2101, Authorization for Community Care Services, Item 4, as the date the form is expected to be mailed to the provider. If this date is not feasible, the beginning date of coverage is negotiated according to the individual's needs and the unique circumstances of the case.

See Section 4664, Time-Limited Services, for additional information.

4664 Time-Limited Services

Revision 22-1; Effective March 1, 2022

If the practitioner believes the individual may not need services ongoing, they may choose to put an end date on Form 3052, Practitioner's Statement of Medical Need. Since time-limited services are not often requested, there are special procedures for handling the request.

1. The initial assessment and referral processes remain the same.
2. When the provider receives Form 3052, indicating a need for time-limited services, the provider sends a copy of the form to the Texas Health and Human Services Commission (HHSC).

3. The case worker (for Primary Home Care (PHC)) or HHSC nurse (for Community Attendant Services (CAS)) completes the authorization for services and enters an end date on Form 2101, Authorization for Community Care Services. Explain the reason for an end date in the comments section. Example: "Individual needs services because of a broken arm; full recovery expected in three months," or "practitioner has specified time limited services ending on XXXXX."
4. The case worker enters a monitor date into the Service Authorization System Online (SASO) scheduler and plans to monitor the individual at least 30 days before the end date on Form 2101.
5. At the scheduled time, the case worker contacts the individual to see if his needs have been met or if he requests continued PHC or CAS services.
6. If the individual's needs have been met, the case worker closes the case by sending the individual Form 2065-A, Notification of Community Care Services, with a 12-day prior notice and enters a date and termination code of "14-No Medical Need" on Form 2101. The effective date of termination on Form 2065-A is the same as the end date on Form 2101.
7. If the individual wishes to continue PHC or CAS services, the case worker must send Form 2065-A at least 12 days prior to, but not more than 30 days prior to, the Form 2101 end date informing the individual that if a new Form 3052 is not received before the end date of Form 2101, services will be terminated. The case worker must complete a new Form 2060, Needs Assessment Questionnaire and Task/Hour Guide, and a new Form 2101. The case worker must also advise the provider that a new Form 3052 is required.
8. If the practitioner refuses to sign Form 3052, the case worker screens the applicant for Family Care (FC) services. If eligible, the case worker refers the applicant for FC services or places the applicant on the FC interest list.
9. If the practitioner signs Form 3052, the case is authorized and the individual remains eligible for service. The case worker must send a new Form 2065-A to inform the individual of the new certification.

If an individual on CAS has time-limited benefits, the regional nurse will add the end date. The case worker must never change or delete the end date added by the regional nurse when adding an effective date for a plan change:

For example, an individual is certified January 2 for CAS with time-limited services ending December 31. The regional nurse will add the end date of 12/31/XX. During the authorized period, the individual requests a change in July that will be effective August 1. When working the change, the case worker must not change or delete the date added by the regional nurse to add an effective date for the change. The case worker will document in the comments of Form 2101 the normal information regarding the change, including "Increase in hours effective 08/01/XX." The case worker will also still include in the comments, along with the change information, that the individual has time-limited benefits ending on 12/31/XX. This will give the provider the information regarding the change, including the effective date of the change, but will leave the end date intact.

Also use this process when an individual's time-limited benefits end after the annual certification. Using the same dates above, the case worker sees the individual for their annual reassessment on October 5 and processes the case October 10, leaving the end date in the authorization of 12/31/XX. Along with the regular annual reassessment comments, the case worker will add the comment that "the individual has time-limited benefits ending on 12/31/XX." The case worker will still follow the same procedure in the list above starting with number 4 to set the scheduler 30 days before the end date to monitor the individual's time limited case.

4665 Service Initiation and Delivery

Revision 17-1; Effective March 15, 2017

Refer to 40 Texas Administrative Code §47.61, Service Initiation.

4665.1 Delays in Service Initiation

Revision 17-1; Effective March 15, 2017

40 Texas Administrative Code (TAC) §47.61(c), Delay in service initiation. A provider may delay service initiation only for reasons not directly caused by the provider, or reasons beyond the provider's control, such as natural or other disasters. The provider must continue efforts to initiate services and set a date, if possible, for service initiation. The provider must document any failure to initiate services by the applicable due date in subsection (a) of this section, including:

(1) the reason for the delay, which must be beyond the provider's control;
(2) either the date the provider anticipates it will initiate services, or specific reasons why the provider cannot anticipate a service initiation date; and
(3) a description of the provider's ongoing efforts to initiate services.
(d) Documentation of service initiation. The provider must maintain documentation of service initiation in the individual's file.

Evaluate the cause of the delay and take whatever action is necessary to ensure the individual receives services at the earliest possible date.

Example: The provider may state the individual's physician is on vacation but is expected to return by a specific date and a practitioner's statement will be obtained as soon as the physician returns. If the delay will not adversely affect the individual, the case worker may decide to take no further action. If the delay is problematic for the individual, the case worker may discuss with the individual the need to obtain a practitioner's statement from another practitioner. Appropriate action may necessitate making a new referral to a different provider.

Each situation is evaluated on a case-by-case basis. The provider may contact the case worker's supervisor if the case worker has a pattern of transferring individuals to other providers even though they have indicated that it is due to reasons beyond their control. The case worker may also contact the contract manager if the provider frequently submits Form 2067, Case Information, to the case worker about a delay in initiating services.

4665.2 Service Delivery Requirements

Revision 17-1; Effective March 15, 2017

The provider agency must ensure:

- services are delivered according to the service plan described in Texas Administrative Code §47.45 (relating to Pre-Initiation Activities);
- (all authorized and scheduled services are provided to an individual, except in the case of a service interruption; and
- an individual does not receive, during a calendar month, more than five times the weekly authorized hours on Form 2101, Authorization for Community Care Services.

4670 Ongoing Case Management

Revision 17-1; Effective March 15, 2017

4671 Ongoing Case Worker Responsibilities

Revision 17-1; Effective March 15, 2017

Monitor the individual according to Section 2710, Monitoring Visits and Contacts, to review the continued adequacy of the service plan, the quality of service delivery and the individual's condition.

The case worker:

- reassesses the individual's functional need within 12 months of the previous functional assessment date on Form 2060, Needs Assessment Questionnaire and Task/Hour Guide, (see Section 2663, Reassessment of Functional Need); and
- reverifies financial eligibility status within 24 months of the previous eligibility date on the Service Authorization System (see Section 2662, Redetermination of Financial Eligibility).

In addition to providing ongoing case management services to the individual, the case worker also reports to, and discusses with, the unit supervisor, the contract manager and the provider any apparent deficiencies noted in the provider's delivery of Primary Home Care or Community Attendant Services.

4672 Transferring Individuals from Family Care to Title XIX Personal Attendant Services

Revision 17-1; Effective March 15, 2017

When the case worker transfers an individual from Family Care (FC) to Primary Home Care (PHC) or Community Attendant Services (CAS), send a referral packet to the receiving provider. The provider will begin pre-initiation activities, as well as coordinate the end date for FC and begin date for PHC/CAS, with the case worker or Texas Health and Human Services Commission nurse.

The FC authorization must be closed in the Service Authorization System before the PHC/CAS authorization can be opened. Send the individual Form 2065-A, Notification of Community Care Services, within two business days of authorizing services as notification of the program change and (if applicable) of the change in providers.

4673 Interim Service Plan Changes

Revision 17-1; Effective March 15, 2017

The individual may request a change in tasks or hours. See Section 2720, Changes Reported in the Individual's Condition or Status during the Certification Period.

The provider may also notify the case worker of any ongoing change in the individual's condition or circumstances that may require a service plan change or service termination. Any of the following changes in the individual's condition or circumstances may require a change in the service plan. (These are examples only.)

- Individual's health improves or deteriorates;
- Individual no longer needs services;
- Individual is discharged from a hospital;
- Problems exist with family relationships;
- Individual is evicted or otherwise loses housing;
- Individual relocates;
- Individual is referred for home health services; and/or
- Changes occur in the individual's household composition.

4673.1 Temporary Service Plan Variances

Revision 17-1; Effective March 15, 2017

The provider may temporarily vary the service delivery plan at the individual's request as long as the variance in tasks can be provided within the total approved hours. The case worker will not be advised of the temporary variance unless the circumstance lasts for more than 60 days.

The provider must provide services according to the existing service delivery plan, until the provider receives a new Form 2101, Authorization for Community Care Services, except the provider may temporarily change the service delivery plan if:

- the individual requests and requires temporary assistance with allowable tasks not identified on the service delivery plan due to a change in circumstances or available supports; and
- the change in tasks does not increase the total approved hours of service or continue for more than 60 days.

The provider must request and obtain a new Form 2101 when a temporary variance in tasks and/or hours on the service delivery plan is to continue for more than 60 days or would result in more hours of services provided than have been approved.

If the temporary variance lasts for more than 60 days, the provider must notify the case worker and request a new Form 2101 for the change. The case worker must follow normal procedures for responding to reported changes as outlined in Section 2720, Interim Changes. If the provider does not request a new authorization, then the service plan delivery must go back to the original authorization of tasks and hours.

4673.2 Ongoing Service Plan Changes

Revision 17-1; Effective March 15, 2017

Refer to 40 Texas Administrative Code §47.67(a), Increase in hours or terminations.

If the case worker receives a request for a change, he must respond to it within 14 calendar days from the date the request is received. Contact the individual and review the individual's service plan to decide whether the change is necessary. If the case worker decides the change is not necessary, document the reasons on Form 2067, Case Information, and send it to the provider. Keep a copy of Form 2067 in the case record.

Depending on the individual's new condition or situation, a new assessment or revision of the service plan (such as the need for more hours or a different priority level) may be necessary. If appropriate, make changes to the service plan on Form 2101, Authorization for Community Care Services, according to Section 2720, Interim Changes. Consult with the supervisor about the requested change, if necessary. If the change in circumstances meets the criteria for Adult Protective Services, refer the individual to that service. See Section 2220, Response to Requests for Service.

For Community Attendant Services interim changes and provider transfers during the service plan year, the case worker can authorize changes without authorization from the HHSC regional nurse. The case worker enters the "Begin Date" on Form 2101 based on the case action (increase or decrease). The effective date on Form 2065-A, Notification of Community Services, must match the "Begin Date" on Form 2101.

4673.3 Increase in Hours

Revision 17-1; Effective March 15, 2017

For expedited or routine service plan changes resulting in an increase in hours, set the begin date on the authorization form. Within two business days of the case decision, the case worker sends the:

- negotiated date of increase as the begin date on Form 2101, Authorization for Community Care Services; or

- routine date of increase as the begin date on Form 2101, which must be seven days later than the date the form is expected to be mailed. There may be times when unique or extenuating circumstances make it more appropriate to make the increase later than seven days. In these circumstances, the begin date of coverage is negotiated between the case worker and the provider according to the individual's unique needs. The increase should not be delayed solely because the delay is more convenient for the provider.

Send Form 2101 to the provider.

4673.4 Immediate Increase in Hours

Revision 17-1; Effective March 15, 2017

Refer to 40 Texas Administrative Code §47.67(c), Immediate increase in hours of service.

Upon notification from the provider that the individual requires an immediate increase in hours, the case worker or the designated case worker immediately contacts the individual to verify the need for the immediate increase. Review the tasks and hours on Form 2060, Needs Assessment Questionnaire and Task/Hour Guide, making the necessary

Revisions to the service plan. Contact the provider and negotiate an effective date for the increase. The request for an immediate increase must be responded to within the same day of the request. Within three business days, send a revised Form 2101, Authorization for Community Care Services, documenting the reason for the increase, the additional tasks and/or hours, the effective date and the provider representative contacted to negotiate the effective date. See Section 2721, Service Plan Changes, for additional information.

The following are examples of situations that require immediate response:

- The individual is experiencing a major illness and has no available caregiver.
- The individual suddenly loses his caregiver and has no other available caregiver and
  - is totally bedridden or unable to transfer from bed to chair without assistance; or
  - cannot manage toileting tasks without personal assistance; or
  - needs meal preparation or feeding to ensure that he receives daily nourishment.

Each region must ensure there is always a case worker available to negotiate an immediate increase in hours.

4673.5 Termination or Reduction of Hours

Revision 17-1; Effective March 15, 2017

Reduce hours or terminate services when the individual:

- requests a reduction or termination;
- gains a resource resulting in fewer unmet needs and the need to reduce service hours; or
- is performing all or some activities of daily living due to long term improvement in functional condition resulting in the need to reduce or terminate services.

Use personal judgment to determine if the individual's long term improvement is expected to last through the current authorization period or beyond before services are reduced or terminated. If the case worker determines the individual's condition has temporarily improved because the individual is performing the task(s) previously done by the attendant, the individual and provider may agree to a temporary variance. To continue to qualify for Title XIX personal attendant services, the individual must need at least one personal care task.

For changes made in conjunction with an annual reassessment of Community Attendant Services cases, the Texas Health and Human Services Commission (HHSC) nurse must authorize the change.

For decreases, the change is effective 12 days from the date in Item 1 on Form 2101, Authorization for Community Care Services, unless waived by the individual. The effective date of decrease on Form 2065-A, Notification of Community Care Services, must match the effective date of decrease entered in Item 4 of Form 2101.

If services are terminated, follow the individual notification procedures in Section 2810, Notice of Ineligibility or Service Reduction. Coordinate the effective date of denial of services with the provider and HHSC nurse (if appropriate) to allow enough time for the individual to appeal.

4673.6 Temporary Loss of Eligibility and Reinstatement Procedures

Revision 17-1; Effective March 15, 2017

When an individual loses Medicaid or financial eligibility as determined by Medicaid for the Elderly and People with Disabilities (MEPD), the case worker must check the Texas Integrated Eligibility Redesign System (TIERS) to verify the denial and the reason. The case worker must contact the individual to discuss the situation and, if feasible, assist the individual with reinstatement of eligibility. If eligibility is reinstated without a gap in eligibility dates, no further action is needed. See Section 3441, Loss of Categorical Status or Financial Eligibility, Section 3441.1, Procedures Pending Reinstatement, and Section 3441.2, Reinstatement Procedures After Denial, for case worker procedures.

If the individual's Medicaid or financial eligibility is later reinstated after a gap in eligibility, the individual may not be automatically placed back on Primary Home Care (PHC) or Community Attendant Services (CAS), if the service has been terminated.

If HHSC notifies the provider that services are terminated, all pre-initiation activities, including medical need determination, must be completed before services are reinstated.

If the case worker has sent Form 2101, Authorization for Community Care Services, terminating services, then the case worker must send a referral Form 2101 for PHC or CAS to the provider for pre-initiation activities, including a new Form 3052, Practitioner's Statement of Medical Need. Expedited procedures may be used in this situation, if appropriate. All policies regarding new referrals apply, including those for CAS and the authorization of services by the HHSC regional nurse. If the individual was placed on another service, the transfer between services must be negotiated for end dates and begin dates and the individual must be notified on Form 2065-A, Notification of Community Care Services.

4673.7 Implementation of Service Delivery Plan Changes

Revision 17-1; Effective March 15, 2017

The provider must implement the service delivery plan change on the following date, whichever is later:

- the authorization begin date on Form 2101, Authorization for Community Care Services; or
- five days after the date the provider receives Form 2101, unless the provider fails to stamp the receipt date on the form, in which case the authorization begin date on the form will be used to determine timeliness.

If a provider does not implement a service delivery plan change on the effective date of the change, the provider must set a new implementation date. The provider must document by the next working day any failure to implement a service delivery plan change on the effective date of the change. The documentation must include:

- the reason for the failure to timely implement the service delivery plan change; and
- the new implementation date.

4674 Service Interruptions

Revision 17-1; Effective March 15, 2017

A service interruption occurs anytime service delivery is discontinued for 14 days or more. The provider should make every effort to ensure that interruptions in service last less than 14 days, particularly if a break in service would jeopardize the individual's health or safety. When an interruption of services is unavoidable, the provider must document in the individual's file all service interruptions by:

- the 30th day after the beginning of the service interruption for priority individuals; and
- the 30th day that exceeds 14 days after the service interruption for non-priority individuals.

The provider is not required to advise the case worker that service interruptions have occurred. If the individual contacts the case worker or if the case worker learns of the interruption during a monitoring contact, the case worker takes the following actions:

- The case worker contacts the individual to determine if the service interruption is jeopardizing the individual's health and safety or is having an adverse impact on the individual.
- If there is no adverse impact and the individual is willing to wait for services, the case worker documents this information in the case narrative.
- If there is an adverse impact, the case worker:
    - contacts the provider to determine the status of resuming services;
    - contacts the individual and discusses the individual's right to change providers if the provider cannot provide a resumption date; and
    - follows procedures in Section 4676, Change of Providers, if the individual elects to change providers.

4675 Interdisciplinary Team

Revision 17-1; Effective March 15, 2017

The interdisciplinary team (IDT) is a designated group that includes the following people who meet when the provider identifies the need to discuss service delivery issues or barriers to service delivery:

- the individual or the individual's representative, or both;
- a provider representative; and
- an HHSC representative, who may be the:
    - case worker (or designee);
    - case worker’s supervisor (or designee);
    - contract manager (or designee); or
    - HHSC regional nurse (or designee).

A Texas Health and Human Services Commission representative must attend all IDT meetings requested by the provider.

Additionally, the case worker may choose to conduct an IDT meeting to resolve problems before the individual elects to transfer from one provider to another. If the individual remains dissatisfied or continues to request to change providers, he may do so. The individual must always have the freedom of choice in selecting a provider and should not be required to go through the IDT process for this purpose. See Section 4676, Change of Providers, for additional information.

See Section 4677, Suspension of Services and Interdisciplinary Team Procedures, for a detailed description of the IDT's role in service suspensions.

4675.1 Individual Reports of Service Delivery Issues

Revision 17-9; Effective September 15, 2017

An individual has the right to voice grievances or complaints concerning the Texas Health and Human Services Commission (HHSC) staff or purchased services without discrimination or retaliation. The individual has a right to report service delivery issues to the Health and Human Services Office of the Ombudsman at 1-877-787-8999. If the case worker is aware of the issue, the case worker must work to resolve the individual's issues. See policy outlined in Section 2746.1, Reporting Service Delivery Issues, for detailed procedures in handling service delivery issues.

4676 Change of Providers

Revision 17-3; Effective May 15, 2017

When the individual plans to change providers, the individual must first contact the case worker who:

- coordinates the transfer to prevent a gap in coverage; and
- attempts to resolve any problems the individual may have with the current provider before he processes the transfer.

Within 14 calendar days after notification of a request to transfer providers, the case worker contacts the individual and the provider to determine:

- the individual's reason for dissatisfaction; and
- whether the individual's satisfaction can be accomplished without changing providers.

The case worker considers if the dissatisfaction is due to services not being provided according to the service plan, problems with the attendant, problems with the provider, or the individual's failure to comply with the service plan.

The case worker may determine that an interdisciplinary team (IDT) meeting is appropriate to discuss the issues and find a resolution to the service delivery issues. (See Section 4675, Interdisciplinary Team, for additional information.) The case worker may terminate the individual's services if the individual refuses more than three times to comply with service delivery provisions by repeatedly and directly, or knowingly and passively, condoning the behavior of someone in his home.

Within three business days of the IDT decision, the case worker authorizes the transfer if:

- he determines that the individual's satisfaction cannot be met without the individual changing providers and services do not have to be terminated based on failure to comply with the service plan; or
- the individual insists on transferring to another provider and the case worker determines that services do not have to be terminated based on failure to comply with the service plan.

Within those three business days, the case worker also:

- asks the individual or the individual's representative to select a new provider and documents the individual's choice in the case record by:
  - coordinating with both providers the date the current provider will stop providing services and the date the new provider will begin services;
  - updating any pertinent information on Form 2059, Summary of Client's Need for Service;
  - updating Form 2101, Authorization for Community Care Services, for ongoing cases by entering the new nine-digit contract number in Item 2; and
  - documenting in the comments section that the individual is changing providers;

- sends the new provider the updated Form 2101 and Form 2059; and
- sends the current provider a copy of the updated Form 2101 that includes the effective date the individual changes to the new provider.

4677 Suspension of Services and Interdisciplinary Team Procedures

Revision 17-1; Effective March 15, 2017

A provider must suspend services if:

- an individual temporarily or permanently leaves the provider agency's contracted service delivery area during a time when the individual would routinely receive services and the individual does not request the provision of services outside the provider agency's contracted service delivery area;
- the provider declines the request of the individual for the provision of services outside of the provider agency's contracted service delivery area and the individual leaves the service delivery area;
- the individual moves to a location where services cannot be provided under the PHC Program;
- the individual dies;
- the individual is admitted to an institution, which is a:
  - hospital;
  - nursing facility;
  - state supported living center;
  - state hospital;
  - intermediate care facility serving individuals with an intellectual disability or related conditions; or
  - correctional facility.
- the individual requests that services end;
- the Health and Human Services Commission denies the individual's Medicaid eligibility (not applicable to Family Care services); or
- the individual or someone in the individual's home exhibits reckless behavior, which may result in imminent danger to the health and safety of the individual, the attendant, or another person in which case the provider agency must make an immediate referral to:
  - the Texas Department of Family and Protective Services or other appropriate protective services agency;
  - local law enforcement, if appropriate; and
  - the individual's case worker.

The provider agency may suspend services if:

- the individual or someone in the individual's home engages in discrimination against a provider or HHSC employee in violation of applicable law; or
- the individual refuses services for more than 30 consecutive days.

The provider agency must notify the case worker of any suspension by the first working day after the provider suspends services. The notice must include:

- the date of service suspension;
- the reason(s) for the suspension;
- the duration of the suspension, if known; and
- a written explanation of the circumstances surrounding the suspension.

Refer to 40 Texas Administrative Code §47.71(d), Interdisciplinary Team (IDT) meeting, and §47.71(e), Resuming services after suspension.

The provider must suspend services if the individual:

- is not available to receive services;
- requests that services end;
- loses Medicaid coverage; or
- someone in the individual's home exhibits reckless behavior that may result in imminent danger to the health and safety of the individual, the attendant or another person.

The provider may suspend services if the:

- individual or someone in the individual's home engages in discrimination against a provider or Texas Health and Human Services Commission (HHSC) employee in violation of applicable law; or
- individual refuses services for more than 30 consecutive days.

In situations of reckless behavior, discrimination or refusal, the provider must convene an IDT meeting within three business days of the date the provider suspends services or identifies an issue that prevents the provider from carrying out a requirement of the program. The IDT meeting may be conducted by telephone or in person.

The IDT must consist of:

- the individual or individual's representative, or both;
- a provider representative; and
- an HHSC representative, which may be the:
  - case worker (or designee);
  - contract manager (or designee); or
  - HHSC nurse (or designee).

If the provider is unable to convene an IDT meeting with all the members present, the provider convenes with available members and sends documentation of the IDT meeting within five days to the regional director for the HHSC region in which the individual resides. Participation by HHSC staff is mandatory; staff must be aware of the requirements for participation in the IDT meeting. Based on a HHSC review of the IDT documentation, further action by the provider may be required.

During the IDT meeting, the team must:

- evaluate the issue;
- identify any solutions to resolve the issue; and
- make recommendations to the provider.

The case worker takes the appropriate action following the IDT meeting, either terminating services or authorizing resuming services. See Section 2820, Service Suspension by Providers. The provider must implement the recommendations of the IDT in accordance with §47.71(e) of the Texas Administrative Code.

4677.1 Individual Temporarily Leaving Service Area

Revision 17-1; Effective March 15, 2017

An individual receiving services may continue to receive services while he is temporarily staying at a location outside of the provider’s contracted service delivery area, but within the state of Texas. This will help prevent a disruption in services and protect an individual’s health and welfare while the individual is traveling or staying at a location other than his location of residence.

When an individual makes a request for services outside of the contracted service delivery area to the provider, the provider may accept or decline this request. If the provider accepts the individual’s request, the provider may provide the allowed service to the individual during a period of no more than 60 consecutive days. The provider is not required to pay for expenses incurred by the provider’s employee who is delivering services outside the

contracted service delivery area. Within three working days after the provider begins providing services outside of the contracted service delivery area, the provider is required to send a written notice to the case worker notifying him:

- the individual is receiving services outside of the provider's contracted service delivery area;
- the location where the individual is receiving services;
- the estimated length of time the individual is expected to be outside the provider's contracted service delivery area; and
- contact information for the individual.

The case worker will receive written notification from the provider when the individual has returned to the provider's contracted service delivery area within three working days after the provider becomes aware of the individual's return.

If the provider declines the individual's request for services outside of the service delivery area, the provider will inform the individual or his primary caregiver, parent, guardian or responsible party, orally or in writing, of the reason(s) for declining the request. The provider's notice will also indicate that the individual or his primary caregiver, parent, guardian or responsible party may request a meeting with the case worker and the provider to discuss the reasons for declining the request. The provider will also inform the case worker in writing, within three working days after declining the request, that the request was declined and the reason(s) for declining the request.

If the individual requests an interdisciplinary team (IDT) meeting, the case worker must convene an IDT meeting with the provider and the individual or his primary caregiver, parent, guardian or responsible party to discuss delivery of services outside the provider's contracted service delivery area and possible resolutions. The case worker must document the contacts with the individual and the provider in the case record. If a resolution cannot be reached, the case worker must offer the individual a choice of providers or the Consumer Directed Services (CDS) option for services.

Out of Area Service Limitations

If an individual receives services outside the provider's contracted service delivery area during a period of 60 consecutive days, the individual must return to the contracted service delivery area and receive services in that service delivery area before the provider may agree to another request from the individual for the provision of services outside the provider's contracted service delivery area.

If the individual intends to remain outside the provider's contracted service delivery area for a period of more than 60 consecutive days, the case worker must transfer the individual to a provider selected by the individual that has a contracted service delivery area that includes the area in which the individual is receiving services.

4678 Annual Reassessments

Revision 17-1; Effective March 15, 2017

For Primary Home Care (PHC) individuals, the case worker must make a home visit and face-to-face interview to conduct an annual functional reassessment and completion/review of Form 2060, Needs Assessment Questionnaire and Task/Hour Guide, every 24 months.

A home visit is not required for a PHC individual if verification of financial eligibility status is not due at the next reassessment. The case worker retains the ability to make a home visit if individual case circumstances require a home visit be made, as indicated in case examples listed Section 2663.2, Determining When a Home Visit is Necessary for Other Services.

For Community Attendant Services individuals, the case worker must make an annual home visit and face-to-face interview to conduct a functional reassessment. If the need for a change in tasks and/or hours is identified at the annual reassessment, Form 2101, Authorization for Community Care Services, will be sent as follows.

4678.1 Primary Home Care Annual Reassessments

Revision 17-1; Effective March 15, 2017

For Primary Home Care cases at reassessment with no changes, the service authorization is open ended and nothing is sent to the provider. If there are changes in the service plan, within five business days of the annual contact, the case worker must send the provider Form 2101, Authorization for Community Care Services, and appropriate forms as noted in Appendix XIII, Content of Referral Packets. See Appendix IX, Notification/Effective Date of Decision, for effective dates.

4678.2 Community Attendant Services Annual Reassessments

Revision 21-4; Effective December 1, 2021

Reassess eligibility for Community Attendant Services (CAS) at least once every 12 months. The reassessment must include a functional assessment, a review by the provider, and an authorization determination by the regional nurse.

Complete the annual reauthorization by the end of the 12th month from the previous authorization. This is either the initial authorization or the last annual reassessment.

Example: CCSE staff complete the annual functional assessment by Oct. 31 and send the referral Form 2101, Authorization for Community Care Services, to the provider. The regional nurse's last annual reauthorization was on Nov. 20 in the previous year and this year will be due by Nov. 30.

Note: Form 2060, Needs Assessment Questionnaire and Task/Hour Guide, is due by the end of the 12th month from the previous Form 2060.

CCSE Staff Procedures

Complete a functional assessment early enough for the reauthorization process to be completed within the 12-month time frame. If possible, complete the annual functional reassessment during the fourth 90-day monitoring visit for the year. If the annual reassessment is not completed during the fourth 90-day monitoring visit, then another home visit is required to complete the reassessment. The annual reassessment may be completed by phone if Form 2060 has been completed within the last 60 days due to an interim change.

Send Form 2101 to the provider within five business days from the home visit and:

- Indicate "Annual Reassessment" in the comments section on Form 2101.
- If there are changes in the service plan, enter the appropriate "Begin Date" on Form 2101 Enter the information in the Service Authorization System Online Wizards (SASOW). Send Form 2065-A, Notification of Community Care Services, to advise the recipient of the changes in the service plan.
- If there are no changes in the service plan, indicate "No Changes" on the Form 2101 and leave the "Begin Date" blank.

For CAS or Primary Home Care services, if a recipient requests a change at the annual reassessment, the change must be worked within five days or by the annual reassessment due date, whichever is earlier.

Regional Nurse Procedures for Annual Reassessments

For ongoing CAS cases, the regional nurse must review and authorize services annually in SASOW. The authorization in SASOW is required with or without any changes in the service plan. The annual reauthorization is due by the end of the 12th month from the last annual authorization.
The provider must send Form 2101 to the regional nurse with a signed statement of the agreement or disagreement with the service plan, within 14 calendar days of receipt of the referral Form 2101 from CCSE staff.

Provider Agreement

If the provider agrees with the service plan, within five business days of receiving Form 2101 from the provider, the regional nurse completes the authorization of CAS as follows:

- If there are no changes to the service plan, the regional nurse enters the "Begin Date," which is the same as the "Mail Date," and sends the provider and CCSE staff a copy of the authorization Form 2101.
- If there are changes in the service plan, the regional nurse reviews the plan and authorizes the service based on the "Begin Date" CCSE staff entered. Enter the "Mail Date" and sends the provider a copy of the authorization Form 2101.
- The regional nurse notifies CCSE staff by either sending a paper copy of Form 2101 or notification of the authorization email.

If the region elects to have the regional nurse notify CCSE staff by email, the nurse must include the recipient's name, identification number, type of case action such as initial or annual reauthorization, and date of authorization in the email. The unit supervisor or other appointed HHSC staff will also receive the notice. CCSE staff must print a copy of the email for the case record and go into the SASO to print a copy of Form 2101 for the case record.

Provider Disagreement

If the provider disagrees with the service plan, within five business days of receiving Form 2101 from the provider, the regional nurse:

- negotiates with the provider and CCSE staff to arrive at an agreement on the service plan and the effective date of the change. If the negotiation results in a decrease in services, the effective date must allow time to provide the recipient with 12 days advance notice on Form 2065-A from CCSE staff;
- makes any necessary changes to Form 2101, noting the negotiated change in the comments;
- completes the authorization in the Authorization Wizard;
- sends Form 2067, Case Information, notifying the provider and CCSE staff of the outcome of the negotiation; and
- sends a copy of the authorization Form 2101.

CCSE staff must send another Form 2065-A to the recipient, noting the negotiated service plan change(s) and the new effective date.

Tracking Receipt of Form 2101 from the Provider

CCSE staff are responsible for tracking the receipt of Form 2101 from the provider. If the authorization Form 2101 is not received from the regional nurse within 14 calendar days of the referral Form 2101 being sent to the provider, CCSE staff will check in SASO to see if services have been authorized by the regional nurse. If services have been authorized, CCSE staff print the authorization Form 2101 and file it in the case folder. If services have not been authorized, CCSE staff contact the regional nurse requesting services be authorized.

The regional nurse enters the authorization in SASO within five business days of receipt of the email from CCSE staff or Form 2101 from the provider, whichever is earlier. The regional nurse sends the provider a copy

of the authorization Form 2101 and sends a copy or email to CCSE staff advising the authorization has been completed.

Related Policy

Annual Recertification, 6333.4
Workflow and Time Frames, Appendix IV

4700, Residential Care Services

4710 Description

Revision 17-1; Effective March 15, 2017

Residential Care (RC) services include RC and Emergency Care (EC).

Residential Care

- Contracted facilities serve eligible adults who require round-the-clock access to services. In RC services, the individual must contribute to the cost of care, including a room and board payment and a copayment, if applicable.
- For details about eligibility for RC, see Section 4721, Residential Care Eligibility.
- For special casework procedures for RC, see Section 4730, Special Casework Procedures for Residential Care.

Emergency Care

- EC is available to eligible individuals for as many as 30 days while the case worker seeks permanent care arrangements. EC may be provided in Adult Foster Care (AFC) homes and in RC facilities. If an individual is not placed in a permanent care arrangement within the initial 30-day period, he is eligible to receive services for one 30-day extension (for a total of as many as 60 days).
- For details about eligibility for EC, see Section 4722, Emergency Care Eligibility.
- For special casework procedures for EC, see Section 4770, Ongoing Casework Procedures.

4711 Required Services

Revision 17-1; Effective March 15, 2017

Refer to 40 Texas Administrative Code §46.41(b), Required services.

An individual in a Residential Care (RC) facility has access to services on an as-needed basis. The frequency of a task is therefore not designated.

4720 Eligibility for Service

Revision 17-1; Effective March 15, 2017

4721 Residential Care Eligibility

Revision 17-1; Effective March 15, 2017

40 Texas Administrative Code §48.2920, Residential Care

(a) Eligibility for residential care is based on the following criteria:

(1) the applicant must be income eligible or Medicaid eligible (not in an institution);

(2) the applicant must meet the functional need criteria as set by the department. The department uses a standardized assessment instrument to measure the client's ability to perform activities of daily living. This yields a score, which is a measure of the client's level of functional need. The department sets the minimum required score for a client to be eligible, which the department may periodically adjust commensurate with available funding. The department will seek stakeholder input before making any change in the minimum required score for functional eligibility;

(3) the applicant's needs may not exceed the facility's capability under its licensed authority; and

(4) the applicant must have financial resources at or below the level established by the department.

(b) The client must contribute to the total cost of care that he receives, including payment for room and board. The room and board amount is calculated from the client's gross income. The client is responsible for paying this amount directly to the provider agency. The client may be required to pay a copayment based on the amount of income remaining after all allowances are deducted.

Applicants/individuals must score at least 18 on Form 2060, Needs Assessment Questionnaire and Task/Hour Guide, and have adequate income to pay the required room and board payment to become/remain eligible for Residential Care (RC). For other eligibility requirements, see:

- Section 3111, Age Limits;
- Section 3200, Resource Eligibility Criteria;
- Section 3300, Income Eligibility; and
- Appendix VIII, Residential Care and Emergency Care Mental and Physical Characteristics.

4722 Emergency Care Eligibility

Revision 17-1; Effective March 15, 2017

Refer to 40 Texas Administrative Code §48.2921(a), Eligibility for emergency care criteria.

4730 Special Casework Procedures for Residential Care

Revision 17-1; Effective March 15, 2017

4731 Assessment

Revision 17-1; Effective March 15, 2017

If an individual is requesting Residential Care (RC) services, determine if services are open and space in an RC facility is available. If services are not open at that time, place the individual on the interest list. If funding and RC spaces are available or if the individual is released from the interest list, proceed with the eligibility determination and assessment.

Advise the individual of spaces available in the RC facilities in his area, and recommend that the individual visit the facilities. If the individual selects a facility and wants to move to the facility, continue with eligibility determination.

To assess if an applicant qualifies for RC, interview the applicant to determine:

- if he meets the Community Care Services Eligibility (CCSE) income and resource limits;
- if he has adequate income to pay the required room and board payment;
- the extent of the applicant's functional disability by scoring his response to Form 2060, Needs Assessment Questionnaire and Task/Hour Guide;
- the applicant's appropriateness using the guidelines for appropriate and inappropriate mental and physical characteristics in Appendix VIII, Residential Care and Emergency Care Mental and Physical Characteristics; and
- if his needs can be met adequately at an RC facility.

The Texas Health and Human Services Commission (HHSC) Licensing Standards for Assisted Living Facilities, in 40 Texas Administrative Code (TAC) §92.41(e)(1), specify that "A facility must not admit or retain: (A) residents whose needs cannot be met by the assisted living facility, or the necessary services secured by the resident. ..."

An individual is, therefore, inappropriate for placement if his needs exceed the facility's capability under its licensed authority. In general, an RC facility may provide services to an individual whose needs correspond with those listed in the Appropriate Characteristics column of the mental and physical characteristics in Appendix VIII. The facility may not be capable of providing services to an individual whose needs correspond with those listed in the Inappropriate Characteristics column. Because each individual's case must be reviewed according to the setting in which care is to be provided, the appropriate and inappropriate characteristics are only examples.

An assessment of an individual who is being considered for RC should include review of his personal abilities to perform activities of daily living, as measured by Form 2060, Needs Assessment Questionnaire and Task/Hour Guide, and other functional areas, such as the need:

- for the routine daily care offered in a group-care setting;
- for a structured environment and the ability to tolerate it;
- and ability to interact with groups and to socialize daily;
- for a home or for one different from his current living environment; and
- for and ability to tolerate daily monitoring or supervision for behavior control or both.

By carefully assessing individuals in relation to the environment of RC facilities, the case worker will be able to develop care plans that make maximum use of the facilities' benefits.

Share findings with facility staff to determine whether the individual is a suitable candidate for RC and to facilitate a smooth transition.

Discuss money management with the individual during the assessment. If the individual expresses an interest in money management, inform the facility on Form 2067, Case Information, or in the comments section of Form 2101, Authorization for Community Care Services. According to 40 TAC §46.61, Trust Fund Management, the facility must provide assistance to the individual in managing his finances only if the individual requests help in writing. The facility is not permitted to assist an individual in writing checks without first establishing a trust fund account for him.

4732 Freedom of Choice

Revision 17-1; Effective March 15, 2017

The applicant maintains the freedom of choice among the facilities that serve the applicant's area.

The applicant can:

- select the facility, or
- choose to take the next facility on the rotation list.

The applicant must indicate his choice of available facilities before beginning the assessment process. If an applicant already has a facility in mind that does not have space available, he may elect to remain on the interest list until a space is available in that facility.

4733 Referral

Revision 17-3; Effective May 15, 2017

Once the applicant has met all eligibility requirements, selected a facility and has been determined appropriate for placement in Residential Care (RC), negotiate a move-in date with the individual and the facility.

Refer to 40 Texas Administrative Code §46.39, Service Initiation.

To refer the applicant to the facility:

- complete Form 2059, Summary of Client's Need for Service, and Form 2101, Authorization for Community Care Services; and
- send these forms to the facility administrator.

If the applicant needs assistance managing his money, inform the facility:

- on Form 2067, Case Information, or
- in the comments section of Form 2101.

4733.1 Delay of Entry into the Facility

Revision 17-1; Effective March 15, 2017

If the individual changes his mind, or for some other reason does not move into the facility on the negotiated date, advise the individual that he has three days from the negotiated date to enter the facility.

Inform the individual that if he does not move into the facility within three days from the negotiated date, the facility may give the bed space to another individual, the referral for services may be withdrawn, and his request for services will be denied. If there are extenuating circumstances and the facility is willing to re-negotiate a move-in date, the date may be changed.

4733.2 Termination

Revision 17-1; Effective March 15, 2017

If the individual does not move in and the move-in date is not re-negotiated, begin termination procedures. Inform the individual that his request for services will be denied and that if he wants to reconsider Residential Care (RC) placement at a later date, his name will be placed on the interest list with a new request date.

Send the individual Form 2065-A, Notification of Community Care Services, citing "Failure to follow the service plan" as the denial reason, and send the facility Form 2101, Authorization for Community Care Services,

to close the referral.

4734 Inappropriate for Residential Care

Revision 17-1; Effective March 15, 2017

If an individual has been hospitalized, or has temporarily gone to a nursing facility or other institution, reassess the individual upon return to the Residential Care (RC) facility. Complete the reassessment using the list of appropriate characteristics in Appendix VIII, Residential Care and Emergency Care Mental and Physical Characteristics, to ensure that the individual's needs do not exceed the facility's licensed capability to provide service to the individual. Other circumstances may also require that the individual be assessed for appropriateness. If the individual no longer meets the appropriate characteristics, work closely with the facility to explore all available resources in making arrangements for the individual's move. Other resources to consider in making arrangements may include, but are not limited to:

- other agencies involved with the individual,
- the individual's family,
- area ambulance service, or
- the local sheriff's department.

4735 Duplication of Services

Revision 17-1; Effective March 15, 2017

A Residential Care (RC) individual may receive Day Activity and Health Services (DAHS) only if the services provided by the DAHS facility are medical services that cannot be provided by the RC facility. Documentation in the case record must clearly specify that at least one medical service is being provided at the DAHS facility that cannot be provided at the RC facility. For example, an individual's needs are being met at the RC facility except for a daily insulin injection. The individual goes to DAHS each morning for the DAHS nurse to administer the injection.

The number of units authorized to an RC individual must be limited to the time needed by the DAHS facility to provide the medical services. Because most RC individuals are not high medical need individuals, the authorized services are limited to one unit (three but less than six hours) per day.

4736 Transfers

Revision 17-1; Effective March 15, 2017

Once the individual is in a facility, he has the right to move from one contracted Residential Care (RC) facility to another. If the individual decides to move to another facility, contact the new facility to share information regarding the individual's needs and to ensure that his needs can be met in the new facility. If the individual is appropriate for the facility, negotiate a date of transfer, and update Form 2101, Authorization for Community Care Services, to reflect the change in facility. Send a copy of this form to the new facility and the former facility, noting in the comments section that the individual's transfer has been completed.

4740 Individual Contribution to the Cost of Care

Revision 17-1; Effective March 15, 2017

40 Texas Administrative Code §48.2920(b). The client must contribute to the total cost of the care that he receives, including payment for room and board. The room and board amount is calculated from the client's

gross income. The client is responsible for paying this amount directly to the provider agency. The client may be required to pay a copayment based on the amount of income remaining after all allowances are deducted.

(1) The client keeps a monthly allowance for his personal and medical expenses. The Medicaid client keeps $123, a qualified Medicare beneficiary (non-Medicaid) keeps $182; and the non-Medicaid non-QMB client keeps $211 and the part B Medicare premium fee.
(2) In addition to the monthly allowance, a client with earned income keeps all of the earned income up to a maximum of $65 per month.
Do not confuse the $65 earnings allowance in this section with the $65 plus 1/2 remainder amount used in the eligibility budget.
(3) In no case may the client's contribution, when added to the department's payment, exceed the rate established for residential care.

§48.3903(e). The client is not eligible for residential care if he is required to contribute to the cost of his care, but refuses to do so.

4740.1 Room and Board Payments

Revision 17-1; Effective March 15, 2017

Individuals entering Residential Care (RC) are required to pay for room and board. The room and board payment is determined by a specific daily rate based on the type of residential setting. After deducting the room and board payment, the individual's copayment will be calculated based on personal needs allowance and any other approved deductions. The case worker must complete Form 1032, Residential Care Copayment Worksheet. Form 1032 is an automated calculation worksheet for determining room and board and copayment amounts. A copy of the worksheet must be filed in the case record.

4740.2 Copayments

Revision 17-1; Effective March 15, 2017

Residential Care (RC) includes a copayment system in which the individual is expected to contribute to the cost of care. (Emergency Care (EC) individuals do not contribute any copayment.) Under the copayment system, each individual is allowed certain monthly deductions for personal expenses and contributes the remainder of his income to the cost of care.

Withholding tax can be deducted from unearned income. Both withholding tax and Federal Insurance Contributions Act (FICA) tax can be deducted from earned income provided the deduction is mandatory. Other forms of mandatory deductions may be deducted if the case worker is able to obtain documentation from the employer to confirm that the individual does not have control of the expense being deducted. This includes mandatory repayments to the Social Security Administration (SSA) or other governmental agencies.

The copayment system takes into consideration the costs of non-Medicaid individuals who must pay for their own medical expenses. Medicaid individuals also keep a small allowance for medical expenses that are not covered by their Medicaid/Medicare insurance. If an individual chooses to receive RC services, inform him about the mandatory contribution to the cost of care, and implications for his income and eligibility.

See Form 1032, Residential Care Copayment Worksheet, and Instructions, for step-by-step instructions on how to calculate the individual's total contribution to the cost of care.

4741 Individuals on Services Before September 1, 2003

Revision 17-1; Effective March 15, 2017

Beginning Sept. 1, 2003, individuals in Residential Care (RC) are required to pay room and board. Individuals authorized for RC before that date were converted to the new payment system by dividing the current copayment into a room and board payment and a copayment.

For individuals authorized for RC before Sept. 1, 2003 with inadequate income to pay room and board, a special payment system was implemented using non-Title XX funds. Individuals in this category were automatically enrolled for the room and board payment with new service codes of 19O for the apartment setting or 19N for the non-apartment setting. The amount authorized is the difference between the individual's income and the room and board amount owed to the provider. Individuals receiving the special room and board payment continue to be eligible for the payment as long as they remain in RC without a break in service. However, these individuals must pursue all possible sources of income and report new income to the case worker. The new income is applied to the room and board fee.

State payment of room and board is available only for this group of individuals and does not apply to new applicants or individuals. Anyone authorized for RC after Sept. 1, 2003, must have adequate income to pay the room and board fee to be eligible for the program.

4742 Case Worker Calculation Procedures

Revision 17-1; Effective March 15, 2017

While the amount of the individual's room and board is a set amount, the copayment amount varies depending on his income and whether he is a Medicaid, Qualified Medicare Beneficiary (QMB) or Specified Low Income Medicare Beneficiary (SLMB) recipient. If a non-Medicaid, non-QMB or non-SLMB individual receives Social Security or Railroad Retirement benefits, his Medicare premium is deducted from the gross amount of the benefit before the allowances are deducted. No other deduction is allowed. If the individual has earned income, consider only the amount of net income over $65 per month. The net earned income is what the individual actually takes home after all the deductions for taxes, Social Security, etc. (See Form 1032, Residential Care Copayment Worksheet, and Instructions, for instructions on calculating copayments.)

Determine the amount that the individual must contribute and enter the amount in Items 20 and 21 of Form 2101, Authorization for Community Care Services. Item 20 reflects the amount of copayment due for the first month of service. Item 21 reflects the ongoing copayment amount. Whenever cost-of-living changes increase benefits, review the affected individuals' cases and increase the copayment amounts accordingly. Increases are effective the first day of the month following the end of the 12-day notification period.

Inform the individual, in writing, about the fees he must contribute and advise him that if fees are not paid he will no longer be eligible for Residential Care (RC). Send a copy of Form 2065-A, Notification of Community Care Services, to the individual and the RC provider whenever there are changes in the fees the individual must contribute.

The individual's contribution to the cost of care must never exceed the daily RC rate established by the department.

4743 Waiver of Copayment

Revision 17-1; Effective March 15, 2017

An individual's copayment (not the room and board payment) may be reduced or waived because of unusual financial obligations such as high medical expenses or a need to purchase mobility aids. Consult with the supervisor to determine who in the region has the authority to waive the copayment for a Residential Care (RC) individual.

Evaluate the individual's circumstances to determine whether his copayment should be reduced or waived. Regional staff may not allow a blanket reduction or waiver for all individuals served in an RC facility. Determine a specific period in which the reduction or waiver is applied.

If the copayment is reduced or waived, document the basis for the reduction or waiver in the individual's case folder and forward a copy of the documentation to the provider. Complete Items 20 and 21 on Form 2101, Authorization for Community Care Services, to reflect waived or reduced copayments and enter a statement in the comments section. Review the waiver or reduction before the waiver expires to determine whether it needs to be continued, and document any continuation of the waiver.

4744 Adjusting Payments

Revision 17-1; Effective March 15, 2017

Whenever there is a change in the individual's income or an increase in the room and board rates, the case worker is responsible for calculating the change in the individual's copayment amount.

Notify the individual about a copayment increase or room and board rate change by using Form 2065-A, Notification of Community Care Services. The individual must be given at least 12 days after the Form 2065-A date to appeal the increase. If the individual does not appeal, the increase is effective the first day of the following month.

The same day the individual is notified, send the facility a copy of Form 2065-A with the new amounts. For increases in copayment, send the facility Form 2101, Authorization for Community Care Services, showing the new copayment amount. This gives the facility time to prepare to collect the new amounts. If the individual appeals the increase during the 12-day notification period, send the facility another Form 2101 authorizing the original amount until the fair hearing is completed.

Room and board rates are set amounts based on the living arrangement and will not change unless there is an across-the-board rate change. Only individuals designated on Sept. 1, 2003, for receiving a room and board payment will have adjustments based on changes in their income. See Section 4741, Individuals on Services Before September 1, 2003, for additional details.

Copayments are based on the individual's income and will change at least yearly with the Retirement, Survivors and Disability Insurance (RSDI) or Supplemental Security Income (SSI) benefit cost-of-living increase. Case workers will be notified yearly of the increased amounts and procedures for adjusting the copayments.

4745 Collection of the Individual's Contribution to the Cost of Care

Revision 17-1; Effective March 15, 2017

The facility must collect the individual's room and board payment and copayment and must keep receipts for all copayments collected. The facility must deduct the copayment amount (entered on Form 2101, Authorization of Community Care Services, and in the Service Authorization System) from reimbursement claims submitted to the department.

The facility collects the room and board payment and copayment monthly from the individual by a set due date determined by the facility. If full payment is not made by the due date, the facility sends a notice to the individual and notifies the case worker using Form 2067, Case Information, by the first working day after the due date. When the due date falls on a holiday or a weekend, the facility collects the room and board payment by the first workday following the holiday or weekend.

When Form 2067 is received from the facility stating that the individual has failed to pay the required payments, refer to Section 4774.1, Termination Due to Failure to Pay the Required Contribution to the Cost of Care, for

procedures.

The facility must:

- keep receipts for each room and board payment collected;
- keep receipts for each copayment collected; and
- deduct all copayments from reimbursement claims submitted to the Texas Health and Human Services Commission (HHSC).

The individual must pay his entire room and board payment. The individual must also pay the entire copayment or request that the case worker ask for a waiver, if financially unable to pay. See Section 4743, Waiver of Copayment, for procedures.

4750 Personal Leave

Revision 17-1; Effective March 15, 2017

40 Texas Administrative Code §48.2920(c). The client is eligible for 14 days of personal leave from the residential Care facility each calendar year. If the client does not pay the bedhold charge for days of personal leave that exceed the limits, he may lose his space in the facility.

Inform the individual that he is allowed up to 14 days per year of personal leave from the facility. Vacations and visits with family or friends are examples of personal leave. The individual must pay the copayment and room and board charges for personal days. The facility may not bill the Texas Health and Human Services Commission (HHSC) for more than 14 days of personal leave taken by an individual each calendar year.

If an individual exceeds the allowable limit of 14 days of personal leave, the individual is responsible for paying all charges for services, according to any existing contract or agreement between the individual and the facility.

Individuals who use excessive additional days of personal leave (as many as 30 days per year) but continue to pay bed hold charges should be assessed to determine their need for Residential Care (RC). Determine whether the institutional placement is still necessary, appropriate and in the individual's best interest.

Excessive use of personal leave may indicate that family members or friends are able and willing to have the individual live with them, and this potential option should be explored. Discuss excessive use of personal leave with the individual to ensure that he understands the limitations and requirements of the RC service.

4760 Hospital, Nursing Home or Institutional Facility Stays

Revision 17-1; Effective March 15, 2017

40 Texas Administrative Code §48.2920(d). To reserve his space in the facility during hospital, nursing home, or institutional stays, the client must pay his copayment or the facility's bedhold charge, whichever is lower. If the copayment amount is less than the bedhold charge, the department pays the difference. Nursing home and institutional stays are limited to 30 days. There is no limit to the length of hospital stays.

For the individual to reserve his space in the facility during a hospital, nursing facility or institutional stay, the facility receives a bedhold charge payment. The bedhold charge is a set rate established by the Texas Health and Human Services Commission (HHSC). As part of the bedhold charge, the individual is responsible for paying an amount equal to his room and board charge. HHSC then pays the difference up to the bedhold charge. The amount HHSC pays is called the bedhold rate.

The individual does not pay his copayment while out of the facility for a hospital, nursing facility or institutional stay. If the copayment has been paid for the month and the individual goes into a hospital, nursing home or

institution, the facility must refund the copayment for the days the individual is out of the facility.

After a hospital or nursing home stay, review the individual's condition to determine whether the facility can continue to meet his needs according to Appendix VIII, Residential Care and Emergency Care Mental and Physical Characteristics. Refer to Section 4734, Inappropriate for Residential Care, for additional procedures if the individual is no longer appropriate for Residential Care (RC).

4770 Ongoing Casework Procedures

Revision 17-1; Effective March 15, 2017

4771 Facility Reporting and Notification Requirements

Revision 17-1; Effective March 15, 2017

Refer to 40 Texas Administrative Code §46.45, Required Notifications.

If you receive a notice from the facility regarding a significant change, you have to determine within 14 calendar days of receiving the notice whether the change is necessary. See Section 2811, Effective Dates, if the nature of the change requires a termination of services.

4772 Monitoring

Revision 17-1; Effective March 15, 2017

Monitor the individual's situation every six months. For monitoring procedures, see Section 2710, Monitoring Visits and Contacts. Assess the individual's satisfaction with the facility and services delivered and the appropriateness of the service plan. If the individual has any complaints regarding the facility or service delivery, report the situation to the facility directly or send Form 2067, Case Information. Work with the individual and the facility to resolve the problem.

Report chronic problems to the unit supervisor, who may forward the information to the program manager and the contract manager.

4773 Annual Reassessment

Revision 17-1; Effective March 15, 2017

The case worker must reassess the individual annually for functional eligibility and redetermine financial eligibility within 24 months of the previous determination of financial eligibility. See Section 2663, Reassessment of Functional Need, and Section 2662, Redetermination of Financial Eligibility, for additional information about reassessments. Update any information on Form 2059, Summary of Client's Need for Services, and any changes to services on Form 2101, Authorization for Community Care Services, and send to the Residential Care (RC) facility.

If the individual no longer meets eligibility requirements or is no longer appropriate for placement in RC, see Section 4774, Termination of Services, and Section 4734, Inappropriate for Residential Care, for procedures to assist the individual in relocation and termination.

4774 Termination of Services

Revision 17-1; Effective March 15, 2017

The Residential Care (RC) individual is not eligible for services if the individual:

- dies;
- is admitted to an institution for more than 30 days;
- requests service termination;
- refuses to comply with his service plan;
- jeopardizes his or others' health or safety;
- loses Medicaid or becomes financially ineligible for services; or
- is able to contribute to the cost of his care, but refuses to do so.

Do not terminate services if there is an adverse change in the individual's health, but his needs can continue to be met by the facility.

When terminating services, follow procedures in Section 2800, Procedures for Denying or Reducing Services. Send the individual Form 2065-A, Notification of Community Care Services, 12 days before the effective date of denial, except in situations threatening the health or safety of the individual or other individuals. Terminate services immediately in situations threatening health/safety as outlined in Section 2840, Threats to Health and Safety, and Section 2811, Effective Dates for Service Reduction and Termination.

The individual has the right to appeal any adverse action within 90 days of the date of Form 2065-A. The individual may continue to receive services pending the outcome of the appeal hearing if the individual:

- is provided with 12 days advance notice, as specified in Section 2800 and Appendix IX, Notification/Effective Date of Decision; and
- notifies the case worker within those 12 days that he wants to appeal the decision.

