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Introduction
General Information
INTRODUCTION

Purpose of Manual

The Texas Health and Human Services Commission (HHSC) Policy and Procedures Manual for the Epilepsy Program is a guide for contractors who deliver epilepsy services using Texas general revenue funds. The policy manual has been structured to provide contractors with information needed to comply with Administrative, Client Services, Community Activities, Reimbursement, Data Collection and Reporting policies.

To provide epilepsy services, contractors are required to be in compliance with specific federal and state laws outlined in the manual. State rules that apply most specifically to epilepsy services in Texas are found in the Texas Administrative Code (TAC).

Authorization

Health and Safety Code – Chapter 40
Texas Administrative Code – Chapter 37, Subchapter K §§ 37.211 – 37.222

Purpose

The Epilepsy Program provides comprehensive outpatient care (diagnostic, treatment and support services) to eligible persons who have epilepsy and/or seizure-like symptoms through subrecipient providers in selected service areas in Texas.

Epilepsy

Epilepsy is a medical condition that produces seizures affecting a variety of mental and physical functions; also called a seizure disorder. A seizure is caused by a brief, strong surge of electrical activity involving part or all of the brain. When a person has two or more seizures without a clear cause (e.g., alcohol withdrawal), it is considered to be epilepsy.
DEFINITIONS

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

**Applicant** – A person who is applying for services.

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

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

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

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

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

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

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

**Diagnosis** – The doctor’s main tool in diagnosing epilepsy is a careful medical history with as much information as possible about what the seizures looked like and what happened just before they began. The doctor will also perform a thorough physical exam and may require microscopic (i.e. culture), chemical (i.e. blood tests), EEG and/or radiological examinations (CAT or MRI).

**Eligibility Date** – Date the applicant submits a completed application to the provider and is deemed eligible.

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

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

**Health and Human Services Commission (HHSC)** – The state agency that has oversight responsibilities for designated Health and Human Services agencies, including DSHS.

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

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

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

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

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

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

**Unduplicated Client** – An enrolled program participant who is counted only one time during the contract period (fiscal year), regardless of the number of times the person is seen or the number of services the individual receives. One client seen four times is counted as one unduplicated client; a family of three seen once is counted as three unduplicated clients.
**ACRONYMS**

- ADA - Americans with Disabilities Act
- CHIP - Children's Health Insurance Plan
- CDSB - Contract Development and Support Branch
- CPU - Claims Processing Unit
- CSHCN - Children with Special Health Care Needs
- DSHS - Department of State Health Services
- EEG - Electroencephalograph
- FCHSD - Family and Community Health Services Division
- FPL - Federal Poverty Level
- FY - State Fiscal Year – September 1 through August 31
- HB - House Bill
- HHS - Human Service Agencies
- HHSC - Health and Human Services Commission
- HIPPA - Health Insurance Portability and Accountability Act of 1996
- HSC - Health & Safety Code
- LEP - Limited English Proficiency
- QI - Quality Improvement
- QM - Quality Management
- QMB - Quality Management Branch
- SDO - Standing Delegation Orders
- TAC - Texas Administrative Code
- TANF - Temporary Assistance for Needy Families
Section I
Administrative Policies

Purpose: Section I assists the contractor in conducting administrative activities such as assuring client access to services and managing client records.
CLIENT ACCESS

The contractor must ensure that clients are provided services in a timely and nondiscriminatory manner. Epilepsy clients should be contacted as soon as possible, with a goal of 30 days from initial phone contact for most clients. The contractor must:

- Have a written policy in place that delineates the timely provision of services.
- Have policies in place to identify and eliminate possible barriers to client care.
- Comply with all applicable civil rights laws and regulations including Title VI of the Civil Rights Act of 1964, the Americans with Disabilities Act (ADA) of 1990, the Age Discrimination Act of 1975, and Section 504 of the Rehabilitation Act of 1973, and ensure services are accessible to persons with Limited English Proficiency (LEP) and speech or sensory impairments.
- Have a policy in place that requires qualified staff to assess and prioritize client’s needs.
- Provide referral resources for individuals that cannot be served or cannot receive a specific service.
- Manage funds to ensure that established clients continue to receive services throughout the budget year.
- Ensure clinic/reception room wait times are reasonable so as not to represent a barrier to service.
ABUSE AND NEGLECT REPORTING

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

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

CHILD ABUSE REPORTING

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

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

CONFIDENTIALITY

All contracting agencies must be in compliance with the U.S. Health Insurance Portability and Accountability Act of 1996 (HIPAA) established standards for protection of client privacy.

Employees and volunteers must be made aware during orientation that violation of the law in regard to confidentiality may result in civil damages and criminal penalties. All employees, volunteers, sub-contractors, and board members and/or advisory board must sign a confidentiality statement during orientation.

The client’s preferred method of follow-up to clinic services (cell phone, email, work phone, and/or text) and preferred language must be documented in the client’s record. (See Client Health Record – Section II Chapter 3)

Each client must receive verbal assurance of confidentiality and an explanation of what confidentiality means (kept private and not shared without permission) and any applicable exceptions such as abuse reporting (See Abuse Reporting, Section I Chapter 2).

