

FISCAL YEAR 2016

**POLICY
and
PROCEDURE
MANUAL**

For

**DSHS
Family Planning
Services**

September 2015



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

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Introduction

General Information

PROGRAM AUTHORIZATION AND SERVICES

Program Background

DSHS Family Planning – State funds to provide family planning services to low-income women.

Title XIX – Medicaid (Title XIX of the Social Security Act) was created by Congress in 1965. All agencies that receive DSHS family planning funding are required also to be enrolled providers of services to Medicaid-eligible women and men. (Federal regulation citation: Title XIX, Social Security Act, [42 USC § 1396-1396v et. seq.] Grants to States for Medical Assistance Programs).

Texas Women’s Health Program (TWHP) – The TWHP is a state-funded program administered by HHSC to provide uninsured women with family planning exams, related health screenings, and birth control. A woman is eligible for TWHP if she meets the following requirements:

- Age 18-44. Women can apply the month of their 18th birthday through the month of their 45th birthday.
- U.S. citizens and qualified immigrants.
- Reside in Texas.
- Do not currently receive full Medicaid benefits, CHIP, or Medicare Part A or B.
- Are not pregnant.
- Have not been sterilized, are infertile, or are unable to get pregnant due to medical reasons.*
- Do not have private health insurance that covers family planning services, unless filing a claim on the health insurance would cause physical, emotional or other harm from a spouse, parent, or other person.
- Have a countable household income at or below 185 percent of the federal poverty level.

*If a woman has received a sterilization procedure (such as Essure), but has not had the sterilization confirmed, the woman may still qualify for TWHP. TWHP covers the confirmation of the sterilization procedure. However, no other TWHP services are covered for women that have received a sterilization procedure.

Funding Sources

Family planning services are supported by the following funding streams: DSHS state funds, TWHP, and Title XIX (Medicaid). DSHS Family Planning Program funds are allocated through a competitive application process. Selected applicants negotiate contracts with DSHS. A variety of types of organizations provide family planning services, such as local health departments, medical schools, hospitals, private non-profit agencies, community-based clinics, federally qualified health centers (FQHCs), and rural health clinics. Providers must enroll with the Texas Medicaid and Healthcare Partnership (TMHP) in order

to provide DSHS Family Planning, TWHP, and Title XIX (Medicaid) services. Reimbursements are managed by TMHP.

State and federal law prohibits the use of funds awarded by DSHS to pay the direct or indirect costs (including overhead, rent, phones and utilities) of abortion procedures by contractors.

PURPOSE OF THE MANUAL

The DSHS *Family Planning Policy and Procedure Manual* is a guide for contractors who deliver DSHS family planning services in Texas. Providers of family planning services who are also reimbursed by Title XIX (Medicaid), must follow policies and procedures as established by the Texas Medicaid Program in the Texas Medicaid Provider Procedures Manual (TMPPM).

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

The state rules that apply most specifically to family planning services in Texas are found in the [Texas Administrative Code \(TAC\), Title 25, Part I, Chapter 56](#).

Family planning contractors also must be in compliance with the [DSHS Standards for Public Health Clinic Services](#).

For additional information about DSHS family planning services, access the [DSHS Family Planning website](#).

Electronic versions of the TAC and DSHS Standards for Public Health Clinic Services, links to other DSHS programs' websites, and other useful information are available through the website.

DEFINITIONS

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

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

Client – An individual who has been screened and has successfully completed the eligibility process. The terms “client” and “patient” will be used interchangeably in this manual.

Compass 21 – Automated system used by Texas Medicaid and Healthcare Partnership to process claims for services delivered to Medicaid and DSHS Family Planning Program; also performs data collection and report functions for DSHS.

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

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

Contractors – 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 implements the services.

Co-Payments – Monies collected directly from clients for services.

Core Tool – A standardized instrument used to review all Community Health Services contractors to ensure compliance with basic requirements for operating a clinic providing health services as reflected in the DSHS Standards for Public Health Clinic Services

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.

DSHS Labs – Austin and South Texas Lab (STL).

Eligibility Date – Date the contractor determines an individual eligible for the program. The eligibility expiration date will be twelve months after the eligibility date.

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

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

Fiscal Year – State fiscal year from September 1 - August 31.

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

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

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

Informed Consent – The process by which a health care provider ensures that the benefits and risks of a diagnostic or treatment plan, the benefits and risks of other appropriate options, and the benefits and risks of taking no action are explained to a patient in a manner that is understandable to that patient and allows the patient to participate and make sound decisions regarding his or her own medical care.