If the individual does not appeal the service termination, the termination is final. If the individual appeals the service termination notice, follow the Texas Health and Human Services Commission (HHSC) appeal procedures in Section 2830, Appeal Procedures.

4774.1 Termination Due to Failure to Pay the Required Contribution to the Cost of Care

Revision 17-1; Effective March 15, 2017

If the individual fails to pay the required contribution to the cost of care (room and board and/or copayment) by the facility's due date, the facility must notify the individual/representative and the case worker in writing that payment was not received no later than the first working day after the due date. The facility may notify the case worker orally by the next workday, and follow up in writing within five calendar days of when the individual or the individual's representative fails to pay the required payments.

Upon receipt of the notice, the case worker will:

- coordinate with the facility to convene a meeting of the interdisciplinary team (IDT) within five working days of receipt of the notification. The IDT must include the individual, a facility representative, the case worker and the individual's authorized representative(s), if applicable;
- explore with the individual and IDT if there are new circumstances preventing the individual from making the required payment. Circumstances to consider are:

    - the individual has a situation involving a mandatory recoupment or other changes in income requiring an adjustment in countable income;
    - the individual meets any of the criteria for waiving the copayment amount, such as increased medical bills (See Section 4743, Waiver of Copayment);
    - circumstances indicate that the individual is being exploited by another person; and
    - other situations exist in which the individual and facility can work out an agreement for the individual to pay the required payments;
- make every effort to resolve the problem with the individual and the facility;
- advise the individual of the consequences that will result from refusal to make the required payments to the RC facility, including:
    - termination of eligibility,
    - eviction, and
    - being placed at the end of the interest list if he reapplies for services in the future; and
- ask the individual to read and sign Form 2119, Residential Care, Adult Foster Care or Assisted Living Contribution Acknowledgement, if the situation cannot be resolved and the individual continues to refuse to pay the required payments. The form states that he refuses to pay the required payments and understands the consequences of not meeting this eligibility requirement. If the individual refuses to sign, document the refusal on the form and have a witness sign. Leave the individual a copy of the form and retain the original copy with the signature in the individual's case record. Advise the individual that he will receive a notice to terminate services. Also advise the individual that he will not be allowed to move to another RC facility while he has an outstanding balance at the current facility, and the current facility may evict the individual for refusal to pay. Coordinate the notice of termination with the facility.

After the IDT meeting, make any appropriate referrals to adjust countable income, request a waiver of copayment or refer to Adult Protective Services (APS), if exploitation is suspected.

If the situation cannot be resolved and the individual is refusing to pay for any reason, the case worker sends Form 2065-A, Notification of Community Care Services, giving the individual a 30-day notice that services will be terminated unless the individual pays the required payments. In the comments section of the form, advise the individual that services will end and the facility may evict the individual if payment is not made by the 30th day. Send the facility a copy of Form 2065-A.

The facility may initiate the eviction proceedings by giving the individual an eviction notice in writing.

If the individual does not appeal, terminate services 30 days from the Form 2065-A notice. The facility will receive payment from HHSC during the 30-day period. If the individual has not made other living arrangements at the end of the 30 days, make a referral to APS. Provided the facility is in compliance with the provisions of its license and contract regarding the eviction of individuals, the facility may evict the individual on the date provided on the written eviction notice.

4774.2 Services During the Appeal

Revision 17-1; Effective March 15, 2017

The individual may appeal the decision to terminate services. If the individual makes the appeal request on or before the date of the action to terminate services, the individual's case will remain open until a hearing decision is made. However, the facility has the right to continue with eviction proceedings and may evict the individual with appropriate notice to the individual, even if the hearing decision has not been made. No services will be provided.

4774.3 Requests to Transfer to Another Residential Care Facility

Revision 17-1; Effective March 15, 2017

The individual may not transfer to another Residential Care (RC) facility as long as the outstanding payment has not been made to the previous facility. The case worker must maintain clear documentation in the case record regarding the individual's refusal to pay and the subsequent actions.

If the individual contacts another facility or the case worker requests placement in a new facility, the gaining case worker must contact the current case worker to determine if the individual is current on all required payments. If the individual has outstanding payments to a facility, the case worker will not approve ongoing RC services at a new facility and the request to transfer will not be processed. The individual may receive other services, if determined eligible, but will remain ineligible for RC services until all outstanding payments are made.

4780 Special Casework Procedures for Emergency Care

Revision 17-1; Effective March 15, 2017

4781 Case Worker Assessment

Revision 17-1; Effective March 15, 2017

Respond to a request for Emergency Care (EC) on the same day the report is received. If an individual is in an emergency situation because he needs a home and no other care arrangement is available, determine whether he meets the remaining eligibility criteria for EC. If he does, complete the eligibility determination process within one workday after he enters the facility.

An individual who moves into a Residential Care (RC) facility or an Adult Foster Care (AFC) home for EC must meet eligibility requirements for EC and meet the mental and physical characteristics specified in Appendix VIII, Residential Care and Emergency Care Mental and Physical Characteristics. If necessary, consult the regional nurse.

4782 Immediate Placement

Revision 17-1; Effective March 15, 2017

To expedite the individual's move into the facility, make the referral by telephone. If space is available, help him and his caregivers arrange for transportation to the Adult Foster Care (AFC) home or the Residential Care (RC) facility. If the case worker determines that the individual does not meet the eligibility criteria and the appropriate characteristic criteria for Emergency Care (EC), help him make other arrangements. An ineligible individual must leave the EC facility within five days of the date he entered.

The provider is entitled to payment for EC services for up to five days after individual entry, regardless of the applicant's eligibility status.

If the provider determines that the individual's needs exceed the facility's capability under its licensed authority, the provider may request an additional review by the supervisor in consultation with the regional nurse. Regional staff are responsible for developing review procedures. The case worker is responsible for making the final decision on the individual's appropriateness for RC services.

4783 Length of Stay

Revision 17-1; Effective March 15, 2017

Residential Care (RC) is provided for up to 30 days while you seek a permanent care arrangement within the initial 30-day period. Obtain your supervisor's approval to extend Emergency Care (EC) beyond 30 days. Obtain this approval before the first 30-day period expires.

Note: An extension must not exceed 30 days.

4800, Reserved for Future Use

Revision 17-1; Effective March 15, 2017

4900, Special Services to Persons with Disabilities (SSPD)

4910 SSPD Program Description

Revision 17-1; Effective March 15, 2017

Special Services to Persons with Disabilities (SSPD) helps individuals with disabilities achieve habilitative or rehabilitative goals according to their service plans.

40 Texas Administrative Code (TAC) §58.73. The client's service plan is a document that contains the services, tasks, and frequency of services a particular client will receive. These services must be part of the provider agency's service array outline in the plan of operation.

40 TAC §58.75. The provider agency must develop the service plan.

Services included in the service plan consist of counseling, personal care and help with the development of skills needed for independent living in the community. Support services may include transportation and information and referral.

Services vary depending on the regional contract. The Community Care Services Eligibility (CCSE) supervisor can provide specific information about regional contracts. SSPD must not be authorized with any other CCSE service, with the exception of Emergency Response Services.

4920 SSPD Eligibility

Revision 17-1; Effective March 15, 2017

40 Texas Administrative Code §48.2914. To be eligible for special services to persons with disabilities, clients must meet the functional need criteria as set by the department. The department uses a standardized assessment instrument to measure the client's ability to perform activities of daily living. This yields a score, which is a measure of the client's level of functional need. The department sets the minimum required score for a client to be eligible, which the department may periodically adjust commensurate with available funding. The department will seek stakeholder input before making any change in the minimum required score for functional eligibility. Applicants may be admitted to the attendant services program only if their needs do not exceed the program's available services.

To be financially eligible for Special Services to Persons with Disabilities (SSPD), the applicant/individual must:

- be at least 18 years of age;
- have Medicaid or meet financial eligibility criteria for individuals in an institution; and
- have a functional assessment score of at least nine.

If the applicant/individual appears to need personal attendant services (PAS), use the guidelines in Appendix III-A, Appropriate/Inappropriate Client Characteristics Special Services to Persons with Disabilities — Attendant Services Program, for appropriate/inappropriate individual characteristics to decide whether the individual's needs can be met adequately by the SSPD PAS program. If services are inappropriate, follow adverse action procedures in Section 2810, Notice of Ineligibility or Service Reduction.

4930 Service Referral, Initiation and Delivery

Revision 20-3; Effective September 1, 2020

Special Services to Persons with Disabilities (SSPD) is currently available only in Regions 03, 04, 06 and 07. Refer interested persons in these locations by completing and sending to the provider Form 2101, Authorization for Community Care Services. Conduct reauthorizations annually according to the same procedure. When necessary, follow procedures in Section 2550, Identifying Individuals at Risk.

The provider agency must develop the service plan before services can be initiated.

- The provider agency must initiate services:
  - within 14 days after the referral date on the DHS Authorization for Community Care Services form; or
  - as required by the procedures developed in the DHS region where services are delivered.

The provider agency may deliver services in the following settings:

- an adult day care facility; or
- other settings approved by the contract manager.

5000, Utilization Review in Community Care Services Eligibility

5100, Overview of Utilization Review

5100 Overview of Utilization Review

Revision 17-1; Effective March 15, 2017

Effective March 1, 2009, the Texas Health and Human Services Commission (HHSC) implemented processes for utilization review (UR) in the Community Care Services Eligibility (CCSE) Services.

The UR process for CCSE includes concurrent reviews of a random sample of individuals receiving:

- Primary Home Care, and
- Community Attendant Services (CAS).

A concurrent review is a UR of an ongoing service (not during the application process) and the cases are randomly selected for review.

5110 Concurrent Reviews of Randomly Selected Active Cases

Revision 17-1; Effective March 15, 2017

Concurrent reviews are conducted on a random sample of active cases in Primary Home Care and Community Attendant Services (CAS). The utilization review (UR) nurse will contact the case worker and request all or a

portion of the documentation specified for reviews, and the case worker will provide the documentation within seven calendar days of the request. Depending on available information, the UR nurse may make a home visit and/or a Home and Community Support Services agency visit in addition to a desk review.

5200, Utilization Review Report to the Regions

5200 Utilization Review Report to the Regions

Revision 17-1; Effective March 15, 2017

Concurrent utilization review (UR) may have findings or no findings to report to the region.

If there are any findings or information that needs to be relayed to the region, the UR manager will email the completed UR tool to the regional director (RD) or his designee. Upon receipt of a UR tool indicating an action is required in the Findings/Summary section of the UR tool, the region can either:

- file an exception within five business days of receipt of the UR tool (See Section 5500, Utilization Review Exception Process, for guidelines); or
- contact the assigned case worker and require the UR recommended changes be implemented.

If there are no findings, the UR nurse will contact the case worker via telephone or email to inform the case worker there were no findings. The UR tool will not be forwarded to the region and no documentation is required in the case record for a concurrent review with no findings.

5210 Other Utilization Review Reporting Processes

Revision 17-1; Effective March 15, 2017

The Utilization Review (UR) nurse managers will also inform the regional director within one HHSC workday if the following situations are identified during the course of any UR:

- immediate threat to health or safety or medical emergency involving the individual;
- risk or threat of danger to an individual;
- abuse, neglect or exploitation of an individual;
- violation of individual rights, problem with quality of services, potential fraud, or potential threat to health and safety; and
- fraud, waste, and abuse of services. If indicated, the regional director will make a referral to the Office of Inspector General through established procedures and report the referral to the UR manager.

5300, Concurrent Review Process

5300 Concurrent Review Process

Revision 17-1; Effective March 15, 2017

For a concurrent review with findings for Primary Home Care or Community Attendant Services cases, the Utilization Review (UR) nurse will contact the case worker and request the documentation for review, and the case worker will provide the documentation within seven calendar days of the request. Depending on available information, the UR nurse may make a home visit and/or a Home and Community Support Services agency visit in addition to a desk review.

If a concurrent UR results in a recommendation to decrease, increase or deny services, or identifies a policy compliance or quality of care issue, the case will be reviewed by the UR nurse manager. If the UR nurse manager concurs, he will email the UR tool to the Regional Director (RD) of the region where the individual resides. If the RD has a designee, only the baseline information and the findings will be sent.

The RD or designee will review the case and will contact the UR nurse manager, state office UR manager, or both, for any additional findings information needed. UR staff will immediately provide additional requested information to the RD.

The RD has seven business days following receipt of information from the UR manager to respond to the UR finding. During this time, the RD may:

- agree with the UR finding and direct the regional staff to implement the finding, if indicated;
- discuss the finding with the UR manager through an informal exception process; or
- file a formal exception to the findings with state office.

If the RD attempts to contact the UR nurse manager by phone to discuss the findings in an informal exception process for a concurrent UR, and the UR nurse manager is not available, the UR nurse manager or designee will return the contact within two working days. If discussion (informal exception process) between the UR nurse manager and the RD results in changes to the UR finding, the UR nurse manager makes the changes on the electronic version of the UR tool and emails the final copy of the revised tool to the RD and case worker.

If the UR finding is not changed through the informal exception process and the RD disagrees with the final findings, the region can either:

- note the disagreement and direct regional staff to implement the finding, if indicated; or
- file a formal exception with state office. If a formal exception is filed, the RD will notify the UR nurse manager via phone or email of the date the exception is filed.

If the RD agrees with the UR recommendation, within one HHSC workday, the RD will notify the UR unit of the agreement and direct the case worker to implement the UR finding.

If no formal exception is filed and the UR finding recommends a change to the existing service plan, the seven business day time frame is part of the 14-calendar-day time frame a case worker has to complete a change request.

5310 Implementation of Utilization Review Findings

Revision 17-1; Effective March 15, 2017

The regional director (RD) or designee will notify the case worker to implement the Utilization Review (UR) findings and will provide the date for completion and any specific instructions regarding the UR findings. The case worker files a copy of the findings page(s) and all service planning documents completed by the UR nurse in the case record to support justification for the changes made to the individual's services. **Under no circumstances should the entire UR tool be filed in the case record.**

The case worker follows the time frames and procedures below to implement the UR findings.

The UR findings for concurrent reviews must be implemented within 14 calendar days of:

- the date the UR manager notifies the RD of the UR findings, unless a formal exception is made; or
- the date state office issues a decision on a formal exception.

To implement the UR findings, the case worker may be required to increase, decrease, add or terminate services. The case worker follows current policy for changing service authorizations. This includes:

- discussing the changes with the individual. For UR recommended changes to personal assistance services (PAS), the case worker must discuss the UR Form 2060, Needs Assessment Questionnaire and Task/Hour Guide, tasks and allocated time changes with the individual;
- documenting the discussion with the individual in the case record;
- completing Form 2065-A, Notification of Community Care Services, documenting the action taken;
- registering the change in the Service Authorization System Online (SASO), as applicable;
- sending a copy of Form 2065-A to the individual; and
- sending Form 2101, Authorization for Community Care Services, to the service provider.

The case worker must ensure all service criteria are met when completing the changes. The case worker must ensure the most current Form 2060 is entered in the SASO Functional Wizard and maintained in the case record.

5320 Individual Agreement or Disagreement with the Change

Revision 17-1; Effective March 15, 2017

The individual may agree or disagree with the Utilization Review (UR) findings when the case worker reviews the change request with the individual. The case worker completes the change action using the following guidelines:

- If the individual agrees with the addition/increase or termination/decrease of services, the case worker implements the change.
- If the individual does not agree with the addition/increase of services from the UR findings, the case worker does not implement the change. The case worker must document in the case record and on the UR tool why the change was not implemented. If the individual's decision places his health and/or welfare at risk, the case worker, in consultation with the regional nurse, must review the UR findings with the individual or primary caregiver to ensure the individual made an informed choice. The case worker must follow procedures in Section 2550, Identifying Individuals at Risk, and Section 2551, Case Worker Actions for Individuals at Risk.
- If the individual does not agree with the termination/decrease, the case worker must implement the UR findings. An exception to implementing the termination/decrease from the UR findings is allowable if the individual has experienced a condition or environmental change since the UR visit and the change would result in the individual's health and/or safety being jeopardized. The case worker must conduct an IDT meeting to review service needs and follow procedures for individuals at risk.

There may be instances where the individual's condition or circumstances have changed, without a threat to the individual's health and safety, since the UR visit and the individual's service plan must be revised to meet the needs of the individual. The case worker takes appropriate action to address the current needs, including reviewing personal assistance services hours or making a referral to the Home and Community Support Services provider for additional services, according to current procedures.

Advance notice must be given for any decisions that result in a reduction or termination of the individual's current services. The case worker documents the decision is based on "no unmet need for services" or "decreased need for service," as appropriate to the change. Refer to Form 2065-A, Notification of Community Care Services, instructions and Attachment A for denial reasons and appropriate comments.

5330 Provider Implementation of the Change

Revision 17-1; Effective March 15, 2017

Upon receipt of Form 2101, Authorization for Community Care Services, from the case worker, the service provider follows established procedures to implement the change request.

If the Home and Community Support Services (HCSS) provider has concerns about meeting an individual's needs based on the new service plan, the HCSS provider follows procedures outlined in Provider Information Letter (IL) 09-30, Implementation of Regional and Local Services (RLS) Utilization Review Program, dated Dec. 23, 2009, and IL 2007-06, Clarification of Licensing Rules and Contract Requirements Regarding Accepting Individuals with Complex Needs for Service, dated June 20, 2007.

Case workers follow current program enrollment policies, including conducting an interdisciplinary team meeting if needed, and assisting the individual with transferring to another provider when necessary.

5400, Reporting Implementation of the Utilization Review Findings

5400 Reporting Implementation of the Utilization Review Findings

Revision 17-1; Effective March 15, 2017

After the case worker implements the Utilization Review (UR) findings, the region must complete the **Completed by Region** items in the Findings/Summary section of the UR tool to indicate the following:

- **Date of regional exception to SO:** If applicable, enter the date the exception was sent to state office for review and decision.
- **CM action complete date:** Enter the date the case worker completed the UR recommended change. This should be the date the change was entered in the Service Authorization System Online (SASO) and the notice was sent to the individual receiving services.
- **Effective date of action:** Enter the date the UR change is effective. This should be the same effective date entered in SASO and on the notice to the individual receiving services.
- **Regional Comments/Reason for Exception:** Enter any regional observations or conclusions. If an exception was filed, note the rule and policy basis for the exception, and the outcome of the state office review.

The completed UR tool must be returned by email to the referring UR unit manager within five business days of implementation of the UR recommended change. A copy of the Baseline Information and Findings page(s), not the entire tool, and all service planning documents completed by the UR nurse must be filed in the case folder.

5500, Utilization Review Exception Process

5500 Utilization Review Exception Process

Revision 17-1; Effective March 15, 2017

If the regional director disagrees with the Utilization Review (UR) recommendation, he will refer the case via email and telephone within five workdays to the manager of the Community Care Services Eligibility (CCSE) unit at state office.

The state office CCSE unit manager will then make a final decision on whether to implement, revise or reverse the UR recommendation. The state office CCSE decision will be made within five workdays of the referral, and the state office CCSE unit manager will notify the regional director, the state office CCSE Regional Support and Program Implementation unit manager and the state office UR manager within one working day of the decision.

The region must implement the state office decision within 14 days of the region being notified of the decision.

6000, Service Delivery Options

6100, Agency Option

6110 Description

Revision 17-1; Effective March 15, 2017

Under the Agency Option (AO), the provider is responsible for managing the day-to-day activities of the attendant and all business details. Most individuals select the AO model because of the simplicity and convenience of receiving services. For example, under AO the individual is not responsible for:

- locating qualified attendant(s) to provide services;
- any negligent acts or omissions by the attendant(s), nor liable for those acts;
- handling all conflicts with the attendant(s);
- any business details related to service delivery; and
- training the attendant(s).

6120 Selection of a Service Delivery Option

Revision 17-1; Effective March 15, 2017

All service delivery options are presented to the applicant/individual at the initial assessment and each subsequent annual recertification. Use Appendix XXXI, It's Your Choice: Deciding How to Manage Your Personal Assistance Services, to assist the individual or applicant in making his service delivery decision.

Obtain a signature on Form 1584, Consumer Participation Choice, and Form 2307, Rights and Responsibilities, indicating the individual's choice of options. The individual's signature on Form 2307 is acknowledgement of the presentation of all service delivery options. It is not necessary to complete Form 1584 at subsequent recertifications unless the individual changes his choice of service options.

If, at any time during the year, a current individual calls requesting information on service delivery options, present the information to the individual at that time.

6121 Individual Decision

Revision 17-1; Effective March 15, 2017

Maintain Form 1584, Consumer Participation Choice, in the individual's case record. Make sure the individual understands that he may request a service delivery option change at any time by contacting the case worker.

6130 Casework Procedures

Revision 17-1; Effective March 15, 2017

Casework instructions throughout the handbook assume that the individual has selected the Agency Option (AO) for service delivery, with the exception of:

- Section 6200, Service Responsibility Option (SRO);
- Section 6300, Consumer Directed Services (CDS); and
- Section 6400, State of Texas Access Reform Plus (STAR+PLUS) Managed Care.

No special procedures are necessary for the AO. Consult the above-referenced sections if the applicant or individual requests another service delivery option.

6200, Service Responsibility Option

6210 SRO Description

Revision 17-1; Effective March 15, 2017

The Service Responsibility Option (SRO) is a service delivery option that empowers the individual to manage most day-to-day activities. This includes supervision of the individual providing personal attendant services through:

- Community Attendant Services (CAS),
- Family Care (FC), and
- Primary Home Care (PHC).

The individual decides how services are provided. It leaves the business details to a provider agency of the individual's choosing. See Appendix XXXI, It's Your Choice: Deciding How to Manage Your Personal Assistance Services, for a comparison of all available service delivery option features.

6220 SRO Roles and Responsibilities

Revision 17-1; Effective March 15, 2017

Form 1582-SRO, Service Responsibility Option Roles and Responsibilities, specifies the roles and responsibilities assigned to the individual, provider and case worker. They receive and sign Form 1582-SRO indicating their agreement to accept the SRO responsibilities.

6221 Case Worker Responsibilities

Revision 17-1; Effective March 15, 2017

The intake, referral and assessment procedures for the Service Responsibility Option (SRO) are handled in the usual way. The case worker is responsible for:

- ensuring the individual has an opportunity to make an informed choice by providing an objective and balanced review of the options, and
- monitoring the quality of services and service delivery.

Once the assessment is complete, the case worker is required to:

- inform the individual about all options for managing personal attendant services, and
- review Appendix XXXI, It's Your Choice: Deciding How to Manage Your Personal Assistance Services, with the individual to determine if the SRO is an appropriate choice.

In addition, the case worker's responsibilities include:

- presenting all service delivery options;
- documenting the individual's choice on Form 1584, Consumer Participation Choice;
- explaining SRO rights, responsibilities and resources to the individual;
- presenting the SRO service provider list and the SRO support consultation provider to the individual;
- presenting the list of providers that are offering the SRO;
- making a referral to the provider(s) selected by the individual;
- processing the individual's request to change service delivery options;

- redeveloping the service plan when an individual's needs change;
- serving as a resource if the individual has health or safety concerns, or worries about being taken advantage of by the attendant;
- convening an interdisciplinary team meeting in instances where the individual:
    - has health and safety concerns,
    - is having difficulty selecting or keeping an attendant, or
    - has other issues relating to services that cannot otherwise be resolved; and
- monitoring services in accordance with Section 6232, Monitoring.

6222 Provider Responsibilities

Revision 17-1; Effective March 15, 2017

The provider is the attendant's employer and handles the business details (for example, paying taxes and doing the payroll). The provider also orients attendants to provider policies and standards before sending them to individuals' homes. The Service Responsibility Option (SRO) provider agency will:

- discuss and negotiate potential back-up plans for those times when the attendant is absent from work;
- send a maximum of three attendants, including any individuals recommended by the individual, for the individual to review;
- explain to the selected attendants that the provider is the employer of record and that the individual is the day-to-day worker;
- provide agency timesheets to the individual and orient the individual to the timesheet submission process, including how frequently timesheets must be completed;
- receive and process attendant timesheets;
- send a substitute attendant within the required time frame, ensuring that a break in services:
    - does not occur (for individuals with priority status), or
    - does not extend past 14 days (for individuals without priority status);
- send new attendants within the required time frame to interview at the individual's request; and
- orient the individual to the provider's attendant evaluation process, including forms and the schedule for evaluating attendants.

6223 Individual Responsibilities

Revision 17-1; Effective March 15, 2017

The individual or designated representative (DR) is responsible for most of the day-to-day management of the attendant's activities, beginning with interviewing and selecting the person who will be the attendant. To participate in the Service Responsibility Option (SRO), the individual must be capable of performing all management tasks as described below, or may identify a DR to assist or to perform those management tasks on the individual's behalf. The individual is responsible for:

- choosing the SRO service delivery option;
- choosing the SRO service and support provider(s);
- meeting with the SRO support provider within 14 days of selecting the SRO;
- coordinating with the provider supervisor as part of the service planning process by:
    - negotiating about the type, frequency and schedule of quality assurance contacts,
    - discussing any concerns about care management,
    - requesting on-site assistance while orienting a new attendant, if desired, and
    - negotiating to develop a back-up plan for when the attendant cannot come to work;
- selecting personal attendant(s) from candidates sent by the provider (including someone the person recommends to the provider supervisor or someone who has completed the provider pre-employment screen);

- informing the provider supervisor within 24 hours:
  - of the personal attendant selected,
  - if the attendant gives notice,
  - if the attendant quits, or
  - if the individual wants to dismiss the attendant;
- training the personal attendant on how to safely perform the approved tasks in the manner desired;
- supervising the personal attendant;
- ensuring that the attendant only does the tasks authorized in the service plan and works only the number of hours authorized in the service plan;
- complying with provider agency payroll and attendant policies;
- evaluating the attendant's job performance at the time designated by the provider;
- reviewing, approving and signing provider agency employee timesheets after the attendant completes them;
- ensuring that employee timesheets are submitted to the provider within the time frames designated by the provider;
- notifying the provider agency as soon as possible if the personal attendant will be absent and a substitute is needed;
- taking responsibility for liability risk if the individual or attendant is injured while doing tasks under the individual's training and supervision;
- using the following complaint procedures:
  - If the provider is not fulfilling the expected responsibilities, address those issues directly with the agency. If the agency and the individual are not able to resolve the concerns/issues, the individual should contact the case worker.
  - If concerns and issues are still not resolved, the individual may select another provider. The individual must contact the case worker to transfer from one agency to another. The case worker will make all the necessary arrangements for the transfer;
- notifying the case worker and/or provider supervisor of any health or safety concerns or worries about being taken advantage of by the attendant (the individual may, at any time, request an interdisciplinary team (IDT) meeting); and
- notifying the case worker and provider supervisor if a change to either the Agency Option or Consumer Directed Services is desired. An IDT meeting will be held to plan for the change.

6230 Casework Procedures

Revision 17-1; Effective March 15, 2017

The Service Responsibility Option (SRO) is not a different service; it is a service delivery option. All financial and non-financial eligibility criteria, including unmet need and "do not hire" policy, continue to apply for each program area. Unless otherwise stated in this section, casework procedures are not impacted by the individual's choice of SRO.

Complete all forms currently required, including the assessment of functional needs on Form 2060, Needs Assessment Questionnaire and Task/Hour Guide. Continue to identify any caregivers who are currently providing for the individual's needs. As discussed in Section 2514, Who Cannot Be Hired as the Paid Attendant, current caregivers are designated as individuals who may not be hired as paid attendants for services they are already providing. This information must be clearly explained to the individual, and the individual must be advised that the information will be relayed to the provider.

6231 Initial Authorization of Services

Revision 17-1; Effective March 15, 2017

The individual's decision to receive services using the Service Responsibility Option (SRO) does not change the manner in which initial services are authorized. See Section 2600, Authorizing and Reassessing Services, for specific information.

6232 Monitoring

Revision 17-1; Effective March 15, 2017

All monitoring for Service Responsibility Option (SRO) individuals is done according to the mandated schedule for their specific services (see Section 2710, Monitoring Visits and Contacts). When health and safety issues arise:

- discuss the issues with the agency;
- talk to the individual to determine if the issues can be resolved; and
- if the issue cannot be resolved, convene an interdisciplinary meeting.

Because the individual now shares responsibility for service delivery, the case worker, in addition to other monitoring requirements, must monitor the individual's:

- satisfaction with the SRO, and
- ability to comply with SRO requirements.

If it is evident that the individual is having difficulty in the management of SRO responsibilities, the case worker will:

- consult the provider; and
- advise the individual of the option to transfer back to the agency service delivery option.

6233 Procedures for Ongoing Cases

Revision 17-1; Effective March 15, 2017

Individuals will be offered the Service Responsibility Option (SRO) option annually, and may request a transfer to the SRO at any time. Additionally, the SRO must be presented to ongoing individuals at each annual reassessment or upon request. If the individual is interested in transferring to the SRO, the individual will sign Form 1582-SRO, Service Responsibility Option Roles and Responsibilities.

Ensure that the individual understands the responsibility he is assuming. Send Form 2067, Case Information, to the provider to advise it of the individual's selection. Notify the provider that that the individual will be contacting it for training. Request that the agency advise the case worker, using Form 2067, when the transition planning is complete. Negotiate a start date with the individual and the provider.

6300, Consumer Directed Services

6310 Description

Revision 17-1; Effective March 15, 2017

The Consumer Directed Services (CDS) option gives the individual more control over his or her personal attendant services by making him or her the attendant's employer. The individual hires and manages the attendant(s), and selects a Financial Management Services Agency (FMSA) to do the employee's payroll and federal and state tax payments. The individual also sets the wages and benefits for his or her attendant. See

Appendix XXXI, It's Your Choice: Deciding How to Manage Your Personal Assistance Services, for a comparison of available service delivery options.

Staff will encounter terminology that is specific to the CDS option, including the following.

- **Agency Option (AO)** — A service delivery option in which the provider manages all aspects of service delivery with input from the individual and case worker.
- **Annual service plan (ASP)** — A 12-month plan that identifies:
  - the individual's specific needs;
  - the annual cost of meeting those needs; and
  - how those needs will be met by the individual's employees and the FMSA.

See 6332.2, Calculation of the Annual Service Plan. Separate from “service plan” or “service planning,” the term ASP is used to determine the amount of service an individual will receive.

- **Designated representative (DR)** — A willing adult appointed by the individual to assist with or perform the individual's required responsibilities to the extent approved by the individual. This individual is not an employee or the legally authorized representative (LAR) and is not paid for his or her services. The DR is not the legally recognized employer.
- **Employee** — A person employed by the individual through a service agreement to deliver program services. This individual is paid an hourly wage for those services.
- **Employer** — The individual or the LAR who chooses to participate in the CDS option.
- **Financial management services (FMS)** — Services delivered by the FMSA to the individual or LAR, such as orientation, training, support, assistance with and approval of budgets, and processing payroll and payables on behalf of the employer.
- **Financial Management Services Agency (FMSA)** – An agency contracted by the Texas Health and Human Services Commission (HHSC) to provide financial management to support the delivery of services to CDS individuals.
- **Legally authorized representative (LAR)** — A person required by law to act on behalf of an individual who is:
  - for adults, a court-appointed guardian.
  - for individuals under 18 years of age, a parent, adopted parent, step-parent, foster parent or Child Protective Services (CPS). If parental rights have been revoked, the court-appointed guardian must be the LAR.
  - Any mention of the individual applies to the LAR.
- **Service planning team** — A term in CDS rules that refers to the interdisciplinary team (IDT). An IDT is a designated group of people who meet when the need arises to discuss service delivery issues. Although other individuals may be asked to participate when needed, the IDT must include:
  - the individual, the individual's representative or both (if there is an LAR, he or she would be a required participant);
  - a provider representative; and
  - an HHSC representative.
- **Service Responsibility Option (SRO)** — A service delivery method that gives the individual control over most of his or her attendant services, while leaving the business details to a provider of the individual's choosing.
- **Support consultation** — An optional service available to CDS individuals that provides a higher level of assistance and training than what is available through FMS. Support consultation helps the individual meet the employer responsibilities of the CDS option.

6311 Risks and Advantages of the CDS Option

Revision 17-1; Effective March 15, 2017

Before the individual can make an informed choice regarding service delivery options, it is essential that he or she understand the risks and advantages of the Consumer Directed Services (CDS) option.

6311.1 Advantages of CDS Service Delivery

Revision 17-1; Effective March 15, 2017

When using the Consumer Directed Services (CDS) option, the individual:

- has control over who provides services and when services are delivered;
- can offer the attendant(s) benefits such as bonuses, vacation pay, sick pay and insurance;
- can control the rate of pay for attendant(s) within the spending limits of the unit rate for the service;
- can hire backup attendants, if necessary;
- can train and supervise the attendant(s);
- can choose a Financial Management Services Agency that will pay attendants and file reports with governmental agencies on their behalf;
- may appoint someone to assist with employer responsibilities or to perform employer responsibilities for them; and
- may get additional training and assistance from a CDS support advisor to be a successful employer in the CDS option.

6311.2 Potential Risks Associated with CDS

Revision 17-1; Effective March 15, 2017

Some of the risks associated with the Consumer Directed Services (CDS) option include:

- The individual controls hiring, training, managing and firing employees. The attendants are not the employees of the Financial Management Services Agency (FMSA), Texas Health and Human Services Commission (HHSC), any state or federal agency, or other contracted provider. The individual is solely responsible and liable for his or her own negligent acts or omissions, as well as those of the employee(s), service provider(s) and the designated representative.
- The individual is responsible for handling all conflicts with the attendant. The FMSA or HHSC case worker is not involved.
- The individual is required to keep certain paperwork, as identified by the FMSA. The individual must safely store the documentation for the length of time specified by the FMSA.
- The individual is ultimately responsible for payroll taxes owed to the Internal Revenue Service and the Texas Workforce Commission, and is liable for any taxes the FMSA fails to pay.
- If the individual is unable to find attendants, backup attendants or out-of-home respite providers, there is no home health agency to provide backup services.

6320 Roles and Responsibilities

Revision 17-1; Effective March 15, 2017

Under the Consumer Directed Services option, the roles and responsibilities of the individual, case worker and provider differ from other service delivery options.

6321 Individual Responsibilities

Revision 17-1; Effective March 15, 2017

To participate in the Consumer Directed Services (CDS) option, the individual must be:

- capable of performing all required employer responsibilities upon completion of training and transition planning provided by the Financial Management Services Agency (FMSA), or
- able to appoint a designated representative (DR) to assist with the responsibilities of being an employer in the CDS option.

Required Employer Responsibilities

An employer is responsible for:

- service planning with the individual's service planning team;
- budgeting allocated program funds in the individual's service plan for services to be delivered through the CDS option;
- determining compensation for service providers within the service rate and spending limits established by the Texas Health and Human Services Commission;
- recruiting, screening, hiring, and training qualified service providers;
- managing and terminating service providers; and
- planning and arranging for backup services.

An employer or DR must hire or retain service providers in accordance with qualifications and other requirements of the individual's program.

Individuals receiving services in the CDS option also have the following responsibilities:

- reviewing, approving and signing timesheets;
- submitting employee timesheets, receipts, invoices and employment forms to the FMSA in a timely manner;
- informing the FMSA of all employees the individual hires, fires or otherwise terminates;
- resolving employee concerns and complaints;
- maintaining a personnel file on each employee; and
- finding appropriate out-of-home respite providers and negotiating a payment rate.

Designated Representative

40 Texas Administrative Code (TAC) §41.205, Employer Appointment of a Designated Representative

40 TAC §41.109(g), Enrollment in the CDS Option

The DR signs an agreement to perform employer functions on behalf of the CDS individual. The individual remains the employer of record and assumes liability. The FMSA can assist the individual in completing the forms for designation of the DR. The DR may not be hired as the personal attendant or be paid for his/her duties.

6322 Case Worker Responsibilities

Revision 17-1; Effective March 15, 2017

The case worker has specific responsibilities regarding Consumer Directed Services (CDS), which include:

- explaining and offering the CDS option;
- reviewing the self-assessment tool (Form 1582, Consumer Directed Services Responsibilities) with the individual to help determine if the CDS option is right for him or her;
- assessing service needs;
- coordinating development of the service authorization;

- presenting the list of Financial Management Services Agencies (FMSAs) participating in the area;
- informing the individual of his or her rights, responsibilities and resources;
- redeveloping service authorizations when the individual's needs change;
- reviewing each quarterly status report received from the FMSA;
- contacting the FMSA or individual (as appropriate) if there are issues (for example, 50 percent of funds authorized on the annual service plan are already expended on the first quarterly report);
- being a resource if the individual has health, safety or exploitation concerns; and
- monitoring and reviewing the individual's satisfaction with the services provided by the FMSA.

6322.1 Casework Procedures

Revision 17-1; Effective March 15, 2017

Consumer Directed Services is not a service; it is a service delivery option. All financial and non-financial eligibility criteria must be met in order to receive personal attendant services. In addition to the procedures specified in the following sections, customary casework procedures apply.

6322.2 Presentation of the CDS Option

Revision 17-1; Effective March 15, 2017

The case worker is responsible for presenting information regarding the Consumer Directed Services (CDS) option to the individual. To assist the individual in making his or her decision, the case worker must carefully present both the advantages and risks associated with the CDS option.

Case workers must follow 40 Texas Administrative Code §41.109, Enrollment in the CDS Option, when presenting the CDS option to an individual.

The case worker thoroughly explains all information on Form 1581, Consumer Directed Services Option Overview, to ensure the individual understands the differences between the CDS and agency options.

6323 FMSA Responsibilities

Revision 17-1; Effective March 15, 2017

40 Texas Administrative Code (TAC) §41.309, Financial Management Services and Employer-Agent Responsibilities

40 TAC §41.317, CDSA Reports

6330 Individual Decision

Revision 20-2; Effective June 1, 2020

Case workers must follow 40 Texas Administrative Code §41.109(c)-(e), Enrollment in the CDS Option, to enroll an applicant or recipient into the CDS option using a Community Care Services Eligibility (CCSE) program.

To enroll in the CDS option, the applicant or recipient must complete the following forms:

- Form 1582, Consumer Directed Services Responsibilities, including Page 4,Consumer Self-Assessment;
- Form 1583, Employee Qualification Requirements;

- Form 1584, Consumer Participation Choice;
- Form 1586, Acknowledgement of Information Regarding Support Consultation Services in the Consumer Directed Services (CDS) Option, if the service is available in the applicant's or recipient's program; and
- Form 1740, Service Backup Plan.

Note: The case manager or service coordinator must review the service backup plan when services are initiated and annually thereafter. If the backup plan requires no revisions, the case manager or service coordinator may initial and date the current backup plan. An applicant or recipient who is not able to complete the self-assessment portion of Form 1582 must appoint a designated representative (DR) in order to participate in the CDS option.

Assist the applicant or recipient in completing the self-assessment. The applicant or recipient must document their ability to meet the following criteria needed to become a CDS employer:

- locate attendants for hire in the community;
- train and supervise attendants to perform each task on the service plan;
- locate and arrange for backup staff and out-of-home respite services, if needed;
- handle conflict with attendants; and
- be willing to accept additional training or help with employer responsibilities, if needed.

If the applicant or recipient is not able to meet all the CDS employer criteria, they must appoint a DR to assist with employer responsibilities. See 6321, Applicant or Recipient Responsibilities, for more information on the requirements of hiring a DR, if needed.

If the applicant or recipient wants to proceed and meets the criteria, or has appointed a DR, present Form 1586 and Form 1583.

Whether the person is interested in the CDS option at the initial presentation or not, have the person sign Form 1584. File the form in the person’s case record. Make sure the person not interested in CDS understand that this option is available at any time, and they must call the case worker to request the CDS option.

6331 Selection of the Financial Management Services Agency (FMSA)

Revision 17-1; Effective March 15, 2017

The Texas Health and Human Services Commission (HHSC) case worker or the individual may go to the HHSC website for a choice list of FMSA. The list, which allows individuals to search for FMSAs by county, can be accessed at: https://hhs.texas.gov/doing-business-hhs/provider-portals/long-term-care-providers/consumer-directed-services-cds.

Under the menu on the left, select “FMS Agencies” and a list of HHSC programs will appear. Select “PHC Consumers.” On the top of the page is a drop-down list of Texas counties. After selecting the individual’s county of residence, click the button labeled "Search." This will create a list of FMSAs serving the selected county. The FMSA’s address does not have to be located in the individual’s county of residence to be able to serve the individual. As long as the FMSA is listed in the program and county list, the individual may select the agency as his/her FMSA. This list can be printed and provided to individuals choosing an FMSA.

FMSAs are not required to provide services to all referred individuals. In rare instances, such as anticipation of contract termination or placement on a vendor or individual hold, an FMSA may not accept individual referrals. FMSAs contract with HHSC to provide financial management services (FMS) to individuals choosing the Consumer Directed Services (CDS) service delivery option. FMS includes employer orientation, assistance with and approval of budgets, and processing payroll and payables on behalf of the employer. An FMSA must make available support consultation services if this service is available in the individual's respective program, and is

requested by the individual. Support consultation offers employer training and support beyond the FMS provided by the FMSA.

Applicants and individuals use Form 1584, Consumer Participation Choice, to identify the choice of service delivery option and choice of Home and Community Support Services Agency (HCSSA) or FMSA, as appropriate. A list of FMSAs in each county is available on the HHSC website to assist the applicant or individual in making this choice. If the applicant or individual chooses CDS, the case worker has five working days from receipt of Form 1584 by an individual, or from receipt of Form 1584 and determination of eligibility for an applicant, to provide the required documentation to the selected FMSA. If the selected FMSA is not able to provide services to the applicant or individual, the FMSA must send the case worker written notification stating this, using Form 2067, Case Information. Receipt of written notification will prompt the case worker to offer the applicant or individual another choice of FMSA and to provide the newly selected FMSA with the required documentation, following the same procedures outlined above.

6332 Initial Authorization of Services

Revision 17-1; Effective March 15, 2017

Before receiving services under the Consumer Directed Services (CDS) option, applicants must:

- be determined eligible for services; and
- have a program service plan developed.

Note: Individuals do not have to receive services through the agency option before receiving services through the CDS option they may go directly to the CDS option.

40 Texas Administrative Code §41.111, Service Planning in the CDS Option

During the initial home visit, provide applicants who choose CDS with the choice list of available Financial Management Services Agencies (FMSAs) for their program and county. After the applicant has made a decision, the applicant must sign the regional contract list indicating his or her FMSA selection.

Once an eligibility determination is made, and pre-enrollment requirements have been met (See 6332.1 that follows), authorize services on Form 2101, Authorization for Community Care Services. In the comments section, note the total annual hours at the current rate per hour and the total dollar amount for the annual service plan, as detailed in 6332.2, Calculation of the Annual Service Plan. Send Form 2065-A, Notification of Community Care Services, to the applicant as notification of eligibility.

6332.1 Pre-Enrollment Requirements

Revision 17-1; Effective March 15, 2017

Case workers must follow 40 Texas Administrative Code §41.401, Enrollment Process, to enroll an individual into the Consumer Directed Services (CDS) option.

Form 2101, Authorization for Community Care Service, must include the:

- hours of service being authorized in the period; and
- hourly payment rate for the service as specified in 6332.2, Calculation of the Annual Service Plan.

The case worker must contact the Financial Management Services Agency (FMSA) to request an initial orientation for the individual and send Form 1584, Consumer Participation Choice, to the FMSA to notify it that the individual has selected the agency. Request that the FMSA advise by Form 2067, Case Information, when the initial orientation is complete.

Once this notification is received, negotiate a CDS begin date with the individual and the FMSA. Send Form 2101, Authorization for Community Care Services, to the individual and the FMSA.

- Authorize the monthly Financial Management Services (FMS) administrative fee using Service Authorization System Service Code 63V. For Community Attendant Services (CAS) applications and recertifications, the FMS fee must be authorized by the regional nurse. Request authorization for the FMS fee from the HHSC designated regional nurse.
- Use the appropriate service code below to initiate CDS Services:
  - 17 V – Primary Home Care (PHC)
  - 17 CV – Family Care (FC)
  - 17 DV – CAS

6332.2 Calculation of the Annual Service Plan

Revision 22-2; Effective June 1, 2022

Consumer Directed Services (CDS) is authorized in the Service Authorization System Online Wizards (SASOW) using an annual service plan (ASP).

Assess the applicant's need for services using Form 2060, Needs Assessment Questionnaire and Task/Hour Guide. The ASP amount is calculated using the required weekly service units determined using Form 2060 and the current CDS hourly provider rate.

Note: In this example, the $9.50 amount is a **fictitious number** used for demonstration purposes only. The current CDS service rate can be accessed at the following Texas Health and Human Services Commission website: pfd.hhs.texas.gov/long-term-services-supports/primary-home-care-phc.

After an applicant is determined eligible for Primary Home Care (PHC), Community Attendant Services (CAS) or Family Care (FC) services and selects the CDS delivery option, use the following steps to calculate the ASP.

Step	
1	Determine the total number of required weekly service units (personal attendant services per week).
2	Enter the required weekly service needs in SASOW. SASOW automatically calculates the annual services needs amount by multiplying the weekly service needs over a 53-week period. SASOW will use the CDS hourly provider rate and the annual service needs amount to calculate the total dollar amount of the ASP.
3	Enter the ASP information, the total weekly services hours, the total annual hours, the current CDS hourly rate = the total dollar amount for the ASP, in the comments section for Form 2101, Authorization for Community Care Services. **Example**: CDS authorized 10 hours per week for a total of 530 hours of service at $9.50 per hour = $5,035.00 total for the ASP.
4	Print Form 2101, showing the CDS ASP.

In addition to the budgeted ASP, a CDS monthly administrative fee must be authorized using Service Code 63V for PHC and FC cases.

For initial and ongoing CAS cases, request authorization from the HHSC regional nurse prior to initial and renewal of the services using the CDS option.

Financial Management Services Agency (FMSA) Procedures

To notify the FMSA agency that it was selected to provide CDS administrative services, send:

- Form 2067, Case Information; and
- Form 1584, Consumer Participation Choice.

After receiving notice, the FMSA:

- schedules a face-to-face interview with the applicant;
- provides training to the applicant covering all orientation material;
- assists the applicant in developing a budget for program services;
- provides information and assistance in completing the criminal history and other required registry checks on the potential attendant; and
- completes all required forms to initiate services under the CDS option.

6332.3 Monitoring CDS Service Initiation

Revision 18-1; Effective June 15, 2018

All Consumer Directed Services (CDS) cases must be monitored either by face-to-face home visit or by telephone within 30 days of the CDS service delivery start date. In all other situations, CDS cases are monitored in accordance with program guidelines, as described in 2700, Service Monitoring, Changes and Transfers. At all mandated contacts, case workers must complete:

- Form 2314, Satisfaction and Service Monitoring; and
- Form 2314-C, Consumer Satisfaction Interview — Consumer Directed Services Addendum.

Any service problems noted must be communicated to the Financial Management Services Agency using Form 2067, Case Information. The case worker may recommend that the employee complete Form 1741, Corrective Action Plan, and additional training if necessary. Concerns about fiscal management must be noted and resolved with the agency. Consult the contract manager if the situation involves contract issues.

6332.4 Responsibility for Responding to Questions

Revision 20-4; Effective December 1, 2020

For questions about the Consumer Directed Services (CDS) option, use the following chart to determine who is responsible for responding to questions from the applicant, recipient or the applicant's or recipient's family.

For questions about the CDS option related to the Financial Management Services Agency (FMSA), refer the recipient to their FMSA. Do not attempt to answer the question or contact the FMSA on behalf of the recipient.

Contact the CDS operations specialist for general non-case specific questions about the CDS option.

CDC Contact Chart

Issue or Question Related to:	Contact:

Issue or Question Related to:	Contact:
• service authorization; • CDS rates (unrelated to wages); • CDS option at enrollment and annually thereafter; • CDS backup service plan requests and approvals; • approve or request a corrective action plan for a recipient who is having difficulty with the CDS option; • program rules, including those specifically related to the CDS option; • service plan, including related forms; • Interdisciplinary Team meetings, including those meetings needed to address CDS issues; • changes in service delivery options at the recipient's request or through involuntary termination of the CDS option; or • changes in FMSA.	Refer to state office CDS program specialists
• initial CDS orientation; • employer-related paperwork; • issues with service delivery; • ongoing training and support related to employer issues; • CDS budget; • criminal history checks; • verification of licensing credentials of potential service providers; • payroll withholdings, deposits, reporting, timesheets, receipts, invoices and payment to service providers; • budget status report; • support consultation; or • support advisor.	Refer to FMSA FMSA must contact CDS policy and operations specialists in the Office of Policy and Program
• billing and payment issues	Refer to the regional CMS coordinator

6333 Service Initiation Directly into CDS for PHC or CAS

Revision 17-1; Effective March 15, 2017

Applicants for Personal Attendant Services (PAS) through Primary Home Care (PHC) or Community Attendant Services (CAS) who choose the Consumer Directed Services (CDS) option may begin services directly in CDS without going through a Home and Community Support Services Agency (HCSSA).

If a PHC or CAS applicant chooses to start services through the CDS option, it is the CDS employer's responsibility to obtain the completed Form 3052, Practitioner's Statement of Medical Need. The employer may be the applicant or the legally authorized representative (LAR). The case worker provides a copy of Form 3052 and Form Instructions to the applicant with a return envelope and instructions on returning the form to the case worker within 14 calendar days. It is the case worker's responsibility to verify that the form is completed. If not, it is returned to the employer for correction or completion. If the applicant is applying for CAS, the case worker will forward the completed Form 3052 to the HHSC regional nurse, upon receipt.

It is the CDS employer's responsibility to get Form 3052 to the practitioner and have it completed and signed by the practitioner. The CDS employer will then send the form to the selected Financial Management Services Agency (FMSA) to complete Part II, Provider's Statement. The FMSA returns the form to the CDS employer, and it is the employer's responsibility to return the form to the case worker. Services will not be authorized until Form 3052 is signed by both the practitioner and the FMSA, is returned, and the applicant meets all eligibility requirements.

All other requirements remain the same, as outlined in 6300, Consumer Directed Services. These procedures are also applicable to individuals who are on the CDS option in another program and are transferring to PHC or CAS. This includes individuals on Family Care or Personal Care Services (PCS) through the Comprehensive Care Program (CCP).

6333.1 Authorizing CDS for Ongoing Individuals

Revision 17-1; Effective March 15, 2017

When the individual receiving services selects the agency option initially and then selects Consumer Directed Services (CDS), he or she will be transitioned to the CDS service delivery option. The case worker must present the official list of all Financial Management Services Agencies (FMSAs) found at the HHSC website: https://hhs.texas.gov/doing-business-hhs/provider-portals/long-term-care-providers/consumer-directed-services-cds/fmsa-agencies and the following forms:

- Form 1581, Consumer Directed Services Option Overview;
- Form 1582, Consumer Directed Services Responsibilities;
- Form 1583, Employee Qualification Requirements;
- Form 1584, Consumer Participation Choice; and
- Form 1586, Acknowledgement of Information Regarding Support Consultation Services in the Consumer Directed Services Option.

The official list must be used as the FMSAs routinely cover multiple regions. When the CDS employer selects an FMSA, the employer signs Form 1584, indicating the choice to use the CDS option and the selected FMSA.

Use the appropriate Service Authorization System code(s) created for use with the CDS option, as provided in 6332.1, Pre-Enrollment Requirements.

Complete Form 2101, Authorization for Community Care Services, to terminate Agency Option services and create another Form 2101 authorizing CDS services. The CDS start date is the date negotiated with the individual and FMSA. Service through the provider agency must be terminated the day before the start date of CDS. There must be no gap in coverage dates.

Send Form 2065-A, Notification of Community Care Services, advising that current services are terminating and CDS services beginning. Time frames in Appendix IX, Notification/Effective Date of Decision, apply.

6333.1.1 Different Program Annual Review and Annual Service Plan Dates

Revision 17-1; Effective March 15, 2017

If an individual decides to transition to the Consumer Directed Services (CDS) option after being on the agency option, the dates for the CDS annual service plan (ASP) will most likely be different than the date for the program annual review.

The case worker must keep the program annual review date the same if the annual review date and the ASP date are within different months. (The next annual review date will be 12 months from the date of the previous annual review date.)

The case worker must complete a separate service authorization wizard in the Service Authorization System Online (SASO) at the end of the ASP year to renew the CDS funds for another year. The case worker should enter a reminder on his/her scheduler in SASO to ensure there is no gap in CDS services.

The case worker does not complete a home visit or contact the individual when the ASP reauthorization is due or complete a financial or functional wizard in SAS. The case worker will only complete the authorization wizard in SAS to renew the funds needed for the CDS option. The case worker must send the updated Form 2101, Authorization for Community Care Services, to the individual's Financial Management Services Agency (FMSA). The case worker will complete the program annual review as usual and ensure the CDS ASP dates remain unchanged.

Note: For Community Attendant Services cases, the case worker must request authorization from the HHSC regional nurse.

Example:

An individual starts Community Care for Aged and Disabled services with the agency option on Jan. 15, 2015. The individual decides in April 2015 to switch to the CDS option. The case worker negotiates a start date with the selected FMSA of April 25, 2015. The effective dates of the ASP are April 25, 2015, through April 24, 2016. The case worker completes the authorization for CDS in accordance with 6333.1.

The case worker also enters a scheduler entry set to **a few days before April 24, 2016, in order to ensure the CDS funds are renewed for another year.** The case worker should already have a scheduler in place to complete the program annual review in January 2016.

In January 2016, the case worker completes the program annual review as usual, in accordance with 4447, Reassessment, or 4678, Annual Reassessments.

In April 2016 (before April 24), the case worker completes the ASP by running the SASO authorization wizard with new dates of April 24, 2016, through April 24, 2017, to renew the CDS option funds. The case worker sends the updated Form 2101 to the FMSA.

6333.2 Transfers and Consumer Directed Services (CDS)

Revision 17-1; Effective March 15, 2017

The individual has the right to:

- transfer to a different Financial Management Services Agency (FMSA);
- elect to receive services through the Service Responsibility Option (SRO), if available; or
- request a transfer back to the Agency Option (AO) at any time.

If the individual feels that the current FMSA is not fulfilling the expected responsibilities, he or she can:

- address those issues directly with the FMSA;
- contact the case worker if he or she is unable to resolve issues or concerns with the FMSA; and/or
- select another FMSA to provide CDS services if concerns and issues are still not resolved.

See 6333.4, Annual Recertification, for instructions on updating the annual service plan (ASP) when transferring to another FMSA.

Transfer to Another FMSA

If issues with the current FMSA cannot be resolved to the individual's satisfaction, he or she has the right to transfer to another FMSA. Follow procedures outlined in 2723, Freedom of Choice, regarding transfer of agencies.

The individual must contact the case worker if he or she decides to transfer from one FMSA to another. The case worker makes all necessary arrangements for the transfer.