NON-DISCRIMINATION

HHSC Contractors must comply with state and federal anti-discrimination laws, including without limitation:

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

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

Contract Terms and Conditions

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

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

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

**LIMITED ENGLISH PROFICIENCY**

To ensure compliance with civil rights requirements related to LEP, contractors must:
- Take reasonable steps to ensure that persons with LEP have meaningful access to its programs and services, and not require them to use friends or family members as interpreters. However, a family member or friend may serve as a client’s interpreter at the client’s request, and the family member or friend does not compromise the effectiveness of the service or violate client confidentiality, and
- Make clients and applicants with language service needs, including persons with LEP and disabilities, aware that the contractor will provide an interpreter free of charge.

**CIVIL RIGHTS POSTERS**

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

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

- **“Need an Interpreter”** [Language Translation] [American Sign Language]
TERMINATION OF SERVICES

Clients must never be denied services due to an inability to pay. Contractors have the right to terminate services to a client if the client is disruptive, unruly, threatening, or uncooperative to the extent that the client seriously impairs the contractor’s ability to provide services or if the client’s behavior jeopardizes his or her own safety, clinic staff, or other clients.

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

RESOLUTION OF COMPLAINTS

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

RESEARCH (HUMAN SUBJECT CLEARANCE)

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

Contractors should first contact the Epilepsy Program at (Epilepsy@hhsc.state.tx.us) to initiate a research request. Next, contractors should complete the most current version of the HHSC IRB #1 application and submit it to Epilepsy@hhsc.state.tx.us. The HHSC IRB will review the materials and approve or deny the application.

The contractor must have a policy in place that indicates that prior approval will be obtained from the Epilepsy Program, as well as the HHSC IRB, prior to instituting any research activities. The contractor must also ensure that all staff is made aware of this policy through staff training. Documentation of training on this topic must be maintained.
CLIENT RECORDS MANAGEMENT

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

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

The written consent of the client is required for the release of personally identifiable information, except as may be necessary to provide services to the client or as required by law, with appropriate safeguards for confidentiality. HIV information should be handled according to law.

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

Contractors, providers, sub-recipients, and subcontractors must maintain for the time period specified by HHSC all records pertaining to client services, contracts, and payments. Record retention requirements are found in 15 TAC §354.1004 (relating to Time Limits for Submitted Medicaid Claims) and 22 TAC 165 (relating to Medical Records). Contractors must follow contract provisions and the HHSC Retention Schedule for Medical Records. All records relating to services must be accessible for examination at any reasonable time to representatives of HHSC and as required by law.
PERSONNEL POLICY AND PROCEDURES

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

Personnel policies and procedures must include:

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

Job descriptions, including those for contracted personnel, must specify required qualifications and licensure. All staff must be appropriately identified with a name badge.

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

Contractors shall establish safeguards to prohibit employees from using their positions for a purpose that constitutes or presents the appearance of personal or organizational conflict of interest or personal gain. All employees and board members must complete a conflict of interest statement during orientation. All medical care must be provided under the supervision, direction, and responsibility of a qualified Medical Director. The Epilepsy Program Medical Director must be a licensed Texas physician.

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

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

Staff development must include orientation and in-service training for all personnel and volunteers. (Non-profit entities must provide orientation for board members and government entities must provide orientation for their advisory committees). Employee orientation and continuing education must be documented in agency personnel files.
QUALITY MANAGEMENT

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

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

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

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

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

The Quality Management Committee, whose membership consists of key leadership of the organization, including the Executive Director/CEO and the Medical and other appropriate staff where applicable, annually reviews and approves the quality work plan for the organization. (The Epilepsy Program Medical Director must be a licensed Texas physician.)

The Quality Management Committee must meet at least quarterly to:

- Receive reports of monitoring activities;
- Make decisions based on the analysis of data collected;
- Determine quality improvement actions to be implemented; and
- Reassess outcomes and goal achievement.

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

The quality work plan at a minimum must:

- Include clinical and administrative standards by which services will be
monitored;

- Include process for credentialing and peer review of clinicians;
- Identify individuals responsible for implementing monitoring, evaluating and reporting;
- Establish timelines for quality monitoring activities;
- Identify tools/forms to be utilized; and
- Outline reporting to the Quality Management Committee.

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

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

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

- Annual license verification (primary source verification);
- Clinical record review;
- Billing and eligibility review;
- Facility on-site review;
- Annual client satisfaction evaluation process; and
- Child abuse training and reporting – subcontractor staff.

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

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

Contracts with Subrecipient Subcontractors – Contractor may enter into contracts with subrecipient subcontractors unless restricted or otherwise prohibited in a specific Program Attachment(s). Prior to entering into an agreement equaling $25,000 or twenty-five percent (25%) of a Program Attachment amount, whichever is greater, contractor shall obtain written approval from DSHS. Contracts with subcontractors shall be in writing and include the following:

- Name and address of all parties;
- Detailed description of the services to be provided;
- Measurable method and rate of payment and total amount of contract;
- Clearly defined and executable termination clause;
- Beginning and ending dates that coincide with the dates of the applicable Program Attachment(s) or cover a term within the beginning and ending dates of the applicable Program Attachment(s);
- Access to inspect the work and the premises on which any work is performed, in accordance with the Access and Inspection Article in this Contract; and
- Copy of General Provisions and the Statement of Work and any Special Provisions in the Program Attachment(s) applicable to the subcontract.

Contractor is responsible to HHSC for the performance of any subcontractor. Contractor shall monitor both financial and programmatic performance and maintain pertinent records that shall be available for inspection by HHSC. Contractor shall ensure that subcontractors are fully aware of the requirements placed upon them by state/federal statutes and regulations and under this contract. Contractor shall not contract with a subcontractor, at any tier, that is debarred or suspended or excluded from or ineligible for participation in federal assistance programs.