Intended pregnancy – Pregnancy a woman reports as timed well or desired at the time of conception.

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

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

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

Patient – An individual receiving medical care, treatment, or services. The terms “patient” and “client” are used interchangeably in this manual.

Program Income – Monies collected directly by the contractor/provider for services provided under the contract award (i.e., third-party reimbursements such as Title XIX, TWHP, private insurance, and patient co-pay fees.) Program income also includes client donations.

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

Referral – The process of directing or redirecting (as a medical case or a client) to an appropriate specialist or agency for definitive treatment; to direct to a source for help or information.

Reproductive Life Plan – A plan that outlines a client's personal goals regarding whether or not to have children, the desired number of children, and the optimal timing and spacing of children. Counseling should include the importance of developing a reproductive life plan and information about reproductive health, family planning methods and services, and obtaining preconception health services, as appropriate.

Texas Medicaid and Healthcare Partnership (TMHP) – The Texas Medicaid Claims and Primary Care Case Management (PCCM) Administrator. HHSC contracts with TMHP to process claims for providers.

Texas Women’s Health Program (TWHP) – The TWHP is a state-funded program, administered by HHSC, to provide uninsured women with family planning exams, related health screenings, and birth control.

Title XIX Family Planning Program – Family planning services provided under Title XIX (Medicaid) of the Social Security Act, 42 United States Code §1396 *et seq.*

ACRONYMS

ADA	Americans with Disabilities Act
AMA	American Medical Association
BCCS	Breast and Cervical Cancer Services
CBE	Clinical Breast Exam
CDC	Centers for Disease Control and Prevention
CHIP	Children’s Health Insurance Program
CHT	Center For Health Training
CLIA	Clinical Laboratory Improvement Amendments
CMB	Contracts Management Branch
CMS	Centers For Medicare and Medicaid
CPR	Cardiopulmonary Resuscitation
CPT	Current Procedural Terminology
DHHS	U.S. Department of Health and Human Services
DES	Diethylstilbestrol
DSHS	Texas Department of State Health Services
EOB	Explanation of Benefit
EDI	Electronic Data Interchange
EHR	Electronic Health Records
EMR	Electronic Medical Records
E/M	Evaluation and Management Services
EPT	Expedited Partner Therapy
FDA	Federal Drug Administration
FP	Family Planning
FPL	Federal Poverty Level
FQHC	Federal Qualified Health Center
FSR	Financial Status Report
HHSC	Texas Health and Human Services Commission
HIPAA	Health Insurance Portability and Accountability Act
HIV	Human immunodeficiency virus

HPV	Human papilloma virus
HSV	Herpes simplex virus
IRB	Institutional Review Board
IUC	Intrauterine Contraception
IUD	Intrauterine Device
LEP	Limited English Proficiency
NPI	National Provider Identifier
NPES	National Plan and Provider Numeration System
PCCM	Primary Care Case Management
QA	Quality Assurance
QM	Quality Management
QMB	Quality Management Branch
R & S	Remittance and Status (Reports)
RFP	Request for Proposals
SDO	Standing Delegation Orders
STD	Sexually Transmitted Disease
STI	Sexually Transmitted Infection
TAC	Texas Administrative Code
TANF	Temporary Assistance for Needy Families
TMHP	Texas Medicaid Healthcare Partnership
TMPPM	Texas Medicaid Provider Procedures Manual
TPI	Texas Provider Identifier
TWHP	Texas Women's Health Program
UPSTF	The United States Preventive Services Task Force
WIC	Special Supplemental Nutrition Program for Women, Infants, and Children

Section I

Administrative Policies

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

CLIENT ACCESS

The contractor must ensure that male and female clients are provided services in a timely and nondiscriminatory manner. The contractor must:

- Have a policy in place that delineates the timely provision of services.*
- Comply with all applicable civil rights laws and regulations including [Title VI of the Civil Rights Act of 1964](#), the [Americans with Disabilities Act](#) 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 at no cost to client.
- Have a policy in place that requires qualified staff to assess and prioritize clients' 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.
- Inform clients of TWHP services and encourage them to bring required documentation to the initial visit for eligibility processing.

**Family planning clients should be given an appointment as soon as possible - no later than 30 days - from initial request. Appointments for adolescents age 17 and younger should be seen as soon as possible - with every effort made to provide an appointment within two weeks of the request.
(See also Section 1 Chapter 3 – Client Rights)*

ABUSE AND NEGLECT REPORTING

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

To report abuse or neglect, call **800-252-5400**, use the [secure website](#) or call any local or state law enforcement agency for cases that pose an imminent threat or danger to the client.