See 6333.3.1, Provider Transfer, for step-by-step budgeting procedures required when transferring from one FMSA to another.

Transfer to the AO or the SRO

Case workers must follow 40 Texas Administrative Code §41.407, Termination of Participation in the CDS Option, to terminate an individual from the CDS option. The individual may return to CDS after the 90-day transfer period has expired by contacting the case worker. All pre-assessment procedures must be completed, including a new Individual Self-Assessment, before the individual is allowed to return to CDS.

Service Resources Available During the Transfer Process

If the individual is without personal attendant services (PAS) and requires assistance before the transfer can take place, he or she may be able to contract for PAS through the AO or SRO provider using CDS funds. The agency is not required to provide this service, however. The individual must be acquainted with other resources, which are outlined in the training provided by the FMSA.

6333.3 Circumstances That Necessitate a Revised Annual Service Plan (ASP)

Revision 17-1; Effective March 15, 2017

The ASP specifies an annualized dollar amount that is the maximum the individual can expend during the year. It is the basis for developing a service budget. The individual and the Financial Management Services Agency (FMSA) share responsibility for ensuring annual expenditures remain within the authorized amount.

Four situations may necessitate revision of the ASP:

- provider transfers,
- rate changes,
- an increase in service units,
- a decrease in service units.

Case workers must use Form 1589, Consumer Directed Services Revision Worksheet, Page 1, to initiate any changes that necessitate a revised ASP. The purpose of Form 1589 is to assist a case worker in obtaining the needed information from an FMSA. The case worker can use the optional second page of Form 1589, Consumer Directed Services Supplemental Calculation Worksheet, to assist in completing the rest of the revision calculation. Case workers must continue to follow instructions to input ASP authorizations into the Service Authorization System, in accordance with 6333.3.1, 6333.3.2, 6333.3.3 and 6333.3.4 that follow.

Changes to the ASP must be made in the order of occurrence. For example, the case worker cannot enter a rate change effective Sept. 1 in the Service Authorization System before making a change in hours that was effective Aug. 15.

6333.3.1 FMSA Transfer

Revision 22-2; Effective June 1, 2022

When notification of a request to transfer Financial Management Services Agency (FMSA), use the following steps to re-calculate the ASP for the remaining time period.

- Send Form 1589, Consumer Directed Services Revision Worksheet, to the FMSA to request the total hours used.
- Re-calculate the ASP based on the number of units or amount of funds needed to complete the service plan period based on the recipient's current service plan.
- Update the information in SASOW.
- Send Form 2101, Authorization for Community Care Services, to notify the FMSA of the revised ASP information.

Use the following example when processing FMSA transfers.

Note: In this example, the $10.00 amount is a **fictitious number** used for demonstration purposes only. When transferring FMSA, the current CDS service rate can be accessed at the following Texas Health and Human Services Commission website: pfd.hhs.texas.gov/long-term-services-supports/primary-home-care-phc.

Example: CDS recipient requests to transfer to a new FMSA. The transfer is effective July 16, 2015. The original ASP was Jan. 1, 2015 through Dec. 31, 2015. The ASP was approved for 1060 hours at $10 per hour.

Step	
1	The recipient requests a FMSA transfer, which will take effect on July 16, 2015. The original authorization was for 1,060 hours of service at $10.00 per hour, for a total of $10,600.00, beginning Jan. 1, 2015 and ending Dec. 31, 2015.
2	Use Form 1589, Consumer Directed Services Revision Worksheet, to contact the FMSA to determine the amount of service delivered by the first agency and the amount the FMSA would like to (if any) reserve that the recipient is expected to use up to the effective date of the transfer. The FMSA reports that 500 hours, for a total of $5,000.00, was used from Jan. 1, 2015 through June 30, 2015. The FMSA reserves 40 hours, for a total of $400.00.
3	Calculate the total amount available remaining in the annual service plan (ASP): $5,000.00(500 hours) amount used + $400.00(40 hours) amount reserved = $5,400.00(540 hours) used or reserved. The remaining ASP amount at the time of the transfer effective date is determined by subtracting the used or reserved from the original ASP amount. $10,600.00 - $5,400.00 = $5,200.00.
4	In the Authorization Wizard, enter a new begin date of July 15, 2015. The system will automatically insert an end date of June 15, 2016. Manually correct the end date to reflect Dec. 31, 2015, and document in Comments: "Provider transfer, Provider A states used units of 500 hours @ $10.00 per hour = $5,000.00 and reserved units of 40 hours @ $10.00 per hour = $400.00. $10,600.00 - $5,400.00 = $5,200.00."
5	Manually correct the "Auth Unit" fields in both authorizations: Jan. 1, 2015 through July 15, 2015 should be $5,400.00 and July 16, 2015 through Dec. 31, 2015 should be $5,200.00.
6	Manually correct the number of units in box 18 to $5,200.00.

CCSE staff must also authorize Financial Management Services (FMS) Service Code 63V for the gaining provider. The regional nurse authorizes the FMS fee for Community Attendant Services applications and recertifications.

6333.3.2 Rate Change

Revision 22-2; Effective June 1, 2022

When notified of a change in the CDS service rate, use the following steps to re-calculate the ASP for the remaining time period.

- Send Form 1589, Consumer Directed Services Revision Worksheet, to the Financial Management Services Agency (FMSA), to request the total hours used.
- Re-calculate the ASP based on the time remaining in the ASP period and the new CDS service rate.
- Update the information in SASOW.
- Send Form 2101, Authorization for Community Care Services, to notify the FMSA of the revised ASP information.

Note: The $10.50 and $10.00 amounts in this example are **fictitious numbers** used for demonstration purposes only. The current rate can be accessed at the following Texas Health and Human Services Commission website: pfd.hhs.texas.gov/long-term-services-supports/primary-home-care-phc.

Example: CCSE staff are notified of a rate increase to $10.50 effective Sept. 1, 2015. The original authorization was for 530 hours of service at $10.00 per hour, for a total of $5,300.00, beginning Feb. 15, 2015 and ending Feb. 16, 2016.

Step	
1	Use Form 1589, Consumer Directed Services Revision Worksheet, to request the ASP information from the FMSA. The FMSA reports 240 hours, for a total of $2,400.00, was used in the period beginning Feb. 15, 2015 and ending Aug. 15, 2015. The FMSA reserves 20 hours, for a total of $200.00 for the period between Aug. 15, 2015 through Aug. 31, 2015. The total used or reserved is $2,600.00.
2	Calculate the amount of time available in the remainder of the annual service plan (ASP): Sept. 1-30, 2015, 30 days + Oct. 1-31, 2015, 31 days + Nov. 1-30, 2015, 30 days + Dec. 1-31, 2015, 31 days + Jan. 1-31, 2016, 31 days + Feb. 1-14, 2016, 14 days = 167 days divided by seven days = 23.86 weeks = 24 weeks **Note**: When the result of this **particular calculation** is not a whole number, it is always rounded up to the next whole number.
3	Calculate the difference in the hourly amount: $10.50 − $10.00 = $0.50
4	Calculate the dollar amount available in the remainder of the ASP: 24 weeks x 10 hours per week x $0.50 = $120.00 increase. $5,300.00 original authorization + $120.00 rate increase amount = $5,420.00 revised ASP amount. $5,420.00 revised ASP amount − $2,600.00 used or reserved amount = $2,820.00 remaining in the ASP.
5	Process the SASO Functional Wizard to pull in the new provider rate.
6	SASO Authorization Wizard: Enter a new begin date of Sept. 1, 2015. The system will automatically insert an end date of Aug. 31, 2016. Manually correct the end date to reflect Feb. 14, 2016, and document in comments, "Unit rate increase – provider states used amount of 260 hours @ $10.00 per hour = $2,600.00."

Step	
7	Manually correct the SASO Wizard "Auth Unit" fields in both authorizations: Feb. 15, 2015 through Aug. 3, 2015 should be $2,600.00, and Sept. 1, 2015 through Feb. 14, 2016 should be $2,820.00.
8	Manual correction of Form 2101, Authorization for Community Care Services: Manually correct the number of units in box 18 to $2,820.00

6333.3.3 Increase in Service Units

Revision 22-2; Effective June 1, 2022

Use the following example when processing increases in service units.

Note: In this example, the $9.50 amount is a **fictional number** used for demonstration purposes only. The current rate can be accessed at the following Texas Health and Human Services Commission website: pfd.hhs.texas.gov/long-term-services-supports/primary-home-care-phc.

Step	
1	The recipient's condition changes, requiring a three-hour increase in service effective June 1, 2015. The original authorization was for 795 hours of service at $9.50 per hour, for a total of $7,552.50, beginning April 15, 2015 and ending April 14, 2016 The recipient received 15 hours of service per week beginning April 15, 2015 and ending May 15, 2015.
2	Use Form 1589, Consumer Directed Services Revision Worksheet, to contact the Financial Management Services Agency (FMSA). The FMSA reports 60 units, for a total of $570.00, were used from April 15, 2015 through May 15, 2015. The FMSA reserves 30 units, for a total of $285.00 to be used from May 15, 2015 through May 31, 2015. The total used or reserved amount is $855.00.
3	Calculate the amount of time remaining in the annual service plan (ASP). June 1-30, 2015 = 30 days + July 1-31, 2015 = 31 days + Aug. 1-31, 2015 = 31 days + Sept. 1-30, 2015 = 30 days + Oct. 1-31, 2015 = 31 days + Nov.1-30, 2015 = 30 days + Dec. 1-31, 2015 = 31 days + Jan.1-31, 2016 = 31 days + Feb. 1-29, 2016 = 29 days + March 1-31, 2016 = 31 days + April 1-14, 2016 = 14 days = 319 days divided by seven days = 45.57 weeks = 46 weeks **Note**: When the result of this **particular calculation** is not a whole number, this amount is always rounded up to the next whole number. For example, a result of 45.57 would be rounded up to 46 weeks.

Step	
4	Calculate the dollar amount available for the remainder of the ASP. 46 weeks x three hours per week = 138 hours 138 hours at $9.50 = $1,311.00 increase $7,552.50 original authorization + $1,311.00 increase amount for remainder of ASP − $855.00 already used or reserved = $8,008.50 partial authorization for the period of Jan. 1, 2015 through April 14, 2016.
5	Calculate the revised ASP. $855.00 already used or reserved + $8,008.50 authorized for remainder of ASP = $8,863.50 revised annual ASP.
6	Enter a new begin date of June 1, 2015 in the Authorization Wizard. The system will automatically insert an end date of May 31, 2016. Manually correct the end date to reflect April 14, 2016, and document in comments: "Increase ASP – 138 hours @ $9.50 per hour for remainder of ASP = $1,311.00 increase. Authorized amount for remainder of period = $8,008.50 + $855.00 used or reserved amount = $8,863.50 revised annual ASP."
7	Manually correct the "Auth Unit" fields in both authorizations: April 15, 2015 through May 31, 2015 is $855.00 June 1, 2015 through April 14, 2016 is $8,008.50
8	Manually correct Form 2101, Authorization for Community Care Services, by correcting the number of units in box 18 to $8,008.50.

6333.3.4 Decrease in Service Units

Revision 22-2; Effective June 1, 2022

Use the following example when processing decreases in service units.

Note: In this example, the $9.75 amount is a **fictitious number** used for demonstration purposes only. The current rate can be accessed at the following Health and Human Services Commission website: https://pfd.hhs.texas.gov/long-term-services-supports/primary-home-care-phc.

Step	
1	The recipient's condition improves, requiring a three-hour decrease in service effective Oct. 1, 2015. The original authorization was for 689 hours of service at $9.75 per hour, for a total of $6,717.75, beginning Feb.15, 2015 and ending Feb. 14, 2016. The recipient received 13 hours of service per week beginning Feb.15, 2015 and ending Sept. 15, 2015.
2	Use Form 1589, Consumer Directed Services Revision Worksheet, to contact the Financial Management Services Agency (FMSA). The FMSA reports 364 units, for a total of $3,549.00, used from Feb.15, 2015 through Sept. 15, 2015. The FMSA reserves 26 units for a total of $253.50 from Sept. 16, 2015 through Sept. 30, 2015. A total amount of $3,802.50 is available for the FMSA on the original annual service plan (ASP).

Step	
3	Calculate the amount of time remaining in the ASP. Oct. 1-31, 2015 = 31 days + Nov. 1-30, 2015 = 30 days + Dec. 1-31, 2015 = 31 days + Jan. 1-31, 2016 = 31 days + Feb. 1-14, 2016 = 14 days = 137 days divided by seven days = 19.57 weeks = 20 weeks. **Note**: When the result of this **particular calculation** is not a whole number, this amount is always rounded up to the next whole number. For example, a result of 19.57 is rounded up to 20 weeks.
4	Calculate the dollar amount available for the remainder of the ASP. 20 weeks x three hours per week = 60 hours 60 hours at $9.75 = $585.00 decrease $6,717.75 original authorization - $585.00 decrease amount for remainder of ASP - $3,802.50 already used or reserved = $2,330.25 partial authorization for the period of Oct. 1, 2015 through Feb. 14, 2016.
5	Calculate the revised ASP. $3,802.50 already used or reserved + $2,330.25 authorized for remainder of ASP = $6,132.75 revised annual ASP.
6	Enter a new begin date of Oct. 1, 2015 in the Authorization Wizard. The system will automatically insert an end date of Sept. 30, 2016. Manually correct the end date to reflect Feb. 14, 2016, and document in comments: "Decrease ASP – 60 hours @ $9.75 per hour for remainder of ASP = $585.00 decrease. Authorized amount for remainder of period = $2,330.25 + $3,802.50 used or reserved amount = $6,132.75 revised annual ASP."
7	Manually correct the "Auth Unit" fields in both authorizations: Feb. 15, 2015 through Sept. 30, 2015 is $3,802.50 Oct. 1, 2015 through Feb. 14, 2016 is $2,330.25
8	Manually correct Form 2101, Authorization for Community Care Services, by correcting the number of units in box 18 to $2,330.25.

6333.4 Annual Recertification

Revision 17-1; Effective March 15, 2017

40 Texas Administrative Code §41.109 (a), Enrollment in the CDS Option, mandates that case workers conduct home visits at least annually for all Consumer Directed Services (CDS) individuals.

Individual rights requirements apply in CDS the same way they apply to any other service delivery option.

6333.4.1 Procedures for the CAS CDS Annual Reassessment

Revision 17-1; Effective March 15, 2017

In accordance with 1929(b) of the Social Security Act and the State Plan under Title XIX of the Social Security Act Medical Assistance Program, in the Community Attendant Services (CAS) program, the Consumer Directed

Services (CDS) employer can be considered the supervisor for the purposes of completing the CAS annual reassessment.

CAS annual reassessment procedures for an individual utilizing the agency option require the case worker to complete the functional assessment, the Home and Community Support Services Agency (HCSSA) supervisor to document agreement or disagreement with the service plan, and the HHSC regional nurse to authorize services within 12 months of the last authorization. Under the State Plan, the CDS employer may fulfill the role of the HCSSA supervisor in signing the agreement or presenting information when in disagreement with the proposed service plan.

When the case worker conducts the home visit for the annual functional reassessment, the role of the CDS employer for the annual reassessment must be explained to the individual/CDS employer. The case worker advises the individual of the following:

- The proposed service plan, Form 2101, Authorization for Community Care Services, for the next year will be faxed or mailed to the individual/CDS employer.
- The individual/CDS employer must review the plan, sign Form 1596, Consumer Directed Services Agreement for the Community Attendant Services Annual Reauthorization, indicating his agreement or disagreement with the proposed plan, and return the form to the case worker within 14 calendar days of receipt to prevent delay in services.

The case worker must schedule the annual reassessment home visit to allow time for all the required steps to be completed within the time frames.

Case Worker Procedures

Within five business days after the functional assessment visit, the case worker faxes or sends the individual/CDS employer a copy of the following forms:

- Referral Form 2101, with the proposed annualized service plan.
- Form 1596, to be completed and signed by the individual/employer with the following information:
    - A statement indicating that the proposed annualized service plan has been reviewed and the individual/employer is in agreement; or
    - A statement indicating that the proposed annualized service plan has been reviewed and the individual/employer disagrees with the tasks or hours indicated on the annualized service plan for the reasons listed on Form 1596.

The individual/CDS employer must sign Form 1596 and return it to the case worker within 14 calendar days of receipt. If the individual/CDS employer signs agreement with the annualized service plan, the case worker, within five business days, sends a copy of Form 1596 and Form 2101 to the HHSC regional nurse for the annual authorization.

Disagreement with the Service Plan

If the individual/CDS employer does not agree with the proposed annualized service plan, the reasons must be documented on Form 1596. The case worker must contact the individual/CDS employer to try to resolve the issues and agree upon a plan. If an agreement is reached, the case worker sends Form 1596 and Form 2101 to the HHSC regional nurse for the annual authorization.

If an agreement cannot be reached, the case worker forwards Form 2101 and Form 1596 to the HHSC regional nurse. Within five business days of receipt of Form 2101 and Form 1596, the HHSC regional nurse contacts the individual/CDS employer and case worker to determine if agreement can be reached on the service plan.

The HHSC regional nurse makes the final decision on the service plan. If the negotiation results in a decrease in services for the individual, the effective date must allow time for the individual to receive a 12-day advance notice of the adverse action. The individual/CDS employer has the right to request a fair hearing and appeal the decision.

The HHSC regional nurse makes any necessary changes to Form 2101, noting any negotiated changes in the comments and completes the authorization in the Authorization Wizard. The nurse sends Form 2067, Case Information, notifying the individual/CDS employer and the case worker of the outcome of the negotiation and sends a copy of the authorization Form 2101 to the case worker by mail or electronic mail.

The case worker sends a copy of Form 2101 and Form 2065-A, Notification of Community Care Services, to the individual/CDS employer and sends Form 2101 to the Financial Management Services Agency.

Note: If the CDS annual service plan (ASP) dates are different than the CAS annual review dates, in accordance with 6333.1.1, Different Program Annual Review and Annual Service Plan Dates, the case worker must ensure the CDS ASP dates remain unchanged after a CAS annual review is completed.

6333.5 Ongoing CDS Monitoring

Revision 17-1; Effective March 15, 2017

All monitoring of Consumer Directed Services (CDS) individuals is done according to the mandated schedule for their specific services. See 2700, Service Monitoring, Changes and Transfers, for details. Because the individual is now responsible for his or her own service delivery, the case worker's function is to:

- monitor the individual's satisfaction with the Financial Management Services Agency (FMSA) services; and
- evaluate the individual's ongoing ability to comply with CDS option requirements.

If it is evident the individual is having difficulty in the management of services under the CDS option, the case worker may consult with the FMSA.

Examples of the individual's inability to manage services include:

- lack of adequate supervision of the attendant so that necessary services are not being delivered; or
- misuse of funds so that the annual authorized amount will be expended before the year is over.

The FMSA must provide the budget status report at least quarterly to the individual or designated representative and case worker. If the case worker does not receive the quarterly report, or the individual reports he or she has not received the quarterly report the case worker must follow-up with the FMSA.

6333.6 Ensuring Individual Health and Safety

Revision 17-1; Effective March 15, 2017

The Financial Management Services Agency (FMSA) and case worker share responsibility for assessing the individual's ability to manage the demands of the Consumer Directed Services (CDS) option. Careful evaluation is necessary to ensure the individual's health and safety are maintained.

As soon as he or she becomes aware of a potential problem, the case worker must:

- notify the FMSA of any concerns regarding the individual's circumstances or ability to comply with CDS option requirements; and
- provide supporting documentation about the circumstances or problems noted to the FMSA.

The individual is responsible for informing the FMSA of the assessment date in time for the FMSA to send the case worker a copy of the individual's annual budget.

See 6323, FMSA Responsibilities, for FMSA responsibilities.

6333.6.1 Responsibilities for HHSC Case Workers in Association with Abuse, Neglect and Exploitation (ANE) Allegations

Revision 17-6; Effective June 28, 2017

Responsibilities for HHSC Case Workers

Responsibilities for HHSC case workers in association with ANE investigation procedures specifically for the Consumer Directed Services (CDS) option when a CDS employee, designated representative, or representative of a Financial Management Service Agency (FMSA) is the alleged perpetrator are as follows.

Initial Intake Actions When a CDS Employee or Designated Representative is the Alleged Perpetrator

When the Department of Family and Protective Services (DFPS) receives an allegation of ANE for an individual using the CDS option, Adult Protective Services (APS) will provide the initial intake report to the CDS employer and the individual's case worker. The case worker must notify the individual's FMSA of the initial allegation. The case worker is required to hold an interdisciplinary team (IDT) meeting in person or by telephone, within four business days of receipt of the initial report, with the CDS employer to:

- discuss the actions the CDS employer has taken or will take to protect the individual during the APS investigation, which may include implementing the service backup plan to allow someone other than the CDS employee who is the alleged perpetrator to provide services;
- inform CDS employers of their responsibilities to protect evidence, such as timesheets and other employee-related documentation; and
- if appropriate, recommend termination of the CDS option, in accordance with 40 Texas Administrative Code (TAC) §41.407(e).

The case worker documents in writing the responses provided by the CDS employer during the IDT and any actions that have been or will be taken as a result of the allegation pending the outcome of the final investigative report.

Final Report Actions

After the investigation is complete, APS will release a final investigatory report, including findings, to the CDS employer and the case worker. The case worker will convene an IDT meeting in person or by phone, within four business days after receipt of the final report, if there is a confirmed or inconclusive finding of ANE or if concerns and recommendations are included in the report, in which:

- the IDT discusses the findings or concerns and recommendations;
- the case worker documents, in writing, any actions that have been or will be taken by the CDS employer as a result of the findings or concerns and recommendations. (Form 1741, Corrective Action Plan, may be used for this purpose); and
- if appropriate, the case worker may recommend termination of the CDS option, in accordance with 40 TAC §41.407(e).

Initial Intake Actions if an FMSA Representative is the Alleged Perpetrator

When DFPS receives an allegation of ANE related to services delivered through the CDS option and an FMSA representative is the alleged perpetrator, APS will provide the initial intake report to the CDS employer and the FMSA of the initial allegation. The FMSA must provide a copy of the initial intake report to the individual's HHSC regional office within one business day. The HHSC regional director or designee will ensure that the individual's case worker receives the intake report and a copy of Information Letter 15-83, "ANE Investigation Procedures for the CDS Option in the PHC Program," as soon as possible.

The case worker will convene an IDT meeting in person or by phone within four business days after receipt of the initial intake report, in which:

- the IDT discusses the actions the CDS employer has taken or will take to protect the individual during the APS investigation, which may include transferring to a different FMSA; and
- the case worker documents in writing any actions that have been or will be taken as a result of the allegation, pending the outcome of the final investigative report.

Final Investigation Report

After the investigation is complete, APS will send a final investigation report, including findings, to the CDS employer and to the individual's FMSA. The FMSA must provide a copy of the final investigation report, within one business day after receipt of the report, to the individual's HHSC regional office. The HHSC regional director or designee will ensure the final investigative report is given to the case worker as soon as possible.

The case worker will convene an IDT meeting in person or by phone, within four business days after receipt of the final report, if there is a confirmed or inconclusive finding of ANE or if concerns and recommendations are included in the report, in which:

- the IDT discusses the findings or concerns and recommendations;
- the case worker documents, in writing, any actions that have been or will be taken by the CDS employer as a result of the findings or concerns and recommendations. (Form 1741 may be used for this purpose); and
- if appropriate, the case worker may recommend termination of the CDS option in accordance with 40 TAC §41.407(e).

6333.6.2 Voluntary Suspension of the CDS Option

Revision 17-1; Effective March 15, 2017

40 Texas Administrative Code §41.405, Suspension of Participation in the CDS Option

Voluntary suspensions are rare; examples include (but are not limited to):

- an individual has turned 18 and no guardian has been appointed (so there is no "employer"); or
- an individual lacks back-up service delivery options.

For the case worker, a voluntary suspension is handled in exactly the same way that a transfer to another service delivery option would be handled. See 6333.2, Transfers and Consumer Directed Services (CDS), for detailed instructions. But, for the Financial Management Services Agency, the provider tasks (as described in 6323, FMSA Responsibilities) do not have to be repeated when the individual transfers back to CDS at the end of the 90-day voluntary suspension period. That is not true when the individual simply transfers from, and then back to, CDS.

6333.6.3 Involuntary Termination of the CDS Option

Revision 17-1; Effective March 15, 2017

40 Texas Administrative Code §41.407, Termination of Participation in the CDS Option

The case worker or Financial Management Services Agency (FMSA) representative may observe that an individual is unprepared to meet the demands of managing the details of service delivery. With supporting documentation from the monitoring visit or from the FMSA, the case worker recommends to the individual that he or she voluntarily request to return to the agency option. If he or she does not agree, the case worker, in consultation with the supervisor and the interdisciplinary team (IDT), (see definition under "service planning team" in 6310, Description) transfers the individual back to the agency option.

The case worker must carefully document the findings of the IDT, including:

Requirement	Example
The date, time and location of the meeting	The IDT meeting was convened at 2 p.m. on Oct. 15, 2014, at the home of Mrs. Scott.
The names of each participant and their relationship to the individual	Present at the meeting were: • Ann Scott, the individual; • Nancy Albright, the individual's daughter; • Angela Jones, FMSA representative; • Linda Sullivan, the HHSC case worker; and • Nelson Travis, the case worker's supervisor.
The reasons for the recommendation that the individual be involuntarily returned to the Agency Option (AO). Documentation must be specific and detailed	Mrs. Scott was contacted by the FMSA on Oct. 8, 2014, after missing the deadline for submitting employee timesheets. The FMSA is informed that the attendant quit without notice over a week ago; Mrs. Scott has gone without services since that time. The individual did not contact the FMSA or the case worker at the time because she couldn't remember who to call, and couldn't find any of her paperwork. During the IDT meeting, Mrs. Scott agreed with the assessment that she currently is unable to fulfill the responsibilities of the Consumer Directed Services (CDS) option. However, she expressed a desire to have her daughter serve as the designated representatives (DR), which would enable her to continue using the CDS. Mrs. Albright was able to stay with the individual the remainder of that week. So the case worker transferred the individual from CDS to AO effective Oct. 22, 2014.
The conditions and time frame established by the IDT that must be met before re-enrollment in CDS	All IDT members agree that the individual may return to the CDS option in six months, at which time her daughter has agreed to begin serving as the DR.
Justification for any time period for a termination in excess of the minimum 90-day requirement	Mrs. Albright is unable to begin serving as the DR for six months, and the individual is unwilling to allow anyone else to serve that function.

Requirement	Example
If applicable, the conditions and time frame specified by a hearing officer as the result of a fair hearing that upholds the termination	The individual filed an appeal and was accompanied to the hearing by her daughter. During the proceedings, the daughter stated that her situation had changed and that she would be able to begin serving as the DR on Feb. 1. The hearing officer overturned the original decision, specifying that the individual can return to CDS Feb. 1, 2014, provided the daughter is able to assume DR responsibilities at that time.

6333.6.4 Re-Enrollment in the CDS Option

Revision 17-1; Effective March 15, 2017

40 Texas Administrative Code §41.409, Re-enrollment for Participation in the CDS Option

The individual may request to re-enroll in the Consumer Directed Services option at any time following the mandatory 90-day suspension period.

6400, State of Texas Access Reform Plus (STAR+PLUS) Managed Care

6410 Program Overview

Revision 18-1; Effective June 15, 2018

The 74th Texas Legislature implemented the State of Texas Access Reform Plus (STAR+PLUS) program to create a cost-neutral managed care system that would combine acute care as well as Long-term Services and Supports. The STAR+PLUS program does not change Medicaid eligibility or services. It changes the way Medicaid services are delivered.

The STAR+PLUS program combines acute care and Long-term Services and Supports, such as assisting in an individual's home with daily activities, home modifications, respite (short-term supervision) and personal assistance. These services are delivered through providers contracted with managed care organizations (MCOs). STAR+PLUS provides a continuum of care with a wide range of options and increased flexibility to meet individual needs. The program has increased the number and types of providers available to Medicaid individuals.

Service coordination, available to all members, is the main feature of STAR+PLUS. It is a specialized case management service for program members who need or request it. Service coordination means that plan members, family members and providers can work together to help members get acute care, Long-term Services and Supports, Medicare services for dual eligible individuals and other community support services.

Elements of the STAR+PLUS system that are different from traditional service delivery include:

- 1115 Waiver – Authority granted to the state of Texas to allow delivery of Medicaid State Plan acute, Long-term Services and Supports (Primary Home Care and Day Activity and Health Services) and delivery of Long-term Services and Supports that assists individuals to live in the community in lieu of a nursing facility through a managed care delivery system.
- Enrollment broker – A contracted entity that assists individuals in selecting and enrolling with an MCO. If requested by the individual, the enrollment broker also may assist in choosing a primary care provider (PCP). Members of STAR+PLUS may request an MCO change at any time by contacting the enrollment broker. The change will be effective the first day of the subsequent month if the request is made before the state cutoff date or the first of the following month if the request is made after cutoff.

- Texas Health and Human Services Commission (HHSC) – The state agency responsible for Medicaid. HHSC staff receiving a request for STAR+PLUS Home and Community Based Services (HCBS) will notify the HHSC Program Support Unit of the request.
- MCO – An insurer licensed by the Texas Department of Insurance as a managed care organization in accordance with Chapter 843 of the Texas Insurance Code. MCOs provide Medicaid benefits for individuals who are required to enroll in STAR+PLUS.
- Member – An individual who is enrolled in and receiving services through a STAR+PLUS MCO.
- Plan of care (POC) – A care plan the MCO develops for its members that includes acute care and Long-term Services and Supports. The plan of care is not the same as the individual service plan (ISP) for STAR+PLUS HCBS program services.
- Program Support Unit (PSU) – HHSC staff who support certain aspects of STAR+PLUS case management.
- Texas Medicaid & Healthcare Partnership (TMHP) – The Texas contractor administering Medicaid claims processing and the Medicaid primary care case management services program.
- TexMedCentral – A secure internet bulletin board that the state and the MCOs use to share information.
- Upgrade – An existing STAR+PLUS individual enrolled in the 1915(b) waiver who requests and is granted STAR+PLUS HCBS (1115 waiver) program services.

6411 Services Available Under the STAR+PLUS Option

Revision 18-1; Effective June 15, 2018

Managed care organizations (MCOs) are required to contact all members upon enrollment. If there is a need identified or a request from the member, the MCO will assess the member to determine needs and to develop an appropriate individual plan of care (POC). Because MCOs are at risk for paying for a range of acute care and long term services and supports, there is an incentive to provide innovative, cost-effective care from the outset in order to prevent or delay the need for more costly institutionalization.

STAR+PLUS Medicaid-only individuals are required to choose an MCO and a primary care provider (PCP) in the MCO's network. These individuals receive all services (both acute care and long term service and supports) from the MCO.

Individuals who receive both Medicaid and Medicare (dual eligible) choose an MCO, but not PCP. This is because they receive acute care from their Medicare providers. STAR+PLUS does not impact Medicare services or service delivery in any way. The STAR+PLUS MCO only provides Medicaid Long-term Services and Supports (LTSS) to dual eligible individuals.

STAR+PLUS serves as an insurance policy that will be available if members have a need for LTSS at a future time.

Medicaid-only individuals (those who do not receive Medicare) receive traditional Medicaid acute care services, plus an annual check-up. For these individuals, the cost of acute care services is included in the payment to the MCO. For dual eligible individuals, the MCO payment does not include the cost of acute care.

Long-term Services and Supports

Additional services are available under the STAR+PLUS HCBS program.

6420 STAR+PLUS Members Requesting Non-Medicaid Services

Revision 18-1; Effective June 15, 2018

Requirements of the 1115 Waiver dictate that STAR+PLUS HCBS program recipients receive all services excluding hospice through the waiver. The CCSE case worker must not authorize any Title XX services for individuals enrolled in the STAR+PLUS HCBS program.

For non-waiver recipients on the STAR+PLUS program, participation in a Medicaid managed care program is not sufficient cause for denial of the right to access non-Medicaid services. Non-Medicaid services should be viewed as any other community resource available to a managed care organization (MCO) member.

STAR+PLUS members are entitled to Title XX services if all eligibility criteria are met. However, the case worker must first ensure that approval of the request would not result in a duplication of services.

See Appendix XX, Mutually Exclusive Services, to determine which Title XX services are available to members in the STAR+PLUS program.

Individuals on the STAR+PLUS program requesting Title XX services will continue to be added to any applicable interest list at the time of the request in order to protect the date and time of the request. The case worker must first determine whether or not there is a slot available for the requested service. If not, the individual's name is added to the appropriate interest list by entering the information in the Community Services Interest List (CSIL) system. Individuals are released from the interest list on a first-come, first-served basis; eligibility determinations are conducted as slots for services become available.

When the member's name is released from the interest list, the case worker must verify the Managed Care Organization's (MCO) service array does not include a service equivalent of the Title XX service requested by viewing the STAR+PLUS Program Health Plan Comparison Charts and value-added services on the Health and Human Services (HHSC) website at:

https://hhs.texas.gov/services/health/medicaid-chip/programs/childrens-health-insurance-program-chip/chip-comparison-charts/star/report-cards/starplus.

Value-added services offered by an MCO are extra services approved by HHSC. Value-added services will vary by MCO.

STAR+PLUS Health Plan profiles are located on the Health and Human Services (HHS) website at: https://hhs.texas.gov/services/health/medicaid-chip/provider-information/information-providers-health-plan-changes.

The case worker is no longer required to wait for appeal decisions from MCOs to process requests for Title XX services if the service requested is not a value-added service on the member's plan. Once released from the Title XX interest list, the case worker verifies the applicant's MCO does not offer an equivalent service as a value-added service and proceeds with the eligibility determination for the requested Title XX service.

In some situations, a STAR+PLUS member or his MCO may request and be granted disenrollment of the member from managed care. Whether the disenrollment is voluntary or involuntary, disenrolled individuals can receive available HHSC services (both Medicaid and Title XX) if determined eligible.

6421 Disenrollment from STAR+PLUS

Revision 17-1; Effective March 15, 2017

In some situations, a STAR+PLUS member or his managed care organization (MCO) may request and be granted disenrollment of the member from managed care. Whether the disenrollment is voluntary or involuntary, disenrolled individuals can receive available HHSC services (both Medicaid and Title XX) if determined eligible.

6421.1 Disenrollment Due to Health and Safety Issues

Revision 17-1; Effective March 15, 2017

When a managed care organization (MCO) requests disenrollment for a STAR+PLUS member due to non-compliance, including behavioral issues, the MCO submits a disenrollment request to the Texas Health and Human Services Commission (HHSC) Health Plan Management (HPM). The HPM team reviews the request to determine if there is sufficient information to send to the HHSC Disenrollment Committee. The Disenrollment Committee reviews the information and determines if disenrollment is appropriate. If so, the STAR+PLUS member is disenrolled from STAR+PLUS.

When an individual on STAR+PLUS personal attendant services or STAR+PLUS Waiver services is disenrolled from STAR+PLUS due to threatening behaviors, the individual may immediately apply with HHSC for services.

HPM will send an email to the HHSC Regional Support and Program Improvement (RSPI) worker advising when a STAR+PLUS member has been disenrolled from STAR+PLUS due to threats to health and safety and will provide information on the nature of the behavioral issues. This is to protect the health and safety of service providers and HHSC staff who will assess the individual for HHSC services. The RSPI worker will send the information to the regional director of the region where the individual lives advising that the individual has been disenrolled from STAR+PLUS and may be calling HHSC to apply for services. The regional director will establish procedures for disseminating this information to staff who perform intakes.

If the individual calls HHSC requesting services, the intake is assigned to a case worker. The intake staff must note in the Comments section on Form 2110, Community Care Intake, this individual has been disenrolled from STAR+PLUS due to threats to health and safety and include all information provided from the regional director.

The case worker conducts the initial interview and assessment according to standard procedures, but during the initial interview the case worker advises the individual:

- he must comply with program guidelines; and
- any threatening behavior may result in immediate termination of services.

Unless the individual displays threatening behavior during the initial interview, the case worker proceeds with the application process and authorizes services if the individual meets eligibility requirements. The case worker must issue a written notice to the individual at the initial authorization advising the individual he must comply with service delivery provisions or his services may be terminated immediately on the first report of any behavior that threatens health or safety.

If the HHSC case worker encounters threatening or non-compliant behavior or receives a report from the Home and Community Support Services Agency (HCSSA) or other providers of threatening behavior or non-compliance with services delivery provisions, services are immediately suspended.

The case worker must consult with the supervisor regarding the alleged behaviors. If the supervisor determines the alleged behavior does not warrant termination, the case worker follows the policy in Section 2831, Suspensions Due to Refusal to Comply with Service Delivery Provisions.

If the supervisor agrees the individual is a threat to health or safety, then services are terminated. The case worker sends Form 2065-A, Notification of Community Care Services, to the individual terminating services on the date of the suspension. The case worker cites 40 Texas Administrative Code (TAC) §48.3903 (b) and enters a statement in comments that services are terminated due to threats to health and safety.

The individual has the right to appeal, but services do not continue during the appeal process. The case worker must document the consultation and all other actions in the case record.

6430 Transition Between HHSC and STAR+PLUS

Revision 22-3; Effective Sept. 1, 2022

Mandatory STAR+PLUS members may continue to receive their current non-Medicaid services from HHSC until the managed care organization (MCO) can authorize Medicaid services.

Example: A member can continue to receive Family Care until the MCO authorizes Primary Home Care (PHC).

These members may also be placed on an interest list for a non-Medicaid service.

Applicants who are already enrolled with an MCO and request PHC or Day Activity and Health Services (DAHS) from HHSC must be advised to contact their MCO.

Use the following procedures for recipients who become eligible for Supplemental Security Income (SSI) or any Medicaid eligibility program that requires mandatory enrollment for STAR+PLUS while on Family Care (FC), Community Attendant Services (CAS) or Title XX DAHS:

- **If the recipient is already enrolled** when CCSE staff are notified of the Medicaid eligibility, check with the provider to see if they have received a service authorization from the MCO.
    - If yes, terminate the case the day before the STAR+PLUS service authorization's begin date.
    - If no, terminate the case and refer the recipient to the MCO. Send Form 2065-A, Notification of Community Care Services, with the contact information for the enrollment broker, deny services and allow 30 calendar days adverse action for the recipient to contact the enrollment broker and request services from the MCO.
- **If the recipient is not enrolled** when CCSE staff are notified of the Medicaid eligibility, CAS or Title XX DAHS will be transferred to PHC or Title XIX DAHS. CCSE staff will notify the recipient of the transfer and refer them to the enrollment broker to choose an MCO that serves their area.
    - Once notified that the recipient has been enrolled with an MCO, CCSE staff will terminate the PHC or Title XIX DAHS effective the day before the enrollment begin date.

Since Medicaid may be authorized retroactively, billing issues may occur during the MCO enrollment process. CCSE staff should address any billing issues that occur with the Regional Claims Management Services coordinator.

To help identify any STAR+PLUS issues, regional staff currently receive a report identifying recipients who are potentially eligible for STAR+PLUS. Regional staff also receive a report to help identify recipients receiving PHC or DAHS but are also enrolled in STAR+PLUS and receiving PAS or DAHS through their health maintenance organization (HMO).

Upon receipt of these reports, staff must review and take appropriate action. Either deny or notify the recipient that they need to contact the enrollment broker for enrollment with an MCO using the same procedures as above.

Related Policy

Interest List Procedures, 2230

7000, Long Term Care Automated Systems

7100, Texas Integrated Eligibility Redesign System (TIERS)

Revision 17-1; Effective March 15, 2017

The Texas Health and Human Services Commission uses the Texas Integrated Eligibility Redesign System (TIERS) as the system of record.

7110 TIERS Inquiries

Revision 21-3; Effective September 1, 2021

Use TIERS to determine the financial eligibility status of people applying for services or currently receiving services.

Inquiries can be completed in two different ways in the HHSC Benefits Portal by using:

- PT Inquiry; or
- clicking the application to launch TIERS.

Refer to the HHSC Benefits Portal and TIERS Inquiry Overview, which can be found in the Program Area Learning Management System (PALMS).

7200, Determination of Financial Eligibility Based on Automated Records

Revision 17-1; Effective March 15, 2017

Refer to Appendix XIV, SAVERR/TIERS Type Program Chart, to determine how existing coverage affects eligibility for Community Care for Aged and Disabled Services.

7210 Safeguarding Personally Identifiable Information

Revision 17-1; Effective March 15, 2017

All personally identifiable information (PII) obtained from the Social Security Administration (SSA) must be safeguarded. Wire Third Party Query (WTPY) System, State On Line Query (SOLQ) or other SSA documentation is considered SSA-protected and cannot be printed or kept in the case record.

Staff must not print or file PII (WTPY/SOLQ) printouts in individual case records. Staff must document the date they verified and viewed the online/printed verification, the amount of income and source (WTPY, SOLQ, other) used to verify the information.

If a WTPY or SOLQ report must be printed for a specific purpose such as a legal request or legislative inquiry, the document must not be filed in the case record or sent for imaging. SSA documents must be stored in a central locked filing cabinet only accessible by Texas Health and Human Services Commission authorized staff.

7220 Financial Eligibility Based on Receipt of Medicaid Buy-In Program Services

Revision 18-1; Effective June 15, 2018

Working Texans are able to purchase health insurance through Medicaid by paying a monthly premium through the Medicaid Buy-In (MBI) program. Participants in MBI must meet specific work, disability, resource and income requirements. Not all MBI recipients pay a premium. Premiums are determined on a sliding scale based on an individual's income.

Categorical Eligibility Status Verification

Individuals applying for Long-term Services and Supports (LTSS) who have MBI coverage are categorically eligible for all Title XX Community Care programs, Title XIX Day Activity and Health Services and Primary Home Care.

MBI coverage can only be verified by:

- searching the Texas Integrated Eligibility Redesign System (TIERS) database for Type Program (TP) 87 coverage (this information will not appear on the System for Applications, Verifications, Eligibility Reports and Referral inquiry screens); or
- an award letter sent to the individual documenting MBI eligibility.

Staff may contact either the regional TIERS coordinator or a Special Workers Assisting with TIERS (SWAT) member to verify an applicant's MBI status.

MBI and Receipt of Waiver Services

An MBI recipient interested in an LTSS waiver program should be added to the appropriate interest list. The case worker can determine if an applicant is an MBI recipient by looking in the TIERS database. The MBI program is coded TP 87, ME-Medicaid Buy-In.

More information about the MBI program is available in Section M-1000, Medicaid Buy-In (MBI) Program, of the *Medicaid for the Elderly and People with Disabilities Handbook*.

7230 Hierarchy of Individual Identification Data

Revision 17-1; Effective March 15, 2017

Before certifying an applicant who has a previously assigned individual number, compare information in the Texas Integrated Eligibility Redesign System (TIERS) to the information in the case record. Note and clear any discrepancies with the individual or other staff involved. Individual demographic information (individual name exactly as it appears in Social Security Administration (SSA) records for date of birth, Social Security number and individual number, if available) should not be entered into a database before a State On Line Query (SOLQ), Wired Third Party Query (WTPY) System or other SSA documentation has been received confirming the validity of the data. See Section 7210, Safeguarding Personally Identifiable Information, for important SSA data security information.

The computer system retains only one set of identification information for each individual. When an individual is active in more than one program area, the identification information is shared by the staff involved. Only the staff member with the highest priority over the information can change the identification information. The following priority applies:

- A program area supplying benefits to an individual takes precedence over a program area not supplying benefits to that individual. **Example:** Temporary Assistance for Needy Families (TANF) caretaker information takes precedence over TANF payee information; status in group Code 1 (Medical Assistance Only (MAO) recipient) information takes precedence over Code 3 (MAO eligible spouse) information; and an active case takes precedence over a denied case.

- For name and birth date identification data:

Priority is given to:	Over:

MAO	TANF, Supplemental Security Income (SSI), Supplemental Nutrition Assistance Program (SNAP)
TANF	SSI, SNAP
SSI	SNAP

- For sex and race identification data:

Priority is given to:	**Over:**
MAO	TANF, SNAP, SSI
TANF	SNAP, SSI
SNAP	SSI

7230.1 Address Changes for SSI Recipients

Revision 17-1; Effective March 15, 2017

For individuals on Supplemental Security Income (SSI) who move from one address to another, inform the individual or his responsible party to contact the Social Security Administration (SSA) to request the residence address change. The address change will be reflected in the Texas Integrated Eligibility Redesign System (TIERS) after SSA makes the change.

HHSC case workers must not send address change requests for SSI recipients to the TIERS Document Processing Center (DPC) in Austin. Although HHSC staff are able to make those address changes, the addresses will revert back to the address on the SSI record at the next state cut off. The address change must be made by SSA.

7240 Merge and Separate

Revision 17-1; Effective March 15, 2017

If an individual is erroneously assigned more than one individual number, or two or more individuals are erroneously assigned the same individual number, the problem should be reported to the state office Data Control Unit.

If the case must be certified prior to merging, decide which number to enter, using the following rules to select the individual number. If you have:

- an active individual and denied individual in the same or different program area, use the individual number from the active case.
- two individual numbers in different program areas, use the individual number from the case with Medicaid coverage.
- an active individual receiving benefits and an active individual not receiving benefits in the same program area, use the individual number from the case receiving benefits.
- a denied individual with Medicaid and one denied individual with no Medicaid, use the individual number from the denied case with Medicaid.
- denied individuals in the same program area, use the individual number most recently denied.

7300, Service Authorization System Online (SASOO) Wizards and Use Requirements

Revision 20-2; Effective June 1, 2020

The Service Authorization System Online (SASO) is the primary repository of service information for all applicants and recipients enrolled in the Texas Health and Human Services Commission (HHSC) Long-term Services and Supports (LTSS) programs. SASO accepts and maintains information relevant to the applicant's or recipient's authorizations for LTSS. Services must be authorized in SASO before a provider can receive payment.

SASO contains wizards with prompting sequences that lead the user through a series of windows required for authorization or denial of services. Wizards used to authorize or terminate Community Care Services Eligibility (CCSE) are the:

- Financial Wizard;
- Functional Wizard; and
- Authorization Wizard.

Related Policy

Service Authorization System Help File, Section 8000

7310 Requirement to Use SASO Wizards

Revision 20-2; Effective June 1, 2020

Regional management must ensure the use of the Community Care Services Eligibility (CCSE) SASO wizards to:

- enhance the accuracy of eligibility determinations, service plans, service authorizations and data;
- improve documentation of recipient satisfaction;
- provide a database for provider monitoring and case reading sample selection; and
- ensure compliance with federal regulations for program delivery.

Wizards must be used to document the following case actions:

- authorizations, including initials, ongoing reassessments and changes;
- monitoring;
- terminations; and
- denials.

7320 Use of the SASO Monitoring Wizard

Revision 20-2; Effective June 1, 2020

SASO Monitoring Wizard is used to document all required monitoring contacts with Community Care Services Eligibility (CCSE) recipients.

Document the recipient’s assessment of how well CCSE services are meeting their needs on Form 2314, Satisfaction and Service Monitoring and enter in the SASO Monitoring Wizard. Data must occur before the end of the month in which the action is due. When a person expresses dissatisfaction with a particular service or if the case worker identifies a concern with a particular service, then case workers should document this information using Form 2314.

Note: Additional contact with the recipient outside of the monitoring home visit or phone call, such as other changes or complaints, should be recorded using Form 2058, Case Activity Record, and not Form 2314, Satisfaction and Service Monitoring.

Depending on the information gathered during the monitoring home visit or phone call, some entries made in the SASO Monitoring Wizard may result in action codes that send referrals to other HHSC staff, such as contract managers, regional nurses or supervisors. When a referral is needed, CCSE staff will go to the SASO Monitoring Wizard Client Satisfaction window, and select: Monitoring Status: Follow-Up Required, then Generate.

To complete follow-up actions, update the SASO monitoring record by entering the additional fields on the Monitor Detail screen:

- Concurs with Previous? Yes or No;
- Problems Alleged;
- Reason; and
- Action.

The Monitoring Status field on the Client Satisfaction screen will be changed to “Completed” once follow-up and resolution is complete.

The Overall Client Satisfaction question must be completed to document the recipient’s overall satisfaction with services. Document the recipient’s level of satisfaction after the resolution of any alleged dissatisfaction.

Regional management is accountable for ensuring compliance with the use of Form 2314 and the SASO Monitoring Wizard. The information entered provides a database for provider monitoring and ensures compliance with federal regulations.

7330 Reserved for Future Use

Revision 20-2; Effective June 1, 2020

7400, Community Services Interest List

Revision 17-1; Effective March 15, 2017

The Community Services Interest List (CSIL) is a web-based application for keeping track of individuals waiting to receive services in various Community Care programs. The CSIL replaces the manual tracking systems used by different community care programs.

The CSIL can be used for a variety of functions. The system works in real time and as soon as you enter data into the system, it is accessible to anyone with the correct permissions. Some functions are restricted to a few people with specific permissions. Permissions are designated by user groups. A "user group" is made up of users who have permission to perform various functions in the CSIL application. **Example:** The IL Admin group will be able to perform some functions that the IL Worker group is not allowed to do. Your region will decide to which group(s) you will be assigned. You may be assigned to more than one group, but the system allows you to work in only one group at a time.

The CSIL system is used to:

- enter an individual in CSIL directly or through the Long Term Care Services Intake (NTK) System;
- track monitoring contacts;
- update information on individuals in CSIL;

- do group releases of individuals on CSIL when slots are available;
- let supervisors assign individuals to case workers;
- close individuals off the interest list when certified;
- search for individuals on the CSIL; and
- determine the individual's status on the CSIL.

Complete instructions for use of the CSIL can be found in the Web Based Training website at http://palms.hhsc.state.tx.us/login/login.asp?refpage=default.asp.

7500, Communication Tools

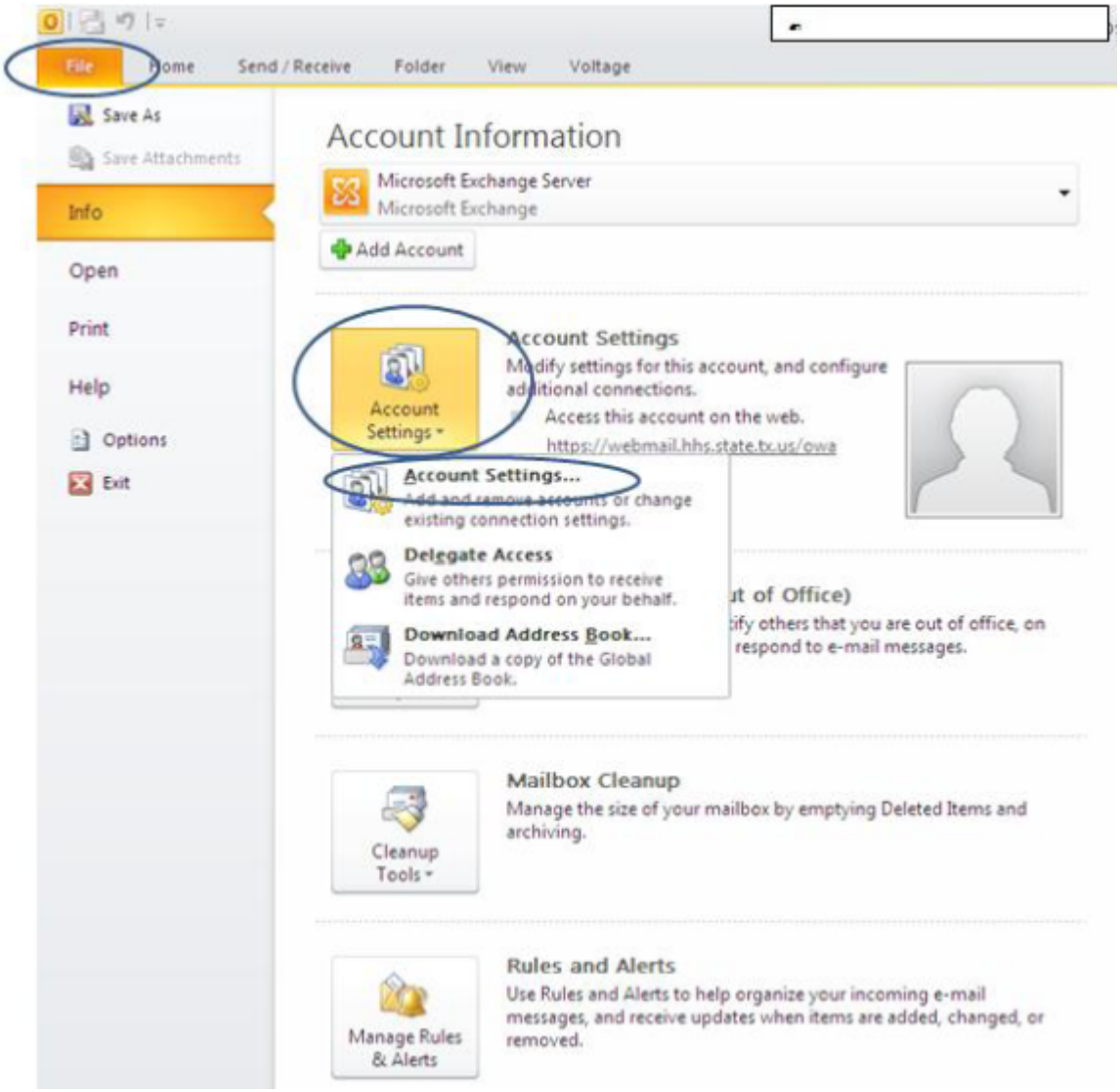
7510 Outlook Mailboxes for Communication from Medicaid for the Elderly and People with Disabilities (MEPD)

Revision 18-1; Effective June 15, 2018

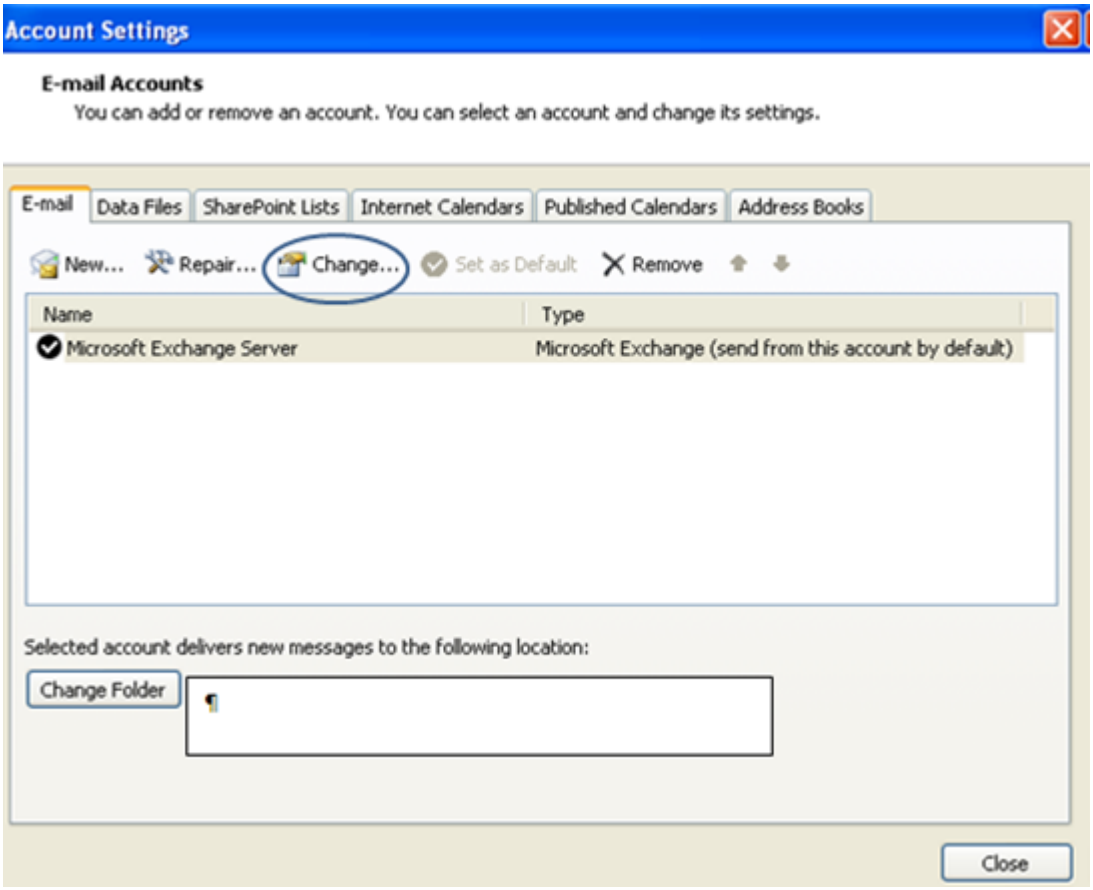
HHSC Information Technology (IT) has established Outlook resource mailboxes and Outlook procedures for HHSC staff to access electronic information sent by MEPD staff using the MEPD Communication Tool.