Status of Subcontractors - Contractor shall require that all subcontractors certify that they are in good standing with all state and federal funding and regulatory agencies; are not currently debarred, suspended, revoked, or otherwise excluded from participation in federal grant programs; are not delinquent on any repayment agreements; and have not had a contract terminated by HHSC. Contractor shall further require that subcontractors certify that they have not voluntarily surrendered within the past three (3) years any license issued by HHSC.
Section II
Eligibility, Client Services, Community Activities, and Clinical Guidelines

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

For an individual to receive epilepsy services with HHSC funds, four (4) criteria must be met:

- Diagnosis of epilepsy certified by a licensed physician, or a statement that applicant is suspected of having epilepsy;
- Gross household income is at or below 200% of Federal Poverty Level (FPL);
- Applicant is a Texas resident; and
- Applicant is not eligible for other programs or benefits providing the same services, such as Medicaid, Medicare, or Children with Special Health Care Needs (CSHCN). If a child (under 21) is on a waiting list for CSHCN, they can receive epilepsy services until removed from the waiting list.

If an applicant meets all eligibility requirements except for the financial criteria the applicant is eligible only for support services.

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

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

Any specified or supporting documentation necessary for the contractor to determine eligibility. The contractor shall allow the individual an opportunity to resolve any discrepancy by providing documentary evidence or by designating a suitable contact to verify information. If the individual fails or refuses to do so, eligibility can be denied. Document this information on the Epilepsy Funding Source - Worksheet.

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

Applicant’s Responsibility –

- Complete the Individual Application Form (Form 3029) or request assistance with completion;
- Provide verification requested by the contractor. Failure to provide all required information will result in denial of eligibility. If verification is not available or is
insufficient to determine eligibility, contractor staff should ask the individual to designate a contact person to provide the information.

The applicant is responsible for completing the Individual Application Form (Form 3029). If the applicant is incompetent, or incapacitated, someone acting on behalf of the client (a representative) may represent the applicant in the application and the review process, including signing and dating the Form 3029 on the applicant’s behalf. This representative must be knowledgeable about the applicant’s finances and household. And have access to any necessary documents. If assistance is needed in completing the form, the contractor shall provide assistance. It is acceptable to fill out the form once and photocopy the form for the number of family members needed. The family member name listed under the family composition chart on question one can be highlighted or circled to indicate the intended client record in which it shall be filed. If confidentiality of services is a concern, separate forms for spouses may be completed. The signature of anyone assisting in completion of the form is required as well. The form is filed in the client record.

**Client’s Responsibility for Reporting Changes** – A client must report changes in the following area: income, family composition, residence, address, employment, types of medical insurance coverage, and receipt of Medicaid and/or third-party coverage benefits. The client may report changes by mail, telephone, in-person, or through someone acting on the individual’s behalf. Changes must be reported no later than 30 days after the client is aware of the change. If changes result in the client no longer meeting eligibility criteria, the individual is denied continued services. By signing the required forms, the individual attests to the truth of the information provided.
SCREENING & ELIGIBILITY DETERMINATION

Clients Screened Potentially Eligible for Other Benefits – Contractors must work to ensure that individuals seeking Epilepsy covered services use other programs or benefits first. If individuals are determined potentially eligible for other benefits, contractors must refer them to the specific programs and assist them in completing the eligibility determination process.

Individuals must be screened for potential Medicaid, CHIP, or other programs by using the Individual Application Form (Form 3029) or a comparable paper or electronic screening and eligibility tool that has the required HHSC information and applicant’s signature for determining eligibility. A copy of the Individual Application Form must be maintained in the medical record.

For Epilepsy purposes, contractors may use the Health and Human Services Commission’s (HHSC) Your Texas Benefits website, www.yourtexasbenefits.com, to assist in the screening of client eligibility for Medicaid or CHIP. The website offers access to information on HHSC benefits including Medicaid, Supplemental Nutrition Assistance Program (SNAP), Temporary Assistance for Needy Families (TANF), and Children’s Health Insurance (CHIP). The use of this system does not replace the contractors’ Application Form. More information about HHSC benefits can also be obtained by calling 2-1-1.

FAMILY HOUSEHOLD

Establishing family household is an important step in the eligibility process. Assessment of income eligibility relies on an accurate count of family members.

An Epilepsy household is a person living alone or two or more persons living together where legal responsibility for support exists. Legal responsibility for support exists between:

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

Children and Family Composition – A child must be under 18 years of age to be counted as part of an Epilepsy household. The configuration of that household will change on the last day of the month the child becomes 18 years of age. This would be processed as a reported change for the Epilepsy household.

A child who is 18 years of age or older and resides with his/her parent(s)/guardian(s), is considered a family of one.

Special Family Composition/Household
If the applicant is a relative and the caretaker (not the natural parent) of a child who is living with the applicant, that child may be considered a part of the applicant’s Epilepsy household if documentation can be provided that verifies the relationship. Acceptable documents include birth certificates or other legal documents that demonstrate the relationship between the applicant and the child.

If a biological relationship does not exist between the applicant and the child, or if documentation is not provided to verify a biological relationship then:

- The child is not included in the applicant’s Epilepsy household;
- The situation must be explained on the worksheet; and
- The applicant may apply for Epilepsy benefits on the child’s behalf, if applicable.