CHILD ABUSE REPORTING

DSHS Child Abuse Compliance and Monitoring

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

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

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

Procedures – During site monitoring of contractors by QMB the following procedures will be utilized to evaluate compliance:

1) The contractor's process used to ensure that staff is reporting according to Chapter 261 and the DSHS Child Abuse Screening, Documenting and Reporting Policy for Contractors will be reviewed as part of the Core Tool. To verify compliance with this item, monitors must review that the contractor:

- a) adopted the DSHS Policy;
- b) has an internal policy which details how the contractor will determine, document, report, and track instances of abuse, sexual or non-sexual, for all clients under the age of 17 in compliance with the Texas Family Code, Chapter 261 and the DSHS Policy;
- c) followed their internal policy and the DSHS Policy; and

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

2) All records of clients under 14 years of age who are a) pregnant, or b) have a confirmed diagnosis of an STI/STD acquired in a manner other than through perinatal transmission or transfusion, will be reviewed for appropriate screening and reporting documentation as required in the clinic or site being visited during a site monitoring visit. The review of the records will involve reviewing that the DSHS Child Abuse Reporting Form was utilized appropriately, a report was made, and the report was made within the proper timeframes required by law.

3) If it is found during routine record review that a report should have been made as evidenced by the age of the client and evidence of sexual activity, the failure to appropriately screen and report will be identified as lack of compliance with the DSHS Policy. Failure to report will be brought to the attention of the staff person who should have made the report or the appropriate supervisor with a request to immediately report. This failure to report will also be discussed with the agency director and during the Exit Conference with the contractor.

4) The report sent to the contractor will indicate the number of applicable records reviewed in each clinic and the number of records that were found to be out of compliance. This report will be sent to the contractor approximately 6 weeks from the date of the review, which is the usual process for Site Monitoring Reports.

5) The contractor will have 6 weeks to respond with written corrective actions to all findings. If the contractor does not provide corrective actions during the required time period, the contractor will be sent a past due letter with a time period of 10 days to submit the corrective actions. If the corrective actions are not submitted during the time period given, failure to submit the corrective action is considered a subsequent finding of noncompliance with Chapter 261 and the DSHS Policy.

If the contractor has other findings that warrant technical assistance or accelerated monitoring review, either regional or central office staff will make the necessary contacts. Records and/or policies will again be reviewed to ensure compliance with Chapter 261 and the DSHS Policy requirements. If any subsequent finding of noncompliance is identified during a subsequent monitoring or technical assistance visit, the contractor will be referred for financial sanctioning.

6) If a contractor is found to have minimal findings overall but did have findings of noncompliance with Chapter 261 and the DSHS Policy, an additional accelerated monitoring visit solely to review child abuse reporting will not be conducted. For agencies that receive technical assistance visits as a result of a quality assurance review, the agency child abuse reporting processes will be reviewed again for compliance with the child abuse reporting requirements with which the agency did not comply. In all cases, the corrective actions submitted by the contractor will be reviewed

to ensure that the issues have been addressed. Agencies who do not receive an accelerated monitoring and/or technical assistance visit will be required to complete the DSHS Progress Report, Compliance with Child Abuse Reporting within 3 months after the corrective actions are begun (no later than 6 months from the initial visit). Failure to submit a Progress Report within the required time period or submission of a report that is not adequate constitutes a subsequent finding of noncompliance with the [DSHS Child Abuse Screening, Documenting, and Reporting Policy for Contractors/Providers](#) and the contractor will be referred for financial sanctions.

HUMAN TRAFFICKING

DSHS mandates that contractors comply with state laws governing the reporting of abuse and neglect. Additionally, as part of the requirement that contractors comply with all applicable federal laws, family planning contractors must comply with the federal anti-trafficking laws, including the Trafficking Victims Protection Act of 2000 (Pub.L.No. 106-386), as amended, and 19 U.S.C. 1591.

Contractors must have a written policy on human trafficking which includes the provision of annual staff training.

INTIMATE PARTNER VIOLENCE (IPV)

[Intimate partner violence \(IPV\)](#) describes physical, sexual, or psychological harm by a current or former partner or spouse. This type of violence can occur among heterosexual or same-sex couples and does not require sexual intimacy.

Contractors must have a written policy related to assessment and prevention of IPV, including the provision of annual staff training.