HHSC will have regional staff designated to monitor MEPD communication by following the steps below to access the resource mailbox in Outlook.

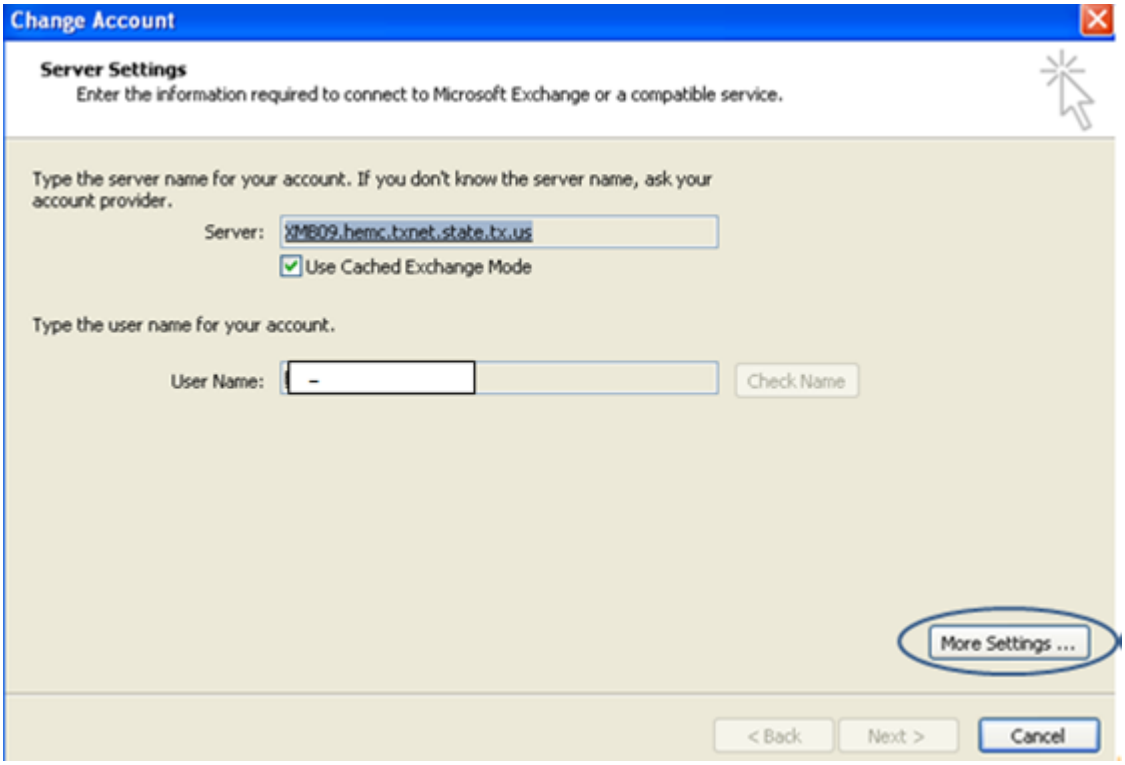
1. With Outlook open, select File from the menu. Then select Account Settings and again, select Account Settings



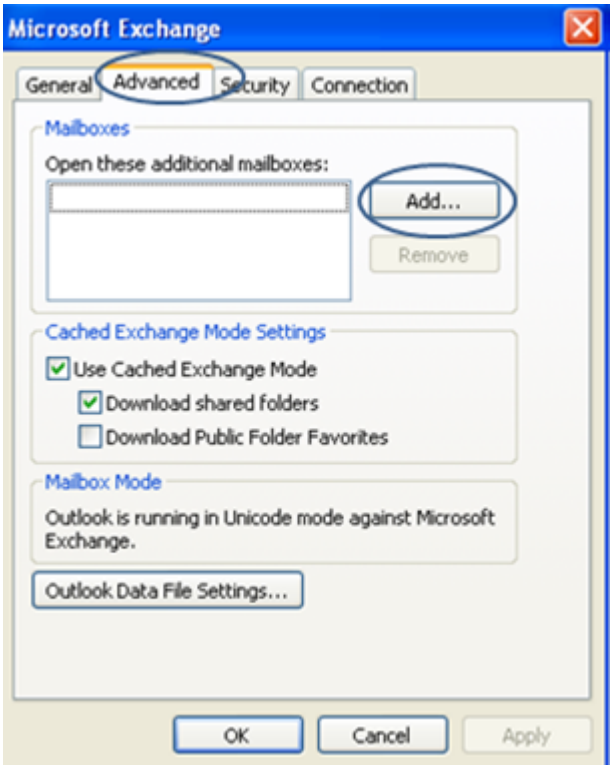
2. Select Change from the list of options



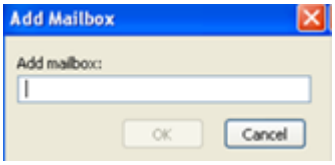
3. Select More Settings.



4. Select Advance from the menu then Add.

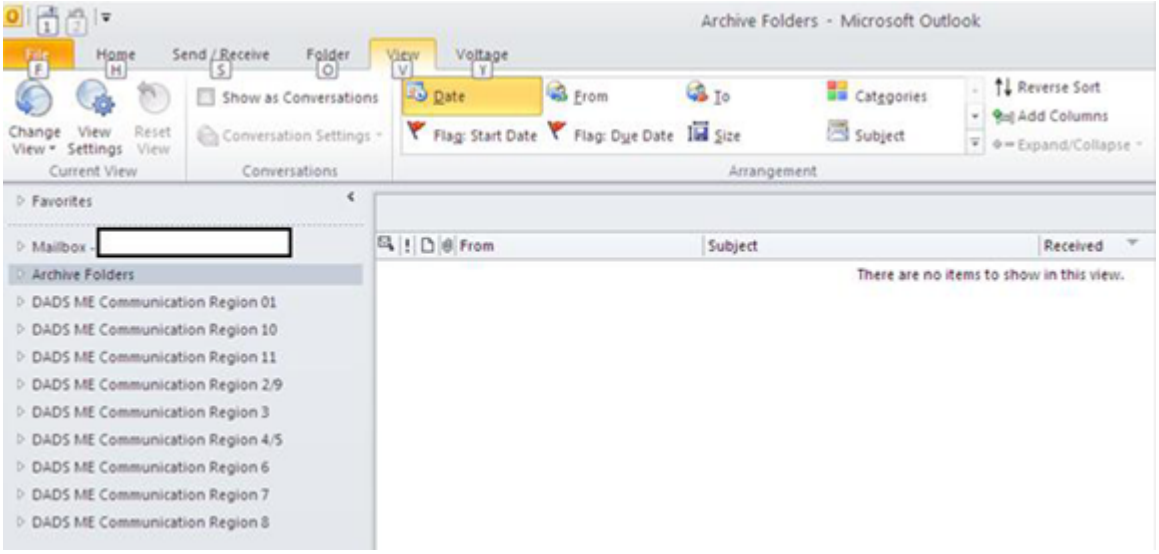


5. Enter the region's designated Alias as listed in the table below. (For example, "mecreg01" is entered for Region 1



Resource Mailbox Display Name	Alias
HHSC ME Communication Region 1	mecreg01
HHSC ME Communication Region 2/9	mecreg29
HHSC ME Communication Region 3	mecreg03
HHSC ME Communication Region 4/5	mecreg45
HHSC ME Communication Region 6	mecreg06
HHSC ME Communication Region 7	mecreg07
HHSC ME Communication Region 8	mecreg08
HHSC ME Communication Region 10	mecreg10
HHSC ME Communication Region 11	mecreg11

6. Once the alias is entered, select OK, Next, Finish, then Close. HHSC regional designated Resource Mailbox users will access the region's resource mailbox folder in the Outlook tree.



Resource Mailbox owners designated by regional management will be able to add, edit or delete Resource Mailbox users by right-clicking on the mailbox folder. *Resource Mailbox owners* must contact the Consolidated Help Desk (512-438-4720) if assistance is needed to add, edit or delete Resource Mailbox users.

Permission to forward information from the resource mailbox requires configuration of a separate Outlook profile. *Resource Mailbox owners* should submit a Help Desk ticket to have this completed for the authorized users.

The regional Resource Mailbox folder will have a single password that will be shared by all authorized users in that region. It is important that one person per mailbox be designated to maintain the password. All other authorized users must understand they are not to reset the password.

8000, Service Authorization System Help File

8100, Community Care Authorizations

8110 Authorizing CCSE Services Using the SASO Wizards

Revision 17-8; Effective September 1, 2017

The following Community Care Services Eligibility (CCSE) services can be authorized using the Service Authorization System Online (SASO) wizards:

- Adult Foster Care (AFC)
- Day Activity and Health Services (DAHS)
- Emergency Response Services (ERS)
- Family Care (FC)
- Home-Delivered Meals (HDM)
- Primary Home Care (PHC)
- Residential Care (RC) Services
- Community Attendant Services (CAS)
- Special Services to Persons with Disabilities (SSPD)

Note: The wizards cannot be used to authorize Consumer Managed Personal Attendant Services (CMPAS). See Section 8220, Consumer Managed Personal Attendant Services (CMPAS) Without the Wizards, for instructions on CMPAS.

8111 Wizard Sequencing — CCSE

Revision 17-1; Effective March 15, 2017

Each SASO CCSE is a prompting sequence that takes the user through a series of windows required for authorization or denial of services.

The five wizards used to authorize, terminate or monitor services are:

- Financial wizard — Community Care Services Eligibility (CCSE)
- Functional wizard — CCSE
- Authorization wizard — CCSE
- Community Living Assistance and Support Services (CLASS) wizard
- Monitoring wizard — CCSE

When authorizing services, users should complete the **Financial wizard** first, the **Functional wizard** second and the **Authorization wizard** last. Information from the Financial and Functional wizards must be submitted prior to accessing the Authorization wizard.

If the Functional wizard is accessed first, the user will see a pop-up Client Error window at the end of the wizard with instructions to complete the Financial wizard before an eligibility decision can be made. Both the Financial and Functional wizards must be completed and information from those wizards submitted before the Authorization wizard can run properly.

If the user closes a wizard prior to completion in order to access other records, then returns to that wizard, the first window in the sequence will display. Click on **NEXT** in each window to get to the desired location in the wizard.

8112 Automatically Populated Folders by the SASO Wizards — CCSE

Revision 17-1; Effective March 15, 2017

Once all five wizards completed, the system automatically populates the following folders and/or forms:

- Applied Income/Co-Pay (Residential Care Cases)
- Authorizing Agent
- Case Ownership
- Diagnosis
- Enrollment
- Level of Service
- Service Authorization
- Service Item
- Title XX Eligibility
- Community Care Fact Sheet
- Form 2059, Summary of Client's Need for Service
- Form 2060, Needs Assessment Questionnaire and Task/Hour Guide
- Form 2064, Eligibility Worksheet
- Form 2101, Authorization for Community Care Services
- Monitoring Report
- Provider Referral Supplement
- Task/Hour Guide

8113 Records that Require User Entries Prior to Completing the SASO Wizards — CCSE

Revision 17-1; Effective March 15, 2017

Prior to working through the SASO wizards, the user must complete the following records:

- Address
- Phone (mandatory for ERS only)
- Other Information
- Case Ownership (if changes are needed)
- Service Request

The user must submit the case to SASO once the address, phone and other information folders are completed. This creates or updates the Location record.

8114 Address Folder — CCSE Services Using the SASO Wizard

Revision 17-1; Effective March 15, 2017

The Address folder records the individual's addresses. The user creates separate address records to record an individual's home or mailing address (if different from the home address), a responsible party's address and/or an executor's address. Information from this folder prints on the Provider Referral Supplement.

To register a home or mailing address:

1. Select the **Folder** icon for **Address** in the **Client** directory.
2. Select **Add** and the **Address** record will appear.
3. Select the **Type code** from the drop-down list in the **Type** field. The system defaults to 05-Mailing/Home.
4. Type the **intake date** as the effective **Begin Date** for initials. Type the **effective date** of the address in the Begin Date field for changes.
5. Type the **address** in the **Address** field.
6. The **Tel. No.** field is used to record the phone number of the **executor** only. **Do not** use this field to record the individual's phone number
7. Type the **city** in the **City** field.
8. Select the **state** from the drop-down list in the **State** field. The system defaults to TX-Texas.
9. Type the **ZIP code** in the **ZIP Code** field.

To register a responsible party's address:

1. Select the **Folder** icon for **Address** in the **Client** directory.
2. Select **Add** and the **Address** record will appear.
3. Select the **Type code 04-Other** from the drop-down list in the **Type** field. The system defaults to 05-Mailing/Home.
4. Type the **intake date** as the effective **Begin Date** for initials. Type the **effective date** of the address in the **Begin Date** field for changes.
5. Type the following in the **address lines:**

Line 1 – Enter the responsible party's name (First, Middle, Last). This line starts with **"C/O"** for "in care of."

Line 2 – Enter the first line of the responsible party's address (usually a street number or a P.O. Box).

Line 3 – Enter the first line of the responsible party's address (if needed, such as for an apartment number).

Note: Do not enter identifiers, such as daughter, directions to the home or any other miscellaneous text in any of these fields.

6. Type the **phone number** of the **responsible party** in the **Tel. No.** field, including the area code. Do not use parentheses. For example, enter 555-123-4567.
7. Type the **city** in the **City** field.
8. Select the **state** from the drop-down list in the **State** field. The system defaults to TX-Texas.
9. Type the **ZIP code** in the **ZIP Code** field.

To register an executor's address:

1. Select the **Folder** icon for **Address** in the **Client** directory.
2. Select **Add** and the **Address** record will appear.
3. Select the **Type code EX-Executor** from the drop-down list in the **Type** field. The system defaults to 05-Mailing/Home.
4. Type the **intake date** as the effective **Begin Date** for initials. Type the **effective date** of the address in the **Begin Date** field for changes.
5. Type the following in the **address lines:**

Line 1 – Enter the executor's name (First, Middle, Last).

Line 2 – Enter the first line of the executor's address (usually a street number or a P.O. Box).

Line 3 – Enter the second line of the executor's address (if needed, such as for an apartment number).

Line 4 – Enter the executor's telephone number, including the area code. Do not use parentheses. For example, enter 555-123-4567. **Note:** Do not enter identifiers, such as daughter, directions to the home or any other miscellaneous text in any of these fields.

6. Type the **city** in the **City** field.
7. Select the **state** from the drop-down list in the **State** field. The system defaults to TX-Texas.
8. Type the **ZIP code** in the **ZIP Code** field.

Address Changes:

When an address changes, add a record using these same instructions and enter the new Begin Date. This record is an exception to the rule of entering an End Date in the existing record before creating another record. SASO reads the most recent address with a HOME type as the individual's current address.

8115 Case Ownership — CCSE Services Using the SASO Wizard

Revision 17-1; Effective March 15, 2017

The Case Ownership folder displays information about the caseload in which the individual resides. The Authorization wizard automatically creates a record with data about the first case worker who submits information about the individual.

Once a budgeted job number (BJN) record is populated and submitted to the server, the BJN field is disabled. Use the following instructions to delete the original BJN record and create a new record with changes, if needed.

1. Select the **Folder** icon for **Case Ownership** in the **Case Worker** directory.
2. Click the original **BJN** record to highlight.
3. Select the **Cancel** button from the menu bar.
4. Submit the individual record.

5. After the record is submitted, again select the **Folder** icon for **Case Ownership** in the **Case Worker** directory.
6. Select the **Add** button from the menu bar.
7. Type the **BJN** of the employee in the **BJN** field.
8. Type the **Mail Code** (without dashes) of the employee in the **Mail Code** field. The other fields in this window automatically populate when the user accesses the Mail Code field.
9. **Submit** the individual record.

8116 Other Information — CCSE Services Using the SASO Wizard

Revision 17-1; Effective March 15, 2017

The Other Information folder contains additional information about the individual. Information from this record prints on the Provider Referral Supplement.

1. Select the **Folder** icon for **Other Information** in the **Client** directory.
2. Select the individual's **marital status** from the drop-down menu in the **Marital Status** field.
3. Select the **language** requiring translation from the drop-down menu in the **Translation Needs** field, if applicable.
4. Type **directions** to the individual's residence in the **Directions** field.

8117 Phone/Community Care — CCSE Services Using the SASO Wizard

Revision 17-1; Effective March 15, 2017

The Phone folder documents an individual's phone number. For ERS recipients, entering a land line (phone number) is mandatory. Additional records can be created to record numbers for relatives, friends or a responsible party.

To register phone information:

1. Select the **Folder** icon for **Phone** in the **Client** directory.
2. Select **Add** and the **Phone** record will appear.
3. The system defaults to **HO-HOME** in the **Type** field. Select **OT-OTHER** from the drop-down menu to register additional phone numbers.
4. Type the **date** the phone number is valid in the **Begin Date** field. This can be the same date as the **Begin Date** for enrollment.
5. Type the **phone number** in the **Phone No** field. There is no End Date field for a phone record.

To cancel a phone record:

1. Select the **Folder** icon for **Phone** in the **Client** directory.
2. Select the **phone record to be cancelled**.
3. Select **CANCEL** on the SASO toolbar.

When the records are completed, the user will submit them. By completing this step, the Location record will be created automatically.

8118 Service Request /Community Care — CCSE Services Using the SASO Wizard

Revision 17-1; Effective March 15, 2017

The Service Request folder displays the services for which an individual is to be screened. Entries in this folder are required before the wizards can be completed. The system defaults to CCSE.

For initial applications:

1. Select the **Folder** icon for **Service Request** in the **Wizards** directory.
2. Select the **program** for which the individual is applying or leave at the default.
3. Select **each service** for which the individual is to be screened. There are no edits in this window to prevent selecting mutually exclusive services.
4. When all requested services are selected, select the **Folder** icon for the **appropriate wizard** in the **Wizards** directory.

For updates, additions or changes:

1. Select the **Folder** icon for **Service Request** in the **Wizards** directory.
2. Select the **program** for which the individual is applying.
3. Select **each service already open and any new services** for which the individual is to be screened. There are no edits in this window to prevent selecting mutually exclusive services.

Business rules will run only on services selected in this window. Wizards overwrite old information as the user progresses through the windows. If currently open services are not selected in addition to the new services requested, data on currently open services may be deleted.

4. When all requested services are selected, move to the **Folder** icon for the **appropriate wizard** in the **Wizards** directory.

8120 Financial Wizard

Revision 17-1; Effective March 15, 2017

The Financial wizard is a prompting sequence of windows used to assess financial eligibility for CCSE services. It can also be used to verify Medicaid eligibility for other programs. Windows are conditional and will only display, if needed. Some windows are for statistical data collection purposes only. The Financial wizard must run before the Functional and Authorization wizards can be completed to authorize services. For Personal Assistance Services (PAS), each time the financial eligibility changes, the Functional wizard must be processed.

If an application is being denied due to functional eligibility and financial eligibility has not been determined, the case worker may enter zeros in the financial information to be able to proceed to the functional wizard.

After selecting the program in the Service Request window, open the Financial wizard:

1. Select the **Folder** icon for the **Financial wizard** in the **Wizards** directory.
2. Progress through the wizard by completing the entries in each window, then select **NEXT**.

8120.1 Service Request Window (Read Only) — Financial Wizard

Revision 17-1; Effective March 15, 2017

The **Service Request window** in the Financial wizard displays information in read-only mode about the program or services to be tested.

1. The status of the current service authorizations, if any, will display as Open or Closed. To make changes in the **Service Request window**, return to the **Service Request folder**.
2. Select **NEXT**.

8120.2 Categorical Eligibility Window — Financial Wizard — CCSE

Revision 17-1; Effective March 15, 2017

The **Categorical Eligibility window** displays information in read-only mode about open Medicaid-related cases, active Supplemental Nutrition Assistance Program (SNAP) cases and managed care. If no information is displayed, the individual has no open eligibility records on the System for Applications, Verifications, Eligibility Reports and Referral (SAVERR). Benefit information from the SAVERR database is updated each time an individual record is retrieved into the Financial or Functional wizards.

A red "H" is displayed in the Medicaid Related Coverage field when the SAVERR record is on hold. If a case is on hold, the SASO record for Medicaid-funded services (PHC and Title XIX DAHS) will process only if the hold is removed or if the Service Authorization record is Forced.

Select **NEXT**.

8120.3 CAS Eligible Window — Financial Wizard — CCSE

Revision 17-1; Effective March 15, 2017

The **CAS Eligible window** is a conditional window that displays only when the individual is applying for PAS and does not receive Medicaid.

1. Select **Yes** if the individual passes CAS screenable requirements. Follow appropriate procedures to process a CAS application.
2. Select **No** if the individual does not meet CAS screenable requirements.
3. Select **NEXT**.

8120.4 Decline QI1 Window — Financial Wizard — CCSE

Revision 17-1; Effective March 15, 2017

The **Decline QI1 window** is a conditional window that displays only when the individual receives Qualified Individual (QI)1. The individual must be willing to decline QI coverage in order to receive CAS.

1. Select **Yes** if the individual is willing to decline QI coverage.
2. Select **No** if the individual is not willing to decline QI coverage.
3. Select **NEXT**.

8120.5 Urgent Need Window — Financial Wizard — CCSE

Revision 17-1; Effective March 15, 2017

The **Urgent Need window** is a conditional window that displays only when the individual is applying for PAS and is not categorically eligible.

1. Select **Yes** if the individual meets the criteria for a verbal (expedited) referral.
2. Select **No** if the individual does **not** meet the criteria for a verbal (expedited) referral.

3. Select **NEXT**.

8120.6 Potential Eligibility Window — Financial Wizard — CCSE

Revision 17-1; Effective March 15, 2017

The **Potential Eligibility window** is a conditional window that displays only when the individual meets the criteria for a verbal (expedited) referral for FC.

If **No** is selected in the Potential Eligibility window, the wizard will display conditional Income and Resource windows to record financial information and verifications. If **Yes** is selected, the wizard will skip the Income and Resource windows.

1. Select **No** if the individual appears to be within the income and resource limits for FC based on the signed application, and financial verifications are available.
2. Select **Yes** if the individual appears to be within the income and resource limits for FC based on the signed application, but financial verifications are not available.
3. Select **No** if the individual does not appear to be within the income and resource limits for FC based on the signed application.
4. Type the **date** that the individual's financial eligibility is determined based on information on the signed application.
5. Select **NEXT**.

When financial verifications are received after services have been started, the user must re-enter this screen and select **No** in order to access the Income and Resource windows to record the verifications.

8120.7 Couple Information Window — Financial Wizard — CCSE

Revision 17-1; Effective March 15, 2017

The **Couple Information window** is a conditional window that displays information used to determine the income/resource limits for financial eligibility determination. The window will not display if the individual is a Supplemental Security Income (SSI) recipient.

1. The window defaults to **No.**
2. Select **Yes** if the individual is married and living in the same household with the spouse.
3. Select **NEXT**.

8120.8 Income Window — Financial Wizard — CCSE

Revision 17-1; Effective March 15, 2017

The **Income window** is a conditional window used to record the value of countable income and the method of verification for that income. The wizard automatically calculates total countable income as each entry is made in the Amount column.

1. Type the **dollar amount of all countable income** in the fields under the **Amount** column.
2. Select the **method of verification** from the drop-down menu in the **Verification** column for each type of income.
3. Select the **check box** under the **Doc Filed** column if verification for a particular type of income is filed in the case folder.
4. Select **NEXT**.

8120.9 Resources Window — Financial Wizard — CCSE

Revision 17-1; Effective March 15, 2017

The **Resources window** is a conditional window used to record the value of countable resources and the method of verification for those resources. The wizard automatically calculates total countable resources as each entry is made in the Amount column.

1. Type the **dollar amount of all countable resources** in the fields under the **Amount** column.
2. Type the **dollar amount of the individual's current monthly income** in the **Less Monthly Income** field if those monies are included in the checking account, savings account or cash on hand totals.
3. Select the **method of verification** from the drop-down menu in the **Verification** column for each resource.
4. Select the **check box** under the **Doc Filed** column if verification for a particular resource is filed in the case folder.
5. Select **NEXT**.

8120.10 Financial Totals Window — Financial Wizard — CCSE

Revision 17-1; Effective March 15, 2017

The **Financial Totals window** displays financial information about a categorically eligible couple or individual. The information is used for statistical purposes.

1. For individuals receiving CAS, Medical Assistance Only (MAO) or SNAP:

- Type the **total income and resources amounts for the couple** in the **Total Income and Total Resources** fields if the individual is married and living in the same household with a spouse; or
- Type the total income and resources amounts for the individual in the Total Income and Total Resources fields in other circumstances.

This window does not display for individuals receiving SSI only.

2. Select **NEXT**.

8120.11 Financial Eligibility Summary Window — Financial Wizard — CCSE

Revision 17-1; Effective March 15, 2017

The **Financial Eligibility Summary window** displays total countable income and resources for non-categorically eligible individuals. The window indicates whether the individual is within or exceeds income and resource limits. Overall financial eligibility displays as Passed or Failed. The window also displays the date financial eligibility is determined.

1. Type the **date the application was received** in MM/DD/YYYY format.
2. Select **NEXT**.

8120.12 Workers Checklist Window — Financial Wizard — CCSE

Revision 17-1; Effective March 15, 2017

The **Workers Checklist window** displays information about individual rights and responsibilities, referral to Area Agencies on Aging (AAA) and citizenship status. The window also displays whether an individual is financially eligible for Title XIX, CAS or Title XX services, or if the individual is not financially eligible for CCSE services.

1. Select **Rights and Responsibilities Discussed with the Client** to certify that the discussion of rights and responsibilities has taken place.
2. Select **Form 2307 given to the individual** to certify that Form 2307, Rights and Responsibilities, was given to the individual.
3. Select **Referral to AAA** if the individual is referred to AAA.
4. Select **Client not a U.S. citizen/is under 18** to indicate that the individual voluntarily acknowledges not having U.S. citizenship or that the individual does not meet the age requirement.
5. Select **GENERATE** once the Financial wizard is complete.
6. Select **OK**.

8130 Functional Wizard — CCSE

Revision 17-1; Effective March 15, 2017

The **Functional wizard** prompts the user through windows required to assess functional eligibility. Some windows are conditional and will display only if needed. The Financial wizard must run before the Functional wizard can be completed to authorize services.

To open the Functional wizard:

1. Select the **Folder** icon for **Service Request** in the **Wizards** directory.
2. Select the **program** for which the individual is applying.
3. Select **each service** for which the individual is to be screened. There are no edits in this window to prevent selecting mutually exclusive services.
4. Select the **Folder** icon for the **Functional Wizard** in the **Wizards** directory.
5. Progress through the wizard by completing the entries in each window, then select **NEXT**.

If the user has followed this procedure to access the Financial wizard and is moving directly from the Financial wizard to the Functional wizard, he does not have to repeat Steps 1 and 3 prior to opening the Functional wizard. Begin with Step 4.

8130.1 Service Request Window (Read Only) — Functional Wizard

Revision 17-1; Effective March 15, 2017

The **Service Request window** in the Functional wizard displays information in read-only mode about the program or services to be tested.

1. The status of current service authorizations, if any, will display as Open or Closed. To make changes in the Service Request window, return to the **Service Request folder**.
2. Select **NEXT**.

8130.2 Interview Window — Functional Wizard — CCSE

Revision 17-1; Effective March 15, 2017

The **Interview window** displays information about the most recent interview.

To delete previous assessment information, select **Clear Assessment**. Selecting Clear Assessment clears previous information from all of the screens in the Functional wizard.

1. Select the **Type of Assessment, Primary Contact** and **Location** specific to the current interview.
2. The **Interview Date** box displays the current date. Type a **different date** in the box, if necessary.
3. Type the **date services are requested** in the **Intake Date** box.
4. Type the **date the case worker received** Form 2110, Community Care Intake, in the **Assignment Date** box.
5. Type the **date the application is denied** for an individual with no active service authorization record in the **Application Denied Date** box. For example, if an individual files an application for services, but dies before those services are authorized, enter the denial date in this box.
6. Select the **reason for the denial** from the drop-down list in the **Denied Reason** box.
7. Select **NEXT**.

8130.3 Household Window — Functional Wizard — CCSE

Revision 17-1; Effective March 15, 2017

The **Household window** displays information about other persons living in the household with the individual.

1. Select **YES** if there are any other adults or CCSE individuals residing in the household. Default entries may appear in this field on reviews. Change the selection, if necessary.
2. Type the **name of any other adult** (whether they are an individual or not) or **CCSE individual** (regardless of age) who lives in the household.
3. For each name listed:

- Select the **CCSE** box if the other person receives any CCSE service.
- Select the **Companion** box if there is another person in the household who receives CCSE PAS.
- Type the **client number** if the other person has a number.

4. Select **NEXT**.

8130.4 Health Concerns Window — Functional Wizard — CCSE

Revision 17-1; Effective March 15, 2017

The **Health Concerns window** displays information about current health conditions resulting in functional limitations or physical, mental or emotional impairment for the individual. Individuals in DAHS must have a medical diagnosis. Individuals receiving CAS or Title XIX PAS must have a medical need.

1. Select **each condition** that describes the individual's current health.
2. Select **Other** for a condition not listed. Type a **description of the condition** in the box provided (maximum 254 characters).
3. Select **NEXT**.

8130.5 Depression Details Window — Functional Wizard — CCSE

Revision 17-1; Effective March 15, 2017

The **Depression Details** window displays questions about depression. If either of the first two questions is selected, the response boxes on the next four questions are activated.

1. Select **each question** to which the individual's response is **Yes**. The wizard will automatically enter a score in the Impairment Scoring window, based on the responses in this window. The score is editable only in this window.
2. Select **NEXT**.

8130.6 Impairment Scoring Window — Functional Wizard — CCSE

Revision 17-1; Effective March 15, 2017

The **Impairment Scoring window** displays functional assessment information (Form 2060, Needs Assessment Questionnaire and Task/Hour Guide).

1. For each task listed, select an **Impairment Score of 0 – 3** from the drop-down menu or type a score of 0 – 3 in the **Impairment Score** field.

Press **ENTER** or use the mouse to move to the next field. Use the scroll bar to the right of the window to scroll down through all of the functional tasks. Continue until all functional tasks have been scored.

2. Type **comments** in the Task Comments box (maximum 254 characters). A separate Task Comments box is available for each functional task. Comments will print out on Form 2060 next to the appropriate task.

If a caregiver partially assists with a task and it will be purchased, enter the part of the task or scheduled time the caregiver will do the task. This task will be marked as P/C. **Example:** Sue Jones, daughter, can lay out bathing supplies, but can't help the individual into the bath tub.

If a caregiver is not available during the time purchased tasks are delivered, but provides care at all other times, the case worker may enter one comment for the entire Form 2060. Since bathing is the first task, a comment may be entered in bathing that applies to all tasks. **Example:** Sue Jones, daughter, assists with all tasks in the evenings and on weekends.

It is not necessary to list the caregiver under other tasks unless the caregiver is performing all of the task (C) or part of the task during the service schedule (P/C).

If an agency is providing part of a task, enter the schedule for the agency in the Comments section. **Example:** ABC Home Health provides bathing on M-W-F and individual needs task purchased on T-Th.

3. For PAS, select **To Be Purchased** for each task that will be purchased.

Note: If the applicant does not meet the minimal functional score required to qualify for PAS, **do not** select tasks in the To Be Purchased column. Do not complete this information because the applicant does not qualify for PAS services.

4. Select **View Activities** to display a Task/Time Allocation window for that task. View Activities is selected by default for the laundry, meal preparation and escort tasks.
5. The **Activities Selected** column displays as "read only" once activities are selected on the Task/Time Allocation window for a specific task.
6. Select the **SET DATE** button when the functional assessment is completed or updated. The current date will be entered and cannot be changed.

This date will default to zeros each time the Functional wizard is opened. The date must be set again at each update. Do not set the date if Form 2060 is not administered.

7. Select **NEXT**.

8130.7 Task Purchased Details Window(s) — Functional Wizard — CCSE

Revision 17-1; Effective March 15, 2017

When the individual lives with another person, the **Task Purchased Details window** displays for each purchased cleaning, meal preparation, shopping and laundry task.

1. Select the **reason(s)** that justify purchasing each task.

- If the household member has stated he is unwilling and refuses to perform the task, check "Household member refuses to perform task." This individual will be listed as a "Do Not Hire."
- If the household member works full time, check "Household member is unable to perform task."

2. Select **NEXT**.

8130.8 Support Assisting Client Window — Functional Wizard — CCSE

Revision 17-1; Effective March 15, 2017

The **Support Assisting Client window** is used to enter or view information about support currently being provided. Impairment scores previously selected in the Impairment Scoring window display in read-only mode. **P** will display for each purchased task. Unless there are actually two supports for a task, only one code should appear on the printed Form 2060, Needs Assessment Questionnaire and Task/Hour Guide. If the task is purchased and there is no other support, then the blank is selected for the primary support type.

1. Select a **primary support type** from the drop-down menu for each functional task listed.
    - If a task is being purchased and the individual does not receive assistance from a caregiver or other agency in performing the task, and the impairment score is 1 or 2, **select self** from the drop-down menu **or leave the default blank** to indicate a not applicable response.
    - If a task is being purchased and a caregiver, other agency or the individual assists some of the time, select the appropriate primary support type from the drop-down menu. The part of the task the caregiver or other agency performs should be noted in the comment section for that task on the Impairment Scoring window.
    - If a task is not being purchased because a caregiver, other agency or the individual performs the task all of the time, select the appropriate primary support type from the drop-down menu.
2. If the **primary support type** is **caregiver**, type the **name** and relationship in the **Support Name field** beside each functional task. If the primary support type is **agency**, type the name of the agency in the **Support Name field** beside each functional task.

Once a name is typed in the Support Name field, that name will automatically display each time the same primary support type is selected. This field is editable. If another caregiver is assisting with other tasks, type the name and relationship in the Support Name field beside the functional task.

3. The **Support Quality and Reliability column** displays when the impairment score is 3 for any of the four priority tasks (feeding, toileting, transfer or meal preparation), and the task is to be purchased. Select a **score** from the drop-down menu to describe the quality and reliability of the available support.
4. Select **NEXT**.

8130.9 Caregiver Support Details Window — Functional Wizard — CCSE

Revision 17-1; Effective March 15, 2017

For a purchased task, a **Caregiver Support Details window** displays for each caregiver listed in the Support Assisting Client window. The caregiver name displays in read-only mode at the top of the screen.

1. Select the **reason(s**) why the caregiver cannot fully perform the purchased task. The reason will default to blank each time the Functional wizard is opened and must be re-entered for each update.
2. Select **Yes** or **No** to indicate if the caregiver is a paid attendant.
3. Select **NEXT**.

8130.10 Paid Attendant Window — Functional Wizard — CCSE

Revision 17-1; Effective March 15, 2017

1. If **Yes** is selected indicating the caregiver is a paid attendant, this window appears. It is no longer applicable and will be removed at a future date.
2. Select **NEXT**.

8130.11 Other Agency Support Details Window — Functional Wizard — CCSE

Revision 17-1; Effective March 15, 2017

For a purchased task, an **Other Agency Support window** displays for each agency listed in the Support Assisting Client window. The agency name displays in read-only mode at the top of the screen.

1. Select the **reason(s)** why the other agency cannot fully perform the purchased task.
2. Select **NEXT**.

8130.12 Task/Time Allocation Window — Functional Wizard — CCSE

Revision 17-1; Effective March 15, 2017

A **Task/Time Allocation window** displays by default for the laundry, meal preparation and escort tasks. It also displays for any other tasks that have **View Activities selected** on the Impairment Scoring window. Impairment scores previously selected display in read-only mode. Rules processed in this window determine whether the Supervisor window is required. If the individual lives with another person, an asterisk displays beside a purchased general household task.

1. Type the **number of minutes per day and days per week** or the **minutes per week** in the appropriate field.
    - For **meals** purchased through **HDM only**, no entries are required in the number of Minutes per Day, Days per Week and Minutes per Week fields.
    - For the **escort** task, type **how often** the task is to be performed. If the task is to be performed less than once per month, no entry is required in Minutes per Day or Minutes per Week fields.
2. Select the **activities** associated with performing the task.

- For **laundry**, select **Washer** or **Dryer**, if the individual has one.
- For **meal preparation**, select the **specific meal(s)**, breakfast, lunch or dinner, to be purchased through PAS. Do not check "lunch" if lunch is purchased through HDM only. Use comments to document if lunch is also delivered through PAS on days not provided by HDM.
- For **meal preparation**, select whether meals will be purchased through **HDM only, HDM/PAS** or **PAS only**.
- For **escort**, if frequency in Days per Week is more than 1, then supervisory approval is required.

3. Select **NEXT**.

8130.13 Task/Hour Guide Summary Window — Functional Wizard — CCSE

Revision 17-1; Effective March 15, 2017

The **Task/Hour Guide Summary window** displays a summary of information entered on individual Task/Hour Tasks windows. The tasks and impairment scores display in read-only mode when the individual is being screened for PAS eligibility. If the individual lives with another person, an asterisk displays beside a purchased general household task.

Use this window to enter the time allocation for any task where a Task/Time Allocation window was not completed.

1. To add or delete purchased tasks or to change impairment scores, return to the Impairment Scoring window by selecting the **BACK** button.
2. To enter or modify time allocations, type the **number of minutes per day** and **days per week** or the **minutes per week** in the appropriate box beside each task. Changes made on this window will automatically update the Task/Time Allocation window.
3. Select the **SET DATE** button to record completion of the task/hour guide. Once the date is set for an assessment, it cannot be changed.
4. Select **NEXT**.

This date will default to zeros each time the Functional wizard is opened. The date must be reset at each update. Do not set the date if the individual is not being screened for PAS eligibility.

8130.14 Supervisor Window — Functional Wizard — CCSE

Revision 17-1; Effective March 15, 2017

The **Supervisor window** displays when supervisory approval to exceed maximum times is required.

1. Select **YES** if **supervisory approval** is received to **exceed the maximum daily** or **weekly times** for a purchased task for any individual.
2. Type the **date of approval**.
3. Select the **method of approval** from the drop-down menu.
4. Select **NEXT**.

8130.15 CCSE Attendant Hours Adjustment Window — Functional Wizard

Revision 17-1; Effective March 15, 2017

The **CCSE Attendant Hours Adjustment window** displays the total impairment score in read-only mode (not including the feeding/eating task).

The priority status displays and can be changed from Priority to Non-Priority.

Authorization calculations based on task/hour information and available aid and attendance (A & A) hours display in read-only mode. The wizard calculates the A & A hours to be deducted from the total authorization based on the monthly amount entered and the current maximum attendant care rate.

1. Select **No** to change from Priority to Non-Priority.
2. If the individual is using A & A or Home-bound Elderly funds to purchase services that meet the intent of A & A or Home-bound Elderly benefits, select the **explanation(s)** of how A & A or Home-bound Elderly benefits are being used. Leave the Monthly Amount box blank.
3. If the individual is using all or part of monthly A & A or Home-bound Elderly funds to purchase services which do not meet the intent of A & A or Home-bound Elderly benefits, type the **whole dollar amount being misspent** in the Monthly Amount box. Do not select an explanation.
4. The Current Status of Medical Need displays as "read only" based on entries made by the nurse in the Authorization wizard. The current status of medical need is not editable in this window.
5. Select **NEXT**.

8130.16 Six Hour Window — Functional Wizard — CCSE

Revision 17-1; Effective March 15, 2017

The **Six Hour window** displays when less than six hours per week of personal attendant service is authorized.

1. Select the **reason** an individual receives less than six hours per week of personal attendant services.
2. Select **NEXT**.

8130.17 Home Environment Window — Functional Wizard — CCSE

Revision 17-1; Effective March 15, 2017

The **Home Environment window** displays information about the location and condition of the individual's residence, the existence or lack of barriers to service delivery in the home environment, and the availability of assistive devices and transportation.

1. Under **Residence**, select the **best description** of the individual's living arrangement.
2. Under **Assistive Devices**, select **any device(s) currently available** at the individual's residence. Select **Other** for any item not on the list and type an **explanation** in the box (maximum 254 characters).
3. Under **Laundry**, select the **best description** of available appliances.
4. Under **Adequate, Unsafe and Questionable**, select the **item(s) that describe the condition** of the residence.
5. Under **Miscellaneous**, select **special-equipped vehicle for transport** if the individual has a specially equipped vehicle.
6. Select **NEXT**.

8130.18 Emergency Response Services Window — Functional Wizard — CCSE

Revision 17-1; Effective March 15, 2017

The **Emergency Response Services window** displays only when ERS is requested.

1. Select **YES** if the ERS applicant is home alone for eight or more hours each day or lives with an incapacitated person who cannot call for help or otherwise assist in an emergency.
2. Select **NEXT**.

8130.19 Eligibility Determination Window — Functional Wizard — CCSE

Revision 17-1; Effective March 15, 2017

The **Eligibility Determination window** displays the results of the functional eligibility determination. A green check mark indicates that the individual is eligible for a specific service. A red X indicates that the individual is not eligible for a specific service. A message displays if the Financial wizard has not already been completed or if there is a discrepancy between current SAVERR information and the information in the Financial wizard.

The Functional wizard will deny PHC or PHC CDS if the individual is under age 21. The user will receive a pop-up message, "PHC failed because the individual is under 21 years old, or no birth date was recorded."

1. Select **Generate** once the Functional wizard is completed
2. Select **OK**.
3. Click on the **Submit** button on the SASO navigator bar to file records to SASO.

The Functional wizard will deny PHC or PHC CDS if the individual is under age 21. The user will receive a pop-up message, "PHC failed because the individual is under 21 years old, or no birth date was recorded."

4. Click on the **Search** button on the SASO navigator bar to re-pull the case or double-click on the individual's name in the SASO List Data window.

Records to be populated by the wizards will display in the appropriate folders, but will not contain all required information until after the Authorization wizard has been completed.

8140 Authorization Wizard

Revision 17-6; Effective June 28, 2017

The Authorization wizard can be accessed directly without going through the Financial and Functional wizards to change providers, authorize a pending service or terminate some open services.

At the beginning of the Authorization wizard, the system will prompt the user to redo the Financial/Functional wizard if there is a discrepancy between current SAVERR information and the information in the Financial wizard. This will also occur if open services were unselected on the Service Request window, which results in data being lost.

8141 Service Request Folder — Authorization Wizard — CCSE

Revision 17-1; Effective March 15, 2017

The **Service Request folder** displays the services on which action is to be taken. Entries in this folder are required before the Authorization wizard can be completed.

For initial applications:

1. Select the **Folder** icon for **Service Request** in the **Wizards** directory.
2. Select the **program** for which the individual is applying.
3. Select **each service** for which Form 2101, Authorization for Community Care Services, is to be created. Unselect any marked services on which no Form 2101 is needed. There are no edits in this window to prevent selecting mutually exclusive services.
4. When all requested services are selected, select the **Folder** icon for the **Authorization wizard** in the **Wizards** directory.

For updates, additions or changes:

1. Select the **Folder** icon for **Service Request** in the **Wizards** directory.
2. Select **each service** in which changes will be made. Unselect any marked services on which no changes occur. There are no edits in this window to prevent selecting mutually exclusive services.
3. When all requested services are selected, move to the **Folder** icon for the **Authorization wizard** in the **Wizards** directory.

8142 Eligibility Details Window — Authorization Wizard — CCSE

Revision 17-1; Effective March 15, 2017

The **Eligibility Details window** displays the results of the financial and functional eligibility determination. A green check mark indicates that the individual is eligible for a specific service. A red X indicates that the individual is not eligible for a specific service.

White radio buttons in the window default to one of the following for each service:

- **Accept** if the individual or applicant is eligible for a particular service.
- **Reject** if the individual or applicant is not eligible for a particular service.
- **Terminate** if the individual is no longer eligible for a particular service and there is an open service authorization.

To indicate the **action to be taken** for each service, **change the radio buttons** as follows:

1. Select **Reject** if the applicant didn't request the service, and there is no open service authorization.
2. Select **Deny** if the applicant requested to be screened for a particular service, and **Reject** is displayed.
3. Select **Provider Transfer** if the individual has requested a new provider for an ongoing service. **Do not** select Provider Transfer for an ongoing CAS service authorization when an agency transfer is completed in conjunction with an annual assessment.
4. Select **Terminate** if there is an open authorization for a service and the service needs to be discontinued.
5. Select **NEXT**.

8143 Service Code Selection Window — Authorization Wizard — CCSE

Revision 17-1; Effective March 15, 2017

The **Service Code Selection window** displays only if PAS, RC or SSPD are selected on the Service Request window.

1. Select **one service code** for each requested service. If the service being authorized is CDS-related, choose the service code under the CDS column. Only one code can be selected per category.

Note: Continue to authorize both RC and room and board at annual reassessment for those RC individuals who were authorized for RC before Sept. 1, 2003, and who did not have adequate income to pay their full room and board fee. When reauthorizing RC services for these individuals, be sure to select the **room and board option** for the appropriate living arrangement. For example, when authorizing 19K – RC Apartment, select 19O – RC – Room and Board – Apt.

2. Select **NEXT**.

8144 Service Arrangement Window — Authorization Wizard — CCSE

Revision 17-1; Effective March 15, 2017

The **Service Arrangement** window displays a list of services as marked on the Service Request window. For each service:

1. Select **View Provider** if a new provider will be selected for an initial or ongoing authorization, or if there is a change in the provider delivering a service.

Notes:

- When authorizing RC services and room and board for those individuals authorized for RC prior to Sept. 1, 2003, be sure to select **View Provider** for both the RC and room and board authorizations.
- When authorizing CDS, Service Code 63V will also appear with Service Code 17V.

2. Select **Client, Doctor or Rotation** to indicate how the provider is to be selected. The field defaults to Client, but is editable.
3. Select the **county in which the individual will receive the service**. The field defaults to the county in the SASO location folder, but is editable.
4. Select **NEXT**.

8145 Provider Selection Window — Authorization Wizard — CCSE

Revision 17-1; Effective March 15, 2017

A **Provider Selection window** displays when **View Provider** is selected on the Service Arrangement window. All providers for a particular service in the selected county will display in alphabetical order by name. If the service being authorized is CDS-related, the wizard will display only those contract providers that are CDS for that service and program group and county.

1. Select the **provider to deliver services** by using the arrow keys on the computer keyboard or by using the Enter key.
2. When the red arrow is pointing to the correct provider, double click on the provider name or contract number. Information about the selected provider name will display at the top of the screen.

Note: When authorizing RC room and board individuals authorized for RC prior to Sept. 1, 2003, be sure to select the same provider selected for the RC service.

3. Select **NEXT**.

8146 Worker's BJN and Nurse's BJN Window — Authorization Wizard — CCSE

Revision 17-1; Effective March 15, 2017

The Worker's BJN and Nurse's BJN window displays in read-only mode the worker information from the Ownership folder. When the nurse is completing the service authorization, the nurse's BJN displays in read-only mode.

Select **NEXT**.

8147 Information for Authorize Window — Authorization Wizard — CCSE

Revision 20-3; Effective September 1, 2020

The **Information for Authorize window** collects data for case workers and nurses to complete the service authorization. A separate window displays for each service to be authorized or terminated. Unique fields display on service-specific windows.

Type Authorization is displayed for each service. Type authorizations that require nurse action are:

- Authorize Initial — CAS or DAHS
- Refer Update — CAS at annual reassessment

Type authorizations that require case worker action are:

- Refer Initial — PHC, CAS and DAHS
- Authorize Initial — All services except CAS and DAHS
- Authorize Update — All services
- Refer Update — CAS with or without changes at annual reassessment
- Authorize Terminate

1. Edit the date Form 2101, Authorization for Community Care Services, is mailed to the contracted agency in the Form 2101 field. The system defaults to today's date. Edit the date, if necessary, for the mail date.
2. For the Begin Date field, enter information according to the following:
    a. **PHC:**
        - **Initial Referral** — Pending, the case worker **leaves the Begin Date field blank**.
        - **Authorization** — The case worker enters the **mail date** (Same as Item #1) in the **Begin Date** field.
    b. **CAS:**
        - **Initial Referral** — Pending, the case worker leaves the **Begin Date field blank**.
        - **Authorization** — The HHSC nurse enters the **mail date** (same as Item #1) in the **Begin Date** field.
    c. **DAHS:**
        - **Initial Referral** — Pending, the case worker leaves the **Begin Date** field blank.
        - **Authorization of Case Worker Referral** — The HHSC nurse enters the **mail date** in the **Begin Date** field.
        - **Authorization of Facility Initiated Referral** — The HHSC nurse enters the date of the physician's orders in the **Begin Date** field.
    d. For **initial referrals** other than PHC, DAHS or CAS, the case worker enters the **effective date of the authorization** in the **Begin Date** field. **Note:** This date should match the effective date on Form 2065-A, Notification of Community Care Services.
    e. For updates, the case worker enters **the date the change is to be effective** in the **Begin Date** field. The wizard will automatically close an open authorization for that same service effective the day before the begin date on the updated authorization.
    f. For reassessments other than CDS, complete the **Begin Date** field according to the following:

- For PHC reassessments with changes in services, the case worker enters **the effective date of the change** in the **Begin Date** field.
- For CAS reassessments without changes (pending), the case worker **leaves the Begin Date field blank**.
- For CAS reassessments with changes, the nurse enters **the effective date of the change** in the **Begin Date** field.
- For CDS reassessments, the case worker enters **the day following the end date of the previous authorization** in the **Begin Date** field.

3. For the **End Date** field, the case worker enters information according to the following:
   a. For initial authorizations other than CDS authorizations, **leave the End Date field blank**.
   b. For CDS authorizations, the end date will **pre-populate** to be one year minus a day from the date entered in the **Begin Date** field.
   c. For terminations, enter **the date the contracted agency is no longer authorized to deliver services** in the **End Date** field.
4. Select the **termination reason** from the drop-down menu.
5. The **Unit Type** field will default to the correct unit type for that service. If the Unit Type field is activated, select the **unit type** for the service from the drop-down menu.
6. The **Adj. Units** field will default to the number of units for that service. If the Adj. Units field is activated, the **number of units** can be edited.

- For 28-SSPD, type **the number of units per week** for day care, counseling or interpreter services in the **Adj. Units** field.
- For 28A-SSPD Case Management, type **1** in the **Adj. Units** field.
- For RC room and board for those persons authorized prior to Sept. 1, 2003, type **the difference between the current room and board amount and the individual's income** in the **Adj. Units** field.

7. Select the **PAS Incr. Approved** field if supervisor approval is needed for increased hours.
8. Select the **living arrangement** from the drop-down menu.
9. If the person meets criteria for Money Follows the Person (MFP), select **Rider 37** from the **Enrolled From** drop-down menu. If the person does not meet Rider 37 criteria, completion of this field is optional. **Warning:** Do **not** select "Nursing Facility" in this field for persons who meet MFP criteria.
10. For RC services, type the **dollar amounts of the initial and ongoing co-payment** in the appropriate fields.
11. Type **documentation or comments to the provider agency** in the **Comments** field.

a. For all PAS, enter the number of days the person is requesting services and if the person requires a specific schedule.
b. Enter the caregiver name and tasks performed, SASO Form 2060, Needs Assessment Questionnaire and Task/Hour Guide, will be sent to the provider containing that information.
c. Enter the name of any person who should not be hired and designate as "**Do Not Hire**."

12. Select the **service authorization status** from the drop-down menu:
    a. Select **Authorize** if:
       - initial services are being authorized by a nurse or a case worker; or
       - changes to the service plan are being authorized by a nurse or a case worker.
    b. Select **Terminate** if:
       - existing services are being closed by a nurse or a case worker; or
       - the "flavor" of a service is being changed based on fund type.
    c. Select **Deny** if:
       - initial PHC is being denied by a case worker; or
       - initial CAS or DAHS is being denied by a nurse.
    d. Select **Pending** if:
       - a case worker is referring a case to the provider for pre-initiation activities; or
       - the case worker completes an annual reassessment for CAS without changes.

e. Select **Reassessment Required** if a nurse is requesting the case worker to reassess the case.

13. Type **documentation or comments** to the provider agency in the **Comments** field.
14. Select **No Order/Statement** or **No medical need**, if appropriate.
15. Type the **name** of the practitioner in the **Name** field.
16. Type the **phone number** of the practitioner in the **Phone** field.
17. Type the **license number** of the practitioner in the **Lic No** field.
18. Type the **date of the practitioner's orders** in MM/DD/YYY format in the **Order Dt** field.
19. Type up to five **diagnosis codes** in the numbered Diagnosis fields for DAHS. Each diagnosis code should have five characters.
20. Select **NEXT**.

8148 Information for Terminate Window — Authorization Wizard — CCSE

Revision 17-1; Effective March 15, 2017

The **Information for Terminate window** displays the services selected for termination on the Eligibility Details window.

1. The Form 2101, Authorization for Community Care Services, Date field defaults to the current date. This field is editable.
2. Type the **end date** of the service in the End Date field.
3. Select the **termination reason** from the drop-down menu.
4. **Submit**.

The system messages the user if changes in the functional assessment are needed based on the denial reason selected.