**Verification/Documentation of Family Household** – If family relationships appear questionable, one of the following items may be provided:

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

Family members who receive other health care benefits are included in the family count.

**RESIDENCY**

To be eligible for the Epilepsy Program, an individual must be physically present within the geographic boundaries of Texas and:

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

If the applicant is a minor child; or a legal dependent of, and residing with, a resident (such as an adult child or spouse); or a person under a legal guardianship, then the parent(s), resident providing support, or legal guardian of the applicant shall meet all of the residency criteria.

If the applicant is a parent residing with their adult child who is a resident of Texas, residency may be determined through the adult child. If the applicant is a parent being supported by their adult child, whether or not the child is a resident of Texas, the residency may be determined by the adult child providing the required
documents supporting the Texas residency of the parent. These provisions apply even if no legal guardianship has been established.

There is no requirement regarding the amount of time an individual must live in Texas to establish residency for the purpose of Epilepsy Program eligibility.

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

- Incarcerated in city, county, state, or federal jail, or prison;
- A ward of the state; or
- A Medicaid-eligible nursing home recipient.

**Verification/Documentation of Residency** – Verification and documentation of residency must be provided. To verify residency, one of the following items may be provided.

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

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

- Observance of personal effects and living arrangement, or
- Statement from landlords, neighbors, other reliable sources.

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

**INCOME**

To be eligible for the Epilepsy Program, clients must have a gross family income at or below 200% FPL. The table below details sources of income that contribute to the
calculation of gross family income as well as income that is exempt from being counted.

<table>
<thead>
<tr>
<th>Types of Income</th>
<th>Countable</th>
<th>Exempt</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adoption Payments</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Cash Gifts and Contributions*</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Child Support Payments*</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Child's Earned Income</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Crime Victim’s Compensation *</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Dividends, Interest, and Royalties*</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Educational Assistance</td>
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<tr>
<td>Worker’s Compensation*</td>
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</table>

*Explanation of countable income provided below

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

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

- Lives in the home with the certified household member,
- Shares household expenses with the certified household member, and
- No landlord/tenant relationship exists.
Child Support Payments – Count income after deducting $75 from the total monthly child support payments the household receives.

Dividends, Interest, and Royalties – Countable. Exception: Exempt dividends from insurance policies as income.

Count royalties, minus any amount deducted for production expenses and severance taxes.

In-Kind Income – Exempt - An in-kind contribution is any gain or benefit to a person that is not in the form of money/check payable directly to the household, such as clothing, public housing, or food.

Loans (Non-educational) – Count as income unless there is an understanding that the money will be repaid and the person can reasonably explain how he/she will repay it.

Lump-Sum Payments – Count as income in the month received if the person receives it or expects to receive it more often than once a year. Exempt lump sums received once a year or less, unless specifically listed as income.

Military Pay – Count military pay and allowances for housing, food, base pay, and flight pay, minus pay withheld to fund education under the G.I. Bill.

Mineral Rights – Countable - A payment received from the excavation of minerals such as oil, natural gas, coal, gold, copper, iron, limestone, gypsum, sand, gravel, etc.

Pensions and Annuities – Countable - A pension is any benefit derived from former employment, such as retirement benefits or disability pensions.

Reimbursements – Countable, minus the actual expenses. Exempt a reimbursement for future expenses only if the household plans to use it as intended.

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

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

SSI Payments – Exempt Supplemental Security Income (SSI) benefits.
**Terminated Employment** – Count terminated income in the month received. Use actual income and do not use conversion factors if terminated income is less than a full month’s income. Income is terminated if it will not be received in the next usual payment cycle.

**Unemployment Compensation Payments** – Count the gross benefit less any amount being recouped for a UIB overpayment.

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

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

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

**Verification/Documentation of Income** – Verification and documentation of income must be provided to complete the HHSC Epilepsy Worksheet. Declarations of “unknown” will not be accepted as representations of required facts and documentation. Incomplete or inadequately documented eligibility determination will result in limitations in the provision of funded services.

To verify income, one of the following must be provided: 2 pay periods that accurately represent their earnings dated within the 60 days prior to the application processing date or one month’s pay (only if paid same gross amount on a monthly basis), unless special circumstances are noted on the HHSC Epilepsy Worksheet. The pay periods must accurately reflect the individual’s usual and customary earnings.

Proof may include, but is not limited to:

- Copy(ies) of pay periods that accurately represent earnings/monthly earning statement(s);
- Employer’s written verification of gross monthly income or the Employment Verification Form (Form 128);
- Award letters;
- Domestic relation printout of child support payments;
- Statement of support;
- Unemployment benefits statement or letter from the Texas Workforce Commission;
- Award letters, court orders, or public decrees to verify support payments; or
- Notes for cash contributions.
Special Circumstances Regarding Verification/Documentation
If the applicant is unable to provide required documentation for verification purposes due to a potential threat of abuse or if an employer/payer refuses to provide information or threatens continued employment, and no other proof can be found staff may make a determination utilizing the best available information. These types of special circumstances should be appropriately documented on the HHSC Epilepsy Worksheet.

Income Determination Procedure
Count income already received and any income the household expects to receive. When an individual has not yet received income for new employment, use the best estimate of the amount to be received. If telephone verification regarding new or terminated employment is made, it must be documented by the contractor on the HHSC Epilepsy Worksheet (Form E101).