CONFIDENTIALITY

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

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

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

***Minors and Confidentiality**

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

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

NON-DISCRIMINATION

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

- Title VI of the Civil Rights Act of 1964 (42 U.S.C. §2000d et seq.);
- Section 504 of the Rehabilitation Act of 1973 (29 U.S.C. §794);
- Americans with Disabilities Act of 1990 (42 U.S.C. §12101 et seq.);
- Age Discrimination Act of 1975 (42 U.S.C. §§6101-6107);

- Title IX of the Education Amendments of 1972 (20 U.S.C. §§1681- et seq.); and
- Administrative rules for HHS agencies, as set forth in the Texas Administrative Code.

More information about non-discrimination laws and regulations can be found on the [HHSC Civil Rights website](#).

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 family planning 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 and complaint procedures;
- Ensure that all contractor staff is trained in the contractor’s non-discrimination policies, including policies for serving clients with LEP, and HHS complaint procedures; and
- Notify the HHSC Civil Rights Office of any discrimination allegation or complaint related to its programs and services no later than ten (10) calendar days after receipt of the allegation or complaint.
- Send notices to:

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

Limited English Proficiency

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

- Take reasonable steps to ensure that LEP persons have meaningful access to its programs and services, and not require a client with LEP to use friends or family members as interpreters. However, a family member or friend may serve as a client's interpreter, if requested, if the family member or friend does not compromise the effectiveness of the service nor violate client confidentiality; and
- Make clients and applicants with language service needs, including persons with LEP and disabilities, aware that the contractor will provide an interpreter free of charge.

Civil Rights Posters

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

- [“Know Your Rights”](#) [\[English\]](#) [\[Spanish\]](#)
Size: 8.5” x 11” (standard size sheet of paper).
Posting Instructions: Post the English and Spanish versions of this poster next to each other.
Questions: Contact the HHSC Civil Rights Office.
- [“Need an Interpreter”](#) [\[Language Translation\]](#) [\[American Sign Language\]](#)
Size: 8.5” x 11” (standard size sheet of paper).
Posting Instructions: Post the “Language Translation” version and “American Sign Language” version next to each other.
Questions: Contact the HHSC Civil Rights Office.
- [Americans with Disabilities Act](#) [\[English A\]](#) [\[Spanish A\]](#) [\[English B\]](#) [\[Spanish B\]](#)
Size: 8.5” x 11” and 11” x 13”
Posting instructions: Post with other civil rights posters.
Questions: Contact the HHSC Civil Rights Office.

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

Civil Rights Survey

Contractors can use the Self-Assessment for Civil Rights Compliance to conduct a self-assessment concerning civil rights compliance, and have copies available of the survey.

The survey can be downloaded from the [Quality Management Branch \(QMB\) website](#). Questions concerning the self–assessment and surveys can be directed to the [DSHS Quality Management Branch](#).

TERMINATION OF SERVICES

Clients must never be denied services due to an inability to pay.

Contractors have the right to terminate services to a client if the client is disruptive, unruly, threatening, or uncooperative to the extent that the client seriously impairs the contractor’s ability to provide services or if the client’s behavior jeopardizes his or her own safety, clinic staff, or other clients.

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

RESOLUTION OF COMPLAINTS

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

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

PROMPT SERVICES

Contractors are responsible for ensuring that family planning services are provided to clients in a timely manner, preferably within 30 days of the request for services.

Clients who request contraception but cannot be immediately provided a clinical appointment must be offered a nonprescription method.

Adolescents age 17 and younger must be provided family planning counseling and medical services as soon as possible of request - with every effort made to provide an appointment within two weeks of the request.

Clinic/reception room wait times should be reasonable so as not to represent a barrier to service.

FREEDOM OF CHOICE

DSHS Family Planning clients are guaranteed the right to choose family planning providers and methods without coercion or intimidation. Acceptance of family planning

services must not be a prerequisite to eligibility for or receipt of any other service or assistance.

Medicaid clients are free to receive services from any Medicaid-enrolled family planning provider, even in managed care areas.

Personnel at contractors' clinics must be informed that they may be subject to prosecution under federal law if they coerce or endeavor to coerce any person to undergo an abortion or sterilization procedure. [Section 205 of Public Law 94-63. Contractors must have a written policy to this effect. (See TAC § 56.11)

RESEARCH (HUMAN SUBJECT CLEARANCE)

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

Contractors should first contact the DSHS Family Planning Program (famplan@dshs.state.tx.us) to initiate a research request. Next, contractors should complete the most current version of the [DSHS IRB #1 application](#) and submit it to famplan@dshs.state.tx.us. The DSHS IRB will review the materials and approve or deny the application.