8149 Authorization Summary Window (Read Only) — Authorization Wizard — CCSE

Revision 17-1; Effective March 15, 2017

The **Authorization Summary window** displays the services that have been referred, authorized or terminated and the authorization status in read-only mode.

1. Select **Generate** once the Authorization wizard is complete.
2. **Submit**.

Note: When terminating an AFC or RC authorization, a pop-up message displays indicating there is an open Applied Income/Co-pay record that must be closed manually as a Force.

8150 Nurse Authorizations Using the Wizards — CCSE

Revision 17-1; Effective March 15, 2017

8151 Nurse Entries to Authorize Initial DAHS or CAS Using the Wizards — CCSE

Revision 17-1; Effective March 15, 2017

To authorize initial DAHS or CAS, the nurse must:

1. Run the **Authorization wizard**, including completing the **Information for Authorize PAS (PHC/FC) window**.
2. **Submit**.

When DAHS is authorized for an individual who is also receiving CLASS, DAHS is the secondary service. SASO recognizes DAHS as an overlapping service with CLASS, and no Force is required.

8152 Nurse Entries to Authorize Changes in CAS Using Wizards — CCSE

Revision 17-1; Effective March 15, 2017

To authorize changes in CAS at the annual reassessment, the nurse must:

1. Run the **Authorization wizard**, making any changes in the **Information for Authorize PAS (PHC/FC)** window.
2. **Submit**.

8160 Changes to CCSE Authorizations Using the Wizards

Revision 17-1; Effective March 15, 2017

The wizards will process most changes and will update all required SASO records. The wizards cannot process an action requiring a Force.

8161 Form 2060 Score Changes Using the Wizards — CCSE

Revision 17-1; Effective March 15, 2017

If the individual's Form 2060, Needs Assessment Questionnaire and Task/Hour Guide, score changes:

1. Select **all currently open services** in the Service Request window.
2. Run the **Functional wizard**, making changes as needed, including setting the date for Form 2060.
3. **Submit** by selecting the Submit button on the toolbar.
4. Run the **Authorization wizard**.
5. **Submit**.

8162 Adding, Changing or Terminating Services Within Service Group 7 Using the Wizards — CCSE

Revision 17-1; Effective March 15, 2017

Note: Generate and submit the Monitoring wizard before changes are made to services in the Authorization wizard.

1. Select the services to be added, changed or terminated in the **Service Request window**. The system will prompt the user to redo the **Financial wizard** if there is a discrepancy between current SAVERR information and the information in the Financial wizard. If needed, make changes to the **Functional Wizard**.

2. If changes were made in the **Financial or Functional wizard**, be sure to **submit**.

Making Changes Using the Authorization Wizard

The **Authorization wizard** can be accessed directly without going through the **Financial and Functional wizards** to change providers, authorize a pending service or terminate some open services.

1. In the Service Request folder, select each service in which changes will be made. Unselect any marked services on which no changes occur. There are no edits in this window to prevent selecting mutually exclusive services.
2. When all requested services are selected, move to the Folder icon for the Authorization wizard in the Wizards directory.
3. The Eligibility Details window displays the results of the financial and functional eligibility determination. A green check mark indicates that the individual is eligible for a specific service. A red X indicates that the individual is not eligible for a specific service.
4. The Service Code Selection window displays only if PAS, Respite, RC or SSPD are selected on the Service Request window.
5. Select one service code for each requested service. If the service being authorized is CDS-related, choose the service code under the CDS column. Only one code can be selected per category.
6. The Service Arrangement window displays a list of services as marked on the Service Request window. For each service, view and select a provider. All providers for a particular service in the selected county will display in alphabetical order by name. If the service being authorized is CDS-related, the wizard will display only those contract providers that are CDS for that service and program group and county. When the red arrow is pointing to the correct provider, double click on the provider name or contract number. Information about the selected provider name will display at the top of the screen.
7. The Information for Authorize window collects data for case workers and nurses to complete the service authorization. A separate window displays for each service to be authorized or terminated.

Changes — RC Using the Wizards

Case workers can terminate the services that are mutually exclusive at the same time that they authorize Assisted Living (AL)/RC by selecting **Terminate** for those services. For RC, the wizard will close the Applied Income/Co-pay record when the end date is a future date. The wizard will not close the Applied Income/Co-pay record when terminating RC services with a prior end date.

After terminating the RC service authorization using the wizard:

1. **Open** the Applied Income/Co-pay Folder and **select** the open co-pay record.
2. **Click** on the Force box (it contains a check mark). **Enter** comments in the pop-up box and click on Unforce.
3. **Enter** the end date used to terminate RC in the End Date field.
4. **Click** on the Force box again (this time there is no check mark in the box). **Enter** comments, **click** on Force and **Submit**.

The following instructions are for individuals who were authorized for services before Sept. 1, 2003, and who did not have adequate income to pay their full room and board fee.

For these individuals, the user must choose AL/RC, along with AL/Room and Board, in the Service Request window.

- Select **SC 19N – RC – Room and Board – Non-Apt** when the service being authorized is RC Non-Apt.
- Select **19O – RC – Room and Board – Apt** when the service being authorized is RC Apt.

In the **Information for Authorize** window, enter the difference between the current room and board fee and the individual's current income in the Adj. Units field. **Example:** The individual's current income is $300 per month

and the current room and board amount is $398.54. Enter $98.54 in the Adj. Units field ($398.54 − $300 = $98.54).

- Type the **date** the individual is authorized to receive RC services in the **Begin Date** field. Leave the End Date field at default zeros.
- Type the **RC provider contract number** in the **Contract No** field. Do not type leading zeros.
- Select **Submit** from the Command Menu or the toolbar to submit the authorization.

An RC individual can reserve his space in the facility during hospital, nursing facility or institutional stays.

To register a service authorization for RC bedhold charges:

1. Select **19H-ASSISTED LIVING BEDHOLD** from the drop-down list in the **Service Code** field.
2. Type the date the individual entered the hospital, nursing facility, etc. in the **Begin Date** field. Type the **day before the individual was discharged** from the hospital or nursing facility in the **End Date** field.
3. Type the **RC provider contract number** in the **Contract No** field. Do not type leading zeros.
4. Select **Submit** from the Command Menu or the toolbar to submit the authorization.

Changes — Transfers Between Programs

If the individual is transferring from FC to PHC, the wizard will detect the individual's eligibility for Title XIX funding and close the Title XX eligibility record, if required. The Service Authorization record will remain open.

If the individual is transferring from CAS to PHC or vice versa based on a fund code change, the wizard will detect the individual's eligibility, but will not close the Service Authorization record. In this situation, terminate the Service Authorization record, and then run the Financial, Functional and Authorization wizards to redo the Service Authorization record.

Other Changes

If the individual record has been denied in the Authorization wizard based on No Medical Need or No Order/Statement, the Functional wizard will detect the reason and fail the individual for PHC or CAS. In this situation, run the Authorization wizard to remove the selection, and then run the Functional and Authorization wizards.

If the individual's financial eligibility changes in the Financial wizard, the Functional wizard must be run to ensure that Form 2101, Authorization for Community Care Services, prints properly.

8163 Case Worker/Nurse Changes Using the Wizards — CCSE

Revision 17-1; Effective March 15, 2017

When the individual is assigned to another case worker/nurse, follow the instructions for editing the Case Ownership record. When the case worker/nurse runs the Authorization wizard, the Authorizing Agent record will be populated with information from the Case Ownership record.

8164 Change in Provider Agency Using the Wizards — CCSE

Revision 17-1; Effective March 15, 2017

To record a change in provider agency:

1. Select each service that will have a provider change in the **Service Request window**.

2. Select the **Authorization wizard**. Select **View Provider** on the **Service Arrangement** window so that the **Provider Selection** window will display. Select the new provider.
3. In the **Information to Authorize** window, enter the first day the new provider is authorized to deliver services in the **Begin Date** field. Select **Authorize** in the **Service Authorization Status** field. Select **Next**.
4. **Submit**.

8165 Change in Co-Pay Using the Wizards — CCSE

Revision 17-1; Effective March 15, 2017

When the co-pay changes:

1. Select **all currently open services** in the Service Request window.
2. Run the **Functional wizard**, making changes as needed.
3. **Submit** by selecting the Submit button on the toolbar.
4. Run the **Authorization wizard**, making any change in co-pay amounts on the **Information for Authorize** window.
5. **Submit**.

8166 Deleting a Registered Task Using the Wizards — CCSE

Revision 17-1; Effective March 15, 2017

To delete a registered task:

1. Select **all currently open services** in the Service Request window.
2. Run the **Functional wizard**, making changes as needed.
3. **Submit** by selecting the Submit button on the toolbar.
4. Run the **Authorization wizard**.
5. **Submit**.

8167 Increases or Decreases in the Number of Units Using the Wizards — CCSE

Revision 17-1; Effective March 15, 2017

When a service plan change results in an increase or decrease in the number of units:

1. Select **all currently open services** in the Service Request window.
2. Run the **Functional wizard**, making changes as needed.
3. **Submit** by selecting the Submit button on the toolbar.
4. Run the **Authorization** wizard.
5. **Submit**.

8168 Priority Changes Using the Wizards — CCSE

Revision 17-1; Effective March 15, 2017

The wizards automatically determine the individual's priority level and display the level on the CCSE Attendant Hours Adjustment window.

To change an individual from Priority to Non-Priority:

1. Select **all currently open services** in the Service Request window.
2. Run the **Functional wizard**, making changes as needed, including changing the priority level on the **CCSE Attendant Hours Adjustment window**.
3. Submit by selecting the **Submit button** on the toolbar.
4. Run the **Authorization wizard**.
5. **Submit**.

8168.1 Retroactive PHC and CAS Authorizations Using the Wizards — CCSE

Revision 17-1; Effective March 15, 2017

The wizards will not handle retroactive PHC authorizations at this time. See Section 8200, Authorizing CCSE Services Without Using the Wizards, and Section 8270, Primary Home Care (PHC) Without the Wizards.

8169 Transfers from Service Group 7 to Another Service Group Using the Wizards — CCSE

Revision 17-1; Effective March 15, 2017

If the individual transfers to another Service Group:

1. Use the wizards to close all Service Group 7 services. See Section 8162, Adding, Changing or Terminating Services Within Service Group 7 Using the Wizards — CCSE, for instructions.
2. Create an authorization for the new service group using instructions for that service.

8170 Monitoring Wizard

Revision 17-1; Effective March 15, 2017

The Monitoring wizard prompts the user through windows required to complete monitoring contacts. Some windows are conditional and will display only if needed. The Monitoring wizard can be used with open services and with services/programs that the individual wants to add. Process the Monitoring wizard before running the Authorization wizard to terminate services.

1. Complete the **Service Request** window to confirm services to be monitored.
2. Select the **Folder** icon for **Monitoring wizard** in the **Wizards** directory.
3. Progress through the wizard by completing the entries in each window, then select **NEXT**.

8171 Service Request Window — Monitoring Wizard

Revision 17-1; Effective March 15, 2017

The **Service Request window** is completed to confirm which services are to be monitored.

1. Select the **program** that is to be monitored.
2. Select **each service** for which a monitoring contact is to be made. Unselect any services not to be monitored. There are no edits in this window to prevent selecting mutually exclusive services
3. Select the **Folder** icon for the **Monitoring wizard** in the **Wizards** directory.

8172 Services Authorized Window — Monitoring Wizard— CCSE

Revision 17-1; Effective March 15, 2017

The **Services Authorized window** operates in two modes: initial and follow-up. The window displays all services selected on the Service Request window.

For an initial monitoring:

1. Unselect any service that is not to be monitored by clicking to remove the **U** next to that service.
2. For open services, the current provider number will be entered by default. This field is editable. If a service is not currently open, type the **provider number** to be printed on the monitoring report. If the provider number is left blank, the system will default to all zeros.
3. Select **NEXT**.

For a follow-up monitoring:

The window displays a read-only copy of the selections made at the initial monitoring.

Select **NEXT**.

8173 Contact Window — Monitoring Wizard — CCSE

Revision 17-1; Effective March 15, 2017

The **Contact window** displays information about the most recent monitoring contact.

For an initial monitoring:

1. Select **Clear Monitoring** to delete previous information from all of the screens in the Monitoring wizard.
2. Select the **primary contact** and **location** specific to the current monitoring contact.
3. The **Interview Date** box displays the current date. Type a **different date** in the box, if necessary.
4. Select a **reason for monitoring contact**. Type any **comments** in the box provided.
5. Select **NEXT**.

8174 Monitor Detail Window — Monitoring Wizard — CCSE

Revision 17-1; Effective March 15, 2017

The **Monitor Detail window** displays a line for each service to be monitored. Different fields are enabled depending on whether the monitoring contact is an initial or a follow-up contact.

For an initial monitoring contact:

1. Highlight the **service to be monitored** by using the mouse to move the arrow to the correct line.
    - Select **Add** to insert a new line for the service highlighted.
    - Select **Delete** to remove an entire line.
2. Select **Problems Alleged** if the individual expresses dissatisfaction with a service.
3. If the user is familiar with the reason and action codes:
    - Select the **reason(s)** for dissatisfaction and the **action(s)** to be taken from the drop-down menus.
    - Type **comments** in the box provided. A separate comment box is available for each action selected.
    - Repeat the process for each service to be monitored.
    - Select **NEXT**.

4. If the user is not familiar with the reason and action codes:
    - Select **NEXT** without selecting reason(s) and action(s).
    - If no reason(s) or action(s) are selected, the wizard will display the Reasons for Dissatisfaction window and the Actions Selection window where those selections can be made.

For a follow-up monitoring contact:

1. Highlight the **service selected for follow-up** by using the mouse to move the arrow to the correct line.
2. If findings in the follow-up contact concur with the initial findings:
    - Select **Y** in the **Concur w/previous** field.
    - Select **NEXT**.
3. If findings in the follow-up contact do not concur with the initial findings:
    - Select **N** in the **Concur w/previous** field.
    - Select **Problems Alleged** to record additional or different reasons for individual dissatisfaction.
    - If the user is familiar with the reason and action codes:
        - Select the **reason(s)** for dissatisfaction and the **action(s)** to be taken from the drop-down menus.
        - Type **comments** in the box provided. A separate comment box is available for each action selected.
        - Repeat the process for each service to be monitored.
        - Select **NEXT**.
    - If the user is not familiar with the reason and action codes, select **NEXT** without selecting reason(s) or action(s).
    - If no reason(s) or action(s) are selected, the wizard will display the Reasons for Dissatisfaction window and the Actions Selection window where those selections can be made.
4. If the individual has selected the CDS option or has a "flavor" of service (e.g. CAS, Service Code 17D), type this information in the **Comments** box.
5. Select **NEXT**.

8175 Reasons for Dissatisfaction Window — Monitoring Wizard — CCSE

Revision 17-1; Effective March 15, 2017

The **Reasons for Dissatisfaction window** displays for each service where **Problems Alleged** is marked, but no reason has been selected on the Monitor Detail window.

The choices displayed at the top of the window are referred to as reason groups. The individually numbered reasons displayed in the middle of the window are reason items.

1. Highlight the **reason group** that best categorizes the individual's dissatisfaction by using the mouse to move the arrow to the correct line.
2. Select the **reason item(s)** that best explain the individual's dissatisfaction. A different list of reason items displays for each reason group. **U** will appear beside the selected items only after both a reason group and a reason item have been selected.
3. Type **comments** in the box provided.
4. Select **NEXT**.

8176 Actions Selection Window — Monitoring Wizard — CCSE

Revision 17-1; Effective March 15, 2017

An **Action Selection window** displays for each reason item selected on the Reasons for Dissatisfaction window.

The reason item displays at the top of the window. The individually numbered actions displayed in the middle of the window are action items.

1. Highlight the **reason item** by using the mouse to move the arrow to the correct line.
2. Select **up to five action items** for the reason item highlighted at the top of the screen. **U** will appear beside the selected items only after both a reason item and at least one action item have been selected.
3. Select **NEXT**.

8177 Client Satisfaction Window — Monitoring Wizard — CCSE

Revision 17-1; Effective March 15, 2017

The **Client Satisfaction window** is the last window in the Monitoring wizard.

1. Select **Overall Client Satisfaction** from the drop-down menu.
2. Select the **monitoring status** from the drop-down menu. Choose:
    - **Pending** if the monitoring contact is not yet complete.
    - **Follow-up Required** if subsequent contacts are necessary.
    - **Completed** if the monitoring contact is complete.
3. Select **Set Date** to enter the current date in the Date field. Type a **different date** in the box, if necessary.
4. If the monitoring status is **Pending**, select **Close** and save the case to **Draft**.
5. If the monitoring status is **Follow-up Required** or **Completed**, select **Generate**, and then **Submit**.

8200, Authorizing CCSE Services Without Using the Wizard

Revision 17-8; Effective September 1, 2017

All CCSE services except CMPAS can be authorized using the wizards.

CCSE services can also be authorized without using the wizards by manually making entries in each required record. Services authorized without using the wizards will store information in the SASO database, but not in the CCSE database. Manually completed cases will not be included in statistical reports generated from the CCSE database.

Many of the records required for each Community Care service are required by more than one service within the Community Care Service Group. However, only one open record at a time is required regardless of how many services are being authorized with the exception of the Service Authorization record. One Service Authorization record is required for each service.

It is critical that all required records cover all authorization periods. There must be no gaps in dates or overlapping Begin and End dates.

All Service Group 7 records are open-ended. Entries are required only when a change occurs.

8200.1 Individual — CCSE Services Without the Wizards

Revision 17-1; Effective March 15, 2017

The Client Details record will be system generated with information from the SAVERR database or from information entered by the case worker in the Create New Client window.

The Create New Client function should only be used when the case worker has verified that the individual does not have an existing SAVERR number. When the Create New Client function is used, SASO assigns an

individual number that will be written to SAVERR within three days. During this time, the SASO record is checked against SAVERR. If the system finds that the individual already has a SAVERR number, the case worker will have to recreate the SASO authorization using the original SAVERR number.

Accurate biographical information must be entered in the Create New Client window to avoid issuance of duplicate numbers.

8200.2 Address Folder — CCSE Services Without the Wizards

Revision 17-1; Effective March 15, 2017

The Address folder records the individual's addresses. Create separate address records to record an individual's home or mailing address (if different than home address), a responsible party's address and/or an executor's address.

Information from this folder prints on the Provider Referral Supplement.

To register a home or mailing address:

1. Select the **Folder** icon for **Address** in the **Client** directory.
2. Select **Add** and the **Address** record will appear.
3. Select the **Type code** from the drop-down list in the **Type** field. The system defaults to 05-Mailing/Home.
4. Type the **intake date** as the effective **Begin Date** for initials. Type the effective date of the address in the **Begin Date** field for changes.
5. Type the **address** in the **Address** field.
6. The **Tel. No.** field is used to record the phone number of the **executor only**. Do **not** use this field to record the individual's phone number.
7. Type the **city** in the **City** field.
8. Select the **state** from the drop-down list in the **State** field. The system defaults to TX-Texas.
9. Type the **ZIP code** in the **ZIP Code** field.

To register a responsible party's address:

1. Select the **Folder** icon for **Address** in the **Client** directory.
2. Select **Add** and the **Address** record will appear.
3. Select the **Type** code **04-Other** from the drop-down list in the **Type** field. The system defaults to 05-Mailing/Home.
4. Type the intake date as the effective **Begin Date** for initials. Type the effective date of the address in the **Begin Date** field for changes.
5. Type the following in the address lines:

Line 1 – Enter the **responsible party's name** (First, Middle, Last). The line automatically starts with "C/O" for "in care of."

Line 2 – Enter the first line of the **responsible party's address** (usually a street number or a P.O. Box).

Line 3 – Enter the second line of the **responsible party's address** (if needed, such as for an apartment number).

Note: Do not enter identifiers, such as daughter, directions to the home or any other miscellaneous text in any of these fields.

6. Type the **phone number** of the responsible party in the **Tel. No.** field, including the area code. Do not use parentheses. For example, enter 555-123-4567.
7. Type the **city** in the **City** field.
8. Select the **state** from the drop-down list in the **State** field. The system defaults to TX-Texas.

9. Type the **ZIP code** in the **ZIP Code** field.

To register an executor's address:

1. Select the **Folder** icon for **Address** in the **Client** directory.
2. Select **Add** and the **Address** record will appear.
3. Select the **Type** code **EX-Executor** from the drop-down list in the **Type** field. The system defaults to 05-Mailing/Home.
4. Type the intake date as the effective **Begin Date** for initials. Type the effective date of the address in the **Begin Date** field for changes.
5. Type the following in the address lines:

Line 1 – Enter the **executor's name** (First, Middle, Last).

Line 2 – Enter the first line of the **executor's address** (usually a street number or a P.O. Box).

Line 3 – Enter the second line of the **executor's address** (if needed, such as for an apartment number).

Line 4 – Enter the **executor's phone** number, including the area code. Do not use parentheses. For example, enter 555-123-4567.

Note: Do not enter identifiers, such as daughter, directions to the home, or any other miscellaneous text in any of these fields.

6. Type the **city** in the **City** field.
7. Select the **state** from the drop-down list in the **State** field. The system defaults to TX-Texas.
8. Type the **ZIP code** in the **ZIP Code** field.

Address Changes

When an address changes, add a record using these same instructions and enter the new Begin Date. This record is an exception to the rule of entering an End Date in the existing record before creating another record. SASO reads the most recent address with a HOME type as the individual's current address.

8200.3 Authorizing Agent/Case Worker — CCSE Services Without the Wizards

Revision 17-1; Effective March 15, 2017

The case worker Authorizing Agent record is used for identifying who the case is assigned to when generating regional and unit statistical reports. The information in the case worker Authorizing Agent folder will be used in generating the Provider Referral Supplement.

To register a case worker Authorizing Agent record:

1. Select the **Folder** icon for **Authorizing Agent** in the **Case Worker** directory.
2. Select **Add** and the **Authorizing Agent** record will appear.
3. Select **CW-Case Worker** from the drop-down list in the **Type** field.
4. Select **7-Community Care** from the drop-down list in the **Group** field.
5. Select **YES** if there is no other existing case worker Authorizing Agent record. Select **NO** if there is another existing record in the **Send to TMHP** field.
6. Type the **date** the case was assigned to the case worker or today's date in the **Begin Date** field. Leave the **End Date** field at default zeros.

7. Type the **case worker's BJN** in the **Auth Agent** field. Type the BJN without dashes (for example, 04599C09). For statistical reporting purposes, this is the most important field.
8. Leave the **Agency** field at the default selection **324-DHS.**
9. Type the **case worker's name** in the **Name** field.
10. Type the **case worker's phone number** in the **Phone** field. Include the area code, phone number and extension. Type "0000" if no extension exists.
11. Type the **case worker's Mail Code** (without dashes) in the **Mail Code** field.

When the Case Worker Changes

When the individual is assigned to another case worker, enter an End Date in the existing case worker Authorizing Agent record and create another record with the new information using these same instructions. To avoid gaps or overlaps in the case worker Authorizing Agent records, the End Date of the existing record should be one day before the Begin Date of the new record.

Currently, although SASO will accept multiple Authorizing Agent records, Texas Medicaid and Healthcare Partnership (TMHP) will only accept two Authorizing Agent records when a SASO file is transmitted to TMHP. Therefore, until this problem is resolved, select NO in the Send To TMHP field for all updates.

8200.4 Eligibility for Title XX Services — CCSE Services Without the Wizards

Revision 17-1; Effective March 15, 2017

One Eligibility record is required for all Title XX Community Care – Service Group 7 authorizations. Only one open record is required regardless of how many Title XX services the individual is receiving.

When the Create New Client function is used to create an initial authorization, the Enrollment and Eligibility records must be submitted to the SASO database before the remaining records are completed.

To register eligibility for Title XX Community Care authorizations:

1. Select the Folder icon for Title XX Eligibility in the Eligibility directory.
2. Select Add and the Eligibility record will appear.
3. Select CC-CCSE-ELIGIBLE from the drop-down list in the Type Elig-Code field.
4. Type the date the individual is eligible to receive CCSE Title XX services in the Begin Date field. The Begin Date must match the earliest date the Title XX CCSE services are being authorized. Leave the End Date field at default zeros.
5. Select 7-COMMUNITY CARE from the drop-down list in the Service Group field.
6. Select A-TITLE XX from the drop-down list in the Category field.
7. Select 1-TITLE XX from the drop-down list in the Cov. Code field.
8. Select A-TITLE XX from the drop-down list in the Type Program field.

This record will remain open until the individual stops receiving a Title XX CCSE service.

To close this record:

No changes to this record are required when the individual's Title XX eligibility is reassessed unless the individual is determined to be ineligible. When the individual stops receiving all Title XX services, enter the last day of service in the End Date field.

8200.5 Enrollment — CCSE Services Without the Wizards

Revision 17-1; Effective March 15, 2017

An individual should be enrolled in only one service group at a time. Only one Enrollment record should be open at a time regardless of how many services the individual is receiving. This record will remain open until the individual transfers to another service group or stops receiving Long-term Services and Supports (LTSS).

When the Create New Client function is used to create an initial authorization, the Enrollment and Eligibility records must be submitted to the SASO database before the remaining records are completed.

To register enrollment for Community Care – Service Group 7:

1. Select the Folder icon for Enrollment in the Program and Service directory.
2. Select Add and the Enrollment record will appear.
3. Select 7-COMMUNITY CARE from the drop-down list in the Service Group field.
4. If the individual meets criteria for MFP, select Rider 37/28 (FAC to COMM) from the Enrolled From drop-down menu. If the individual does not meet MFP criteria, completion of this field is optional. Warning: Do not select Nursing Facility for individuals who meet MFP criteria.
5. Type the beginning date of Community Care services in the Begin Date field. Leave the End Date field at default zeros.

When Changes Occur

No changes to this record are required if the individual transfers from one service within Community Care (Service Group 7) to another service in Community Care.

If the individual transfers to another service group without an overlap of services, enter the last day the individual received Community Care – Service Group 7 as the End Date of this record.

If the individual transfers to another service group and there was an overlap in services, enter the day the terminated service stopped as the End Date of this record. Create a new record for the new service with a Begin Date of the day the new service started, even if dates overlap.

If the individual stops receiving LTSS, enter the last day the individual received services as the End Date of this record.

8200.6 Location — CCSE Services Without the Wizards

Revision 17-1; Effective March 15, 2017

The Location record is used to register the county and region in which an individual resides. This information is used in statistical reporting by region and county. The individual's county is also matched against a provider agency's list of authorized counties.

When an individual who has never received any HHSC LTSS is registered in SASO, the Location record will be system generated from the information entered on the Create New Client window. The Location record will be created before the service authorization is filed to the HHSC database.

When an individual who has never received any HHSC LTSS is registered in SASO and already has a SAVERR number, the Location record will not be created until the initial individual file is submitted to the HHSC database. Once the service authorization is submitted and filed to the SASO database, the Location record is system generated from information on SAVERR.

Warning: To avoid creating duplicate Location records, the authorizing agent should never add a Location record before the initial individual file is submitted to the HHSC database.

If the county identified in the Location record is incorrect (because the county on SAVERR is actually the guardian's county, the individual has moved or any other reason), the location information must be corrected. SAVERR updates SASO every month on the day after SAVERR cutoff. Therefore, the most effective way to correct the county is to correct the county in SAVERR. Since Medicaid for the Elderly and People with Disabilities (MEPD), Social Security Administration or Texas Works staff must do most of these corrections, timely updates to SAVERR may not be possible. The county information can be corrected in SASO. However, the corrected record must be Forced or SAVERR will rewrite the information at the next SAVERR/SASO reconciliation.

To correct the location information:

1. Select the Folder icon for Location in the Client directory.
2. Select the existing open record from the list in the tree directory or the SASO List Data window on the right-hand side of the screen.
3. Type the day before the new county will be registered in the End Date field.
4. Select the Folder icon for Location in the Client directory.
5. Select Add and a blank Location record will appear.
6. Select the appropriate county from the drop-down list in the County field.
7. Type the date the new county is being registered in the Begin Date field. Leave the End Date field at default zeros.

In order for SAVERR to not overwrite this record, move to the Force field and set the Force Flag. Enter comments explaining why the record is being forced.

8200.7 Phone — CCSE Services Without the Wizards

Revision 17-1; Effective March 15, 2017

The Phone folder documents an individual's phone number and is mandatory for ERS recipients. Additional records can be created to record numbers for relatives, friends or a responsible party.

To register phone information:

1. Select the Folder icon for Phone in the Client directory.
2. Select Add and the Phone record will appear.
3. The system defaults to HO-HOME in the Type field. Select OT-OTHER from the drop-down menu to register additional phone numbers.
4. Type the date the phone number is valid in the Begin Date field. This can be the same date as the Begin Date for enrollment.
5. Type the phone number in the Phone No field.

8200.8 Level of Service/Form 2060 — CCSE Services Without the Wizards

Revision 17-1; Effective March 15, 2017

One open Level of Service Form 2060, Needs Assessment Questionnaire and Task/Hour Guide, record is required for individuals receiving Adult Foster Care (AFC), Emergency Response Services (ERS), Family Care (FC), Home-Delivered Meals (HDM), Primary Home Care (PHC), Residential Care (RC) Services and Special Services to Persons with Disabilities (SSPD). Only one record should be open at a time regardless of how many Community Care – Service Group 7 services the individual is receiving. This record is used to document the individual's functional eligibility based on the Form 2060 score.

To register a Form 2060 level of service record:

1. Select the Folder icon for Level of Service in the Medical directory.
2. Select Add and the Level of Service record will appear.
3. Select 20-2060 score from the drop-down list in the Type field.
4. Select 7-COMMUNITY CARE from the drop-down list in the Service Group field.
5. Leave the Contract No. field blank.
6. Type the 2060 score in the Level field.
7. Type the date the individual is functionally eligible for Community Care – Service Group 7 services in the Begin Date field. The Begin Date must match the earliest date the individual was authorized to begin receiving services. Leave the End Date field at default zeros.

This record remains open until the individual's score changes, the individual transfers to another service group, or the individual stops receiving a service that requires this record.

Retroactive PHC and CAS authorizations:

If the applicant is determined eligible for ongoing services based on the Form 2060 score, type the ongoing 2060 score with a Begin Date of the first day of the retroactive period.

If the applicant is determined ineligible for ongoing services based on the Form 2060 score, type 24 as the 2060 score with the Begin Date and End Date for the retroactive period.

Create a second Level of Service record for the individual's priority level. Always use Level 1, Non-Priority, with a Begin Date of the first day of the retroactive period.

When the Form 2060 score changes:

If the individual's Form 2060 score changes, enter an End Date in the existing open 2060 Level of Service record. Using these same instructions, add another record with the new information. To avoid gaps or overlaps in the records, the End Date of the existing record should be one day before the Begin Date of the new record.

When the individual transfers to another service within Service Group 7:

If this record is required for the new service, leave the record open. If the individual stops receiving all services that require a 2060 Level of Service record, enter the last day the individual received services as the End Date.

When the individual transfers to another service group:

If the individual transfers to another service group, enter the last day the individual received services as the End Date.

8210 Adult Foster Care (AFC) Without the Wizards

Revision 17-1; Effective March 15, 2017

The following records are either system generated or created by the case worker to authorize AFC – Service Code 18. Detailed instructions for completing each record are found in Section 8200, Authorizing CCSE Services Without Using the Wizards, and in this section.

When the Create New Client function is used for an initial service authorization, the Enrollment and Eligibility records must be submitted to the SASO database before the remaining records are completed. In all other situations, all the records may be completed before submitting to the SASO database.

- Individual

- Address
- Authorizing Agent – Case Worker
- Eligibility
- Enrollment
- Location
- Phone
- Level of Service – Form 2060, Needs Assessment Questionnaire and Task/Hour Guide
- Service Authorization

Do not create a co-payment record for CCSE AFC individuals. CCSE AFC individuals pay room and board but do not pay a co-payment. Room and board is an agreement between the individual and the provider. It is not registered in SASO.

8211 Service Authorization — AFC Services Without the Wizards

Revision 17-1; Effective March 15, 2017

To register a service authorization for AFC:

1. Select the Folder icon for Service Authorization in the Program and Service directory.
2. Select Add and the Service Authorization record will appear.
3. Select 7-COMMUNITY CARE from the drop-down list in the Service Group field.
4. Select 18-ADULT FOSTER CARE from the drop-down list in the Service Code field.
5. Leave the Agency field at the default selection 324-DHS.
6. Select 5-DAILY from the drop-down list in the Unit Type field.
7. Type 1 in the Units field.
8. Type the date the individual is authorized to receive AFC services in the Begin Date field. Leave the End Date field at default zeros.
9. Type the AFC provider contract number in the Contract No. field. Do not type leading zeros.
10. Select Submit from the Command Menu or the toolbar to submit the authorization.

See Section 8300, Changes to CCSE Authorizations Without the Wizards, for instructions for making changes to this record.

8220 Consumer Managed Personal Attendant Services (CMPAS) Without the Wizards

Revision 17-1; Effective March 15, 2017

The following records are either system generated or created by the case worker to authorize CMPAS – Service Code 27. Detailed instructions for completing each record are found in Section 8200, Authorizing CCSE Services Without Using the Wizards, and in this section.

When the Create New Client function is used for an initial service authorization, the Enrollment and Eligibility records must be submitted to the SASO database before the remaining records are completed. In all other situations, all the records may be completed before submitting to the SASO database.

- Individual
- Address
- Authorizing Agent – Contract Manager
- Authorizing Agent – Agency
- Eligibility
- Enrollment

- Location
- Phone
- Applied Income – Co-pay
- Service Authorization – Agency Model
- Service Authorization – CDS Model

8221 Authorizing Agent/Contract Manager — CMPAS Services Without the Wizards

Revision 17-1; Effective March 15, 2017

To register a contract manager Authorizing Agent record:

1. Select the Folder icon for Authorizing Agent in the Case Worker directory.
2. Select Add and the Authorizing Agent record will appear.
3. Select OT-OTHER from the drop-down list in the Type field.
4. Select 7-Community Care from the drop-down list in the Group field.
5. Select YES if there is no other existing contract manager Authorizing Agent record, and select NO if there is an existing record in the Send to TMHP field.
6. Type the first date of service or today's date in the Begin Date field. Leave the End Date field at default zeros.
7. Type the contract manager's BJN in the Auth Agent field. Type the BJN without dashes (for example, 04599C09). For statistical reporting purposes, this is the most important field.
8. Leave the Agency field at the default selection 324-DHS.
9. Type the contract manager's name in the Name field.
10. Type the contract manager's phone number in the Phone field. Include the area code, phone number and extension. Type 0000 if no extension exists.
11. Type the contract manager's Mail Code in the Mail Code field.

8222 Authorizing Agent/Agency — CMPAS Services Without the Wizards

Revision 17-1; Effective March 15, 2017

To register an agency Authorizing Agent record:

1. Select the Folder icon for Authorizing Agent in the Case Worker directory.
2. Select Add and the Authorizing Agent record will appear.
3. Select OT-OTHER from the drop-down list in the Type field.
4. Select 7-Community Care from the drop-down list in the Group field.
5. Select YES in the Send to TMHP field.
6. Type the date the case was assigned to the agency or today's date in the Begin Date field. Leave the End Date field at default zeros.
7. Type Direct in the Auth Agent field.
8. Leave the Agency field at the default selection 324-DHS.
9. Type the name of the CMPAS provider agency in the Name field.
10. Type the telephone number of the CMPAS provider agency in the Phone field.

Agency Changes

When the individual transfers to another agency, enter an End Date in the existing agency Authorizing Agent record. Using these same instructions, add another record with the new information.

8223 Applied Income/Co-Pay — CMPAS Services Without the Wizards

Revision 17-1; Effective March 15, 2017

This record registers the co-pay for CMPAS. If the co-pay for the initial month in which the CCSE individual receives CMPAS is prorated, then two Applied Income records must be created. The CCSE case worker will register the prorated co-pay amount in the first record and create a second record to register the ongoing co-pay amount. If one of these records is for a month prior to the month the information is being entered, a Force is required.

To register initial co-pay information for a CMPAS individual:

1. Select the Folder icon for Applied Income in the Program and Service directory.
2. Select Add and the Applied Income/Co-pay record will appear.
3. Select CO-CO-PAY (AMOUNT OR PERCENTAGE) from the drop-down list in the A/I Type field.
4. Select 2-CO-PAY (PERCENTAGE) from the drop-down list in the Co-Pay Type.
5. Type the percentage of the cost of services that the individual is responsible for paying in the Percent field.
6. Type the date that the individual is responsible for paying the percentage of the cost of services in the Begin Date field. Leave the End Date field at default zeros.

Co-Pay Changes

When the co-pay changes, enter an End Date in the existing Applied Income record. Using these same instructions, create another record with the new information.

8224 Service Authorization/Agency Model — CMPAS Services Without the Wizards

Revision 17-1; Effective March 15, 2017

To register a service authorization for a CMPAS individual using the Agency Model:

1. Select the Folder icon for Service Authorization in the Program and Service directory.
2. Select Add and the Service Authorization record will appear.
3. Select 7-COMMUNITY CARE from the drop-down list in to the Service Group field.
4. Select 27-CLIENT MANAGED ASSISTED SERVICES from the drop-down list in the Service Code field.
5. Leave the Agency field at the default selection 324-DHS.
6. Select 1-WEEK from the drop-down list in the Unit Type field.
7. Type the number of hours per week of CMPAS services the individual is authorized to receive in the Adj. Units field.
8. Type the date the individual is authorized to receive CMPAS services in the Begin Date field. Leave the End Date field at default zeros.
9. Type the CMPAS provider contract number in the Contract No field. Do not type leading zeros.
10. Select Submit from the Command Menu or the toolbar to submit the authorization.

See Section 8300, Changes to CCSE Service Authorizations Without the Wizards, for instructions for making changes to this record.

8225 Service Authorization/CDS Model — CMPAS Services Without the Wizards

Revision 17-1; Effective March 15, 2017

To register a service authorization for a CMPAS individual using the CDS Model:

1. Select the Folder icon for Service Authorization in the Program and Service directory.
2. Select Add and the Service Authorization record will appear.
3. Select 7-COMMUNITY CARE from the drop-down list in to the Service Group field.
4. Select 27A-CMPAS Consumer Directed Services from the drop-down list in the Service Code field.
5. Leave the Agency field at the default selection 324-DHS.
6. Select Y – Per Auth from the drop-down list in the Unit Type field.
7. Type the number of dollars per year of CMPAS services the individual is authorized to receive in the Adj. Units field.
8. Type the date the individual is authorized to receive CMPAS services in the Begin Date field. Leave the End Date field at default zeros.
9. Type the CMPAS provider contract number in the Contract No field. Do not type leading zeros.
10. Select Submit from the Command Menu or the toolbar to submit the authorization.

See Section 8300, Changes to CCSE Service Authorizations Without the Wizards, for instructions for making changes to this record.

8230 Day Activity and Health Services (DAHS) Without the Wizards

Revision 17-1; Effective March 15, 2017

The following records are either system generated or completed by the CCSE case worker and the HHSC regional nurse for Title XIX and Title XX DAHS – Service Code 29 authorizations.

When the Create New Client function is used for an initial service authorization, the Enrollment and Eligibility records must be submitted to the SASO database before the remaining records are completed. In all other situations, all the records may be completed before submitting to the SASO database.

Using the instructions in Section 8200, Authorizing CCSE Services Without Using the Wizards, the CCSE case worker completes these records:

- Individual
- Address
- Authorizing Agent – Case Worker
- Eligibility for Title XX DAHS Only
- Enrollment
- Location
- Phone

Using the following instructions, the HHSC nurse completes these records to create an authorization for Title XIX or Title XX DAHS:

- Diagnosis
- Authorizing Agent – Nurse
- Authorizing Agent – Practitioner
- Service Authorization

When DAHS is authorized for an individual who is also receiving CLASS, DAHS is the secondary service. SASO recognizes DAHS as an overlapping service with CLASS, and no Force is required.

8231 Diagnosis — DAHS Services Without the Wizards

Revision 17-6; Effective June 28, 2017

To register diagnosis code(s) for a Title XIX or Title XX DAHS individual:

1. Select the Folder icon for Diagnosis in the Medical directory.
2. Select Add and the Diagnosis record will appear.
3. Select 7-COMMUNITY CARE in the Service Group field.
4. Type the date the diagnosis codes are effective in the Begin Date field. For an initial case, this is the date the individual is approved for Title XIX or Title XX DAHS services. Leave the End Date field at default zeros.
5. Type the numeric code(s) for the individual's primary diagnosis in the Diagnosis fields. If the individual has additional diagnoses from practitioner's orders for PHC, list all diagnosis codes. Up to five diagnoses codes can be entered. There should be only one Diagnosis record for Service Group 7, even if the individual is receiving both PHC and DAHS.
6. Select 10-ICD-10-CM CODE from the drop-down list in the Version field.

This record will remain open until the individual stops receiving a service that requires this record or there is a change in diagnosis.

8232 Authorizing Agent/Nurse — DAHS Services Without the Wizards

Revision 17-1; Effective March 15, 2017

To register a nurse authorizing agent for a Title XIX or Title XX DAHS individual:

1. Select the Folder icon for Authorizing Agent in the Case Worker directory.
2. Select Add and the Authorizing Agent record will appear.
3. Select NU-NURSE from the drop-down list in the Type field.
4. Select 7-COMMUNITY CARE from the drop-down list in the Group field.
5. Select YES if there is no other existing nurse Authorizing Agent record in the Send to TMHP field. Select NO if there is another existing record.
6. Type the date this individual was assigned to the nurse or the date of the Enrollment record in the Begin Date field. Leave the End Date field at default zeros.
7. Move to the Auth Agent field and enter the BJN for the nurse.
8. Leave the Agency field at the default selection 324-DHS.
9. Type the nurse's name in the Name field.
10. Type the nurse's phone number in the Phone field. Type the area code, phone number and extension. Type 0000 if no extension exists.
11. Type the nurse's Mail Code in the Mail Code field.

This record will remain open until the case is assigned to another nurse, the individual transfers to another service that does not require this record or the individual stops receiving services.

Nurse Changes

When the individual is assigned to another nurse, enter an End Date in the existing nurse Authorizing Agent record. Using these same instructions, create another record with the new information. To avoid gaps or overlaps in the nurse Authorizing Agent records, the End Date of the existing record should be one day before the Begin Date of the new record.

Currently, although SASO will accept multiple Authorizing Agent records, TMHP will only accept two Authorizing Agent records when a SASO file is transmitted to TMHP. Until this problem is resolved, select NO in the SEND TO TMHP field for all updates.

8233 Authorizing Agent/Practitioner — DAHS Services Without the Wizards

Revision 17-1; Effective March 15, 2017

The HHSC regional nurse registers the practitioner Authorizing Agent record. If the practitioner authorizing agent is not registered for a Title XIX or Title XX DAHS individual, the authorization will reject.

To register a practitioner Authorizing Agent for a Title XIX or Title XX DAHS individual:

1. Select the Folder icon for Authorizing Agent in the Case Worker directory.
2. Select Add and the Authorizing Agent record will appear.
3. Select P-PRACTITIONER from the drop-down list in the Type field.
4. Select 7-COMMUNITY CARE from the drop-down list in the Group field.
5. Leave the Send to TMHP field at the default (blank) or select NO. The practitioner registration does not require an entry in this field.
6. Type the beginning date of the practitioner's orders in the Begin Date field. Leave the End Date field at default zeros. The Begin Date must be equal to or earlier than the first day the individual is being authorized to receive services.
7. Enter the practitioner's license number in the Auth Agent field.
8. Select HHSC from the drop-down list in the Agency field.
9. Type the practitioner's last name in the Name field.
10. Type the practitioner's phone number in the Phone field. Type the area code, phone number and extension. Type 0000 if no extension exists.
11. Leave the Mail Code field blank.

8234 Service Authorization — DAHS Services Without the Wizards

Revision 17-1; Effective March 15, 2017

The HHSC regional nurse completes the Service Authorization record for Title XIX or Title XX DAHS cases when services are approved.

To register a Service Authorization for a Title XIX or Title XX DAHS individual:

1. Select the Folder icon for Service Authorization in the Program and Service directory.
2. Select Add and the Service Authorization record will appear.
3. Select 7-COMMUNITY CARE from the drop-down list in the Service Group field.
4. Select 29-DAHS from the drop-down list in the Service Code field.
5. Leave the Agency field at the default selection 324-DHS.
6. Select 1-WEEK from the drop-down list in the Unit Type field.
7. Type the number of units per week of DAHS services the individual is authorized to receive in the Adj. Units field.

8. Type the date the individual is authorized to receive DAHS services in the Begin Date field. Leave the End Date field at default zeros.
9. Type the DAHS provider contract number in the Contract No field. Do not type leading zeros.
10. Select Submit from the Command Menu or the toolbar to submit the authorization.

See Section 8300, Changes to CCSE Authorizations Without the Wizards, for instructions for making changes to this record.

8240 Emergency Response Services (ERS) Without the Wizards

Revision 17-1; Effective March 15, 2017

The following records are either system generated or created by the case worker to authorize ERS – Service Code 20. Detailed instructions for completing each record are found in Section 8200, Authorizing CCSE Services Without Using the Wizards, and in this section.

When the Create New Client function is used for an initial service authorization, the Enrollment and Eligibility records must be submitted to the SASO database before the remaining records are completed. In all other situations, all the records may be completed before submitting to the SASO database.

- Individual
- Address
- Authorizing Agent – Case Worker
- Eligibility
- Enrollment
- Location
- Phone
- Level of Service – Form 2060, Needs Assessment Questionnaire and Task/Hour Guide
- Service Authorization

8241 Service Authorization — ERS Services Without the Wizards

Revision 17-1; Effective March 15, 2017

To register a Service Authorization for an ERS individual:

1. Select the Folder icon for Service Authorization in the Program and Service directory.
2. Select Add and the Service Authorization record will appear.
3. Select 7-COMMUNITY CARE from the drop-down list in the Service Group field.
4. Select 20-ERS from the drop-down list in the Service Code field.
5. Leave the Agency field at the default selection 324-DHS.
6. Select 2-MONTH from the drop-down list in the Unit Type field.
7. Type 1 in the Adj. Units field.
8. Type the date the individual is authorized to receive ERS services in the Begin Date field. Leave the End Date field at default zeros.
9. Type the ERS provider contract number in the Contract No. field. Do not type leading zeros.
10. Select Submit from the Command Menu or the toolbar to submit the authorization.

See Section 8300, Changes to CCSE Authorizations Without the Wizards, for instructions for making changes to this record.

8250 Family Care (FC) Without the Wizards

Revision 17-1; Effective March 15, 2017

The following records are either system generated or created by the case worker to authorize FC – Service Code 17. Detailed instructions for completing each record are found in Section 8200, Authorizing CCSE Services Without Using the Wizards, and in this section.

When the Create New Client function is used for an initial service authorization, the Enrollment and Eligibility records must be submitted to the SASO database before the remaining records are completed. In all other situations, all the records may be completed before submitting to the SASO database.

- Individual
- Address
- Authorizing Agent – Case Worker
- Eligibility
- Enrollment
- Location
- Phone
- Level of Service – Form 2060, Needs Assessment Questionnaire and Task/Hour Guide
- Level of Service – Priority
- Service Authorization
- Service Item

8251 Level of Service/Priority — FC Services Without the Wizards

Revision 17-1; Effective March 15, 2017

All FC individuals must have a priority level registered on the Level of Service record. This record is used to tell the billing system which rate the provider is authorized to use for each individual. SASO will accept the authorization without this record but provider claims will reject.

To register the Priority Level of Service record for an FC individual:

1. Select the Folder icon for Level of Service in the Medical directory.
2. Select Add and the Level of Service record will appear.
3. Select PR-PRIORITY from the drop-down list in the Type field.
4. Select 7-COMMUNITY CARE from the drop-down list in the Service Group field.
5. Leave the Contract No. blank.
6. Type 1 for Non-Priority cases or 2 for Priority cases in the Level field.
7. Type the date the individual is eligible for this level of service in the Begin Date field. The Begin Date must match the first day the individual is authorized to receive this level of FC services. Leave the End Date field at default zeros.

Priority Changes

When the individual's priority level changes, enter an End Date in the existing record. Using these same instructions, create another record with the new information. To avoid gaps or overlaps in the Priority Level of Service records, the End Date of the existing record should be one day before the Begin Date of the new record.

8252 Service Authorization — FC Services Without the Wizards

Revision 17-1; Effective March 15, 2017

To register a Service Authorization for an FC individual:

1. Select the Folder icon for Service Authorization in the Program and Service directory.
2. Select Add and the Service Authorization record will appear.
3. Select 7-COMMUNITY CARE from the drop-down list in the Service Group field.
4. Select 17C-PERSONAL ASSISTANCE SERVICES PAS from the drop-down list in the Service Code field.
5. Leave the Fund field at the default setting. No entry is required in this field unless an individual who is eligible for full Medicaid benefits is being authorized to receive FC. For these situations, a Force is required to change the Fund.
6. Leave the Agency field at the default selection 324-DHS.
7. Select 1-WEEK from the drop-down list in the Unit Type field.
8. Type the number of PAS hours per week the individual is authorized to receive in the Adj. Units field.
9. Type the date the individual is authorized to receive FC services in the Begin Date field. Leave the End Date field at default zeros.
10. Type the FC provider contract number in the Contract No field. Do not type leading zeros.

See Section 8300, Changes to CCSE Authorizations Without the Wizards, for instructions for making changes to this record.

8253 Service Item — FC

Revision 17-1; Effective March 15, 2017

The Service Item record is used to register tasks. At least one task authorized on Form 2101, Authorization for Community Care Services, must be registered for FC. Additional tasks can be registered, if desired.

To register a Service Item record for an FC individual:

1. Select the Folder icon for Service Item in the Program and Service directory.
2. Select Add and the Service Item record will appear.
3. Select 7-COMMUNITY CARE from the drop-down list in the Service Group field.
4. Select 17-PERSONAL ASSISTANCE SERVICES PAS from the drop-down list in the Service Code field.
5. Select T-TASK from the drop-down list in the Type field.
6. Type the two-digit code for one task authorized on Form 2101 in the Item field.
7. Type the date that the individual is eligible for CCSE services in the Begin Date field. Leave the End Date field at default zeros.
8. Select Submit from the Command Menu or the toolbar to submit the authorization.

When the individual stops receiving a registered task:

If the individual stops receiving the registered task, enter an End Date in the existing record. Using these same instructions, create another record with another task. To avoid gaps or overlaps in the Service Item records, the End Date of the existing record should be one day before the Begin Date of the new record.

When the individual transfers from FC to PHC:

When an individual transfers from FC to PHC, this record can remain open if the registered task is a personal care task and the individual is still authorized to receive the registered task. If the individual stops receiving PHC or FC, enter the last day of service as the End Date for this record.

8260 Meals Without the Wizards

Revision 17-1; Effective March 15, 2017

The following records are either system generated or created by the case worker to authorize Meals Service – Group 25. Detailed instructions for completing each record are found in Section 8200, Authorizing CCSE Services Without Using the Wizards, and in this section.

When the Create New Client function is used for an initial service authorization, the Enrollment and Eligibility records must be submitted to the SASO database before the remaining records are completed. In all other situations, all the records may be completed before submitting to the SASO database.

- Individual
- Address
- Authorizing Agent – Case Worker
- Eligibility
- Enrollment
- Location
- Phone
- Level of Service – Form 2060, Needs Assessment Questionnaire and Task/Hour Guide
- Service Authorization

8261 Service Authorization — Meals Services Without the Wizards

Revision 17-1; Effective March 15, 2017

To register a Service Authorization for a Meals Services individual:

1. Select the Folder icon for Service Authorization in the Program and Service directory.
2. Select Add and the Service Authorization record will appear.
3. Select 7-COMMUNITY CARE from the drop-down list in the Service Group field.
4. Select 25-MEALS from the drop-down list in the Service Code field.
5. Leave the Agency field at the default selection 324-DHS.
6. Select 1-WEEK from the drop-down list in the Unit Type field.
7. Type the number of meals the individual is authorized to receive per week in the Adj. Units field.
8. Type the date the individual is authorized to receive meals in the Begin Date field. Leave the End Date field at default zeros.
9. Type the meals provider's contract number in the Contract No field. Do not type leading zeros.
10. Select Submit from the Command Menu or the toolbar to submit the authorization.

See Section 8300, Changes to CCSE Service Authorizations Without Using the Wizards, for instructions for making changes to this record.

8270 Primary Home Care (PHC) Without the Wizards

Revision 17-1; Effective March 15, 2017

The following records are either system generated or completed by the CCSE case worker for non-CAS (Service Code 17) and the HHSC regional nurse for CAS (Service Code 17D) authorizations.

Using the instructions in Section 8200, Authorizing CCSE Services Without Using the Wizards, and the following additional instructions, the CCSE case worker completes these records:

- Individual
- Address
- Authorizing Agent – Case Worker
- Enrollment

- Location
- Phone
- Level of Service – Form 2060, Needs Assessment Questionnaire and Task/Hour Guide
- Level of Service – Priority
- Service Item
- Service Authorization

8271 Level of Service/Priority — PHC Services Without the Wizards

Revision 17-1; Effective March 15, 2017

All PHC individuals must have a priority level registered on the Level of Service record. This record is used to tell the billing system which rate the provider is authorized to use for each individual. SASO will accept the authorization without this record but provider claims will reject.

To register the Priority Level of Service record for a PHC individual:

1. Select the Folder icon for Level of Service in the Medical directory.
2. Select Add and the Level of Service record will appear.
3. Select PR-PRIORITY from the drop-down list in the Type field.
4. Select 7-COMMUNITY CARE from the drop-down list in the Service Group field.
5. Leave the Contract Number blank.
6. Type 1 for Non-Priority cases or 2 for Priority cases in the Level field.
7. Type the date the individual is eligible for this level of service in the Begin Date field. The Begin Date must match the first day the individual is authorized to receive this level of PHC services. Leave the End Date field at default zeros.

Priority Changes

When the individual's priority level changes, enter an End Date in the existing record. Using these same instructions, create another record with the new information. To avoid gaps or overlaps in the Priority Level of Service records, the End Date of the existing record should be one day before the Begin Date of the new record.

8272 Service Item — PHC Services Without the Wizards

Revision 17-1; Effective March 15, 2017

The Service Item record is used to register tasks. At least one personal care task authorized on Form 2101, Authorization for Community Care Services, must be registered for PHC. Additional tasks can be registered, if desired.

To register Service Item records for a PHC individual:

1. Select the Folder icon for Service Item in the Program and Service directory.
2. Select Add and the Service Item record will appear.
3. Select 7-COMMUNITY CARE from the drop-down list in the Service Group field.
4. Select 17-PERSONAL ASSISTANCE SERVICES PAS from the drop-down list in the Service Code field.
5. Select T-TASK from the drop-down list in the Type field.
6. Type the two-digit code for one personal care task authorized on Form 2101 in the Item field.
7. Type the date that the individual is eligible for CCSE services in the Begin Date field. Leave the End Date field at default zeros.
8. Select Submit from the Command Menu or the toolbar to submit the authorization.