Use 2 pay periods that accurately represent their earnings dated within the 60 days prior to the application processing date. If the client is paid one time per month and receives the same gross pay each month, then one pay period will suffice.

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

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

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

Income Deductions
Dependent childcare or adult with disabilities care expenses shall be deducted from the total income when determining eligibility, if paying for the care is necessary for the employment of a member in the Epilepsy household. This deduction is allowed even when the child or adult with disabilities is not included in the Epilepsy household. Deduct the actual expenses up to:

- $200 per month for each child under age 2
- $175 per month for each child age 2 or older, and
- $175 per month for each adult with disabilities.

Deduct the actual payment amount of child support payments made by a member of the Epilepsy household group. Payments made weekly, every two weeks or twice a month must be converted to a monthly amount by using one of the conversion factors below.
Self-Employment Income – If an applicant earns self-employment income, it must be added to any income received from other sources. Annualize self-employment income that is intended for an individual or family’s annual support, regardless of how frequently the income is received.

If the household had self-employment income for the past year, use the income figures from the previous year's U.S. Internal Revenue Service (IRS) tax forms or their business records if the records are anticipated to reflect current self-employment income and expenses. Staff may accept the costs listed on the IRS tax forms associated with producing self-employment income or allow the following deductions when self-employment income is verified with documents other than an IRS tax form:

- Capital asset improvements;
- Capital asset purchases, such as real property, equipment, machinery and other durable goods, i.e., items expected to last at least 12 months;
- Fuel;
- Identifiable costs of seed and fertilizer;
- Insurance premiums;
- Interest from business loans on income-producing property;
- Labor;
- Linen service;
- Payments of the principal of loans for income-producing property;
- Property taxes;
- Raw materials;
- Rent;
- Repairs that maintain income-producing property;
- Sales tax;
- Stock;
- Supplies;
- Transportation costs. The person may choose to use 50.0 cents per mile instead of keeping track of individual transportation expenses. Do not allow travel to and from the place of business, and
- Utilities.

Verify four recent pay amounts that accurately represent the person’s pay when determining the amount of self-employment income received. Verify one month’s pay amount that accurately represents the person’s pay for self-employed income received monthly.

Accept the applicant’s statement as proof of their income and expenses if there is a reasonable explanation why documentary evidence or a collateral source is not available and the applicant’s statement does not contradict other individual statements or other information provided. Inform the applicant that Epilepsy coverage will not be renewed on subsequent applications without acceptable
verification and documentation of self-employment income or expenses. Verification may include but is not limited to: Statement of Self-Employment Income Form 149, current IRS tax forms, bookkeeping or business records and receipts, etc.

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

- If the self-employment income is only intended to support the individual or family for part of the year, average the income over the number of months it is intended to cover.
- If the individual has had self-employment income for the past year, use the income figures from the previous year’s business records or tax forms.
- If current income is substantially different from income the previous year, use more current information, such as updated business ledgers or daybooks. Remember to deduct predictable business expenses.
- If the individual or family has not had self-employment income for the past year, average the income over the period of time the business has been in operation and project the income for one year.
- If the business is newly established and there is insufficient information to make a reasonable projection, calculate the income based on the best available estimate and follow-up at a later date.

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

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

Steps for Processing the Individual Application Form (Form 3029)

- Accept the Individual Application Form (Form 3029).
- Conduct an interview, if needed.
- Request supporting documentation/verification and if necessary, pend the case.
- Check that all information is complete, consistent, and sufficient to make an eligibility determination.
- Determine eligibility.
- Issue the appropriate forms.
- Document on the HHSC Epilepsy Worksheet (Form E101) the information to support the determination.

Completed Application Date – The date the Individual Application Form (Form 3029) is completely filled out and all supporting information necessary to make an eligibility determination is received by the contractor.

Decision Pended - If eligibility cannot be determined because components that pertain to the eligibility criteria are missing, the contractor should issue Form 104, Request for Information. The contractor should ensure that all information that needs to be provided by the applicant is listed, as well as the due date by which the information should be submitted. If the requested information is not provided by the due date, issue Form 117, Notice of Ineligibility. When the requested information is the result of a referral to another program and is dependent on other programs making an eligibility determination, the due date should be a best estimate. Inform the applicant of their responsibility to contact the contractor by this date to provide the status of their application for the other benefits. If the requested information is provided by the due date, proceed with processing the application.

Eligibility Determination – The contractor must consider the information provided by the client and document the basis for the eligibility decision on the HHSC Epilepsy Worksheet (Form E101).

After an eligibility determination is made, the contractor must inform the individual of the following:

- If eligible
  - Complete and issue Notice of Eligibility (Form 103)
  - The date eligibility begins; and
  - The services the individual is entitled to receive.
- If ineligible
  - Complete and issue the Notice of Ineligibility (Form 117);
  - The reason the application was denied;
  - The effective date of denial;
  - The individual’s right to appeal.

Issue the appropriate referrals to alternative agencies/programs for services, if applicable.
**Date Eligibility Begins** – An applicant/household is eligible for services beginning with the date the contractor determines the applicant/household eligible for the program and signs the completed application.

**Appeal of Eligibility Determination** – Applicant/recipient can request an appeal regarding the denial of eligibility for the Epilepsy Program, if they disagree with the determination that was issued on their case. The contractor will ensure that the applicant/recipient is aware of their right to request an appeal.