This record remains open until the individual no longer receives this task or stops receiving either PHC or FC.

When the individual stops receiving a registered task:

If the individual stops receiving the registered personal care task, enter an End Date in the existing record. Using these same instructions, create another record with another personal care task. To avoid gaps or overlaps in the Service Item records, the End Date of the existing record should be one day before the Begin Date of the new record.

When the individual stops receiving PHC or FC:

No change is required to this record when an individual transfers between PHC and FC, as long as the individual is still authorized to receive the registered task. If the individual stops receiving PHC or FC, enter the last day of service as the End Date for this record.

Using the following instructions, the HHSC nurse completes these records to create an authorization for CAS:

- Authorizing Agent – Nurse
- Authorizing Agent – Practitioner
- Service Authorization

8273 Authorizing Agent/Nurse — CAS Services Without the Wizards

Revision 17-1; Effective March 15, 2017

To register a nurse Authorizing Agent record for a CAS individual:

1. Select the Folder icon for Authorizing Agent in the Case Worker directory.
2. Select Add and the Authorizing Agent record will appear.
3. Select NU-NURSE from the drop-down list in the Type field.
4. Select 7-COMMUNITY CARE from the drop-down list in the Group field.
5. Select YES from the drop-down list in the Send to TMHP field if there is no other existing nurse Authorizing Agent record. Select NO if there is another existing record.
6. Type the date this individual was assigned to the nurse or the date of the Enrollment record in the Begin Date field. Leave the End Date field at default zeros.
7. Type the BJN for the nurse in the Auth Agent field.
8. Leave the Agency field at the default selection 324-DHS.
9. Type the nurse's name in the Name field.
10. Type the nurse's phone number in the Phone field. Type the area code, phone number and extension. Type 0000 if no extension exists.
11. Type the nurse's Mail Code in the Mail Code field.

This record remains open until the case is assigned to another nurse, the individual transfers to another service that does not require this record, or the individual stops receiving services.

Nurse Changes

When the individual is assigned to another nurse, enter an End Date in the existing nurse Authorizing Agent record. Using these same instructions, create another record with the new information. To avoid gaps or overlaps in the nurse Authorizing Agent records, the End Date of the existing record should be one day before the Begin Date of the new record.

Currently, although SASO will accept multiple Authorizing Agent records, TMHP will only accept two Authorizing Agent records when a SASO file is transmitted to TMHP. Until this problem is resolved, select NO

in the SEND TO TMHP field for all updates.

8274 Authorizing Agent /Practitioner — PHC Services Without the Wizards

Revision 17-1; Effective March 15, 2017

The case worker registers the practitioner Authorizing Agent record for a PHC individual and the HHSC regional nurse enters information for a CAS individual. If the practitioner authorizing agent is not registered for a PHC or CAS individual, the authorization will reject.

To register a practitioner Authorizing Agent record for a PHC or CAS individual:

1. Select the Folder icon for Authorizing Agent in the Case Worker directory.
2. Select Add and the Authorizing Agent record will appear.
3. Select P-PRACTITIONER from the drop-down list in the Type field.
4. Select 7-COMMUNITY CARE from the drop-down list in the Group field.
5. Leave the Send to TMHP field at the default of No. The practitioner registration does not require an entry in this field.
6. Type the beginning date of the practitioner's orders in the Begin Date field. Leave the End Date field at default zeros. The Begin Date must be equal to or earlier than the first day the individual is being authorized to receive services.
7. Type the practitioner's license number in the Auth Agent field.
8. Select HHSC from the drop-down list in the Agency field.
9. Type the practitioner's last name in the Name field.
10. Type the practitioner's phone number in the Phone field.
11. Leave the Mail Code field blank.

8275 Service Authorization — PHC Services Without the Wizards

Revision 17-1; Effective March 15, 2017

The case worker will complete the Service Authorization record for PHC and the HHSC regional nurse will complete the Service Authorization record for CAS cases when services are approved.

To register a Service Authorization record for an initial PHC or CAS individual:

1. Select the Folder icon for Service Authorization in the Program and Service directory.
2. Select Add and the Service Authorization record will appear.
3. Select 7-COMMUNITY CARE from the drop-down list in the Service Group field.
4. Select 17-PERSONAL ASSISTANCE SERVICES (PAS) or 17D-COMMUNITY ATTENDANT (CAS) from the drop-down list in the Service Code field.
5. Leave the Agency field at the default selection 324-DHS.
6. Move to the Unit Type field and select 1-WEEK from the drop-down list.
7. Type the number of PAS hours per week that the individual is authorized to receive in the Adj. Units field.
8. Type the date the individual is authorized to receive PHC or CAS services in the Begin Date field. This date will match the mail date unless it is a negotiated start date. Leave the End Date field at default zeros.
9. Type the PHC provider's contract number in the Contract No field. Do not type leading zeros.

When creating a Service Authorization record for CDS PAS, a Service Authorization record for Service Code 63V must also be created:

1. Select the Folder icon for Service Authorization in the Program and Service directory.

2. Select Add and the Service Authorization record will appear.
3. Select 7-COMMUNITY CARE from the drop-down list in the Service Group field.
4. Select 63-V CDS Monthly Administrative Fee.
5. Leave the Agency field at the default selection 324-DHS.
6. Move to the Unit Type field and select 2-Month.
7. Type 1.00 in the Units field.
8. Type the date the individual is authorized to receive CDS PHC services in the Begin Date field. Leave the End Date field at default zeros.
9. Type the CDS PHC provider's contract number in the Contract No field. Do not type leading zeros.

See Section 8300, Changes to CCSE Service Authorizations Without Using the Wizards, for instructions for making changes to this record.

Retroactive PHC Authorizations

For retroactive PHC or CAS authorizations, Form 2101, Authorization for Community Care Services, is completed for the retroactive period and a second Form 2101 is completed if the individual is eligible for ongoing services. For the retroactive period, the Begin Date is the service initiation date if all other criteria are met. The End Date is the day prior to the initiation of ongoing services or the date of notification of ineligibility.

If the applicant is determined ineligible for ongoing services, one Service Authorization record for the retroactive period is required.

8280 Residential Care Services (RC or Emergency Care) Without the Wizards

Revision 17-1; Effective March 15, 2017

The following records are either system generated or created by the case worker to authorize Residential Care Services, which includes RC and Emergency Care. These services are authorized using Service Code 19. Detailed instructions for completing each record are found in Section 8200, Authorizing CCSE Services Without Using the Wizards, and in this section.

When the Create New Client function is used for an initial service authorization, the Enrollment and Eligibility records must be submitted to the SASO database before the remaining records are completed. In all other situations, all the records may be completed before submitting to the SASO database.

- Individual
- Address
- Authorizing Agent – Case Worker
- Eligibility
- Enrollment
- Location
- Phone
- Applied Income – Co-Pay (for Supervising Living Only)
- Level of Service – Form 2060, Needs Assessment Questionnaire and Task/Hour Guide
- Service Authorization

8281 Applied Income — RC Services Without the Wizards

Revision 17-1; Effective March 15, 2017

This record is used to record the co-pay for RC and must be completed even if the co-pay amount is $0. If the co-pay for the initial month the CCSE individual enters an RC facility is prorated, then two Applied Income records must be created – one record to register the prorated co-pay amount and a second record to register the ongoing co-pay amount. If one of these records is for a month prior to the month the information is being entered, a Force is required.

To register initial co-pay information for an RC individual:

1. Select the Folder icon for Applied Income/Co-pay in the Program and Service directory.
2. Select Add and the Applied Income/Co-pay record will appear.
3. Select CO-CO-PAY (Amount or Percentage) from the drop-down list in the A/I Type field.
4. Select 1-CO-PAY (Amount) from the drop-down list in the Co-Pay Type field.
5. If the co-pay amount for the initial month is prorated, continue. If the amount is not prorated, skip to Step #13.
6. Type the amount of co-pay the CCSE individual is responsible for paying for the initial month in the Amount field.
7. Type the first day of the initial month in the Begin Date field.
8. Type the last day of the initial month in the End Date field.
9. Select the Folder icon for Applied Income/Co-Pay in the Program and Service directory.
10. Select Add and the Applied Income/Co-Pay record will appear.
11. Select CO-CO-PAY (Amount or Percentage) from the drop-down list in the A/I Type field.
12. Select 1-CO-PAY (Amount) from the drop-down list in the Co-Pay Type field.
13. Type the full amount of co-pay the individual is responsible for paying in the Amount field.
14. Type the first day of the month the individual is responsible for paying the full amount of co-pay in the Begin Date field. Leave the End Date field at default zeros.

Co-pay changes:

When the co-pay changes, enter an End Date in the existing Applied Income record. Using these same instructions, create another record with the new information.

When RC services terminate, end the co-pay record:

1. Terminate the RC service authorization.
2. Open the Applied Income/Co-Pay folder and select the Open Co-Pay record.
3. If the end date is in the past, click on the Force box (it contains a check mark). Enter comments in the pop-up box and click on Unforce. If the end date is the current date or a future date, enter the end date and submit.
4. Enter the End Date used to terminate RC in the End Date field.
5. Click on the Force box again (this time there is no check mark in the box). Enter comments, click on Force and Submit.

8282 Service Authorization — RC Services Without the Wizards

Revision 17-1; Effective March 15, 2017

To register a Service Authorization record for RC (RC Apt., RC Non-Apt. or Emergency Care):

1. Select the Folder icon for Service Authorization in the Program and Service directory.
2. Select Add and the Service Authorization record will appear.
3. Select 7-COMMUNITY CARE from the drop-down list in the Service Group field.
4. Select the appropriate service code from the drop-down list in the Service Code field.
5. Leave the Agency field at the default selection 324-DHS.
6. Select 5-DAILY from the drop-down list in the Unit Type.

7. Type 1 in the Adj. Units field.
8. Type the date the individual is authorized to receive RC services in the Begin Date field. Leave the End Date field at default zeros.
9. Type the RC provider's contract number in the Contract No field. Do not type leading zeros.
10. Select Submit from the Command Menu or the toolbar to submit the authorization.

To register a Service Authorization record for RC Room and Board charges for individuals certified for RC prior to Sept. 1, 2003:

1. Select the Folder icon for Service Authorization in the Program and Service directory.
2. Select Add and the Service Authorization record will appear.
3. Select 7-COMMUNITY CARE from the drop-down list in the Service Group field.
4. Select the appropriate service code from the drop-down list in the Service Code field.
    - Select SC 19N – RC – Room and Board – Non-Apt when the service being authorized is RC Non-Apt.
    - Select 19O – RC – Room and Board – Apt when the service being authorized is RC Apt.
5. Leave the Agency field at the default selection 324-DHS.
6. Select 2-MONTHLY for room and board.
7. Type the ongoing monthly room and board amount in the Adj. Units field.
8. Type the date the individual is authorized to receive RC services in the Begin Date field. Leave the End Date field at default zeros.
9. Type the RC provider's contract number in the Contract No field. Do not type leading zeros.
10. Select Submit from the Command Menu or the toolbar to submit the authorization.

An RC individual can reserve his space in the facility during hospital, nursing facility or institutional stays.

To register a Service Authorization record for RC bedhold charges:

1. Select the Folder icon for Service Authorization in the Program and Service directory.
2. Select Add and the Service Authorization record will appear.
3. Select 7-COMMUNITY CARE from the drop-down list in the Service Group field.
4. Select 19H-ASSISTED LIVING BEDHOLD from the drop-down list in the Service Code field.
5. Leave the Agency field at the default selection 324-DHS.
6. Select 5-DAILY from the drop-down list in the Unit Type field.
7. Type 1 in the Adj. Units field.
8. Type the date the individual entered the hospital, nursing facility, etc. in the Begin Date field. Type the day before the individual was discharged from the hospital or nursing facility in the End Date field.
9. Type the RC provider's contract number in the Contract No field. Do not type leading zeros.
10. Select Submit from the Command Menu or the toolbar to submit the authorization.

See Section 8300, Changes to CCSE Authorizations Without the Wizards, for instructions for making changes to these records.

8290 Special Services to Persons with Disabilities (SSPD) Without the Wizards

Revision 20-3; Effective September 1, 2020

The following records are either system generated or created by the case worker to authorize SSPD Service Code 28. Detailed instructions for completing each record are found in Section 8200, Authorizing CCSE Services Without Using the Wizard, and in this section.

When the Create New Client function is used for an initial service authorization, the Enrollment and Eligibility records must be submitted to the SASOO database before the remaining records are completed. In all other

situations, all the records may be completed before submitting to the SASOO database.

- Individual
- Address
- Authorizing Agent – Case Worker
- Authorizing Agent – Agency
- Eligibility
- Enrollment
- Location
- Phone
- Level of Service – Form 2060, Needs Assessment Questionnaire and Task/Hour Guide, for Day Care
- Service Authorization

8291 Authorizing Agent/Agency — SSPD Services Without the Wizards

Revision 17-1; Effective March 15, 2017

To register an agency Authorizing Agent record for an SSPD individual:

1. Select the Folder icon for Authorizing Agent in the Case Worker directory.
2. Select Add and the Authorizing Agent record will appear.
3. Select OT-OTHER from the drop-down list in the Type field.
4. Select 7-COMMUNITY CARE from the drop-down list in the Group field.
5. Select NO in the Send to TMHP field.
6. Type the effective date for the authorizing agent to authorize services in the Begin Date field. Leave the End Date field at default zeros.
7. Type the word Direct in the Auth Agent field.
8. Leave the Agency field at the default selection 324-DHS.
9. Type the name of the SSPD provider agency in the Name field.
10. Type the phone number of the SSPD provider agency in the Phone field. Type the area code, phone number and extension. Type 0000 if no extension exists.

8292 Service Authorization — SSPD Services Without the Wizards

Revision 20-3; Effective September 1, 2020

To register a Service Authorization record for an SSPD recipient:

1. Select the **Folder** icon for **Service Authorization** in the **Program and Service** directory.
2. Select **Add** and the **Service Authorization** record will appear.
3. Select **7-COMMUNITY CARE** from the drop-down list in the **Service Group** field.
4. Select **28-SSPD** or **28A-SSPD** from the drop-down list in the **Service Code** field.
5. Select **HHSC** from the drop-down list in the **Agency** field.
6. Select **1-WEEK** for 28-SSPD or 2-Month for 28A-SSPD Case Management from the drop-down list in the Unit Type field.
7. For 28-SSPD, type the **number of units per week** for Day Care, Counseling and Interpreter Services in the **Adj. Units** field. For 28A-SSPD Case Management, type **1** in the **Adj. Units** field.
8. Type the **date** the person is authorized to receive SSPD services in the **Begin Date** field. Leave the **End Date** field at default zeros.
9. Type the **SSPD provider contract number** in the **Contract No** field. Do not type leading zeros.
10. Select **Submit** from the Command Menu or the toolbar to submit the authorization.

See Section 8300, Changes to CCSE Authorizations Without the Wizards, for instructions for making changes to this record.

8300, Changes to CCSE Authorizations Without the Wizards

8310 Authorizing Agent Entered the Wrong Contract Number — CCSE Services Without the Wizards

Revision 17-1; Effective March 15, 2017

The Contract No. field in the Service Authorization record cannot be changed once the record is submitted to the SASO database on the HHSC database. If the wrong contract number was submitted, the record must be cancelled. Once the record is cancelled, create another record using the correct contract number.

8311 Change in Provider Agency — CCSE Services Without the Wizards

Revision 17-1; Effective March 15, 2017

When an individual changes from one provider agency to another provider agency, enter an End Date on the existing Service Authorization record. Create a new Service Authorization record for the new provider agency using the instructions for the appropriate service. To avoid gaps or overlaps, the End Date of the existing record should be one day before the Begin Date of the new record. Authorizations for overlapping services require a Force.

8312 Increases or Decreases in the Number of Units — CCSE Services Without the Wizards

Revision 17-1; Effective March 15, 2017

When a service plan change results in an increase or decrease in the number of units, enter the End Date on the existing Service Authorization record. Create a new Service Authorization record using the instructions for the appropriate service. To avoid gaps or overlaps, the End Date of the existing record should be one day before the Begin Date of the new record.

The user must not decrease or increase units by changing the number of units on an existing record, unless correcting an error. If decreasing units for a prior time period, CMS will recalculate what the provider should have been paid and will take back the difference.

8313 Transfers from One CCSE Service to Another Without Wizards

Revision 17-1; Effective March 15, 2017

Type the day before the new service begins as the End Date for the existing Service Authorization record.

Using the instructions for the appropriate service, create a new Service Authorization record for the new service. To avoid gaps or overlaps, the Begin Date of the new record must be one day after the End Date of the existing record. Authorizations for overlapping services do not require a Force.

Check each required record for the new service. If it exists, is open and continues to be correct, leave it open. If not, create the required record using the instructions for the appropriate service.

Check the remaining folders and close any records that are not required for the services the individual will be receiving. Be sure not to close a record needed by another service the individual is receiving.

8314 Transfers from Service Group 7 to Another Service Group Without Wizards

Revision 17-1; Effective March 15, 2017

Enter the day before the new service begins as the End Date for the existing enrollment and Service Authorization record. To avoid gaps or overlaps, the Begin Date of the new record must be one day after the End Date of the existing record.

Identify the records that are required for the service that is being closed. Enter an End Date of the day before the new service will begin in all records that are specific to that service. For example, there is no need to close the Address, Phone and Location records because these records are applicable to all services, but the Form 2060, Needs Assessment Questionnaire and Task/Hour Guide – Level of Service record is closed because it is specific to Service Group 7.

Create the authorization for the new service using the instructions for that service.

8315 Closing Nursing Facility Records Due to Transitions to the Community — CCSE Services Without the Wizards

Revision 17-1; Effective March 15, 2017

If the date of discharge from a nursing facility is within 60 days prior to the new current start date for CCSE services, nursing facility records are closed either:

- the date prior to the nursing facility discharge date; or
- the date prior to start of CCSE services.

1. Close the following records:
    - Enrollment
    - Service Authorization for:
        - Daily Skilled Care – Service Code 1 or 3
        - Unlimited Prescriptions – Service Code 60
        - State Personal Needs Allowance Supplement (PNA) – Service Code 50, if applicable
        - Any other nursing facility-related Service Authorization record – Service Code 1

Do not close any of the following records:

2.
    - Diagnosis
    - Medical Necessity
    - Applied Income
    - Level of Service – Resource Utilization Group (RUG)
    - Authorizing Agent
3. Complete the CCSE wizards to authorize Community Care services.

If the individual is receiving Community Care services under the terms of MFP, indicate this on the Information for the Authorize window.

8400, Draft Functionality in CCSE Wizards

Revision 17-1; Effective March 15, 2017

A functionality called Draft is available in conjunction with the CCSE wizards. Draft permits the user to store a partially finished case for completion at a later time. Draft appears as a button in the Navigator shortcut window.

If the software shuts down in an abnormal operation, the individual record is automatically saved in Draft. Access the case record in Draft after rebooting.

8410 Storing a Case in Draft — CCSE

Revision 17-1; Effective March 15, 2017

If the Service Request folder or one of the wizards has been accessed for a case:

1. The user can close that case by clicking the X in the upper right-hand corner of the window on display. A message box will appear with the following choices:
    - Submit changes to the individual to the Outbox.
    - Save changes into Draft to continue with the individual later.
    - Delete changes/No changes made to the individual.
2. Select Save changes into Draft to continue with the individual later.
3. Select OK.

The user can exit out of the SASO application and the case will be saved in Draft, including all entries made to that point.

8411 Accessing a Case Stored in Draft — CCSE

Revision 17-1; Effective March 15, 2017

To continue working on a case previously stored in Draft:

1. Select the Draft button in the Navigator shortcut window.
2. Double click on the case name displayed in the SASO Data List window.

The case will open and is available for the user.

8500, CCSE Information

8510 Financial Information — CCSE

Revision 17-1; Effective March 15, 2017

The Financial Info folder is located in the Case Management directory. Folders in the Case Management directory contain all of the information entered by the case worker or nurse for any given individual record. Selecting the Financial Info folder displays screen-by-screen snapshots of windows in the Financial wizard. The number of history files stored in this folder is unlimited, and files are stored for an indefinite period of time.

To view information in the Financial Info folder:

1. Select the Financial Info folder in the Case Management directory.

2. Click on the + to the left of the Financial Info folder to expand the tree and to display dates and summary information for the history files which can be viewed.
3. Click on the + to the left of the File icon beside the date to be viewed to expand the tree and display additional folders.
4. Double click on the specific date to view information entered in the wizard.

8520 Authorization Information — CCSE

Revision 17-1; Effective March 15, 2017

The Authorization Info folder is located in the Case Management directory. Folders in the Case Management directory contain all of the information entered by the case worker or nurse for any given individual record. Selecting this folder displays the submit date, time and BJN for each authorization. The number of history files stored in this folder is not limited, and files are stored for an indefinite period of time.

To view information in the Authorization Info folder:

1. Select the Authorization Info folder in the Case Management directory.
2. Click on the + to the left of the Authorization Info folder to expand the tree and to display dates and summary information for the history files which can be viewed.
3. Click on the + to the left of the File icon beside the date to be viewed to expand the tree and to display additional folders.
4. Double click on a specific folder to view information entered in the wizard. If there is a + to the left of the Folder icon, there are multiple records which can be viewed. It is important to expand folders to the lowest level of detail to get to the screen copy of the information entered on that window.

8530 Functional Information — CCSE

Revision 17-1; Effective March 15, 2017

The Functional Info folder is located in the Case Management directory. Folders in the Case Management directory contain all of the information entered by the case worker or nurse for any given individual record. Selecting this folder displays read-only summaries and snapshots of windows from the Functional wizard. The number of history files stored in this folder is not limited, and files are stored for an indefinite period of time.

To view information in the Functional Info folder:

1. Select the Functional Info folder in the Case Management directory.
2. Click on the + to the left of the Functional Info folder to expand the tree and to display dates and summary information for the history files which can be viewed.
3. Click on the + to the left of the File icon beside the date to be viewed to expand the tree and to display additional folders.
4. Select a specific folder to view information entered in the wizard. If there is a + to the left of the Folder icon, there are multiple records which can be viewed. Select the Assessment folder to view a summary of the results of an eligibility determination associated with a specific date. Other folders are screen-by-screen snapshots of history files.

8540 Monitoring Information — CCSE

Revision 17-1; Effective March 15, 2017

The Monitoring Info folder is located in the Case Management directory. Selecting this folder displays read-only summaries of windows from the Monitoring wizard. The number of history files stored in this folder is not

limited, and files are stored for an indefinite period of time.

To view information in the Monitoring Info folder:

1. Select the Monitoring Info folder in the Case Management directory.
2. Click on the + to the left of the Monitoring Info folder to expand the tree and to display dates and summary information for the history files which can be viewed.
3. Click on the + to the left of the File icon beside the date to be viewed to expand the tree and to display additional information about that specific monitoring contact.
4. Select the Monitor Details folder to display information about problems alleged at that specific monitoring contact.

8600, CCSE Forms Directory

Revision 17-1; Effective March 15, 2017

The CCSE Forms directory is functional for cases worked through the wizards.

To view and/or print forms:

1. Select the Folder icon for the desired report in the CCSE Forms directory. The report(s) will display in read-only mode.
2. If there are multiple versions of the desired report (for example, more than one Form 2101, Authorization for Community Care Services), scroll down until the desired report is displayed.
3. Select the Print icon on the toolbar. Select from the Print Range section to print the page that displays the desired report.

Appendices

Appendix I, Transferring Individuals Due to Provider Contract Terminations or Contract Assignments

Revision 17-2; Effective March 31, 2017

Terminology

A **contract termination** occurs when a provider (business entity) will no longer have a contract with the Texas Health and Human Services Commission (HHSC). A contract termination requires that the individual receiving services from HHSC be transferred to a different provider before the effective date of the contract termination. For Community Care for Aged and Disabled (CCAD), the term contract termination replaces contract cancellation.

A **contract assignment** occurs when a contract is transferred from one business entity to another business entity. In this situation, there is an exchange between two business entities and the receiving business entity is assigned a new provider number. When a contract assignment occurs, the affected individual's service authorization record is transferred to the new provider through an automated mass transfer process in the Service Authorization System (SAS).

Not all changes in the provider's operation will require a provider change action. A contracted provider may have a change in ownership in which part of the business ownership changes, a complete change in ownership or

a name change in the provider's license. Not all of these provider operations result in the change in provider number. For CCAD, the term contract assignment replaces contract conversion.

Contract Termination Transfer Determination Procedures

When a contracted provider decides to terminate its contract with HHSC or when a contract assignment is needed, the contractor must notify HHSC contract staff. Notification of a contract termination may be received by contract or regional management staff. The contract termination end date negotiated with the provider must be 60 calendar days or less after the date the written notice of contract termination is received. If contract termination is due to license revocation, the end date is 30 calendar days or less. Expedited transfer procedures must be used if the contract termination or assignment occurs with less than 10 calendar days notification to HHSC.

Upon notification of a contract termination or contract assignment, the regional director will determine whether transfers will be handled as either routine or expedited transfers. The regional director must immediately report to the Community Care Services Eligibility (CCSE) director when a decision to apply expedited transfer procedures is made. A decision to apply routine procedures does not require notification to state office staff. The regional director will advise the case worker whether the transfer will be accomplished using routine or expedited transfer procedures.

The case worker must not initiate transfer procedures due to a contract termination until contract or regional management staff issues an official written notice to the provider.
If there is adequate time to refer the individual to a new provider without disrupting services or adversely impacting the individual, the regional director will advise the case worker to use routine transfer procedures.

If there is not adequate time to refer the individual to a new provider without disrupting services or if implementing routine procedures may adversely impact the individual, the regional director will advise the case worker to use expedited transfer procedures. An adverse impact is likely to occur when the individual:

- requires total care;
- is unable to transfer from a bed to a chair without help;
- is unable to manage toileting tasks without help;
- is in danger of not receiving daily nourishment because he is unable to prepare or eat his meals without help;
- requires nursing services; or
- has no caregiver available to provide the tasks necessary to maintain the individual's health or welfare.

In some instances, services may be disrupted for a short time; however, if there is no adverse impact to the individual, the regional director may advise the case worker to use routine transfer procedures.

CCAD Routine Transfer Procedures for Contract Terminations

If the regional director directs staff to apply routine transfer procedures, the CCAD case worker completes the following activities:

- Contacts the individual to advise of the contract termination and to request the individual's choice of a new provider. If the individual does not select a provider agency from the list of contracted agencies in the service area, an agency may be selected for the individual as a last resort. The selection is assigned from a regional agency rotation log. The rotation log must be maintained and kept up to date. The regional director may designate a time frame for provider selection depending on the contract termination date.
- Reviews the individual's service plan for accuracy and if any changes are needed, revises the service plan. If the CCAD case worker is unable to determine the individual's needs by telephone, or if an annual assessment is due within 30 days, the CCAD case worker makes a home visit to complete a reassessment

of the individual. If there are changes in the service plan, the CCAD case worker sends Form 2101, Authorization for Community Care Services, to the current provider agency. The required time frame for conducting an annual reassessment is no longer three months.
- Negotiates the transfer date with both provider agencies avoiding any service disruption to the individual whenever possible.
- Sends an initial referral packet to the new provider agency within five calendar days of the contact and sends the losing provider a copy of Form 2101.

For a routine transfer referral, the receiving provider follows procedures and requirements for initial referrals except for Primary Home Care (PHC) and Community Attendant Services (CAS). For PHC and CAS, a new practitioner's statement is not required for the transfer.

Expedited Transfer Procedures for CCAD Contract Terminations

An expedited transfer must be used when there is not adequate time to use the routine referral process to refer the individual to a new provider without disrupting services. In an expedited transfer, special procedures are used to quickly transfer the individual to a provider that can promptly begin service delivery. The regional director determines when an expedited transfer should be used. Generally, an expedited transfer is used when the contract termination occurs with less than 10 calendar days notification to HHSC, a large number of individuals are involved in the transfer, or both.

The regional director designates a coordinator to work with contract staff and providers to establish transfer dates. The coordinator or case worker identifies individuals whose annual reassessments are due or in process and negotiates, as instructed by the regional director or coordinator, an expedited service initiation date for individuals with the new provider.

Using the expedited transfer process, the individual is offered a choice of providers. If the individual does not select a provider agency from the list of contracted agencies in the service area at the point of contact, the case worker assigns a provider from the regional agency rotation log. The rotation log must be maintained and kept up to date.

CCAD Expedited Transfer Procedures for Contract Terminations

If the regional director determines to apply expedited transfer procedures, the CCAD case worker completes the following activities:

- Contacts the individual to advise of the contract termination and to request the individual's choice of a new provider. If the individual does not select a provider agency from the list of contracted agencies in the service area within the designated time frame, the individual will be assigned to a provider agency by rotation. The selection is assigned from a regional agency rotation log. The rotation log must be maintained and kept up to date.
- Reviews the individual's service plan for accuracy and if any changes are needed, revises the service plan. If the CCAD case worker is unable to determine the individual's needs by telephone or if an annual assessment is due within 30 days, the CCAD case worker makes a home visit to complete a reassessment of the individual. If there are changes in the service plan, the CCAD case worker sends Form 2101 to the current provider agency. The required time frame for conducting an annual reassessment is no longer three months.
- Negotiates, as instructed by the regional director or coordinator, an expedited service initiation date for each individual with the new provider and documents on Form 2065-A, Notification of Community Care Services, the negotiated effective date is due to expedited contract termination.
- Sends a referral packet to the new provider agency and notes "Expedited Transfer" on Form 2101 within five calendar days of the provider agency selection and sends the losing provider a copy of Form 2101.

For an expedited transfer referral, the receiving provider follows procedures and requirements for initial referrals except for PHC and CAS. For PHC and CAS, a new practitioner's statement is not required for the transfer.

Contract Termination – Residential Living Arrangements

The transfer process for an individual residing in an adult foster care (AFC) home, assisted living (AL) facility, host family setting or residential care (RC) facility is complicated by the necessity to find a new living arrangement for the individual. Use the following steps when handling a contract termination affecting an individual residing in an AFC, AL, host family or RC setting.

Step	Responsibility	Action
1	Regional Director	• works with contract staff, the case worker and providers to negotiate the date the transfer must be completed; and • identifies resources available to regional staff in facilitating transfer activities (for example, HHSC ombudsman).
2	Contract Staff	• surveys regional facilities to identify available residential settings; and • provides a list of available residential settings to the case worker and the individual.

3	Case Worker	• meets with residents (individually or as a group) to present available options that may include:
		  ◦ remaining in the current residential setting as a private pay resident;
		  ◦ transferring to a residential setting contracted with HHSC;
		  ◦ receiving services in the individual's own home; or
		  ◦ moving to a nursing facility;
		• negotiates, as instructed by the regional director or coordinator, an expedited service initiation date for each individual with the new residential setting contracted provider, if that option is selected;
		• documents on Form 2065-A or Form 2065-B the negotiated effective date is due to expedited contract termination; and
		• completes the same procedures noted for routine or expedited transfers, except for time frames provided by the regional director or coordinator based on the contract termination end date.

Depending on the option selected by the individual when a residential setting contract is terminated, the case worker completes the appropriate procedures to complete the action. For example, if an individual in a residential setting chooses to go to his daughter's home in the community, the case worker follows normal procedures for authorizing services in the community. If an individual chooses to move or return to a nursing facility permanently, the case worker follows normal procedures to terminate program eligibility and services.
Contract Terminations When No Other Provider is Available

In some situations, a provider may request to terminate its contract and there is no other provider available in the service area to provide that service. For example, if a Home-Delivered Meals provider terminates its contract, there may not be another provider in the service area to deliver meals. In that case, the HHSC case worker must contact the individual and offer any other available resources to meet that need. In this example, the individual may elect to receive services by an attendant to prepare meals or locate a congregate meal location.

When a service is terminated rather than transferred to a new provider, the HHSC case worker must send Form 2065-A or Form 2065-C, Notification of Ineligibility or Suspension of Waiver Services, to the individual noting the service is terminated due to the contract termination.

Contract Assignment

Residential and Non-Residential Settings

After HHSC contract staff have negotiated the contract assignment effective date, contract staff will notify the regional director that the provider plans to assign its contract, as well as the contract assignment effective date. A transfer due to a contract assignment must not occur before the contract assignment effective date.

On or within two working days after the contract assignment effective date, regional staff must send Form 2097, Provider Contract Assignment Notification Letter, to the individual informing him of the change in provider. The letter informs the individual of the change in contract and offers the option to change to a provider selected by the individual or remain with the new provider. The letter informs the individual of the change in contract and offers the option to change to a provider selected by the individual or remain with the new provider.

Individual Chooses to Remain With the New Provider

After receiving confirmation of the automated mass transfer, the case worker reviews the Texas Medicaid and Healthcare Partnership error page in the Service Authorization System (SAS) to identify an individual whose service authorization record transfer was not processed. It should not be necessary to check each service authorization record. However, for CCAD, the SAS wizard will not replicate the provider change until the case worker runs the wizard, selecting "Provider Transfer." To prevent billing problems, the CCAD case worker must complete a provider transfer in the SAS wizard immediately for an individual whose service authorization records were not automatically converted. For assistance with an individual whose service authorization records were not automatically converted, contact the coordinator or the regional Claims Management Services (CMS) coordinator.

The losing provider should provide the new provider with all applicable forms. If the losing provider does not provide the forms to the new provider, the case worker must provide copies of the current forms to the new provider. For CCAD, refer to Appendix XIII, Contents of Referral Packets, for the list of forms to be sent for provider transfers.

It is not necessary to obtain acceptance by the new provider or send Form 2065-A to the individual or new provider. The case worker must document in the case record the transfer was due to a contract assignment from the losing provider to the new provider. In a mass transfer completed through the automated transfer process, only the SAS service authorization records are automatically changed to end the losing provider and authorize all services to the gaining provider.

For CCAD, the SAS wizard does not automatically update all data. The provider transfer must be processed in the wizard so the history and Form 2101 data will match changes to the service authorization records.

Individual Chooses to Change to a Different Provider

If the individual chooses to change from the new provider that received the contract assignment to a provider selected by the individual, the case worker must complete two provider change actions. The CCAD case worker uses the SAS wizard to complete the provider change actions. The first provider change action is to change service authorizations from the losing provider to the new provider for services delivered after the contract assignment effective date. The second provider change action is to change service authorizations from the new provider to the provider selected by the individual for services.

Both CCAD provider change actions must be completed within the time frame in Section 4676, Change of Providers.

For all programs, the individual may change providers at any time, as described in current procedures regardless of any changes in the provider's operation.

Questions may be directed to the Policy Development and Oversight mailbox at: pdo@hhsc.state.tx.us.

Appendix II, Cost Limit for Purchased Services

Revision 17-1; Effective March 15, 2017

Under state law, the Texas Health and Human Services Commission may not purchase alternate care for an individual when the cost per day of the care exceeds the cost per day in a nursing facility. Few combinations of Community Care for Aged and Disabled (CCAD) services even approach this cost. However, case managers must be careful when authorizing maximum levels of personal attendant services along with another CCAD service.

To determine rates for services that vary by region or contract (for instance, Family Care, Emergency Response Services or Home-Delivered Meals), the highest allowable rate is used. To ensure the correct amount of services are purchased, contact the regional contract manager to obtain the actual unit rate in a specific region.

When an individual receives multiple services, contact the regional contract manager to:

- obtain current unit rates that apply to the services authorized; and
- determine the total cost of services to ensure that the nursing facility average is not exceeded.

Appendix III, Appropriate or Inappropriate Individual Characteristics Special Services to Persons with Disabilities

Revision 21-1; Effective March 1, 2021

Attendant services are inappropriate for an applicant or recipient whose needs exceed the scope of the contract. Community Care Services Eligibility (CCSE) staff use the following examples of appropriate and inappropriate characteristics to decide if an applicant or recipient's needs can be adequately met through the program.

Appropriate	Inappropriate
• Requires assistance with personal care or health-related tasks. Has other reliable resources to meet health, safety, and independent living needs not authorized or provided through the service or contract.	• Will be dependent upon the contractor for medical care or health-related tasks that are not within the scope of the service or contract.

Appropriate	Inappropriate
• Manages their emotional or mental disorder with prescribed drug regimen.	• Threatens the safety of themselves or others or does not maintain their medication regimen.
• May have occasional periods of forgetfulness, confusion, or disorientation, or lack social or communication skills.	• Is totally disoriented, confused, incoherent, or incapable of following or giving instructions.
• Requires medication for rest or sleep.	• Requires attendant visits during the night to control disruptive behavior.
• Occasionally uses alcohol or non-prescribed drugs that do not result in disruptive behavior.	• Is addicted to alcohol or non-prescribed drugs and is not in an active treatment plan.
• Is realistic about responsibilities for semi-independent living and limitations of services provided through this contract.	• Requires a highly structured living arrangement or does not demonstrate semi-independent living skills.

Appendix IV, Workflow and Time Frames

Revision 21-4; Effective December 1, 2021

Workflow and Time Frames for Expediate and Immediate

Time Frames	Action
Intake received and determined to be expedited or immediate	Schedule the visit and assess the applicant within the appropriate time frame for an immediate referral (24 hours) or an expedited referral (five calendar days).
By the **next business day** after the home visit date	Make an oral request to the provider to begin pre-initiation activities and negotiate a date for the completion of pre-initiation activities (which is less than 14 days). CCSE staff then send the referral packet, including referral Form 2101, Authorization for Community Care Services, with the negotiation information in the comments.
By the **negotiated date**	The provider calls CCSE staff and provides the information from the completed Form 3052, Practitioner's Statement of Medical Need. CCSE staff and the provider negotiate a start date.
Within **five business days** after the negotiation contact from the provider	Send the authorization Form 2101 to the provider, entering the negotiated start date in Item 4.

Time Frames	Action
Within **two business days** from the negotiated start date	Complete and send Form 2065-A, Notification of Community Care Services, to the applicant.
Within **seven business days** from the negotiation contact	The provider sends CCSE staff Form 3052.

Workflow and Time Frames for a Routine Primary Home Care (PHC) Referral

Time Frames	Action
Within **14 calendar days** after receipt of intake	Schedule a visit and complete an assessment. The application must be completed within 30 calendar days from the assessment date.
Within **five business days** after the home visit (The date of the home visit is day "0.")	Enter the assessment information in the Service Authorization System Online Wizard (SASOW) and send the provider a referral packet. This begins the pre-initiation activities.
Within **14 calendar days** after receipt of referral packet	The provider completes the pre-initiation activities, obtains Form 3052 and sends the form to HHSC.
Within **five business days** after receipt of Form 3052 (The date of receipt of Form 3052 is day "0.")	Review Form 3052. If complete, send authorization Form 2101 to the provider. The "Mail Date" (Item 1) and the "Begin Date" (Item 4) are the same date.
Within **two business days** of the Begin Date on Form 2101	Complete and send Form 2065-A to the applicant.
Within **30 calendar days** of assessment or face-to-face contact	Send the authorization Form 2101 to the provider to complete the application.
Within **seven calendar days** after Receipt of the authorization Form 2101	The provider initiates services.

Workflow and Time Frames for an Initial Referral for Community Attendant Services (CAS)

Time Frames	Action
Within **14 calendar days** after receipt of intake	Schedule a visit and assess the applicant for services. **Note**: If the intake is immediate or expedited, schedule according to the appropriate time frame. Unless new intakes are being placed on the interest list by the region, a referral to Family Care is mandatory for immediate or expedited intakes.
Within **two business days** after receipt of the application form (Date of receipt is day "0.")	Fax Form H1746-A, MEPD Referral Cover Sheet and Form H1200, Application for Assistance – Your Texas Benefits, to the Medicaid for the Elderly and People with Disabilities (MEPD) staff.
Within **seven business days** after receipt of the eligibility notification from MEPD	Enter the assessment information in the SASOW and send the provider a referral packet. This begins the pre-initiation activities.

Time Frames	Action
Within **14 calendar days** after receipt of the referral packet	The provider sends Form 3052 to the HHSC nurse. The provider may send a courtesy copy of Form 2101.
Within **five business days** after receipt of completed Form 3052 (The date of receipt of Form 3052 is day "0.")	The HHSC nurse enters the information in SAS and sends the provider authorization Form 2101 with a copy to CCSE staff.
Within **two business days** after receipt of Form 2101 from the HHSC nurse (The date of receipt is day "0.")	Send the applicant Form 2065-A.
Within **seven calendar days** after receipt of authorization on Form 2101	The provider initiates services.

Workflow and Time Frames for a CAS Reassessment

Time Frames	Action
Within **12 months** after the previous assessment	Conduct a home visit for the annual reassessment.
Within **five business days** after the home visit	Send referral Form 2101 to the provider. If there are no changes in the service plan, leave the "Begin Date" blank. If there are changes in the service plan, enter the "Begin Date" according to the action: • The effective date for an increase is seven calendar days from the Item 1 (Mail Date) on Form 2101. • The effective date for a decrease is 12 days from the Item 1 (Mail Date) on Form 2101. This date must match the date on Form 2065-A. Send Form 2065-A to the person to notify them of the change in the service plan. A person is entitled to be notified 10 days before any reduction or termination of their services, or to have the notification mailed 12 days before the date of reduction or termination.
Within **14 calendar days** after receipt of Form 2101 from CCSE staff	The provider sends Form 2101 and signed statement of the agreement or disagreement* with the plan to the HHSC regional nurse.
Within **five business days** after receipt of Form 2101 from the provider	The HHSC nurse reviews the service plan and completes the authorization in the Authorization Wizard. The nurse sends authorization Form 2101 to the provider and CCSE staff. * If the provider disagrees with the service plan, within five business days the HHSC nurse negotiates with the provider and CCSE staff to arrive at an agreement. If Form 2101 is not received from the provider within 21 calendar days, the HHSC nurse contacts the provider to request the form.

Workflow and Time Frames for a Day Activity and Health Services (DAHS) Referral

Time Frames	Action
Within **14 calendar days** after receipt of intake	Schedule a visit or contact the applicant by phone and assess the applicant for services.
Within **five business days** after the assessment	Enter the assessment information in SASOW and send the provider a referral packet. This begins the pre-initiation activities.
Within **14 calendar days** after receipt of the referral packet	The provider sends the prior approval request packet to the HHSC regional nurse, which includes: • Form 2101; • Form 3050, Day Activity and Health Services (DAHS) Health Assessment/Individual Service Plan; and • Form 3055, Physician's Orders (DAHS).
Within **five business days** after receipt of the packet (The date of receipt of the packet is day "0.")	The HHSC regional nurse determines if the applicant meets the medical criteria for DAHS and if so, enters the information in SAS. The nurse sends approval or denial to the provider on authorization Form 2101 with a copy to CCSE staff.
Within **two business days** after receipt of Form 2101 from the HHSC Regional Nurse (The date of receipt is day "0.")	Send the applicant Form 2065-A to notify them of the eligibility determination.
Within **seven calendar days** after the *Begin Date* on Form 2101	The provider initiates services, unless the applicant has been attending the facility under a facility-initiated referral.

Appendix V, Guidelines for Completing Form H1746-A, MEPD Referral Cover Sheet

Appendix VI, Reserved for Future Use

Revision 21-3; Effective September 1, 2021

Appendix VII, Casework Procedures

Revision 20-4; Effective December 1, 2020

Appendix is available for staff use here.

Appendix VIII, Residential Care and Emergency Care Mental and Physical Characteristics

Revision 21-3; Effective September 1, 2021

Appendix is available for staff use on the LOOP.

Appendix IX, Notification Effective Date of Decision

Revision 22-3; Effective Sept. 1, 2022

Case Action	Date Form Is Mailed or Given to Applicant or Recipient	Effective Date to be Entered on Form 2065-A, Notification of Community Care Services
If application is denied, includes when the applicant is denied for one service that was requested but granted another service:	Within two business days of denial.	Not applicable for denials.
		The effective date is the date on Form 2064, Eligibility Worksheet, or the negotiated date.
If application is certified:	Within two business days of certification.	The effective date for Primary Home Care (PHC), Community Attendant Services (CAS) and Title XIX Day Activity and Health Services (DAHS) cases is not applicable. Check the "pending" box to indicate eligibility is contingent on medical approval. For Residential Care (RC) cases in which the applicant is determined eligible for Emergency Care, enter the date the applicant was determined eligible.
If a verbal referral is necessary or priority status is added:	Within two business days of certification.	The date is negotiated with the provider for PHC and Family Care (FC) or the provider and regional nurse for CAS.
If there is: • denial of priority status at the recipient's request, • a decrease in copayment, or addition of a service;	Within two business days of the decision.	The date the action is completed is the date the change goes into effect.
If there is an increase in units:	Within two business days of the decision.	The date must be within seven calendar days after the date on Form 2101, Authorization for Community Care Services.

Case Action	Date Form Is Mailed or Given to Applicant or Recipient	Effective Date to be Entered on Form 2065-A, Notification of Community Care Services
If the recipient loses PHC eligibility and is transferred to FC, whether or not there is a change in units or if priority status is terminated due to the: • loss of a personal care task needed for PHC, CAS or DAHS; • addition of a resource from a community or social network, support system or caregiver which performs all of the previously purchased tasks; • recipient becomes financially ineligible; • loss of unmet need; or • recipient requests that service(s) be terminated;	12 calendar days before the date services are decreased, terminated or transferred, unless the recipient loses Medicaid.	12 calendar days following the date Form 2065-A is mailed. *
If services are decreased or terminated because: • a recipient loses CAS eligibility for financial reasons and is not transferred to FC;	Within two business days of the learned denial date	The last day of the final month of CAS eligibility as determined by the Medicaid for the Elderly and People with Disabilities (MEPD) staff.
• an interest list person withdraws;	Not applicable.	No notice is sent in this situation.

Case Action	Date Form Is Mailed or Given to Applicant or Recipient	Effective Date to be Entered on Form 2065-A, Notification of Community Care Services
• a DAHS facility-initiated recipient does not want to have the initial paperwork processed for continued DAHS services;	12 calendar days before the case is closed.	12 calendar days following the date Form 2065-A is mailed.*
• changes in federal law or state regulations require that services be decreased or terminated for an entire categorical recipient group;	Before the date of action.	Services continue only through the termination date of the categorical recipient group, even if appealed.
• of functional ineligibility for personal attendant services (PAS) or loss of the need for six hours of PAS;	12 calendar days before the case is closed (only at annual review).	12 calendar days following the date Form 2065-A is mailed.*
• a recipient moves to a skilled or intermediate care facility, or any other facility where 24-hour supervision is available;	Within two business days of the date information that a nursing facility stay is permanent or notification of the effective date.	The date the recipient entered the facility.
• a recipient threatens their health or safety or others; • a recipient or someone in their home threatens the department	Within two business days of the date information is received.	The date CCSE staff become aware of the action. Services are not reinstated before the outcome of the appeal hearing.

Case Action	Date Form Is Mailed or Given to Applicant or Recipient	Effective Date to be Entered on Form 2065-A, Notification of Community Care Services
• a recipient loses Medicaid and does not qualify for FC;	Within two business days of the date information is received.	The last date of eligibility for Medicaid.
• the Texas Health and Human Services Commission has facts confirming the death of the recipient;	Not applicable.	Not applicable.
If services are decreased or terminated for any reason not given above:	at least 12 calendar days before services are decreased or terminated.	12 calendar days following the date Form 2065-A is mailed *, unless the recipient: • requests that services end, or • enrolled in another program equivalent or better. In some cases, the recipient might request a specific effective date. For decreased services, day 12 is the last day the recipient has the right to appeal. Day 13 is the first day the recipient will receive the decreased service hours. For denied services, day 12 is the last day the recipient has the right to appeal and is the last day the recipient will receive services. **Note**: When the recipient orally requests their services be decreased or terminated, document the recipient's reason and obtain their signature in the comments section of Form 2065-A. The effective date of the adverse action is the date that Form 2065-A is dated and given to the recipient.

* If day 12 falls on a weekend or holiday, the effective date is the following business day.

Refer to the instructions for Form 2065-A for the procedures to follow when a recipient requests a hearing in writing or in person.

Notes:

- For terminations, the effective date on Form 2065-A must be the same as the "End Date" on Form 2101.
- Do not send Form 2065-A when a recipient's forwarding address is unknown, such as situations when the post office sends notification that the recipient left no forwarding address.
- Send Form 2065-A when a recipient is transferring from one service to another, regardless of whether the change is considered to be positive or negative.

Appendix X, CCSE Case Management Filing Guide

6-2019

LEFT SIDE

Retention tab
Form 3052, Practitioner's Statement of Medical Need
Form 3055, Physician's Orders (DAHS)
Form 3050, DAHS Health Assessment/Individual Service Plan
Form 1582, Consumer Directed Services Responsibilities
Form 1584, Consumer Participation Choice
Form 1575, Medicaid Estate Recovery Program Worksheet
Form 8001, Medicaid Estate Recovery Program Receipt Acknowledgement
Form 2061, Notification of Medicaid Estate Recovery Program Status
Form 2307, Rights and Responsibilities
Interdisciplinary Team (IDT) Letters
Guardianship Documents

RIGHT SIDE

Forms Checklist for Attendant Care Programs

2019 tab
All forms created or received during this calendar year that are not required to be filed under the retention tab.

Filing Notes:

The Community Care Services Eligibility (CCSE) Case Management Filing Guide is a suggested filing format to promote consistency in CCSE case records.

The objective will be to always have the forms and documents which need to be retained on the top left side under Retention tab. All other forms and documents should be filed under yearly tabs beginning with 2019, 2020 and so on, with the current calendar year on the top right side. The intent of the yearly tabs is to file forms as they are created or received.

Appendix XI, Income and Resource Limits

Appendix XII, Examples of Methods to Verify Income and Resources

Revision 17-1; Effective March 15, 2017

Resources — CCSE Handbook Section 3420

Element	Verification Sources	Documentation

Element	Verification Sources	Documentation
1. Bank accounts, checking, savings, certificates of deposit (CD), money market	• Current bank statement • Letter or contact with financial institution or bank • Medicaid eligibility (ME) Form H1239 • Current savings statements • Recent entry in a savings passbook	• Owner, if different from applicant's name • Type of account • Name and address of financial institution, if not listed on application • Source of verification • Account number, if not listed on application • Account balance and date, if different from face-to-face contact • If representative contacted, his name and telephone number
2. Bonds	• Newspaper • Bank or other financial institution • Brokerage firm/securities firm • Public library's research department • For savings bonds, the U.S. Treasury Office or its publication that is used by banks and is available on request	• Owner, if different from applicant's name • Name of bond issuer and type of bond, if not listed on application • Source of verification and date, if different from face-to-face contact • Number of bonds and serial numbers (if applicable) • Current market or cash value. Corporate and municipal bonds may be discounted so the cash value may be less than the face amount. Some U.S. savings bonds must be held for 60 days before being cashed. • If representative contacted, his name and telephone number
3. Cash on hand, safe deposit boxes	• Statement of individual	• Statement of individual regarding the contents • Date, if different from face-to-face contact
4. Notes and mortgages (exempt if buyer fulfilling the contractual obligations)	• Statement of individual	• Statement of individual regarding the current market value • Date, if different from face-to-face contact

Element	Verification Sources	Documentation
5. Real property (unless in probate) (If property is exempt because the individual is making a good faith effort to sell, then he must supply evidence of the attempt to sell and the worker must verify that the selling price is at fair market value.)	• Tax bill or assessment notice • Tax assessor • Local real estate broker • Local bank	• Owner, if different from applicant's name • Source of verification and date, if different from face-to-face date • Current equity value of individual's interest • If collateral used, pertinent name and telephone number
6. Revocable trust funds	• Bank statement • Trust agreement • Will • Trustee • Bank representative	• Name of trustee/beneficiary, if not listed on application • Source of verification and date, if different from face-to-face date • Accessibility of trust • Amount held in trust • If collateral used, pertinent name and telephone number
7. Stocks	• Recent statement from 1. Brokerage house 2. Issuing company • Securities firm • Newspaper • Public library's research department	• Owner, if different from applicant's name • Name of company • Source of verification and date, if different from face-to-face contact • Number and type of shares • Market value • Use the closing price on the day of application or recertification • If collateral used, pertinent name and telephone number
8. Vehicles (if not eligible for exclusion)	• "Blue" or National Automobile Dealers Association (NADA) Book (gold) • Newspaper ads • Auto dealer • Finance company, or bank	• Owner, if different from applicant's name • Year, make, and model • Source of verification and date, if different from face-to-face date • Market value • Equity value • If collateral used, pertinent name and telephone number • Assess $100 value for inoperable junk vehicle if individual's total resources are less than $4,900 for a single person or $5,900 for a couple

Element	Verification Sources	Documentation
9. Work equipment (excluded if required for employment, self-employment, or self-support)	• Individual's estimate of value • Dealer	• Owner, if different from applicant's name • Description of property, if not on application • Individual's estimate of value • Equity value • Source of verification and date, if different from face-to-face contact • If collateral used, pertinent name and telephone number

Income Eligibility — CCSE Handbook Section 3300

Element	Verification Sources	Documentation
1. The individual's total earnings (monthly gross) 1. Money 2. Wages 3. Salary 4. Armed forces pay 5. Commissions 6. Tips 7. Piece-rate payments 8. Cash bonuses	• Employer • Oral statement • Written statement • Viewing check stubs • Copies of earnings statements (check stubs)	• Who is employed, if not indicated on application • Name, address, telephone number of employer, if not on application • Date verified, if different from face-to-face contact • How information was verified ◦ If by telephone, include name and telephone number of the contact ◦ If by viewing, include description of document and date, if different from face-to-face contact ◦ Gross amount ◦ Frequency of pay • Show your calculations

Element	Verification Sources	Documentation

2. Net income from non-farm self-employment	• Business receipts/records maintained by individual
	• Most recent Internal Revenue Service (IRS) Form 1040 (Income Tax Return) (In instances where complete verification of self-employment income is impossible, accept the individual's word if the information seems reasonably valid.)
		• Who is self-employed, if not indicated on application
		• Name and kind of business (address and telephone number if different), if not on application
		• Date verified, if different from face-to-face contact
		• Types of records used and period covered
		• Amount of gross income
		• Amount of expenses
		  ◦ Costs of purchased goods
		  ◦ Rent, heat, light, power
		  ◦ Depreciation charges
		  ◦ Wages/salaries paid
		  ◦ Business taxes (not personal income taxes or Social Security taxes)
		• If amount of net countable income is anticipated to be different, explain reason.
		• Amount of net countable income and calculations used to arrive at countable income.