**ANNUAL RE-CERTIFICATION**

The contractor will determine the system used to track clients’ status and renewal eligibility for their annual re-certification. Eligibility determination using the Individual Application Form (Form 3029) form is required for all clients. Eligibility services must be re-determined for each individual/household every 12 months.

**ASSESSMENT OF CO-PAYMENTS/FEES**

Epilepsy clients may be charged a co-payment (co-pay) fee for services according to the determinations of the contracting agency.
GENERAL CONSENT

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

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

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

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

Parental Consent for Services Provided to Minors

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

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

Consent for HIV Tests

Texas Health and Safety Code §81.105 and §81.106 are as follows:
§81.105. Informed Consent
   a) Except as otherwise provided by law, a person may not perform a test
designed to identify HIV or its antigen or antibody without first obtaining the
informed consent of the person to be tested.

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

§81.106 General Consent
   a) A person who has signed a general consent form for the performance of
medical tests or procedures is not required to also sign or be presented with
a specific consent form relating to medical tests or procedures to determine
HIV infection, antibodies to HIV, or infection with any other probable
causative agent of AIDS that will be performed on the person during the time
in which the general consent form is in effect.

Except as otherwise provided by the chapter, the result of a test or procedure to
determine HIV infection, antibodies to HIV, or infection with any probable causative
agent of AIDS performed under the authorization of a general consent form in
accordance with this section may be used only for diagnostic or other purposes
directly related to medical treatment.
CLINICAL GUIDELINES

Clinical Guidelines are intended to establish minimal expectations of contractor agencies that receive funds to support epilepsy services. In general, specific decisions about tests for diagnostic evaluation, treatment modalities, and ongoing follow-up are to be based on the discretion of the clinician in consultation with the client and/or the client's family, with the understanding that these decisions will be in line with nationally recognized standards of credible organizations.

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

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

The client health record must include:
- Client identification and personal data, including financial eligibility;
- Preferred language and method of communication;
- Client contact information must include the best way to reach the client to facilitate continuity of care, assure confidentiality, and adhere to HIPAA regulations;
- Medical history;
- Health risk assessment (HRA);
- Physical examination;
- Laboratory and other diagnostic tests orders, results and follow-up;
- Radiographs and/or photographs, if taken;
- Assessment or clinical impression;
- Plan of care, including education, counseling, treatment, special instructions, scheduled visits, and referrals;
- Documentation regarding follow-up of missed appointments;
- Informed consent documentation;
- Refusal of services documentation – when applicable;
- Medication allergies and other allergic reactions recorded prominently in a specific location;
- Problem list; and
- Client education, including education/counseling regarding health risks identified through the HRA.

**Medical History and Risk Assessment** – At the initial comprehensive clinical visit, a complete medical history must be obtained on all clients. Any pertinent history must be updated at each subsequent clinical visit. The comprehensive medical history must at least address the following:

- Reason for visit;
- Current health status, including acute and chronic medical conditions, to include a detailed description of seizures and possible precipitating factors as reported by the client and significant observers;
- Significant past illness or injury, including hospitalizations;
- Previous surgery and biopsies;
- Blood transfusions and other exposure to blood products;
- Current medications, including prescription, over the counter (OTC) as well as complementary and alternative medicines (CAM);
- Allergies, sensitivities, or reactions to medicines or other substance(s);
- Use of tobacco/alcohol/illicit drugs (including type, duration, frequency, route);
- Immunization status/assessment;
- Review of systems (with pertinent positives and negatives clearly noted);
- Pertinent history of immediate family, with a particular focus on seizures or other neurological disorders; and
- Assessment for family violence (including safety assessment, if indicated).

**Health Screening** – All clients must be provided an appropriate physical assessment as indicated by client history. The following are the required components of initial exams:

- Height measurement;
- Weight measurement;
- Blood pressure evaluation;
- Cardiovascular assessment;
- Neurological assessment;
- Evaluation of thyroid, lungs, and abdomen; and
- Other systems as indicated by history.

**Client Education** – All clients must be provided counseling and health education by a person who:

- Is knowledgeable, objective, non-judgmental, and sensitive to the rights and differences of individual clients;
- Provides accurate, current information;
- Documents session in the client record;
- Provides information appropriate to client’s age, level of knowledge and socio-cultural background; and
- Presents information in an unbiased manner.
Educational counseling session should provide the following minimum content:

- Types of seizure disorders;
- Possible symptoms;
- Common first aid procedures;
- Emergency contact numbers;
- Presence and absence of auras;
- Medication, dosages, side effects and interactions;
- Drug level monitoring;
- Signs of toxicity;
- Diagnostic tests;
- Treatment options;
- Frequency of follow-up visits; and
- After-hour assistance.

Other topics as appropriate:

Epilepsy and women’s health
- Pre-conception counseling;
- Birth control and anti-epileptic drugs (AED’s);
- Pregnancy and AED’s;
- Bone health; and
- Menopause.

Epilepsy and men’s health
- Self-image;
- Mental health.

General issues
- Employment;
- Driving restrictions;
- Safety (school, sports, jobs);
- Financial assistance;
- Community resources, support group, legal aid and social services;
- Sexuality;
- Mental health; and
- Personal violence.