3. Net income from farm self-employment	• Business receipts/records maintained by individual
	• Most recent IRS income tax return
	• Statements from other knowledgeable sources (e.g., county farm agent)
		• Who is self-employed, if not indicated on application
		• Type of farm income, if not indicated on application
		• Date verified, if different from face-to-face contact
		• Type of records used and period covered
		• Amount of gross income
		  ◦ Value of products sold
		  ◦ Government crop loans
		  ◦ Money from rental of farm equipment to others

Element	Verification Sources	Documentation
		◦ Incidental money from the sale of wood, sand, gravel, etc. Note: Do not include value of fuel, food, or other farm products used for family living • Amount of operating expenses ◦ Cost of feed, fertilizer, seed, and other farming supplies ◦ Cash wages paid to farmhands ◦ Depreciation charges ◦ Cash rent ◦ Interest on farm mortgages ◦ Farm building repairs ◦ Farm taxes (not personal income taxes or Social Security taxes) • If amount of net countable income is anticipated to be different, explain reason. • Amount of net countable income and calculations used to arrive at countable income.
4. Social Security (Retirement, Survivors, and Disability Insurance (RSDI)) 1. Pensions 2. Survivor's benefits 3. Permanent disability insurance	• Recent award letter • Recent cost-of-living increase notice from the Social Security Administration (SSA) • RSDI check or direct deposit slip • WTPY response • Form SSA 1610 (use only if no other source is available) • Texas Department of Health and Human Services Commission (HHSC) computer inquiry • Contact with SSA representative	• Payee/beneficiary, if not indicated on application • Gross benefit amount before deductions for Medicare insurance • Claim number/suffix • Date received, if different from face-to-face date • Source of verification and date, if different from face-to-face contact • If SSA representative contacted, name and telephone number

Element	Verification Sources	Documentation
5. Railroad retirement (RR)	• Form 1026 • Recent award letter from RR Board • Contact with representative of RR Board • Most recent check or direct deposit slip	• Payee/beneficiary, if different from applicant's name • Gross benefit amount before deductions for Medicare insurance • Claim number • Date received • Source of verification and date, if different from face-to-face date • If RR representative contacted, name and telephone number
6. Dividends 1. Stocks 2. Membership in associations	• Recent check stubs or checks • Letter from company making payments • Telephone contact with representative of company • Recent statement from a brokerage house or the company issuing the stock to verify dividends	• Payee/beneficiary, if different from applicant's name • Payor (company) • Source of verification and date • Account number, if not listed on application • Gross amounts • Dates received • Frequency • Reason for dividend • If company representative contacted, name and telephone number • If excludable, reason for exclusion • If countable, show calculations used to arrive at an average amount.

Element	Verification Sources	Documentation
7. Net rental income 1. House, store or other property 2. Boarders or lodgers	• Business receipts/records maintained by individual • Most recent IRS income tax return • Statements from individual and renter • Copy of lease or rent check	• Type of rental income, if not indicated on application • Date verified, if different from face-to-face contact • Types of records used and period covered • Amount of gross income • Amount of expenses ◦ Property tax receipts ◦ Mortgage payment interest ◦ Insurance payments ◦ Bills for repair and upkeep of property Note: Capital expenditures for additions or improvements and depreciation are not deductible • If amount of income is anticipated to be different, explain reason. • Amount of net countable income and calculations used to arrive at countable income.

Element	Verification Sources	Documentation
8. Net income from lease of mineral rights 1. Gross royalty payments 2. Yearly lease payments	• Royalty interest statements (check stubs) • Contact with representative of oil company • Check stub from lease payments	• Name of payor/payee, if different from applicant's name • Source of verification and date, if different from face-to-face date • Account number • Amount of yearly lease payments • Gross amounts over past 12 months (royalty payments) • Dates received • Frequency • If representative contacted, name and telephone number • Deduction amounts ◦ Excise taxes ◦ Property taxes Note: Federal windfall profits taxes are not deductible—may have to add it back if company deducted it • Amount of net countable income and calculations used to arrive at a 12-month average (royalty payments)
9. Income from mortgages or contracts (notes) 1. Negotiable and 2. Non-negotiable	• Copy of contract • Copy of document with the statement of terms of repayment • Copy of recent check from payor • Contact with bank representative • Statements from the individual and payor	• Name of payee/payor, if different from applicant's name • Source of verification and date, if different from face-to-face contact • Payment amount • Frequency • Date received • If representative contacted, name and telephone number

Element	Verification Sources	Documentation
10. Public assistance 1. Temporary Assistance for Needy Families (TANF) 2. Supplemental Security Income (SSI) 3. General assistance from county or city 4. Medicaid Qualified Medicare Beneficiary (MQMB) 5. Qualified Medicare Beneficiary (QMB) only 6. Specified Low-Income Medicare Beneficiary (SLMB) only 7. Qualifying Individuals (QI) coverage 8. Food stamps	• HHSC computer inquiry • Most recent SSI award letter or SSI check • Most recent individual notice or check • Contact with a representative ◦ Texas Works worker ◦ MEPD case specialist ◦ SSI representative ◦ City or county worker • TANF case record	• Name of recipient, if different from applicant's name • Type of benefit • Source of verification and date, if different from face-to-face contact • Benefit amount • Date received • If representative contacted, name and telephone number
11. Private pensions (retirement benefits) 1. Former employer 2. Union 3. Insurance company	• Current check stub • Pension plan • Letter from company • Contact with company representative	• Name of payor/payee/beneficiary, if different from applicant's name • Source of verification and date, if different from face-to-face contact • Gross benefits amount • Date received • Claim number • Whether any increase is anticipated • If representative contacted, name and telephone number

Element	Verification Sources	Documentation
12. Civil service annuity (CSA)	• Recent CSA increase award card • Letter from CSA • Contact with CSA representative • Current check • Form 1243	• Name of payee/beneficiary, if different from applicant's name • Source of verification and date, if different from face-to-face contact • Gross benefit amount before deductions for health insurance • Date received • Claim number • If representative contacted, name and telephone number
13. Irrevocable trust funds	• Trust agreement • Will • Trustee • Representative of bank or financial institution managing trust • Recent bank statement	• Name of trustee/beneficiary, if different from applicant's name • Source of verification and date, if different from face-to-face contact • Amount and frequency of income from trust to individual • Date of bank statement • If trustee or representative contacted, name and telephone number

Element	Verification Sources	Documentation
14. Veterans Administration (VA) benefits 1. Pension 2. Compensation (disability) 3. Subsistence allowance for education and on-the-job training 4. Refunds paid to ex-servicemen (GI insurance premiums)	• Current check or direct deposit slip • Recent bank statement • Form 1240 • Recent VA Award Letter • Contact with VA representative	• Name of recipient, if different from applicant's name • Type of benefit • Source of verification and date, if different from face-to-face contact • Gross payment amount and exclusions: ◦ Aid-and-attendance benefits ◦ VA Homebound Elderly Benefits ◦ Payments for purchase of medications • Date received • Claim number • If representative contacted, name and telephone number
15. Educational loans and grants	• School • Organizations • Clubs • Institutions • Award letter • Government loans	• Beneficiary, if different from applicant's name • Payor • Type of loan or grant • Amount received for current living costs • Source of verification and date • Date received and period covered (frequency) • If representative contacted, name and telephone number
16. Unemployment compensation 1. Government 2. Private 3. Strike benefits from union funds	• Texas Workforce Commission Form B-11 or other official correspondence • Recent check • Recent bank statement • Contact with government agency, employer, union	• Payee/payor, if different from applicant's name • Source of verification and date, if different from face-to-face contact • Gross amount received • Date received and period covered (frequency) • Claim number • If representative contacted, name and telephone number

Element	Verification Sources	Documentation
17. Worker's compensation and disability payments	• Recent check • Attorney • Claim Adjuster • Recent bank statement • Legal Correspondence • Correspondence from insurance company • Employer	• Payee/beneficiary, if different from applicant's name • Source of verification and date, if different from face-to-face contact • Gross amount received • Date received and frequency • Length of disability • Lump-sum settlement • If collateral contacted, name and telephone number
18. Alimony	• Contact ex-spouse • Divorce Decree • Court/payment records • Recent check • Receipts	• Payor • Source of verification and date, if different from face-to-face contact • Amount received • Date received and frequency • If collateral contacted, pertinent name and telephone number
19. Cash support payments from friends or relatives (regular monthly)	• Contact or statement from contributor • Recent check • Receipts	• Payee/beneficiary, if different from applicant's name • Relationship/name/address and telephone number of payor • Source of verification and date, if different from face-to-face contact • Amount received and frequency (exclude if infrequent or irregular and less than $20/mo.)

Element	Verification Sources	Documentation
20. Net income from individual's share of life estate 1. Mineral lease 1. Bonus payments 2. Delays rentals 3. Shut-in royalty 2. Other types of leases (farming, grazing, hunting) 3. Rental	• Lease agreements • Rental agreements • Oil company representative • Check stubs • Lessee or tenant (renter)	• Payee, if different from applicant's name • Payor • Source of verification and date, if different from face-to-face contact • Gross amount • Date received and frequency • If representative contacted, name and telephone number • Address and telephone number of lessee or tenant
21. Teacher retirement (TRS)	• Form 1297 • Contact with TRS employee • Recent check if previously verified no deductions	• Payee/beneficiary, if different from applicant's name • Source of verification and date, if different from face-to-face contact • Gross benefit amount • Claim number • Date received • If TRS representative contacted, name and telephone number

Appendix XIII, Content of Referral Packets

Revision 21-4; Effective December 1, 2021

Initial Referral Packet Forms

The initial packet must Include:

- a cover sheet;
- the Long-term Care Services Intake System (NTK) generated Form 2110, Community Care Intake; and
- a copy of the following Service Authorization System Online Wizards (SASOW) generated forms.

Community Attendant Services (CAS) **Primary Home Care (PHC)** **Day Activity and Health Services (DAHS)** **DAHS Facility -Initiated Referrals**	**Family Care (FC)** **Residential Care (RC)**	**Emergency Response Services (ERS)** **Home Delivered Meals (HDM)**	**Adult Foster Care (AFC)**

Community Attendant Services (CAS) **Primary Home Care (PHC)** **Day Activity and Health Services (DAHS)** **DAHS Facility -Initiated Referrals**	**Family Care (FC)** **Residential Care (RC)**	**Emergency Response Services (ERS)** **Home Delivered Meals (HDM)**	**Adult Foster Care (AFC)**
Form 2059, Summary of Client's Need for Service; Provider Referral Supplement; Form 2060, Needs Assessment Questionnaire and Task/Hour Guide; and referral Form 2101, Authorization for Community Care Services. **Note**: For DAHS, Form 2060 and Task/Hour Guide are not required.	Form 2059; Provider Referral Supplement; Form 2060; Task/Hour Guide; and authorization Form 2101.	Form 2059; Provider Referral Supplement; and Form 2101 as an authorization.	Authorization Form 2101; Form 2327, Individual/Member and Provider Agreement; Form 2330, Assessment and Service Plan Approval for Adult Foster Care.

Annual Reauthorization and Interim Reassessment Packet Forms

Must include a cover sheet and a copy of the following SASOW generated forms.

Community Attendant Services (CAS) **Primary Home Care (PHC)** **Day Activity and Health Services (DAHS)** **DAHS Facility -Initiated Referrals**	**Family Care (FC)** **Residential Care (RC)**	**Emergency Response Services (ERS)** **Home Delivered Meals (HDM)**	**Adult Foster Care (AFC)**
Even if there is not a change for CAS send: Form 2101 (For DAHS and PHC only send Form 2101 if there is a change with appropriate forms) Only if information has changed send: Form 2059; Provider Referral Supplement; Form 2060; and Task/Hour Guide. **Note**: For DAHS, Form 2060, and Task and Hour Guide are not required.	Only if information has changed send: Form 2059; Provider Referral Supplement; Form 2060; Task/Hour Guide; and Form 2101	Only if information has changed send: Form 2059; Provider Referral Supplement; Form 2060; Task/Hour Guide; and Form 2101	**Even if there is not a change send:** Form 2101; and Form 2330 Only if information has changed send: Form 2327

Termination Packet Forms

Must include a cover sheet and a copy of the following SASOW generated forms.

Community Attendant Services (CAS) **Primary Home Care (PHC)** **Day Activity and Health Services (DAHS)** **DAHS Facility-Initiated Referrals**	**Family Care (FC)** **Residential Care (RC)**	**Emergency Response Services (ERS)** **Home Delivered Meals (HDM)**	**Adult Foster Care (AFC)**
Authorization Form 2101	Authorization Form 2101	Authorization Form 2101	Authorization Form 2101

Note: In the SASOW, the following forms are generated as two forms:

- Form 2059 is generated as Form 2059 and the Provider Referral Supplement.
- Form 2060 is generated as Form "2060 and the Task/Hour Guide."

Appendix XIV, SAVERR/TIERS Type Program Chart

Revision 17-1 Effective March 15, 2017

The following chart may be used for the determination of financial eligibility based on automated records. It indicates the type of programs registered on the System for Applications, Verifications, Eligibility Reports and Referral (SAVERR) and the Texas Integrated Eligibility Redesign System (TIERS), and how existing coverage affects eligibility for Community Care Services Eligibility (CCSE) services.

If the automated record shows:				
SAVERR Type Program (TP) and	**SAVERR Base Plan (BP) or**	**TIERS Type of Assistance**	**...then the individual has**	**Eligibility for Community Care Program?**
01	n/a	TP 01	Temporary Assistance for Needy Families (TANF) and Medicaid (three prescriptions, or unlimited if covered by HMO)	Check SAVERR individual screen to determine if applicant is receiving Regular Medicaid – if so, categorically eligible for Title XIX.
03	13	TP 03	Medicaid for the Elderly and People with Disabilities (MEPD) Medicaid (three prescriptions)	Title XIX categorical eligibility

SAVERR Type Program (TP) and	SAVERR Base Plan (BP) or	TIERS Type of Assistance	...then the individual has	Eligibility for Community Care Program?
07	n/a	TP 07	Medicaid only, for 12 months after TANF eligibility ends (three prescriptions, or unlimited if covered by managed care organization (MCO))	Title XIX categorical eligibility
08	n/a	TP 98	Child Protective Services (CPS) Foster Care Medicaid (unlimited prescriptions)	Title XIX categorical eligibility
09	29 31 32 33 34 35 n/a	TP 70 TP 87 TP 88 TP 93 TP 94 TP 97 TP 99	CPS Foster Care Medicaid (unlimited prescriptions)	Title XIX categorical eligibility
10	30 31 32 33 34 35 n/a	TP 52 TP 53 TP 54 TP 57 TP 58 TP 59 TP 70	TANF foster care (unlimited prescriptions)	Title XIX categorical eligibility
11	13	TA 27	Prior Medicaid for an individual applying for institutional or waiver Medicaid	Categorically eligible for Title XIX during the months in which individual has active coverage.
11	13	TP 11	MEPD three-months-prior Medicaid (three prescriptions)	Categorically eligible for Title XIX during the months in which individual has active coverage.
11	n/a	TP PM	Historical prior medical – MEPD or Texas Works (TW)	Categorically eligible for Title XIX during the months in which individual has active coverage.

SAVERR Type Program (TP) and	SAVERR Base Plan (BP) or	TIERS Type of Assistance	...then the individual has	Eligibility for Community Care Program?
12	10	TA 06	Manual Supplemental Security Income (SSI) Medicaid for nursing facility resident	Not eligible for Community Care Services Eligibility (CCSE) under this TP/BP. Confirm living arrangement, then check with MEPD staff to determine if they are aware the individual has moved from the facility. They will test for community programs; inform MEPD if this will be a Community Attendant Services (CAS) referral.
12	13	TA 03	Manual SSI recipient waivers	Already covered under a Medicaid Waiver, so may or may not be eligible for CCSE. Community Living Assistance and Support Services (CLASS) **cannot** receive any CCSE service, except Title XX Day Activity and Health Services (DAHS). See Appendix XX, Mutually Exclusive Services.
12	13	TA 22	Manual SSI	Title XIX categorically eligible
12	15	TA 05	Manual SSI recipient, non-state community based group homes	Not eligible for CCSE under this TP/BP. Confirm living arrangement, then have the individual or authorized representative contact Social Security Administration (SSA) (at the local office or at 1-800-772-1213) to correct the eligibility record.
12	15	TA 07	Medicaid for state hospital resident	Not eligible for CCSE under this TP/BP. Confirm living arrangement, then have the individual or authorized representative contact SSA (at the local office or at 1-800-772-1213) to correct the eligibility record.
12	16	TA 09	Medicaid for state supported living center resident	Not eligible for CCSE under this TP/BP. Confirm living arrangement, then have the individual or authorized representative contact SSA (at the local office or at 1-800-772-1213) to correct the eligibility record.
12	17	TA 04	Manual SSI recipient, state community based group homes	Not eligible for CCSE under this TP/BP. Confirm living arrangement, then have the individual or authorized representative contact SSA (at the local office or at 1-800-772-1213) to correct the eligibility record.

SAVERR Type Program (TP) and	SAVERR Base Plan (BP) or	TIERS Type of Assistance	...then the individual has	Eligibility for Community Care Program?
12	n/a	TP 12	Temporary manual SSI	Title XIX categorically eligible
13	10	TP 38	Institutional SSI Medicaid coverage for individuals in nursing facilities (unlimited prescriptions)	Not eligible for CCSE under this TP/BP. Confirm living arrangement, then have the individual or authorized representative contact SSA (at the local office or at 1-800-772-1213) to correct the eligibility record.
13	13	TA 01	Interim SSI denied child	Categorically eligible for Title XIX CCSE services during active months.
13	13	TA 02	SSI recipient waivers	Already covered under a Medicaid Waiver, so may or may not be eligible for CCSE. CLASS cannot receive any CCSE service, except Title XX DAHS. See Appendix XX.
13	13	TP 13	SSI Medicaid for individuals living in the community (three prescriptions)	Title XIX categorical eligibility
13	15	TA 26 TP 39 TP 41	Institutional SSI Medicaid coverage for individuals in ICF/IID facilities (unlimited prescriptions)	Not eligible for CCSE under this TP/BP. Confirm living arrangement, then have the individual or authorized representative contact SSA (at the local office or at 1-800-772-1213) to correct the eligibility record.
13	16	TP 46	Institutional SSI Medicaid coverage for individuals in state supported living centers (unlimited prescriptions)	Not eligible for CCSE under this TP/BP. Confirm living arrangement, then have the individual or authorized representative contact SSA (at the local office or at 1-800-772-1213) to correct the eligibility record.
13	17	TA 08	SSI recipient, state community-based group home	Not eligible for CCSE under this TP/BP. Confirm living arrangement, then have the individual or authorized representative contact SSA (at the local office or at 1-800-772-1213) to correct the eligibility record.

SAVERR Type Program (TP) and	SAVERR Base Plan (BP) or	TIERS Type of Assistance	...then the individual has	Eligibility for Community Care Program?
13	17	TA 21	SSI Medicaid for recipients in chest hospitals	Not eligible for CCSE under this TP/BP. Confirm living arrangement, then have the individual or authorized representative contact SSA (at the local office or at 1-800-772-1213) to correct the eligibility record.
13	n/a	TP SS	Temporary SSI	Categorically eligible for Title XIX CCSE services during active months.
14	10	TP 17	Institutional Medical Assistance Only (MAO) Medicaid coverage for individuals in nursing facilities (unlimited prescriptions)	Not eligible for CCSE under this TP/BP. Confirm living arrangement, then check with MEPD staff to determine if they are aware the individual has moved from the facility. They will test for community programs; inform MEPD if this will be a CAS referral.
14	10	TP IN	Temporary institutional	Not eligible for CCSE under this TP/BP. Confirm living arrangement, then check with MEPD staff to determine if they are aware the individual has moved from the facility. They will test for community programs; inform MEPD if this will be a CAS referral.
14	13	TA 10	Medicaid waivers – Home and Community-based Services (HCS), CLASS, Deaf Blind with Multiple Disabilities (DBMD) (unlimited prescriptions)	Already covered under a Medicaid waiver, so may or may not be eligible for CCSE. CLASS cannot receive any CCSE service, except Title XX DAHS. See Appendix XX.
14	13	TP WA	Temporary waivers	Already covered under a Medicaid waiver, so may or may not be eligible for CCSE. CLASS cannot receive any CCSE service, except Title XX DAHS. See Appendix XX.

SAVERR Type Program (TP) and	SAVERR Base Plan (BP) or	TIERS Type of Assistance	...then the individual has	Eligibility for Community Care Program?
14	15	TP 15	Institutional MAO Medicaid coverage for individuals in Intermediate Care Facilities for Individuals with an Intellectual Disability or Related Condition (ICF/IID) (unlimited prescriptions)	Not eligible for CCSE under this TP/BP. Confirm living arrangement, then check with MEPD staff to determine if they are aware the individual has moved from the facility. They will test for community programs; inform MEPD if this will be a CAS referral.
14	15	TP 16	Medicaid for state hospital residents	Not eligible for CCSE under this TP/BP. Confirm living arrangement, then check with MEPD staff to determine if they are aware the individual has moved from the facility. They will test for community programs; inform MEPD if this will be a CAS referral.
14	16	TP 10	Institutional MAO Medicaid coverage for individuals in state supported living centers (unlimited prescriptions)	Not eligible for CCSE under this TP/BP. Confirm living arrangement, then check with MEPD staff to determine if they are aware the individual has moved from the facility. They will test for community programs; inform MEPD if this will be a CAS referral.
14	17	TA 12	Medicaid for ICF/IID resident	Not eligible for CCSE under this TP/BP. Confirm living arrangement, then check with MEPD staff to determine if they are aware the individual has moved from the facility. They will test for community programs; inform MEPD if this will be a CAS referral.
14	20	TP 14	CAS (no prescription coverage)	The CAS program provides PHC, funded through §1929(b)(2)(B) of the Social Security Act.
14	n/a	TP IW	Historical institutional waivers	Not eligible for CCSE under this TP/BP. Confirm living arrangement, then check with MEPD staff to determine if they are aware the individual has moved from the facility. They will test for community programs; inform MEPD if this will be a CAS referral.

SAVERR Type Program (TP) and	SAVERR Base Plan (BP) or	TIERS Type of Assistance	...then the individual has	Eligibility for Community Care Program?
18	13	TP 18	Medicaid for disabled adult children (three prescriptions)	Title XIX categorical eligibility
19	13	TP 19 TA 01	SSI transitional Medicaid for children (three prescriptions) Interim SSI denied child (three prescriptions)	Title XIX categorical eligibility – will be denied or transferred to other coverage at age 18.
20	n/a	TP 20	Additional four months of Medicaid for the child following denial due to receipt of child support (three prescriptions)	Title XIX categorical eligibility for the child during eligible months
21	n/a		Adoption assistance	Not categorically eligible
22	13	TP 21	Disabled widow/widowers – Medicaid (three prescriptions)	Title XIX categorical eligibility
22	13	TP 22	Early Aged widow/widowers – Medicaid (three prescriptions)	Title XIX categorical eligibility
22	13	TP WI	Temporary widow/widowers – Medicaid (three prescriptions)	Title XIX categorical eligibility during eligible months
23	13	TP 23	Specified Low-Income Medicare Beneficiary (SLMB) – Pays Part B premium, but no Medicaid (no prescription coverage)	Title XX categorical eligibility

SAVERR Type Program (TP) and	SAVERR Base Plan (BP) or	TIERS Type of Assistance	...then the individual has	Eligibility for Community Care Program?
23	13	TP 26	Qualifying Individual (QI)-1 – Pays Part B premium, but no Medicaid (no prescription coverage)	Title XX categorical eligibility
23	13	TP SL	Temporary SLMB/QI-1	Title XX categorical eligibility
24	13	TP 24	Qualified Medicare Beneficiary (QMB). Pays Part B premium, deductibles, co-insurance, but no Medicaid (no prescription coverage)	Title XX categorical eligibility
25	13	TP 25	Qualified disabled and working individuals	Title XX categorical eligibility
29	n/a	TP 29	Medicaid for 12-18 months after TANF for certain caretakers (three prescriptions, or unlimited if covered by MCO)	Title XIX categorical eligibility during eligible months
30	13	TP 30	Aid and Attendance emergency Medicaid for aliens (three prescriptions)	Title XIX categorical eligibility during eligible months
30	n/a	TP 31	Medicaid for an emergency condition	Title XIX categorical eligibility during eligible months

SAVERR Type Program (TP) and	SAVERR Base Plan (BP) or	TIERS Type of Assistance	...then the individual has	Eligibility for Community Care Program?
30	n/a	TP 32	Medicaid for an emergency condition with spend-down	Categorically eligible for Title XIX services **for the coverage period** if an effective date appears on the SAVERR record. The case worker will be required to confirm continued eligibility on a monthly basis. Failure to confirm eligibility could result in an invalid finding if the case is pulled for casereading and the individual is no longer Title XIX eligible. If the individual name, but no effective date, appears in the SAVERR record, resource eligibility for Title XX already determined by TANF. Test for **income eligibility only** for Title XX.
30	n/a	TP 33	Medicaid for an emergency condition for children 1-5	Title XIX categorical eligibility during eligible months
30	n/a	TP 34	Medicaid for an emergency condition – for children 6-18	Title XIX categorical eligibility during eligible months
30	n/a	TP 35	Medicaid for an emergency condition – for children under 1	Title XIX categorical eligibility during eligible months
30	n/a	TP 36	Medicaid for an emergency condition for pregnant women	Title XIX categorical eligibility during eligible months
30	n/a	TP AL	Medicaid for an emergency condition (historical Family Medical Assistance (FMA))	Title XIX categorical eligibility during eligible months
30	n/a	TA 31	Medicaid for an emergency condition for TF-level families	Title XIX categorical eligibility during eligible months

SAVERR Type Program (TP) and	SAVERR Base Plan (BP) or	TIERS Type of Assistance	...then the individual has	Eligibility for Community Care Program?
37	n/a	TP 37	Medicaid for 12-18 months after TANF eligibility (three prescriptions, or unlimited if covered by MCO)	Title XIX categorical eligibility during eligible months
40	n/a	TP 40	Medicaid for pregnant women – coverage ends two full months after birth of child (three prescriptions, or unlimited if covered by MCO)	Title XIX categorical eligibility during eligible months
42	n/a	TP 42	Presumptive Medicaid for pregnant women – converted to TP-40 if ongoing coverage is granted (three prescriptions, or unlimited if covered by MCO)	Very short-term Title XIX categorical eligibility during eligibility period – check SAVERR for ongoing TP 40 coverage.
43	n/a	TP 43	Medicaid for children under age 12 months – coverage may convert to another TP at end of eligibility period	Title XIX categorical eligibility **for the child**
44	n/a	TP 44	Medicaid for children age 6-18 – coverage ends at 19th birthday	Title XIX categorical eligibility **for the child**
45	n/a	TP 45	Medicaid for newborns – coverage opened by TMHP when mother is covered by Medicaid in birth month. Coverage under this program ends at end of 12th month, although may convert to another TP	Title XIX categorical eligibility

SAVERR Type Program (TP) and	SAVERR Base Plan (BP) or	TIERS Type of Assistance	...then the individual has	Eligibility for Community Care Program?
47	n/a	TP 47	Medicaid for children ineligible for TANF based on stepparent or grandparent income	Title XIX categorical eligibility **for child**
48	n/a	TP 48	Medicaid for children at least 13 months, but under 6 – may convert to another TP at end of eligibility period	Title XIX categorical eligibility **for child**
51	10	TA 17	Grandfathered institutional MAO Medicaid coverage for individuals in nursing facilities (unlimited prescriptions)	Not eligible for CCSE under this TP/BP. Confirm living arrangement, then check with MEPD staff to determine if they are aware the individual has moved from the facility. They will test for community programs; inform MEPD if this will be a CAS referral.
51	13	TA 17	Grandfathered Medicaid individuals in the community who were discharged from an institution setting when the ICF II level was phased out (three prescriptions)	Title XIX categorical eligibility
51	13	TP 50	Grandfathered Medicaid individuals eligible under Rider 51J	Title XIX categorical eligibility
51	13	TP 51	Rider 51 waiver recipients	Already covered under a Medicaid waiver during covered months, so may or may not be eligible for CCSE. CLASS cannot receive any CCSE service, except Title XX DAHS. See Appendix XX.

SAVERR Type Program (TP) and	SAVERR Base Plan (BP) or	TIERS Type of Assistance	...then the individual has	Eligibility for Community Care Program?
51	13	TP RI	Temporary Rider 51	Title XIX categorically eligible during eligible months unless receiving waiver services. If so, not eligible for CCSE under this TP/BP. Confirm living arrangement, then check with MEPD staff to determine if they are aware the individual has moved from the facility. They will test for community programs; inform MEPD if this will be a CAS referral.
51	15	TA 15	Grandfathered institutional MAO Medicaid coverage for individuals in ICF/IID facilities (unlimited prescriptions)	Not eligible for CCSE under this TP/BP. Confirm living arrangement, then check with MEPD staff to determine if they are aware the individual has moved from the facility. They will test for community programs; inform MEPD if this will be a CAS referral.
51	15	TA 25	Grandfathered institutional MAO Medicaid coverage for individuals in state hospitals (unlimited prescriptions)	Not eligible for CCSE under this TP/BP. Confirm living arrangement, then check with MEPD staff to determine if they are aware the individual has moved from the facility. They will test for community programs; inform MEPD if this will be a CAS referral.
51	16	TA 16	Grandfathered institutional MAO Medicaid coverage for individuals in state supported living centers (unlimited prescriptions)	Not eligible for CCSE under this TP/BP. Confirm living arrangement, then check with MEPD staff to determine if they are aware the individual has moved from the facility. They will test for community programs; inform MEPD if this will be a CAS referral.
51	17	TA 24	Rider 51 ICF/IID state community-based homes	Not eligible for CCSE under this TP/BP. Confirm living arrangement, then check with MEPD staff to determine if they are aware the individual has moved from the facility. They will test for community programs; inform MEPD if this will be a CAS referral.
55	n/a	TP 02	Medicaid for refugees	Categorically eligible for Title XIX during eligible months
55	n/a	TP 55	Medicaid for the medically needy	Categorically eligible for Title XIX during eligible months

SAVERR Type Program (TP) and	SAVERR Base Plan (BP) or	TIERS Type of Assistance	...then the individual has	Eligibility for Community Care Program?
55	n/a	TP 56	Medicaid spend-down program – eligibility for CCSE services depends on eligibility status on the SAVERR record.	Categorically eligible for Title XIX services **for the coverage period** if an effective date appears on the SAVERR record. The case worker will be required to confirm continued eligibility on a monthly basis. Failure to confirm eligibility could result in an invalid finding if the case is pulled for casereading and the individual is no longer Title XIX eligible. If the individual name, but no effective date, appears in the SAVERR record, resource eligibility for Title XX already determined by TANF. Test **for income eligibility only** for Title XX.
61	n/a	TP 61	TANF and Medicaid for two-parent households (three prescriptions, or unlimited if covered by MCO)	Title XIX categorical eligibility
63	n/a		Medicaid for two-parent households (three prescriptions, or unlimited if covered by MCO)	Title XIX categorical eligibility
71	n/a	TP 71	One-time TANF – no Medicaid coverage (one adult)	Not categorically eligible
72	n/a	TP 72	One-time TANF – no Medicaid coverage (two parents)	Not categorically eligible
n/a	n/a	TP 87	Medicaid Buy-In	Categorically eligible for all Title XX programs, DAHS XIX, PHC and Texas Home Living waiver

Individuals with an active Supplemental Nutrition Assistance Program case are also categorically eligible for Title XX benefits.

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Eligibility

Does the individual continue to meet all eligibility requirements for the Community Care Services Eligibility (CCSE) services that are authorized?

- Does the individual continue to be financially eligible? Have there been any changes in income, resources, or categorical status?
- Does the individual appear still to be functionally eligible? (See "Individual Condition" below.)
- Does the individual need and want CCSE services?
- Does the individual still need assistance that would not be met without this CCSE service?

Condition

Has there been any change in the individual's condition that affects service delivery or the adequacy of the service plan?

- What is the individual's current medical, physical and mental condition? Has it changed?
- Has the individual been hospitalized? Has there been an accident or illness? Is the individual getting medical services as needed?
- Has there been a change in the individual's degree of self-sufficiency?
- Has there been a change in the tasks the individual can perform?
- What are the individual's current needs? Have these changed?
- What is the individual's risk status?

Situation

Has there been any change in the individual's situation that affects service delivery or the adequacy of the service plan?

- Has the individual moved? Has there been another change in the individual's home or environment? Does any change affect the individual's safety or service needs?
- Who (if anyone) has moved in with the individual? Who has moved out of the individual's residence?
- Has there been any change in the individual's social support or resources? Has there been any change in the assistance that is given by family or community resources?
- Does the individual continue to have the same caregivers? Has there been any change in the amount or type of assistance they give the individual? Has there been any change in the ability, dependability, or availability of the individual's caregiver?

CCSE Services

Have CCSE services been delivered according to the service plan?

- Were services initiated as scheduled? Has the provider agency delivered the correct amount of services at the scheduled times?
- Is the individual satisfied with the service? Does the service meet the individual's needs?
- What is the quality of the services that are being provided to the individual? Are there any problems with the quality of the services? Does the paid attendant carry out the required tasks? Does the attendant arrive on time? Is there a problem that needs to be reported to the agency supervisor or the contract manager?
- Has the individual been away from his residence when in-home services were scheduled? Has the individual used out-of-home services as authorized? Has the individual in some other way prevented the delivery of authorized services?

Service Plan

Does the service plan need to be changed?

- Are the authorized services meeting the individual's current needs?
- Does the individual still concur with the service plan?
- Does the individual continue to need the same amount of services?
- Is the current schedule effective for meeting the individual's needs?
- Does the individual need additional service(s)?
- Does the individual need a referral to some other agency or community resource?

Appendix XVII, Service/Score Code Guide

Revision 17-1; Effective March 15, 2017

Service	Form 2060, Needs Assessment Questionnaire and Task/Hour Guide, Score	Form 2101, Authorization for Community Care Services, Item 16 Service Code

Service	Form 2060, Needs Assessment Questionnaire and Task/Hour Guide, Score	Form 2101, Authorization for Community Care Services, Item 16 Service Code
Adult Foster Care	18	18
Consumer Managed Personal Assistant Services	Not required	27
Community Attendant Services (CAS)	24	17D (CAS) 17DS (CAS/SRO) 17DV (CAS/CDS)
Individual Directed Services (CDS) – Financial Management Services	Not applicable	63V 63VY (ICM)
CDS – Support Consultation	Not applicable	57V (for PHC and CAS) 57CV (for FC) 57V4 (For PHC in ICM)
Day Activity and Health Services	Not required	29 29Y (ICM)
Residential Care (RC)	18	19I (RC Bed Hold, Non-Apt., Title XX) 19J (RC, Apt., Title XX) 19L (RC, Non Apt., Title XX) 19M (RC Emergency Care) 19N (grandfathered RC, R&B, Non-Apt.) 19O (grandfathered RC, R&B, Apt.)
Emergency Response Service	20	20
Family Care (FC)	24	17C (FC) 17CS (FC/SRO) 17CV (FC/CDS)
Home-Delivered Meals	20	25
Primary Home Care (PHC)	24	17 (PHC) 17S (PHC/SRO) 17V (PHC/CDS) 17Y (PHC/ICM) 17SY (PHC/SRO/ICM) 17VY (PHC/CDS/ICM)
Special Services to Persons with Disabilities	9	28

Appendix XVIII, Time Calculation

Appendix XIX, Case Management Time Frames

Revision 18-1 Effective June 15, 2018

Intake Procedures

Section 2320	Visit with individual requiring immediate response:	within 24 hours from the date of assignment.
Section 2320	Visit with individual requiring expedited response:	within five calendar days from date of assignment.
Section 2320	Visit with individual requiring routine response:	within 14 calendar days from date of assignment.

Assessment and Reassessment Procedures

Sections 2611, 2611.1	Determine eligibility for Community Care Services Eligibility (CCSE) services:	within 30 calendar days from date the signed application is received by the Texas Health and Human Services Commission (HHSC). Applications for Community Attendant Services (CAS) must be referred to Medicaid for the Elderly and People with Disabilities (MEPD) staff for a financial eligibility determination. Because the MEPD process can take up to 45 days for regular referrals and 90 days if a disability determination is required, this may delay Community Care Services Eligibility (CCSE) certification beyond the 30-day time frame.
Section 2330	Conduct a home visit with all individuals who had initial assessments conducted in a place other than the individual's home:	within 30 calendar days after service initiation.
Section 2711	Reassess the individual's need for CCSE services (Form 2060, Needs Assessment Questionnaire and Task/Hour Guide, Part A):	by the end of the 12th calendar month following the previous functional assessment date on Form 2060. within 90 days of last monitoring visit.
	Case workers coordinating Community Attendant Services (CAS) reassessments with the 90-day monitoring visit will have to complete the reassessment within 90 days of the previous monitoring visit to avoid a monitoring timeliness error.	
Section 2810	Notify applicant in writing of eligibility for service:	within two business days of the date of the decision.
	Reassess individual need and redetermine eligibility with a face-to-face or telephone interview as required by the region:	Financial: by the end of the 24th month following the date eligibility rules processed on Form 2064, Eligibility Worksheet. Functional: by the end of the 12th month following the date of the previous assessment.

Service Planning Procedures

Section 2344	Obtain a new Form 2307, Rights and Responsibilities:	Adult Foster Care: before services are authorized or reauthorized. A new form must be completed and signed whenever information on the original form becomes outdated or incomplete.

		all other services: initially. A new form must be completed and signed whenever information on the original form becomes outdated or incomplete.
Section 2440	Complete or update Form 2060, Part B, for CAS, Primary Home Care (PHC) and Family Care (FC):	at initial assessment; at each annual review; and when raising or lowering hours for a task or a service.
	Authorizations and Reassessments	
Sections 2631, 4652.2	Initiate verbal referrals for individuals who meet the criteria for immediate or expedited responses and who need immediate initiation of service:	no later than the next business day after the day the individual is visited and it is determined that a verbal referral is necessary.
Section 2631	After initiating verbal referral, send Form 2101, Authorization for Community Care Services, to the provider:	within two business days from the date the applicant was determined eligible for a verbal referral.
Section 2632	For applicants who do not require verbal referrals, authorize services by sending Form 2101 to the provider:	within five business days from the date the applicant is determined eligible.
Section 2632	For services other than CAS, contact the provider if Form 2101 or another notification of status of referral is not received:	by the 21st calendar day from the date of referral.
Section 2611.1	If the eligibility process is delayed past the 30-day time frame due to pending Medicaid for the Elderly and People with Disabilities (MEPD) eligibility:	the case worker verifies MEPD status on or before the 25th day from the application date and performs weekly checks until the eligibility decision is received using the Texas Integrated Eligibility Redesign System (TIERS) records. The TIERS checks must be documented in the record.
Sections 2721.4	If a functional reassessment mandates a change in the individual's service plan:	the change must be completed as part of that reassessment.
	Service Monitoring and Evaluation	
Section 2710.2	Make a home visit for CAS individuals (regardless of priority):	at least every 90 calendar days from the previous home visit.
Section 2710.2	Make a home visit, if required by the region, for priority status individuals (other than CAS individuals):	by the end of the sixth month following the previous monitoring contact.
	Make a home visit, if required by the region, for non-priority status individuals (other than CAS individuals):	within six months of the last monitoring contact.
	Denying or Reducing Services	
Section 2810	Notify applicant in writing of ineligibility for service:	within two business days of the date of the decision.
Sections 2810,	Notify the individual in writing of reduction or termination of	at least 12 calendar days before the effective date of the decision. (See Appendix IX, Notification/Effective Date of Decision, or

2811	service:	Section 2811, Effective Dates for Service Reduction and Termination, for exceptions to 12 days notice and for effective dates for service reduction or termination in cases of appeal).
Section 2822.1	If an individual enters a nursing facility or an institution, verify the action and determine probable length of stay. If length of stay is likely to be more than 30 days:	immediately terminate any authorized CCSE services by submitting Form 2101, using the date of entry into the nursing facility as the termination date and close out on the Service Authorization System (SAS).
Section 2840, Appendix IX	If an individual threatens his own health or safety or that of others, purchased services may be terminated:	send Form 2065-A, Notification of Community Care Services, by the next work day after receiving a notice from the provider that services have been suspended for threats to health and safety. Services may be terminated immediately.
	Responding to Requests for Service Interruptions, Suspensions and Reported Changes	
Sections 2810, 2814	Notify the individual in writing when there is a change in type or amount of services authorized:	any changes in the individual's service plan. Examples include increases/decreases in units/hours of service, increases/decreases in units/hours of service, increases/decreases in copay, adding a new service or transfers from FC to PHC
Section 2814, Appendix IX	Transfers from PHC/CAS to FC:	allow 12 calendar days advance notice (See Appendix IX for exceptions).
Section 2821	The provider must notify the case worker of a suspension:	on the day of the suspension or by the first workday following the suspension.
Section 2822.1	If an individual enters a nursing facility, hospital or an institution, verify the action and determine probable length of stay. If length of stay is likely to be 30 days or less:	suspend services effective the date the individual enters the nursing facility, hospital or institution and send Form 2067, Case Information, to providers.
Section 2721	When learning of a change in the individual's condition/status, revise the service plan or document why no changes are needed:	within 14 calendar days of learning of a change.
Sections 4445, 4673.4	When the individual requires an immediate change in CAS, FC or PHC service plan due to situations listed in these sections, respond:	for FC, by the next workday and for PHC or CAS, within the same day of receipt of the request.
Section 2736.1	When there is a reason to believe that an individual has been abused, neglected or exploited, make a referral to Adult Protective Services or Child Protective Services, as appropriate:	within 24 hours if there is an immediate or imminent threat to the health and safety of the individual.
Section 2723	When there is a request to change providers:	within 14 days of the individual's request.

Appendix XX, Mutually Exclusive Services

Appendix XXI, Reserved for Future Use

Revision 20-4; Effective December 1, 2020

Appendix XXII, Community Attendant Services Financial Eligibility Requirements

Revision 17-1; Effective March 15, 2017

Section 42, Code of Federal Regulations, §431.10, specifies that Medicaid eligibility must be determined by a single state agency. The Texas State Plan designates the Texas Health and Human Services Commission (HHSC) as the sole agency with the authority to make eligibility determinations for Medical Assistance Only (MAO) cases.

Therefore, financial eligibility for Community Attendant Services (CAS) is determined exclusively by Medicaid for the Elderly and People with Disabilities (MEPD) staff. However, Community Care Services Eligibility (CCSE) staff must make an effort during the initial visit with each applicant to gather as much documentation as possible to hasten the MEPD specialist's completion of the eligibility determination.

I. Income and Resource Eligibility

The following income and resource verifications/documentations must be included in the MEPD specialist's case record to make a financial eligibility decision for a CAS case.

As verification of:	the MEPD specialist:
bank accounts	must document the: • name of the financial institution and account number; • account accessibility by the individual; • account balance as of 12:01 a.m. on first day of the appropriate month(s); and • source of verification.
cash	may accept without verification the individual's statement about the amount of cash on hand. Ask the individual if he has any cash in a safety deposit box or if any of his cash on hand is in the form of valuable coins.
trusts	must document the: • name of the trustee, settlor and beneficiary; • accessibility of the trust; • value of the trust that is accessible; • amount and frequency of income from the trust to the individual; and • source of verification.
stocks	must document the: • name of the company, number of shares and type of shares; • market value as of 12:01 a.m. on the first day of the appropriate month; and • source of verification.
bonds	must document the:

	• name of the company, type of bond and serial number; • market value as of 12:01 a.m. on the first day of the appropriate month; and • source of verification.
promissory notes, loans and property agreements	must document the: • ownership of the note; • accessibility by the individual; • term and whether it is negotiable; • reason for exclusion, if excluded; • current market value of the note; and • source of verification.
other real property	must document the: • location and description of the property; • individual’s ownership interest in the property; • current equity value of the individual's interest; and • source of verification.
life estates	must document the: • location of the life estate property; • current equity value; and • source used as verification.
life insurance	must document the: • name of the insurance company, policy number and face value (including the possibility of dividends, if participating); • type of insurance coverage; • current cash value; and • source used to verify the value.
burial spaces	must document the: • name of the cemetery; • number of vacant spaces and the names and relationships of the designees; • ownership; • current market value; and • source used as verification.
burial funds	must document the: • type of liquid resource being designated; • amount of assets being designated; • written statement from the individual or responsible person designating the asset for burial, unless the resource being designated is a prepaid burial contract or a bank account styled "for burial"; and • copy of the insurance policy if a funeral home is listed as the beneficiary.
mineral rights	must document the:

	• location of the property; • percentage of interest in mineral rights; • individual's accessibility to the interest in mineral rights; • current equity value of the individual's interest; and • source of verification.
earned income	must document the: • gross earned income (if income fluctuates, amounts for the previous six months or less, depending on the review cycle); • sources of all earnings; and • source of verification.
support and maintenance provided to individuals living outside of an institution	must document the: • name(s) of the person(s) who provided support and maintenance and type of in-kind benefit given to the individual; • amount of any payment or contributions made by the individual; and • actual market value of the in-kind benefit.
farm income	must document the: • type of farm income and the individual's interest and accessibility of the farm income; • amount of gross income and allowable expenses from the previous six months; • reason, if the amount of income is anticipated to be different; and • source of verification.
Social Security benefits	must document the: • amount of the gross benefit and the amount of the Supplementary Medical Insurance Benefit (SMIB) premium, if appropriate; • claim number; • source of verification; and • gross benefit verification (for applications).
Railroad Retirement benefits	must document the: • gross amount of the benefit and the amount of the SMIB premium, if appropriate; • railroad retirement claim number; and • source of verification.
Veterans Affairs (VA) compensation and pensions	must document the: • gross amount of the benefit and the amount of any deductions, if appropriate; • amount of aid-and-attendance or housebound benefits, if any; • VA claim number; and • source of verification.
other annuities, pensions and retirements plans	must document the:

	• source of payments; • amount of the gross benefit; • claim number, if a civil service annuity; and • source of verification.
interest and dividends	must document the: • name of the financial institution or other source of interest or dividend income; • account number, if received from a financial institution; • frequency of receipt and the amounts paid in the last six months; and • source of verification.
rents	must document the: • type of rental income and the individual's interest and accessibility of the income; • amount of gross income and expenses from the previous six months; • reason for the difference in the income, if the amount is anticipated to be different; and • source of verification.
royalties	must document the: • name, payor and reason for payment; • frequency of payment and the amounts paid during the previous six or 12 months; and • source of verification.
gifts, inheritances, support and alimony	determines whether the gift, inheritance, support or alimony is to be treated as a lump sum payment, infrequent or irregular income, or regular and predictable income. He documents the: • source of the income; • frequency received and the amount; and • expected continuation.
notes and mortgages	must document the: • name of the person making note payments and whether income is accessible to the individual; • amount of payment and the frequency of the payments; and • source of verification.
the home as a countable resource	must document the location and ownership of the homestead.

II. Citizenship Requirements for Eligibility

Public Law 109-171, Deficit Reduction Act of 2005, requires that documentation be provided at the initial determination, and for ongoing cases, at the next redetermination of eligibility for all Medicaid cases.

Verification of citizenship and identity for eligibility purposes is a one-time activity. Once verification of citizenship is established and documented by MEPD staff, verification is no longer required, even after a break in eligibility.

Long Term Services and Supports (LTSS) case workers must be prepared to assist individuals with this process by informing LTSS individuals of the requirement and helping to identify the documentation needed to prove citizenship and identity. Information available at the time of the home visit must be collected and submitted with the application for an MEPD determination. Individuals may obtain and forward copies to HHSC for transmittal to MEPD staff.

MEPD staff accept copies and faxes only if clear and legible. If the LTSS case worker receives an affidavit as verification, ensure that the reason the applicant or recipient is unable to produce documentary evidence of citizenship and identity is documented on the affidavit. If the affidavit does not contain this information, the reason another source is not available is documented and transmitted to MEPD staff on Form 2067, Case Information, along with the affidavit. The case worker must ensure the applicant/individual is signing the affidavit under penalty of perjury.

Acceptable Documentation for Both Citizenship and Identity

Supplemental Security Income (SSI) Recipients – State Data Exchange (SDX) contains the needed information to verify citizenship. For any active Supplemental Security Income (SSI) recipient, MEPD staff are able to use SDX as verification of both citizenship and identity. For any denied SSI recipient, SDX can be used as a valid verification source of both citizenship and identity when the denial is for any reason other than citizenship. The SDX printout will show action code N13 if the denial is for citizenship.

Medicare Recipients – Active Medicare recipients are exempt from the requirement to provide evidence of citizenship and identity. The Social Security Administration documents citizenship and identity for Medicare recipients.

For any individual entitled to or enrolled in Medicare Part A or B, and subsequently denied Medicare, use the State On Line Query (SOLQ) or Wire Third Party Query (WTPY) System as documentation of both citizenship and identity when the denial is for any reason other than citizenship. If there is an end date listed for Medicare, the individual must provide documentation regarding the loss of Medicare.

All Other Individuals – The following primary documents may be accepted as proof of both identity and citizenship:

- U.S. passport,
- Certificate of Naturalization (N-550 or N-570), or
- Certificate of U.S. Citizenship (N-560 or N-561).

Documents that establish citizenship are divided into second, third and fourth levels based on the reliability of the evidence:

- One document that establishes U.S. citizenship, and
- One document that establishes identity.

Hierarchy of Approved Documentation Sources

Primary Evidence of Citizenship and Identity

- U.S. passport
- Certificate of Naturalization
- Certificate of U.S. citizenship
- SDX for denied SSI recipients when the denial reason is for any reason other than citizenship (N13)
- SOLQ/WTPY and documentation on reason for Medicare denial

If primary evidence of citizenship is not available, the individual must provide **two** documents – one to establish U.S. citizenship and one to establish identity, as outlined below. Begin with the second level of evidence of citizenship and continue through the levels to locate the best available documentation.

Second Level of Evidence of Citizenship (Use only when primary evidence is not available)

- A U.S. public birth certificate showing birth in one of the 50 States, the District of Columbia, Puerto Rico (if born on or after Jan. 13, 1941), Guam (on or after April 10, 1899), the Virgin Islands of the U.S. (on or after Jan. 17, 1917), American Samoa, Swain's Island or the Northern Mariana Islands (after Nov. 4, 1986) - Contact Bureau of Vital Statistics (BVS) for an individual born in Texas. If an individual's date of birth is earlier than 1903 or if the birth was out of state, accept a legible/non-questionable copy. For a birth out of state, individuals may obtain a birth certificate through the following: BirthCertificate.com; vitalchek.com; usbirthcertificate.net or the toll-free number, 1-888-736-2692.
- Report of Birth Abroad of a U.S. Citizen (FS-240)
- Certification of Birth Abroad (FS 545 or DS-1350)
- U.S. Citizen identification card (Form I-179 or I-197)
- Northern Mariana identification card (I-873)
- American Indian card (I-872) issued by Department of Homeland Security with classification code "KIC"
- Final adoption decree showing the child's name and U.S. place of birth
- Evidence of U.S. Civil Service employment before June 1, 1976
- U.S. Military record showing a U.S. place of birth (**Example:** DD-214)

Third Level of Evidence of Citizenship (Use only when primary and second level evidence is not available)

- Hospital record of birth showing a U.S. place of birth
- Life, health or other insurance record showing a U.S. place of birth
- Religious record of birth recorded in the U.S. or its territories within three months of birth, which indicates a U.S. place of birth showing either the date of birth or the individual's age at the time the record was made

Fourth Level of Evidence of Citizenship (Use only when primary, second level and third level evidence is not available)

Any listed documents must include biographical information including a U.S. place of birth.

- Federal or state census record showing U.S. citizenship or a U.S. place of birth and the individual's age (generally for individuals born 1900-1950)
- Seneca Indian Tribal census record showing a U.S. place of birth

- Bureau of Indian Affairs Tribal census records of the Navajo Indians showing a U.S. place of birth
- U.S. State Vital Statistics official notification of birth registration showing a U.S. place of birth
- Statement showing a U.S. place of birth signed by the physician or midwife who was in attendance at the time of birth
- Institutional admission papers from a nursing facility, skilled care facility or other institution showing a U.S. place of birth
- Medical (clinic, doctor or hospital) record, excluding an immunization record, showing a U.S. place of birth
- Affidavits from two adults regardless of blood relationship to the individual **(use only as a last resort when no other evidence is available)**

Evidence of Identity

- Driver license issued by a state either with a photograph or other identifying information such as name, age, sex, race, height, weight or eye color
- School identification card with a photograph
- U.S. Military card or draft record
- Department of Public Safety identification card with a photograph or other identifying information such as name, age, sex, race, height, weight or eye color
- Birth certificate
- Hospital record of birth
- Military dependent's identification card
- Native American Tribal document
- U.S. Coast Guard Merchant Mariner card
- Certificate of Degree of Indian Blood or other U.S. American Indian/Alaskan Native and Tribal document with a photograph or other personal identifying information
- Data matches with other state or federal government agencies (for example, Employee Retirement System and Teacher Retirement System)
- Adoption papers or records
- Work identification card with photograph
- Signed application for Medicaid (accept the signature of an authorized representative or a responsible person acting on the individual's behalf)
- Health care admission statement
- School records for children under age 16, which may include nursery or day care records
- An affidavit signed by a parent or guardian for a child under age 16, stating the date and place of birth of the child **(use as a last resort when no other evidence is available and if an affidavit is not used to establish citizenship)**

In the hierarchy of approved documentation sources, some documents listed to verify citizenship are also acceptable to verify identity. When using the hierarchy of approved documentation sources, the same document cannot be the source to verify both citizenship and identity.

If an individual is unable to provide any other documentary evidence of citizenship, an affidavit signed under penalty of perjury will only be accepted as a last resort. MEPD staff are required to document the reason another source is not available to verify citizenship. If the LTSS case worker is provided an affidavit, ensure the reason the applicant or recipient is unable to produce documentary evidence of citizenship and identity is documented on the affidavit. If the affidavit does not contain this information, the reason another source is not available is documented and transmitted to MEPD staff on Form 2067, along with the affidavit. The copies of the affidavit form, available online at https://hhs.texas.gov/laws-regulations/forms, are to be made available in all HHSC benefits offices.

Reasonable Opportunity to Provide Verification

The LTSS case worker must inform all applicants if MEPD staff do not receive documentation of citizenship and identity by the application due date, certification may be delayed and eventually denied if verification documentation is not provided.

Inform ongoing recipients that they will be asked to provide documentation verifying citizenship and identity at the redetermination. If an ongoing recipient cannot provide the required verification(s) at the initial request, eligibility will continue until the next redetermination. Eligibility will be denied if the recipient does not provide the required verification(s) at the next complete redetermination.

Assistance to Individuals in Obtaining Documentary Evidence

To assist an individual who is unable to provide documentary evidence of citizenship and identity in a timely manner because of incapacity of mind or body or the lack of a representative to assist, staff may make referrals to the following entities:

- Department of Family and Protective Services, Adult Protective Services
- Legal Aid
- Community-based organizations
- Social Security Administration
- 2-1-1

For individuals born out of state, some sources to obtain a birth certificate are:

- BirthCertificate.com
- Vitalchek.com
- Usbirthcertificate.net or the toll free number, 1-888-736-2692

When assisting the individual in providing documentary evidence of citizenship and identity, use any available documents, regardless of level of evidence.

Appendix XXIII, Form 2101 Coverage Dates for Title XIX Services

Revision 17-1; Effective March 15, 2017

The case worker completes Form 2101 to renew the prior approval process for all ongoing Primary Home Care individuals (including transfer cases) not certified as Community Attendant Services (CAS) individuals. Instructions for items other than numbers 4 and 5, are covered in the instructions for Form 2101 in the Forms and Reports section.

Renewals	Item 4 "Begin" date	Item 5 "End" date
Renewal — no service plan change	NA — Do not send Form 2101.	NA — Do not send Form 2101.
Renewal with increase	Seven days from date mailed or negotiated date.	Leave blank — date remains the same as current authorization.

Renewals	Item 4 "Begin" date	Item 5 "End" date
Renewal with decrease	12 days from the Form 2101 date unless appealed.	Leave blank — date remains the same as current authorization.

Service plan change between assessments	Item 4 "Begin" date	Item 5 "End" date
Increase	Seven days from the Form 2101 date or negotiated date.	Leave blank — date remains the same as current authorization.
Decrease	12 days from the Form 2101 date unless appealed.	Leave blank — date remains the same as current authorization.

Terminations	Item 4 "Begin" date	Item 5 "End" date
Loss of Medicaid eligibility	Remains unchanged.	Last day of month in which individual is determined ineligible for Medicaid.
Other eligibility criteria change (i.e., type of residence, functional eligibility, unmet need)	Remains unchanged.	12 days from the Form 2065 date, unless appealed.
Individual or someone in home threatens health or safety of provider	Remains unchanged.	Date case worker becomes aware of action.

Appendix XXIV, Legal Basis for Community Care Programs

Revision 17-1; Effective March 15, 2017

All rules referenced below appear in the Texas Administrative Code (TAC), Title 40, Part I.

Adult Foster Care is provided under Title XX of the Federal Social Security Act (relating to block grants to states for social services) at 42 USC §1397 et seq.

Case management rule base: TAC §48.2913

Contracting rule base: TAC Chapter 48, Subchapter K

Community Attendant Services is provided under Title XIX of the Federal Social Security Act (relating to grants to states for medical assistance programs) at 42 USC §1396t (relating to home and community care for functionally disabled elderly individuals). This program was formerly known as §1929(b) or Frail Elderly.

Case management rule base: TAC §48.2918

Contracting rule base: TAC Chapter 47

Consumer Managed Personal Attendant Services is provided under Title XX of the Federal Social Security Act (relating to block grants to states for social services) at 42 USC §1397 et seq.

Rule base: TAC Chapter 44

Day Activity and Health Services is provided under Title XX of the Federal Social Security Act (relating to block grants to states for social services) at 42 USC §1397 et seq.

Case management rule base: TAC §48.2915

Contracting rule base: TAC Chapter 98, Subchapter H

Emergency Care is provided under Title XX of the Federal Social Security Act (relating to block grants to states for social services) at 42 USC §1397 et seq.

Case management rule base: TAC §48.2921

Emergency Response Services is provided under Title XX of the Federal Social Security Act (relating to block grants to states for social services) at 42 USC §1397 et seq.

Case management rule base: TAC §48.2928

Contracting rule base: TAC Chapter 52

Family Care is provided under Title XX of the Federal Social Security Act (relating to block grants to states for social services) at 42 USC §1397 et seq.

Case management rule base: TAC §48.2911

Contracting rule base: TAC Chapter 47

Home-Delivered Meals is provided under Title XX of the Federal Social Security Act (relating to block grants to states for social services) at 42 USC §1397 et seq. Additional funding is provided by local resources and contractor match.

Case management rule base: TAC §48.2912

Contracting rule base: TAC Chapter 55

Primary Home Care is provided under Title XIX of the Federal Social Security Act (relating to state plans for medical assistance) at 42 USC §1396a.

Case management rule base: TAC §48.2918

Contracting rule base: TAC Chapter 47

Residential Care/Assisted Living is provided under Title XX of the Federal Social Security Act (relating to block grants to states for social services) at 42 USC §1397.

Case management rule base: TAC §48.2920

Contracting rule base: TAC Chapter 46

Special Services to Persons with Disabilities is provided under Title XX of the Federal Social Security Act (relating to block grants to states for social services) at 42 USC §1397 et seq.

Case management rule base: TAC §48.2914

Contracting rule base: TAC Chapter 58

Appendix XXV, Community Services Interest List (CSIL) Closure Code User's Guide

Revision 21-3; Effective September 1, 2021

Appendix is available for staff use on the LOOP.

Appendix XXVI, Determining Unmet Need

Revision 21-3; Effective September 1, 2021

Appendix is available for staff use on the LOOP.

Appendix XXVII, Reserved for Future Use

Revision 21-3; Effective September 1, 2021

Appendix XXVIII, Do Not Hire

Revision 21-3; Effective September 1, 2021

Appendix is available for staff use on the LOOP.

Appendix XXIX, Community Care Services Flow Charts

Revision 21-3; Effective September 1, 2021

Appendix is available for staff use on the LOOP.

Appendix XXX, Income and Resource Exemptions for Determining Financial Eligibility

Revision 17-8 Effective September 1, 2017

Income and Resource Exemptions

Exempt income is not included in the income eligibility calculation. Once identified and documented, caseworkers will not be required to monitor exempt income at subsequent financial redetermination. Sources of exempt income include:

(1) interest income.

(2) cash received from the sale of a resource. This cash is a resource, not income.

(3) income of minor children who are supported by or dependent upon the client.

(4) refunds from the Internal Revenue Service for earned income tax credit.

(5) reimbursement from an insurance company for health insurance claims.

(6) any cash from a non-governmental medical or social services organization if the cash is:

for medical or social services already received by the individual and approved by the organization, and which does not exceed the value of those services; or a payment restricted to the future purchase of a medical or social service.

(7) proceeds of either a commercial loan or an informal loan, for which repayment is required with or without interest. The proceeds (amount borrowed) are not counted as income in the month in which they are received, but are considered to be a resource in the following month(s). To claim exemption of the proceeds of a loan, a client must prove that he acknowledges an obligation to repay and that some plan for repayment exists. If these conditions can be verified, no written contract is required.

(8) the amount of the cost-of-living increase in any pension or benefit, received on or after January 1, 1985, that would cause the client to be ineligible for continued services. This exclusion applies only to community care clients who are already receiving services or case management and would become ineligible because of the increase. It does not apply to applicants.

(9) in-kind income, such as food, clothing, shelter, rent subsidies.

(10) one-time or lump-sum payments from any source.

(11) funds from the Transition to Life in the Community Program.

(12) payments from the Agent Orange Settlement Fund or any other fund established in settlement of the Agent Orange product liability litigation. Public Law 101-239 exempts the payments from countable income and resources. The law is retroactive as of January 1, 1989.

(13) any payment received under the Radiation Exposure Compensation Act (Public Law 101-246).

(14) any payment received under the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970.

(15) payments to volunteers under the Domestic Volunteer Services Act. This exclusion applies to any payments to volunteers in the Retired Senior Volunteer Program, and Foster Grandparent Program, and the Senior Companion Program. Also included are payments under Title III of the same act, which includes the Service Corps of Retired Executives (SCORE), the Active Corps of Executives (ACE), and the Action Cooperative Volunteer Program (ACV).

(16) interest or other earnings on any designated account established for Supplemental Security Income (SSI) clients under age 18 for retroactive benefits, as required by Public Law 104-193, effective August 22, 1996.

(17) payments by the Federal Disaster Assistance Administration authorized by the Disaster Relief Act, as amended.

(18) value of any housing assistance paid on a house under the United States Housing Act of 1937, the National Housing Act, the Housing and Urban Development Act of 1965, §101, or Title V of the Housing Act of 1949, as authorized by Public Law 94-375.

(19) home energy assistance, except food or clothing, under Public Laws 97-377 and 97-424. Home energy assistance is assistance in cash or in-kind that is provided by a private, nonprofit organization or a utility company. Some examples of home energy assistance are heating, cooling, weatherization, storm windows, and blankets.

(20) reparation payments received by Holocaust survivors from the Federal Republic of Germany. The payments may be made periodically or as a lump sum. The Texas Department of Human Services accepts the client's signed statement of amounts involved and dates of payment. Public Law 101-508 established this exemption effective January 1, 1991.

(21) payments from a state-administered fund to aid victims of crime. Public Law 101-508 established this exemption effective May 1, 1991.

(22) payments a state or local government may make as relocation assistance. Public Law 101-508 established this exemption effective October 15, 1990.

(23) hazardous duty pay of a spouse or parent absent from the home because of active military service.

(24) restitution payments made by the United States government under Public Law 100-383 to Japanese-American (or, if deceased, to their survivors) who were interned or relocated during World War II.

(25) reparation payments received under §§500-506 of the Austrian General Social Insurance Act.

(26) payments under the Netherlands' Act on Benefits for Victims of Persecution 1940-1945 (Dutch acronym, WUV).

(27) payment from any source made to individuals because of their status as victims of Nazi persecution. Public Law 103-286 established this exemption effective August 1, 1994.

Emergency or Disaster Relief

Payments precipitated by an emergency or major disaster are not counted as income or resources when determining financial eligibility.
A major disaster is any natural catastrophe such as a hurricane or drought, or, regardless of cause, any fire, flood or explosion, which the President determines causes damage of sufficient severity and magnitude.

An emergency is any occasion or instance for which the President determines that federal assistance is needed to supplant state and local efforts and capabilities to save lives and to protect property and public health and safety, or to lessen or avert the threat of a catastrophe.

Disaster Unemployment Assistance is emergency assistance authorized under Public Law (P.L.) 100-107 and received by individuals who are unemployed as a result of a major disaster. Individuals receiving Disaster Unemployment Assistance are not eligible for other unemployment compensation and cannot receive both at the same time.

If precipitated by an emergency or a major disaster, do not consider the following as income:

- Payments received under the Disaster Relief Act of 1974 (P.L. 93-288, Section 312(d)), as amended by the Disaster Relief and Emergency Assistance Amendments of 1988 (P.L. 100-707, Section 105(i)) and disaster assistance comparable to these payments provided by states, local governments and disaster assistance organizations
- Payments from the Federal Emergency Management Agency (FEMA), Individual and Family Grant Assistance program (IFG), grants or loans by the Small Business Administration (SBA), voluntary disaster assistance organizations, such as the Red Cross, or private insurance payments for losses due to a major disaster such as flood, wind, land movement
- Each payment made to farmers under the Disaster Assistance Act of 1988 (P.L. 100-387) for crop losses or failure in a disaster
- Income received from public and private organizations by individuals working in disaster relief efforts and funded under a National Emergency Grant by WIA, Title 1 (P.L.105-220)
- Disaster Unemployment Assistance
- Payments for flood mitigation received by a homeowner under the National Flood Insurance Act of 1968, as amended by P.L. 109-64
- Government payments designated for the restoration of a home damaged in a disaster.

Additional Exemptions

Income from the following sources is exempt as income and as a resource and must not be considered in determining eligibility. Exempt the following payments:

- Payments from the Ricky Ray Hemophilia Relief Fund
- Alaska longevity bonus
- Payments from the Energy Employees Occupational Illness Compensation Act (EEOICA) (Public Law 106-398, October 2000) for medical benefits and compensation
- Filipino Veterans Equity Compensation Fund created by the American Recovery and Reinvestment Act of 2009.
- The value of assistance to children under the National School Lunch Act (60 Stat. 230, 42 U.S.C. 1751 et seq.) as amended by Public Law 90-302 (82 Stat. 117, 42 U.S.C. 1761(h)(3))
- Any grant or loan to any undergraduate student for educational purposes made or insured under any program administered by the commissioner of education, as provided by Section 507 of the Higher Education Amendments of 1968, Public Law 90-575 (82 Stat. 1063)
- Incentive allowances received under Title I of the Comprehensive Employment and Training Act of 1973 (87 Stat. 849, 29 U.S.C. 821(a))
- Compensation provided to volunteers by the Corporation for National and Community Service (CNCS), unless determined by the CNCS to constitute the minimum wage in effect under the Fair Labor Standards Act of 1938 (29 U.S.C. 201 et seq.), or applicable state law, pursuant to 42 U.S.C. 5044(f)(1)
- Value of federally donated foods distributed pursuant to Section 32 of Public Law 74-320 or Section 416 of the Agriculture Act of 1949 (7 CFR 250.6(e)(9), as authorized by 5 U.S.C. 301)
- All funds held in trust by the Secretary of the Interior for an Indian tribe and distributed per capita to a member of that tribe under Public Law 98-64
- Funds held by Alaska Native Regional and Village Corporations (ANRVC) are not held in trust by the Secretary of the Interior and therefore ANRVC dividend distributions are not excluded from resources under this exclusion.
- Home energy assistance payments or allowances under the Low-Income Home Energy Assistance Act of 1981, as added by Title XXVI of the Omnibus Budget Reconciliation Act of 1981, Public Law 97-35 (42 U.S.C. 8624(f))
- Student financial assistance for attendance costs received from a program funded in whole or in part under Title IV of the Higher Education Act of 1965, as amended, or under Bureau of Indian Affairs student assistance programs if it is made available for tuition and fees normally assessed a student carrying the same academic workload, as determined by the institution, including:

    - costs for rental or purchase of any equipment;
    - materials or supplies required of all students in the same course of study; and
    - an allowance for books, supplies, transportation and miscellaneous personal expenses for a student attending the institution on at least a half-time basis, as determined by the institution, under Section 14(27) of Public Law 100-50, the Higher Education Technical Amendments Act of 1987 (20 U.S.C. 1087uu), or under Bureau of Indian Affairs student assistance programs.
- Amounts paid as restitution to certain individuals of Japanese ancestry and Aleuts under the Civil Liberties Act of 1988 and the Aleutian and Pribilof Islands Restitution Act, Sections 105(f) and 206(d) of Public Law 100-383 (50 U.S.C. app. 1989 b and c)
- Any matching funds and interest earned on matching funds from a demonstration project authorized by Public Law 105-285 that are retained in an Individual Development Account, pursuant to Section 415 of Public Law 105-285 (112 Stat. 2771)
- Any earnings, Temporary Assistance for Needy Families matching funds, and accrued interest retained in an Individual Development Account, pursuant to Section 103 of Public Law 104-193 (42 U.S.C. 604(h)(4))
- Payments made to individuals who were captured and interned by the Democratic Republic of Vietnam as a result of participation in certain military operations, pursuant to Section 606 of Public Law 105-78 and Section 657 of Public Law 104-201 (110 Stat. 2584)
- Payments made to the children of women Vietnam veterans who suffer from certain birth defects, pursuant to Section 401 of Public Law 106-419 (38 U.S.C. 1833(c))
- For the nine months following the month of receipt, any unspent portion of any refund of federal income taxes under Section 24 of the Internal Revenue Code of 1986 (relating to the child care tax credit), pursuant to section 431 of Public Law 108-203 (118 Stat. 539)
- Wages and salaries from Title V of the Older Americans Act, such as Green Thumb and the Senior Texan Employment Program (STEP), are not exempt income. See (15) in the section above.

In the income eligibility budget, do not count the hostile fire pay or imminent danger pay portion from military income. For the nine-month period following the month of receipt, exclude the unspent portion of any retroactive payment (see (23) above) of:

- hostile fire and imminent danger pay (pursuant to 37 U.S.C. 310) received by the ineligible spouse or parent from one of the uniformed services; and
- family separation allowance (pursuant to 37 U.S.C. 427) received by the ineligible spouse or parent from one of the uniformed services as a result of deployment to or while serving in a combat zone.

Other exemptions include:

1. Payments from the Remembrance, Responsibility and Future Foundation of Germany.
2. Interest or other earnings on any designated account established for Supplemental Security Income (SSI) individuals under age 18 for retroactive benefits, as required by Public Law 104-193, effective August 22, 1996.
3. Payments made in the class settlement of the Susan Walker vs. Bayer Corporation lawsuit, as required by Public Law 105-33, effective August 5, 1997.
4. Payments from the Department of Veterans Affairs made to or on behalf of certain Vietnam veterans' natural children regardless of their age or marital status, for any disability resulting from spina bifida suffered by such children as required by Public Law 104-204, effective October 1, 1997.
5. Gifts from tax-exempt organizations, such as the Make-A-Wish Foundation, to children with life-threatening conditions, as required by Public Law 105-306, effective retroactively to October 28, 1996. The exclusions apply to children under age 18. The gift must be from an organization described in Section 501(c)(3) of the Internal Revenue Code of 1986 and which is exempt from taxation under Section 501(c). The case manager documents the case record with an oral or written statement from the organization that the gift was made based on the child having a life-threatening condition. No additional verification of medical eligibility is necessary.
6. The following gifts to or for the benefit of a child described above are excluded from income:

1. any in-kind gift, not converted to cash; and
2. a cash gift to the extent that the cash excluded under this provision does not exceed $2,000 in any calendar year. Cash in excess of $2,000 received in a calendar year is included in the income eligibility budget.

7. Payments for foster care of a child if the child:
    1. is not eligible for SSI; and
    2. was placed in the individual's home by a public or private, non-profit child-placement or child-care agency.
8. Benefits received under Title III, Public Law 100-175, which amends the Older Americans Act of 1965 to authorize appropriations for the fiscal years 1988-1991.
9. Value of benefits provided under the Child Nutrition Act of 1966.

There are also a number of legislatively-mandated exemptions that apply to members of recognized Native American tribes.

§48.2908. Indian-related Exemptions.

(a) Type of payment. The following statutes provide that certain types of payments made to members of Indian tribes are exempt from income and resources as specified in paragraphs (1)-(4) of this subsection, or only from income as specified in paragraph (5) of this subsection.

(1) Indian Judgment Funds Distribution Act — Public Law 93-134. Effective October 19, 1973, per capita distribution payments to members of Indian tribes who are due judgment funds, according to a plan of the Secretary of the Interior (or legislation, when a plan cannot be prepared or is not approved by the Congress) are exempted from income and resources. This does not include payments of funds distributed or held in trust (i.e., in the possession or care of a trustee) according to public laws enacted before October 19, 1973.

(2) Distribution of Indian Judgment Funds — Public Law 97-458. Effective January 12, 1983, Indian judgment funds held in trust (i.e., in the possession or care of a trustee) or distributed per capita, pursuant to an approved plan, or their availability, are exempted from income and resources. Indian judgment funds include interest and investment income accrued while the funds are held in trust. Initial purchases made with distributed judgment funds are exempted from resources.

(3) Per Capita Act — Public Law 98-64.

(A) Effective August 2, 1983, per capita distributions of all funds held in trust by the Secretary of the Interior to members of an Indian tribe are exempted from income and resources.

(B) Any local tribal funds that a tribe distributes to individuals on a per capita basis, but which have not been held in trust by the Secretary of the Interior (e.g., tribally managed gaming revenues) are not exempted from income and resources under this provision.

(4) Alaska Native Claims Settlement Act (ANCSA) — Public Law 100-241.

(A) Effective February 3, 1988, the following items received from a native corporation are exempted from income and resources:

(i) cash received from a native corporation (including cash dividends on stock received from a native corporation) to the extent it does not exceed $2,000, per individual per year;

(ii) stock (including stock issued or distributed by a native corporation as a dividend or distribution on stock);

(iii) a partnership interest;

(iv) land or an interest in land (including land or an interest in land received from a native corporation as a dividend or distribution on stock); and

(v) an interest in a settlement trust.

(B) The ANCSA also provides that up to $2,000 in retained distributions from a native corporation may be exempted from resources for each year beginning with 1988.

(5) Payments from Individual Interests in Trust or Restricted Lands — Public Law 103-66.

(A) Effective January 1, 1994, up to $2,000 per year received by Indians that is derived from individual interests in trust or restricted lands is exempted from income.

(B) Interests of individual Indians in trust or restricted lands are exempted from resources.

(b) Payments to specific Indian tribes and groups. The following statutes provide that certain payments made to members of specified Indian tribes and groups are exempt from income and resources.

(1) Distribution of Per Capita Funds — Public Law 85-794. Effective August 28, 1958, per capita payments to members of the Red Lake Band of Chippewa Indians from the proceeds of the sale of timber and lumber on the Red Lake Reservation are exempted from income and resources.

(2) Distribution of Judgment Funds — Public Law 92-254. Effective March 18, 1972, per capita distribution payments by the Blackfeet and Gros Ventre tribal governments to members, which resulted from judgment funds to the tribes, are exempted from income and resources.

(3) Distribution of Claims Settlement Funds — Public Law 93-531 and Public Law 96-305. Effective December 22, 1974, settlement fund payments to members of the Hopi and Navajo Tribes, and the availability of such funds, are exempted from income and resources.

(4) Receipts from Lands Held in Trust for Indian Tribes — Public Law 94-114.

(A) Effective October 17, 1975, receipts derived from the following trust lands and distributed to members of designated Indian tribes are exempted from income and resources.

(B) The first four Indian groups had lands conveyed with mineral rights prior to Public Law 94-114; that law conveyed the rest of the land to the remaining Indian groups.

(5) Distribution of Judgment Funds — Public Law 94-189. Effective December 31, 1975, judgment funds distributed per capita to, or held in trust for, members of the Sac and Fox Indian Nation, and the availability of such funds, are exempted from income and resources.

(6) Distribution of Judgment Funds — Public Law 94-540. Effective October 18, 1976, judgment funds distributed per capita to, or held in trust for, members of the Grand River Band of Ottawa Indians, and the availability of such funds, are exempted from income and resources.

(7) Distribution of Judgment Funds — Public Law 95-433. Effective October 10, 1978, any judgment funds distributed per capita to members of the Confederated Tribes and Bands of the Yakima Indian Nation or the Apache Tribe of the Mescalero Reservation are exempted from income and resources.

(8) Receipts from Lands Held in Trust — Public Law 95-498. Effective October 21, 1978, receipts derived from trust lands awarded to the Pueblo of Santa Ana and distributed to members of that tribe are exempted from income and resources.

(9) Receipts from Lands Held in Trust — Public Law 95-499. Effective October 21, 1978, receipts derived from trust lands awarded to the Pueblo of Zia and distributed to members of that tribe are exempted from income and

resources.

(10) Distribution of Judgment Funds — Public Law 96-318. Effective August 1, 1980, any judgment funds distributed per capita or made available for programs for members of the Delaware Tribe of Indians and the absentee Delaware Tribe of Western Oklahoma are exempted from income and resources.

(11) Maine Indian Claims Settlement Act — Public Law 96-420. Effective October 10, 1980, all funds and distributions to members of the Passamaquoddy Tribe, the Penobscot Nation, and the Houlton Band of Maliseet Indians under the Maine Indian Claims Settlement Act, and the availability of such funds, are exempted from income and resources.

(12) Distribution of Judgment Funds — Public Law 97-95. Effective December 17, 1981, any distributions of judgment funds to members of the San Carlos Tribe of Arizona are exempted from income and resources.

(13) Distribution of Judgment Funds — Public Law 97-371. Effective December 20, 1982, any distributions of judgment funds to members of the Wyandot Tribe of Indians of Oklahoma are exempted from income and resources.

(14) Distribution of Judgment Funds — Public Law 97-372. Effective December 20, 1982, distributions of judgment funds to members of the Shawnee Tribe of Indians (Absentee Shawnee Tribe of Oklahoma, the Eastern Shawnee Tribe of Oklahoma, and the Cherokee Band of Shawnee descendants) are exempted from income and resources.

(15) Distribution of Judgment Funds — Public Law 97-376. Effective December 21, 1982, judgment funds distributed per capita or made available for programs for members of the Miami Tribe of Oklahoma and the Miami Indians of Indiana are exempted from income and resources.

(16) Distribution of Judgment Funds — Public Law 97-402. Effective December 31, 1982, distributions of judgment funds to members of the Clallam Tribe of Indians of the State of Washington (Port Gamble Indian Community, Lower Elwha Tribal Community, and the Jamestown Band of Clallam Indians) are exempted from income and resources.

(17) Distribution of Judgment of Funds — Public Law 97-403. Effective December 31, 1982, judgment funds distributed per capita or made available for programs for members of the Pembina Chippewa Indians (Turtle Mountain Band, Chippewa Cree Tribe, Minnesota Chippewa Tribe, and Little Shell Band of Chippewa Indians of Montana) are exempted from income and resources.

(18) Distribution of Judgment Funds — Public Law 97-408. Effective January 3, 1983, per capita distributions of judgment funds to members of the Gros Ventre and Assiniboine Tribes of Fort Belknap Indian Community, and the Papago Tribe of Arizona, are exempted from income and resources.

(19) Distribution of Judgment Funds — Public Law 97-436. Effective January 8, 1983, up to $2,000 of per capita distributions of judgment funds to members of the Confederated Tribes of the Warm Springs Reservation are exempted from income and resources.

(20) Distribution of Judgment Funds — Public Law 98-123. Effective October 13, 1983, judgment funds distributed to the Red Lake Band of Chippewa Indians are exempted from income and resources.

(21) Distribution of Judgment Funds — Public Law 98-124. Effective October 13, 1983, funds distributed per capita or family interest payments for members of the Assiniboine Tribe of the Fort Belknap Indian Community of Montana and the Assiniboine Tribe of the Fort Peck Indian Reservation of Montana are exempted from income and resources.

(22) Distribution of Claims Settlement Funds — Public Law 98-432. Effective September 28, 1984, judgment funds and income therefrom distributed to members of the Shoalwater Bay Indian Tribe are exempted from

income and resources.

(23) Distribution of Claims Settlement Funds — Public Law 98-500. Effective October 19, 1984, all distributions to heirs of certain deceased Indians under the Old Age Assistance Claims Settlement Act are exempted from income and resources.

(24) Distribution of Judgment Funds — Public Law 98-602. Effective October 30, 1984, judgment funds distributed per capita or made available for any tribal program, for members of the Wyandotte Tribe of Oklahoma and the Absentee Wyandottes, are exempted from income and resources.

(25) Distribution of Judgment Funds — Public Law 99-130. Effective October 28, 1985, per capita and dividend payment distributions of judgment funds to members of the Santee Sioux Tribe of Nebraska, the Flandreau Santee Sioux Tribe, and the Prairie Island Sioux, Lower Sioux, and Shakopee Mdewakanton Sioux Communities of Minnesota are exempted from income and resources.

(26) Distribution of Judgment funds — Public Law 99-146. Effective November 11, 1985, funds distributed per capita or held in trust for members of the Chippewas of Lake Superior and the Chippewas of the Mississippi are exempted from income and resources.

(27) Distribution of Claims Settlement Funds — Public Law 99-264. Effective March 24, 1986, distributions of claims settlement funds to members of the White Earth Band of Chippewa Indians as allottees, or their heirs, are exempted from income and resources.

(28) Distribution of Judgment Funds — Public Law 99-346. Effective June 30, 1986, payments or distributions of judgment funds, and the availability of any amount for such payments or distributions, to members of the Saginaw Chippewa Indian Tribe of Michigan are exempted from income and resources.

(29) Distribution of Judgment Funds — Public Law 99-377. Effective August 8, 1986, judgment funds distributed per capita or held in trust for members of the Chippewas of Lake Superior and the Chippewas of the Mississippi are exempted from income and resources.

(30) Distribution of Judgment Funds — Public Law 100-139. Effective October 26, 1987, judgment funds distributed to members of the Cow Creek Band of Umpqua Tribe of Indians are exempted from income and resources.

(31) Aleutian and Pribilof Islands Restitution Act — Public Law 100-383. Effective August 10, 1988, per capita restitution payments made to eligible Aleuts who were relocated or interned during World War II are exempted from income and resources.

(32) Distribution of Claims Settlement Funds — Public Law 100-411. Effective August 22, 1988, per capita payments of claims settlement funds to members of the Coushatta Tribe of are exempted from income and resources.

(33) Hoopa-Yurok Settlement Act — Public Law 100-580. Effective October 31, 1988, funds distributed per capita for members of the Hoopa Valley Indian Tribe and the Yurok Indian Tribe are exempted from income and resources.

(34) Distribution of Judgment Funds — Public Law 100-581. Effective November 1, 1988, judgment funds held in trust by the United States, including interest and investment income accruing on such funds, and judgment funds made available for programs or distributed to members of the Wisconsin Band of Potawatomi (Hannahville Indians Community and Forest County Potawatomi) are exempted from income and resources.

(35) Distribution of Money and Land — Public Law 101-41. Effective June 21, 1989, all funds, assets, and income from the trust fund transferred to the members of the Puyallup Tribe under the Puyallup Tribe of Indians Settlement Act of 1989 are exempted from income and resources.

(36) Distribution of Judgment Funds — Public Law 101-277. Effective April 30, 1990, judgment funds distributed per capita, or held in trust, or made available for programs, for members of the Seminole Nation of Oklahoma, the Seminole Tribe of Florida, the Miccosukee Tribe of Indians of Florida, and the independent Seminole Indians of Florida, (plus any interest and investment income accruing on the funds held in trust), and the availability of those funds, are exempted from income and resources.

(37) Distribution of Settlement Funds — Public Law 101-503. Effective November 3, 1990, payments, funds, distributions, or income derived from them under the Seneca Nation Settlement Act of 1990 are exempted from income and resources.

(38) Distribution of Settlement Funds — Public Law 101-618. Effective November 16, 1990, per capita distributions of settlement funds under the Fallon Paiute Shoshone Indian Tribes Water Rights Settlement Act of 1990 are exempted from income and resources.

(39) Distribution of Settlement Funds — Public Law 103-116. Settlement funds, assets, income, payments or distributions from trust funds to members of the Catawba Indian Tribe under the Catawba Indian Tribe of South Carolina Land Claims Settlement Act of 1993 are exempted from income and resources.

(40) Distribution of Settlement Funds — Public Law 103-436. Effective November 2, 1994, settlement funds held in trust, including interest and investment income accruing on such funds, and payments made to members of the Confederated Tribes of the Colville Reservation under the Confederated Tribes of the Colville Reservation Grand Coulee Dam Settlement Act are exempted from income and resources.

If the total resources are not within $100 of the eligibility limit, no additional documentation is required in order for payments and benefits to be excluded from resources. If total resources are within $100 of the eligibility limit, then additional verification documentation of the funds is required in order for the payments and benefits to be excluded.

Appendix XXXI, It's Your Choice: Deciding How to Manage Your Personal Assistance Services

Revision 17-1; Effective March 15, 2017

This information at the link below assists consumers to compare available service delivery option features.

https://hhs.texas.gov/services/disability/consumer-directed-services

Appendix XXXII, Medicaid Program Actions

Appendix XXXIII, Requests for Services from Individuals Under 21 Years of Age

Revision 17-1; Effective March 15, 2017

Since Sept. 1, 2007, Primary Home Care (PHC) has not been available for individuals under 21 years of age with full Medicaid benefits. Individuals requiring personal attendant services receive benefits through the Texas

Health and Human Services Commission (HHSC) Personal Care Services (PCS).

Referring Requests for PCS Services

Any requests for services for Medicaid eligible individuals under age 21 must be referred to the appropriate Texas Department of State Health Services (DSHS) PCS regional office. A current list of regional offices and contact information follows.

For non-Medicaid eligible individuals under age 21:

- refer to the Social Security Administration to apply for Supplemental Security Income (SSI), if the individual has not previously applied; and
- begin the application process for Community Attendant Services (CAS) as outlined in the *Community Care for Aged and Disabled Handbook*, Section 2332, Requests for Services from Individuals Under Age 21.

If the individual subsequently becomes eligible for Medicaid, he must be referred to PCS and CAS services must be terminated.

Requests for Services from Individuals Turning 21 Years of Age

Individuals who will be turning 21 years of age within two months of the initial request for services should be given a choice to apply for either PCS or PHC services. If the individual chooses to apply for PCS, explain that two assessments will be required; one for PCS and one for PHC. If the individual decides to apply for PHC, begin the application process. All PHC policy and procedures apply. If eligible, services may begin as soon as the applicant is 21 years of age and certified for services.

PCS Eligible Individuals Turning 21 Years of Age

For individuals already receiving PCS who are interested in PHC, the regional PCS case worker will encourage the individual/family to contact the HHSC at least two months before the individual's 21st birthday. Since there are differences in PCS and PHC services, the HHSC case worker will thoroughly explain the allowable PHC services at the time of the initial PHC assessment. PHC may not offer some of the services provided through the PCS program.

The applicant must meet all PHC eligibility criteria, including medical, functional and unmet need. If the applicant is eligible, PHC services are negotiated to begin on the individual's 21st birthday. PCS services should end at midnight on the day before the individual's birthday. Coordinate the transition with the PCS case worker and applicant to ensure there are no gaps in services.

DSHS PCS Regional Office Contact Numbers

DSHS Region	Address	Telephone Number	Fax Number
Region 1	PO Box 60968, WT AMU Canyon, TX 79016	806-655-7151	806-655-0820
Region 2/3	1301 South Bowen Road, Suite 200 Arlington, TX 76013	817-264-4627	817-264-4911
Region 4/5 North	1517 West Front Street Tyler, TX 75702	903-533-5231	903-595-4706

DSHS Region	Address	Telephone Number	Fax Number
Region 6/5 South	5425 Polk Avenue, Suite J Houston, TX 77023-1497	713-767-3111	713-767-3125
Region 7	2408 South 37th Street Temple, TX 76504-7168	254-778-6744	254-778-4066
Region 8	7430 Louis Pasteur Drive San Antonio, TX 78229	210-949-2155	210-949-2047
Region 9/10	401 East Franklin, Suite 210 El Paso, Texas 79901-1206	915-834-7675	915-834-7804
Region 11	601 West Sesame Drive Harlingen, TX 78550	956-423-0130	956-444-3294

Appendix XXXIV, Program Descriptions

Revision 18-1; Effective June 15, 2018

Comparison charts for the Texas Long-term Services and Supports (LTSS) programs are found at:

https://hhs.texas.gov/doing-business-hhs/provider-portals/resources/compare-long-term-services-supports-ltss-programs.

Appendix XXXV, Long Term Services and Supports

Appendix XXXVI, Roles and Responsibilities of the Regional Complex Needs Coordinators

Revision 18-1; Effective June 15, 2018

Community Care Services Eligibility (CCSE) asked each region to designate a complex needs coordinator. This appendix provides a description of the role and expectations of the designated complex needs coordinator.

While there are other situations which require the expertise of the coordinator, the primary responsibilities are in the coordination of high needs individuals transitioning from children's programs to adult programs. Due to the complexity of some of these situations, the skills of the complex needs coordinator are necessary.

Outlined below are the duties of the complex needs coordinator. Regional directors may assign additional staff to assist with these duties, but the designated coordinator will be the point of contact for issues and questions.

Quarterly Comprehensive Care Program (CCP) Transition Report

The designated complex needs coordinator is responsible for:

- completing the quarterly CCP Transition Report for the region and submitting it back to the state office Special Initiatives coordinator by the designated due date. The report includes all transitioning individuals,

including Personal Care Services (PCS) to Primary Home Care (PHC) applicants;
- being the point of contact for any questions on the quarterly CCP Transition Report;
- ensuring the 12-month visit and contacts are made and reporting back to the state office CCSE contact any individuals who may potentially be over the cost limit based on current services;
- identifying the high needs individuals and ensuring all aging out assessments are started on time and remain on track; and
- submitting frequent progress reports to the state office CCSE contact on the individuals who have been identified as high needs.

Identification and Tracking of High Needs Aging Out Individuals

The complex needs coordinator is responsible for:

- identifying the aging out individuals who may be close to the cost limit or have other issues that may complicate the development of an acceptable individual service plan (ISP);
- coordinating the regional interdisciplinary team (IDT) meetings, as needed;
- being the regional contact person for state office staff for questions on pending applications or ongoing individuals with high needs;
- requesting and participating in the state office IDT, including assuring the chronology and other required documentation are submitted; and
- assisting with collecting and submitting the required medical and service documentation if a physician's clinical visit is required for the Rider 36 General Revenue (GR) process.

Providing Assistance and Overview of High Needs Assessments

The complex needs coordinator is responsible for:

- working with the assigned case worker and other regional staff on all high needs assessments;
- reviewing the draft ISP packet to check for the following;
    - Are the Medical Necessity/Level of Care (MN/LOC) and Resource Utilization Group (RUG) levels set correctly? Is the individual a ventilator patient and if so, is the RUG coded correctly for the 6 to 23-hour or 24-hour vent care?
    - Are the nursing hours calculated correctly? Are the registered nurse (RN) required hours included? Has the type of nursing (specialized or non-specialized) been discussed and set up correctly?
    - Do the nursing hours reflect the informal support hours the family has agreed to, and is this information reflected the same on Form 8598, Non-Waiver Services? Is the family in agreement with the plan and is Form 8598 signed in agreement with the overall plan?
- assisting regional staff in working with provider agencies and contract management to assure a cost effective ISP is developed that assures health and safety and is ready to be implemented on the age out date; and
- working with state office staff if the Rider 36 process is initiated.

Regional Complex Needs Coordinators Procedures for Individuals in the STAR+PLUS Program

The role of the complex needs coordinator is different in STAR+PLUS areas due to the differences in STAR+PLUS procedures. Listed below are the complex needs coordinator's responsibilities for individuals in STAR+PLUS.

Quarterly CCP Transition Report

The designated complex needs coordinator is responsible for:

- completing the quarterly CCP Transition Report for the region and submitting it back to the state office Special initiatives coordinator by the designated due date;
- being the point of contact for any questions on the quarterly CCP Transition Report; and
- ensuring all STAR+PLUS Home and Community Based Services (HCBS) aging out referrals (Form H3676, Managed Care Pre-Enrollment Home Health Assessment Authorization) are sent on time.

Identification and Tracking of High Needs Aging Out Individuals

The complex needs coordinator will be responsible for coordinating with the STAR+PLUS Support Unit (SPSU) supervisor for:

- identifying the aging out individuals who may be close to the cost limit or have other issues that may complicate the development of an acceptable ISP and reporting this information to HHSC-MCO and state office staff;
- being the regional contact person for state office and HHSC-MCO staff for questions on pending applications or ongoing individuals with high needs;
- assisting with collecting and submitting the required medical and service documentation for an IDT or for when a physician's clinical visit is required for the Rider 36 GR process;
- working with HHSC-MCO and state office staff if the Rider 36 process is initiated.

Appendix XXXVII, Reserved for Future Use

Revision 21-3; Effective September 1, 2021

Appendix XXXVIII, Caregiver Support Assessment Initiative

Revision 17-1 Effective March 15, 2017

As described in Section 2223, Caregiver Support Assessment Initiative, below are the forms for completing the caregiver support assessment.

Form 1027, Caregiver Status Questionnaire, and Instructions
Form 1027-S, Caregiver Status Questionnaire (Spanish), and Instructions

For assistance in completing the questionnaire, staff may use the Caregiver Status Questionnaire Script, provided in both English and Spanish.

Attachment 1 – English
Attachment 2 – Spanish

Forms

ES = Spanish version available.

Form	Title	
1019	Opportunity to Register to Vote/Declination	ES
1025	Request for Information Medicare Advantage Coordination	
1027	Caregiver Status Questionnaire	ES
1031	Case Record Transfer	
1032	Residential Care Copayment Worksheet	
1131	Individually Identifiable Health Information Fax Transmittal	
1581	Consumer Directed Services Option Overview	ES
1581-SRO	Service Responsibility Option (SRO) Overview	ES
1582	Consumer Directed Services Responsibilities	ES
1582-SRO	Service Responsibility Option Roles and Responsibilities	ES
1583	Employee Qualification Requirements	ES
1584	Consumer Participation Choice	ES
1586	Acknowledgement of Information Regarding Support Consultation Services in the Consumer Directed Services (CDS) Option	ES
1589	Consumer Directed Services Revision Worksheet	
1590	Request for a Fair Hearing Exception	
1596	Consumer Directed Services Agreement for Community Attendant Services Annual Reauthorization	ES
1741	Corrective Action Plan	ES
2058	Case Activity Record	
2059	Summary of Client's Need for Service	
2059-W	Summary of Individual's Need for Services Worksheet	
2060	Needs Assessment Questionnaire and Task/Hour Guide	
2060-B	Needs Assessment Addendum	ES
2064	Eligibility Worksheet	
2065-A	Notification of Community Care Services	
2067	Case Information	
2068	Application, Redetermination, or Monitoring for Community Care Services	
2076	Authorization to Release Medical Information	ES
2084	Risk Management Team Meeting Summary	
2097	Provider Contract Assignment Notification	
2101	Authorization for Community Care Services	
2110	Community Care Intake	
2111	Interest List Notification	
2113	Community Services Interest List Registration and Follow-Up	
2115	Conflict of Interest Notification	

Form	Title	
2119	Residential Care, Adult Foster Care or Assisted Living Contribution Acknowledgement	ES
2247	Interest List Contact Notification	
2307	Rights and Responsibilities	ES
2314	Satisfaction and Service Monitoring	
2314-C	Consumer Satisfaction Interview Consumer Directed Services Addendum	
2327	Individual/Member and Provider Agreement	
2327-A	Room and Board Amendment to the Individual and Provider Agreement	
2330	Assessment and Service Plan Approval for Adult Foster Care	
2423	Request for Medical Evidence	ES
3050	DAHS Health Assessment/Individual Service Plan	
3052	Practitioner's Statement of Medical Need	
3054	Primary Home Care Service Delivery Record	ES
3055	Physician's Orders (DAHS)	
3062	DAHS Utilization Review Report	
3070	Day Activity and Health Services Notification of Critical Omissions	
3070-A	PHC Notification of Critical Omissions/Errors in Required Documentation	
4100	Money Receipt	
4116	Authorization for Expenditures	
8001	Medicaid Estate Recovery Program Receipt Acknowledgement	ES
H0003	Agreement to Release Your Facts	
H0005	Policy Clarification Request	
H0025	HHSC Application for Voter Registration	ES
H1026	Verification of Railroad Retirement Benefits	
H1026-FTI	Verification of Railroad Retirement Benefits - FTI	
H1027-A	Medicaid Eligibility Verification	
H1200	Application for Assistance - Your Texas Benefits	
H1200-EZ	Application for Assistance - Aged and Disabled (Large Print)	
H1232	Notification of Ineligibility	ES
H1235	Notice of Appointment or Delay	
H1239	Request for Verification of Bank Accounts	
H1240	Request for Information from Bureau of Veterans Affairs and Client's Authorization	
H1240-FTI	Request for Information from Bureau of Veterans Affairs and Client's Authorization - FTI	
H1243	Verification of Civil Services Benefits	
H1243-FTI	Verification of Civil Services Benefits - FTI	
H1270	Data Integrity SAVERR Notification	
H1746-A	MEPD Referral Cover Sheet	
H1746-B	Batch Cover Sheet	

Form	Title	
H1826	Case Information Release	ES
H1297	Request for Information from Teacher Retirement System of Texas	
H3034	Disability Determination Socio-Economic Report	ES
H3035	Medical Information Release/Disability Determination	ES
H4800	Fair Hearing Request Summary	
H4800-A	Fair Hearing Request Summary (Addendum)	
H4807	Action Taken on Hearing Decision	
H4808	Notice of Change in Applied Income/Notice of Denial of Medical Assistance	

CCSE Service Authorization System Updates

The purpose of this section is to make the most current CCSE SAS updates readily available via a single resource. Memoranda containing CCSE SAS update information will be placed on this list at the time of distribution. They will remain on the list until the information is completely incorporated into the CCSE SAS Help file.

Policy Revisions

22-3, September Quarterly Revision

Effective Sept. 1, 2022

Archived Revision 22-2, Effective June Quarterly Revision
Archived Revision 22-1, Effective March Quarterly Revision
Archived Revision 21-4, Effective December Quarterly Revision
Archived Revision 21-3, Effective September Quarterly Revision

Revisions

The following sections were revised in the *Community Care Services Eligibility (CCSE)* Handbook:

Section	Title	Change
2540	Priority Status Individuals	Clarifies priority policy. Adds related policy sections.
2652	Changing the Service Schedule Between Reassessments	Clarifies priority policy. Adds related policy sections.
2710.2	Monitoring Ongoing Services	Clarifies initial monitoring contacts are set for all cases except CAS. Adds related policy section.
4210	Description	Removes Texas Administrative Code (TAC) rule citations and obsolete information. Adds related policy sections.
4220	Eligibility	Removes Texas Administrative Code (TAC) rule citations and obsolete information. Adds related policy sections.

Section	Title	Change
4222	Medical Eligibility Criteria	Removes Texas Administrative Code (TAC) rule citations and obsolete information. Adds related policy sections.
4231.1	Facility-Initiated Referrals	Removes Texas Administrative Code (TAC) rule citations and obsolete information. Adds related policy sections.
4232	Facility Choice	Removes Texas Administrative Code (TAC) rule citations and obsolete information. Adds related policy sections.
4234	Facility Response for Facility-Initiated Referrals	Removes Texas Administrative Code (TAC) rule citations and obsolete information. Adds related policy sections.
4235	Facility Response to Case Worker Referrals	Removes Texas Administrative Code (TAC) rule citations and obsolete information. Adds related policy sections.
4236	Critical Omissions	Removes Texas Administrative Code (TAC) rule citations and obsolete information. Adds related policy sections.
4261	Service Plan Changes Reported by the Facility	Removes Texas Administrative Code (TAC) rule citations and obsolete information. Adds related policy sections.
4263	Suspensions	Removes Texas Administrative Code (TAC) rule citations and obsolete information. Adds related policy sections.
4264	Ensuring Health and Safety at DAHS Facility	Removes Texas Administrative Code (TAC) rule citations and obsolete information. Adds related policy sections.
4270	Reassessment	Removes Texas Administrative Code (TAC) rule citations and obsolete information. Adds related policy sections.
4445	Service Plan Changes	Clarifies priority policy. Adds related policy sections.
6430	Transition Between HHSC and STAR+PLUS	Clarifies enrollment broker and MCO information. Adds related policy section.
Appendix IX	Notification and Effective Date of Decision	Clarifies priority policy. Adds related policy sections.

22-2, June Quarterly Revision

Effective June 1, 2022

Archived Revision 22-1, Effective March Quarterly Revision
Archived Revision 21-4, Effective December Quarterly Revision
Archived Revision 21-3, Effective September Quarterly Revision
Archived Revision 21-2, Effective June Quarterly Revision

Revisions

The following sections were revised in the Community Care Services Eligibility (CCSE) Handbook:

Section	Title	Change

Section	Title	Change
4325 4332 4333 4340 4341	Selection of Providers and Provider Changes; System Checks; Equipment Malfunction; Suspension and Termination of Services; Interdisciplinary Team (IDT) Meeting.	Removes Texas Administrative Code (TAC) rule language and simplifies policy description.
4322 4323 4331 4350 4353	Securing Responders; Equipment Installation; Alarm Calls; Rates and Contracts; Participant Records.	Removes sections that contain TAC references for providers and reserves for future use.
6332.2 6333.3.2 6333.3.3 6333.3.4	Calculation of the Annual Service Plan; Rate Change; Increase in Service Units; Decrease in Service Units.	Updates hyperlink to the Provider Finance Department. It is no longer the Rate Analysis Department (RAD).
6333.3.1	Provider Transfer	Updates hyperlink to the Provider Finance. It is no longer the Rate Analysis Department (RAD). Updates section title change from Provider Transfer to FMSA Transfer.
Appendix XI	Income and Resource Limits	Incorporates policy from CCSE Bulletin 22-02, 2022 Federal Poverty Level, released on Feb. 11, 2022. Revises appendix and updates chart with new 2022 limits based on Federal Poverty Limits.

Forms

The following forms were revised in the Community Care Services Eligibility (CCSE) Handbook:

Form	Title	Change
Form H0025 and Instructions	HHSC Application for Voter Registration	Updates form to include new perjury statement. Removes outdated references in instructions. (all programs)

Retired Bulletins

The following bulletins are deleted from the Community Care Services Eligibility (CCSE) Handbook. The information has either been incorporated into the handbook or is no longer necessary:

Release Date	Bulletin Number	Title
Feb. 11, 2022	22-02	2022 Federal Poverty Level
Dec. 7, 2021	21-05	Federal Benefits 2022 Cost-of-Living Adjustment (COLA)

22-1, March Quarterly Revision

Effective March 1, 2022

Archived Revision 21-4, Effective December Quarterly Revision
Archived Revision 21-3, Effective September Quarterly Revision
Archived Revision 21-2, Effective June Quarterly Revision
Archived Revision 21-1, Effective March Quarterly Revision

Revisions

The following sections were revised in Community Care Services Eligibility (CCSE) Handbook:

Section	Title	Change
2100 2200 2300 2400 2500 2600 2700 2800 2900 3100 3200 3400 5100 6400	Handbook Sections	Changes each mention of “CCAD” to CCSE
2200 2300 2400 2500 2600 2700 2900 3400 4200 4600 5300 5400 6300	Handbook Sections	Changes each mention of “SAS” to “SASOW”
Appendix X	Income and Resource Limits	Incorporates policy in MEPD and TW Bulletin 21-05, Federal Benefits 2022 Cost-of-Living Adjustments (COLA), released on Dec. 7, 2021.
Appendix XI	CCSE Case Management Filing Guide	Corrects title name of Appendix XI.

Forms

The following forms were revised in the CCSE Handbook:

Form	Title	Change
Form 1589 and Instructions	Consumer Directed Services Revision Worksheet	Changes each mention of "CCAD" to "CCSE"
Form 2059 Instructions	Summary of Client's Need for Service	Changes each mention of "CCAD" to "CCSE"
Form 2059-W Instructions	Summary of Individual's Need for Service Worksheet	Changes each mention of "CCAD" to "CCSE"
Form 2064 and Instructions	Eligibility Worksheet	Changes each mention of "CCAD" to "CCSE"
Form 2067 Instructions	Case Information	Changes each mention of "CCAD" to "CCSE"
Form 2076 Instructions	Authorization to Release Medical Information	Changes each mention of "CCAD" to "CCSE"
Form 2084	Risk Management Team Meeting Summary	Changes each mention of "CCAD" to "CCSE"
Form 2101 Instructions	Authorization for Community Care Services	Changes each mention of "CCAD" to "CCSE"
Form 2111 Instructions	Interest List Notification	Changes each mention of "CCAD" to "CCSE"
Form 2119 Instructions	Residential Care, Adult Foster Care or Assisted Living Contribution Acknowledgement	Changes each mention of "CCAD" to "CCSE"
Form 2307 Instructions	Rights and Responsibilities	Changes each mention of "CCAD" to "CCSE"
Form 2314 Instructions	Satisfaction and Service Monitoring	Changes each mention of "CCAD" to "CCSE"
Form 2314-C	Consumer Satisfaction Interview Consumer Directed Services Addendum	Changes each mention of "CCAD" to "CCSE"
Forms 2327 and 2327-S (Spanish)	Individual/Member and Provider Agreement	Changes each mention of "CCAD" to "CCSE"
Form 3062 Instructions	DAHS Utilization Review Report	Changes each mention of "CCAD" to "CCSE"
Form H1027-A Instructions	Medicaid Eligibility Verification	Changes each mention of "CCAD" to "CCSE"
Form H4808 Instructions	Notice of Change in Applied Income/Notice of Denial of Medical Assistance	Changes each mention of "CCAD" to "CCSE"

21-4, December Quarterly Revision

Effective December 1, 2021

Archived Revision 21-3, Effective September Quarterly Revision
Archived Revision 21-2, Effective June Quarterly Revision
Archived Revision 21-1, Effective March Quarterly Revision
Archived Revision 20-4, Effective December Quarterly Revision

Revisions

The following sections were revised in Community Care Services Eligibility (CCSE) Handbook:

Section	Title	Change
2680 4151 4233 4440 4653 Appendix IV Appendix XIII Contact Us	Recertification; Individual and Provider Agreement; Initial Eligibility Determination and Referral; Referral Process; Referral to the Provider; Workflow and Time Frames; Content of Referral Packets; CCSE Contact Us	Corrects formatting, grammatical and hyperlink errors.
4234.1 4235.1 4678.2	RNR for Facility-Initiated Referrals; RNR for Case Worker Referrals; Community Attendant Services Annual Reassessments	Aligns references to Form 2101 and adds related policy.
4621 4623	Allowable Tasks; Personal Attendants	Adds allowable tasks related to assistance with medications. Removes Texas Administrative Code hyperlinks.
1147 2613	Privacy Notice; Case Record Documentation	Incorporates policy from CCSE Bulletin 21-04, HIPAA – Notice of Privacy Practices, released on 10/18/2021, This is to update policy about the distribution of the notice of privacy practices.
1142.1 1145 1148 (Reserved)	Table of Contents; Telephone Contact; When and What Information May Be Disclosed; Personal Authorization	Updates policy to reflect that Form H1826, Case Information Release, is the correct form to authorize release of personal information.

Forms

The following forms were revised in the CCSE Handbook:

Form	Title	Change
Form 2060 Instructions	Needs Assessment Questionnaire and Task/Hour Guide, Instructions	Adds allowable tasks related to assistance with medications.
Form 1826-D and Form Instructions	Case Information Release	Retiring Duplicate Form

Retired Bulletins

The following bulletins are deleted from the CCSE Handbook. The information has either been incorporated into the handbook or is no longer necessary:

Release Date	Bulletin Number	Title
10/18/2021	21-04	HIPAA – Notice of Privacy Practices

Policy Bulletins

The purpose of this section is to make the most current policy and procedures available within a single resource. Memoranda containing policy or procedural information will be placed on this list at the time of distribution. They will remain on the list until the information contained is either completely incorporated into the handbook or retired as obsolete.

Release Date	Bulletin Number	Title
Feb. 1, 2022	22-01	1. Personal Attendant Rate Change for Consumer Directed Services 2. Residential Care Room and Board and Copayment Amounts
Dec. 31, 2021	21-06	Revised - Return to Face to Face Home Visits
Oct. 18, 2021	21-04	Health Insurance Portability and Accountability Act (HIPPA) – Notice of Privacy Practices
July 16, 2021	21-03	COVID-19 Update: Child Tax Credit (CTC) and Earned Income Tax Credit (EITC)
April 9, 2021	21-02	1. COVID-19 Update: Recovery Rebates 2. COVID-19 Update: Pandemic Unemployment Compensation 3. COVID-19 Update: Face to Face Home Visits 4. COVID-19 Update: Maintaining Eligibility

Nurse Memos

The purpose of this section is to make the most current policy and procedures affecting regional nurses readily available. Memoranda containing policy or procedural information will be placed on the list for the program that it impacts at the time of distribution. They will remain on the list until the information contained is completely incorporated into the handbook.

Release Date	Title
01-29-10	RLS#10–01-009 - Clarification Regarding the Health Assessment/Individual Service Plan (Form 3050) and Regional Nurse duties Related to Day Activity and Health Services (DAHS) Eligibility Determination

Contact Us

For technical or accessibility issues with this handbook, email the HHS Form & Handbook Request.

For questions about the Community Care Services Eligibility Handbook (CCSEH), email the HHSC CCSE Policy mailbox.