Referral and Follow-up – Contractor should assist clients to meet all identified health care needs either directly or by referral. Contractor must have written policies and procedures for follow-up on referrals that are made as a result of abnormal physical examination or laboratory test findings. These policies must be sensitive to clients’ concerns for confidentiality and privacy and must be in compliance with state or federal requirements for transfer of health information. For services determined to be necessary, but are not provided by the contractor, clients
must be referred to other resources for care. Whenever possible, clients should be given a choice of referral resources from which to select.

When a client is referred to another resource or for emergency clinical care, the contractor must:
- Make arrangements for the provision of pertinent client information to the referral resource (obtaining required client consent with appropriate safeguards to ensure confidentiality – i.e., adhering to HIPAA regulations);
- Advise client about his/her responsibility in complying with the referral;
- Counsel client on the importance of the referral and follow-up method.

**Laboratory Tests and Diagnostic Evaluation** – All initial and routine follow-up clients must be provided appropriate laboratory and diagnostic tests or interventions as indicated by contractor policy or procedure or clinician judgment.

Tests may include:
- Routine blood tests such as complete blood count, glucose, serum electrolytes, calcium, magnesium, blood urea nitrogen (BUN), creatinine, liver function tests;
- Toxicology screening of blood/urine;
- Serum drug concentrations;
- Lumbar puncture and cerebrospinal fluid analysis;
- Electroencephalogram (EEG);
- Magnetic resonance imaging (MRI);
- Positron emission tomography (PET);
- TB skin test as indicated by risk assessment, history, or physical, either on-site or by referral; and
- Other lab as indicated by risk assessment, history, and physical, either on-site or by referral.

Agencies must have written plans to address laboratory and other diagnostic tests orders, results and follow-up to include:
- Tracking and documentation of tests ordered and performed for each client
- Tracking test results and documentation in client's records
- Mechanism to notify clients of results in a manner to ensure confidentiality, privacy and prompt, appropriate follow-up

**Treatment** – Treatment decisions must be made individually for each client. Before initiating anti-epileptic drugs (AEDs) as therapy, factors to discuss with the client/family are the likelihood of further seizures without drug treatment, the efficacy of the drug, adverse effects, and client/family preferences. Non-AED treatment may include implantation of a vagus nerve stimulator (VNS) or surgical intervention in selected clients.
Protocols, Standing Delegation Orders, and Procedures

Contractors that provide clinical services must develop and maintain written clinical protocols and standing delegation orders (SDOs) in compliance with statutes and rules governing medical and nursing practice. The written clinical protocols and/or SDOs must be signed by the Medical Director or supervising physician on an annual basis or more often if changes are made. Requirements addressing scope of practice and delegation of medical and nursing acts can be accessed at the following websites: [http://www.tmb.state.tx.us/](http://www.tmb.state.tx.us/) (Texas Medical Board) and [http://www.bne.state.tx.us/](http://www.bne.state.tx.us/) (Board of Nurse Examiners for the State of Texas). Rules that are most pertinent to this topic are: Texas Administrative Code, Title 22, Part 9, Chapter 193, Texas Administrative Code, and Title 22, Part 11, Chapters 221 and 224

Contractors that employ Advanced Practice Nurses or Physician Assistants must have written protocols to delegate authorization to initiate medical aspects of client care. The protocols must be agreed upon and signed by the supervising physician and the physician assistant and/or advanced practice nurse, reviewed and signed at least annually, and maintained on site. They also must contain a list of the types or categories of dangerous drugs and controlled substances available for prescription, limitations on the number of dosage units and refills permitted, and instructions to be given to the patient for follow-up monitoring or contain a list of the types or categories of dangerous drugs and controlled substances that may not be prescribed. The protocols need not describe the exact steps that an advanced practice nurse or a physician assistant must take with respect to each specific condition, disease, or symptom.

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

In addition to the above, contractor must have written plans for client education that include goals and content outlines to ensure consistency and accuracy of information provided. The Medical Director must sign client education plans.
COMMUNITY EDUCATION, OUTREACH AND PARTICIPATION

Epilepsy contractor must develop and implement an annual plan to provide community education to inform the public of its purpose and services, to disseminate knowledge of epilepsy, to enlist community support, and to educate potential clients. The plan should be based on an assessment of the needs of the community and contain an evaluation strategy. Promotional activities should be reviewed annually.

**Informational Brochure** – Contractor shall have an informational brochure with the following minimum content:
- Mission statement
- Hours of operation
- Location
- Services offered
- Eligibility requirements
- Phone number of each community clinic site
- Toll free number or web address

**Duplication of Services** – In order to prevent the duplication of services, contractor shall coordinate activities with but not limited to the following types of related agencies, organizations, and health and social service agencies in the area:
- Area hospital physicians
- School personnel
- Local epilepsy association and support groups

**Professional Education** – Contractor shall provide the opportunity for community-wide professional education events for primary care providers, nurses, emergency workers and social workers, etc.
Section III
Reimbursement, Data Collection & Reporting

Purpose: Section III provides policy requirements for submitting reimbursement, data collection, and required reports.
VOUCHER & REPORT SUBMISSION INFORMATION

PROGRAM INFORMATION:
Program Name: Epilepsy Services
Contract Type: Categorical
Contract Term: September 1--August 31

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

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<th>Original Required</th>
<th>Accepted Method of Submission</th>
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<td>Accounting Section/Claims Processing Unit (CPU)</td>
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Instructions: Submit one B-13 with expense documents attached to CDSB. Submit one B-13 only to CPU.

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

VOUCHER: Report 1--Supporting
Report Name: Expense Documents
Submission Date: Within 30 days following the end of the month. Final due within 45 days after end of contract term.
Submit Copy to:

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Instructions: Attach expense documents to B-13 for CDSB only.

REPORT: Report 1
Report Name: Epilepsy Program Quarterly Report
Submission Date: Quarterly reports are due by the 5th business day of the first month following the quarter for which the contractor is reporting. 1st quarter (Sept, Oct, Nov) is due December; 2nd quarter (Dec, Jan, Feb) is due March; 3rd quarter (Mar, Apr, May) is due June; and 4th quarter (June, July, Aug) is due September.
Submit Copy to:

<table>
<thead>
<tr>
<th>Name of Unit/Branch</th>
<th>Original Required</th>
<th>Accepted Method of Submission</th>
<th># Copies</th>
</tr>
</thead>
<tbody>
<tr>
<td>Community Health Services Section (CHSS)</td>
<td>X</td>
<td>Email (preferred), or Fax</td>
<td>1</td>
</tr>
</tbody>
</table>

Instructions: Short turn around on these reports requires contractors to submit timely, no exceptions.
REPORT: Report 2  
Report Name: Financial Status Report 269A

Submission Date: Quarterly, Sep 1-Nov 30, Dec 1-Feb 28, Mar 1-May 31, and Jun 1-Aug 31. Submit by the last business day of the next month following the quarter for which the contractor is reporting. The 4th quarter is the final report and due within 45 days after the end of the contract term. The 4th quarter report includes all final charges and expenses associated with the program contract. Mark the 4th quarter report as "Final".

Submit Copy to:

<table>
<thead>
<tr>
<th>Name of Unit/Branch</th>
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<th># Copies</th>
</tr>
</thead>
<tbody>
<tr>
<td>Contract Development &amp; Support Branch (CDSB)</td>
<td>X</td>
<td>Email (preferred), Fax</td>
<td>1</td>
</tr>
<tr>
<td>Accounting Section/Claims Processing Unit (CPU)</td>
<td>X</td>
<td>Email scanned signed document, fax, or mail</td>
<td>1</td>
</tr>
</tbody>
</table>

Instructions: Financial Status Report 269A must have original signature (scanned or fax accepted).

Email Addresses:  
- CDSB: cdsb@hhsc.state.tx.us  
- CPU: invoices@HHSC.state.tx.u  
- CHSS: Epilepsy@hhsc.state.tx.us

Fax Numbers:  
- CDSB: (512) 776-7521  
- CPU: (512) 776-7442  
- CHSS: (512) 776-7203

Mail Codes:  
- CDSB: Mail code 1914  
- CPU: Mail code 1940  
- CHSS: Mail code 1923

Mailing Address for CPU:  
P.O. Box 149347  
Austin, TX  78714-9347

Please use mail codes on all mail coming into HHSC to ensure accurate delivery.

Last Updated/Reviewed:  
1/17/19
DATA COLLECTING AND REPORTING

Contractor shall submit quarterly progress reports on or before the 5th business day of December, March, June, and September. Report includes unduplicated client count, diagnostic and support services performed and client demographics.

Quarterly Progress Report Instructions

I. Client Count
A. Total number of unduplicated HHSC clients determined eligible and provided an Epilepsy service* during quarter.
B. Total number of clients from all other funding sources provided an Epilepsy service during quarter.

II. ALL CLIENT SERVICES PROVIDED (including HHSC clients)
A. Number of clinic visits (all clients) - The total number of clinic visits by all Epilepsy clients during the reported quarter.
B. Number of diagnostics (all clients) (AED, EEG, CAT, other labs) – The total number of diagnostics (AED, EEG, CAT, other labs) provided for all Epilepsy clients during the reported quarter.
C. Number of phone encounters (all clients) - The total number of phone encounters provided for all Epilepsy clients during the reported quarter.
D. Number of case management services (including counseling, referrals, and medication management) - (all clients) – The total number of case management services provided (including counseling, referrals, and medication management) for all Epilepsy clients during the reported quarter.
E. Total number of all encounters (includes non-clinic encounters) - This is the total number of clients seen during the reported quarter (total of rows A, B, C and D).

III. Community Education/Outreach
A. Education/Outreach Sessions - Total number of Education/Outreach Sessions held during the reporting quarter (does not include clinic visits).
B. Number of Persons Attending - Total number of persons attending community/group presentations during the reporting quarter.

IV. NARRATIVE
Include a narrative (maximum three pages) that provides an update on program work plan, including, but not limited to, updates on the following:
• Services provided, locations, clients from outside of service area served,
• Changes in workforce, infrastructure, and/or policies,
• Staff trainings attended,
• Changes in data collection or reporting,
• Description of networking with other Health and Human Service providers, and
• QA/QI activities
REPORTING

Due to a legislative requirement, quarterly reports for the Epilepsy Program must be received by the 5th business day of the month following the quarter for which the contractor is reporting. Failure to submit the report as required will result in contact by the assigned Contract Manager and further action as necessary.

ADDITIONAL INFORMATION – WEB-LINKS

Additional information is available at the following web-links:

Texas Administrative Code

General Provisions
https://hhs.texas.gov/laws-regulations/handbooks/lshcssa/subchapter-a-general-provisions

Texas Benefits Website
http://www.yourtexasbenefits.com

Texas Abuse Hotline
http://www.txabusehotline.org/

2-1-1 Texas Hotline
http://www.211texas.org/