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

CLIENT RECORDS MANAGEMENT

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

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

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

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

Contractors, providers, subrecipients, and subcontractors must maintain for the time period specified by DSHS all records pertaining to client services, contracts, and payments. Record retention requirements are found in Title 1, Part 15 TAC §354.1003 (relating to Time Limits for Submitted Claims) and Title 22, Part 9 TAC §165 (relating to Medical Records). Contractors must follow contract provisions and the [DSHS Retention Schedule for Medical Records](#). All records relating to services must be accessible for examination at any reasonable time to representatives of DSHS and as required by law.

PERSONNEL POLICY AND PROCEDURES

Contractors must develop and maintain personnel policies and procedures to ensure that clinical staff are hired, trained, and evaluated appropriately for their job position. Personnel policies and procedures must include:

- job descriptions,
- a written orientation plan for new staff to include skills evaluation and/or competencies appropriate for the position, and
- a 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 Family Planning 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.

FACILITIES AND EQUIPMENT

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

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

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

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

Medical Equipment – Contractors must have a written policy and maintain documentation of the maintenance, testing, and inspection of medical equipment, including automated external defibrillators (AED). Documentation must include:

- assessments of the clinical and physical risks of equipment through inspection, testing, and maintenance;
- reports of any equipment management problems, failures, and use errors;
- an orientation and education program for personnel who use medical equipment; and
- manufacturer recommendations for care and use of medical equipment.

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

Disaster Response Plan – Written and oral plans that address how staff are to respond to emergency situations (i.e., fires, flooding, power outage, bomb threats, etc.). The disaster plan must identify the procedures and processes that will be initiated during a disaster and the staff (position/s) responsible for each activity. A disaster response plan must be in writing, formally communicated to staff, and kept in the workplace available to employees for review. For an employer with ten or fewer employees the plan may be communicated orally to employees.

For additional resources on facilities and equipment, see the [Occupational Safety and Health Administration website](#).

QUALITY MANAGEMENT

Organizations that embrace [Quality Management](#) (QM) concepts and methodologies and integrate them into the structure of the organization and day-to-day operations discover a very powerful management tool. 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,
- measurement, and
- teamwork.

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

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

The Quality Management Committee, whose membership consists of key leadership of the organization, including the Executive Director/CEO and the Medical Director, and any other appropriate staff where applicable, annually reviews and approves the quality work plan for the organization. The 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, 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 management program is unique, the following activities must be undertaken by all agencies providing client services:

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

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

- Annual license verification (primary source verification);
- Clinical record review;
- Eligibility and billing review;
- On-site facility 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.

PHARMACY

In order to facilitate client access to and compliance with contraceptive methods and related medications, **it is required that all contractors have at least a Class D pharmacy at each DSHS Family Planning clinic site.**

Pharmacies must be operated in accordance with federal and state laws relating to security and record-keeping for drugs and devices. The inventory, supply, and provision of pharmaceuticals must be conducted in accordance with state pharmacy laws and professional practice regulations. It is essential that each facility maintain an adequate supply and variety of drugs and devices on-site to effectively manage the contraceptive needs of its patients.

Class D Pharmacy Exemption

Contractors may request an exemption to the on-site Class D pharmacy requirement, if such an exemption would facilitate client access to contraceptive methods and related medications. Requests for exemptions must be made in writing to the DSHS Preventive Care Branch and will be considered on a case-by-case basis. Exemption requests must 1) describe the process through which a patient obtains medication from the referral pharmacy/pharmacies, and 2) include justification wherein referring clients to an off-site pharmacy benefits the agency and/or clients. The following criteria must be met in order to potentially qualify for an exemption:

1. A signed and fully executed Memorandum of Understanding (MoU) with referral pharmacy/pharmacies, which includes the purpose of cooperation and details coordination with between the contractors and the referral pharmacy/pharmacies to provide the following medications:
 - non-clinician administered hormonal contraceptive methods [oral contraceptives; transdermal hormonal contraceptives (patch); and vaginal hormonal contraceptives (ring)];
 - anti-infectives for the treatment of STIs and other infections; and
 - other medications necessary to treat health care needs of the family planning patient population.
2. The agreement made with referral pharmacy/pharmacies must not create barriers to the client receiving the prescribed medication.
3. The referral pharmacy/pharmacies is/are located within a reasonable distance to participating clients.
4. Clients do not incur additional costs to obtain medications.

5. The contractor has a written policy that ensures clients can obtain prescribed medication refills from the cooperating pharmacy/pharmacies without an additional clinic visit (unless medically indicated/necessary).

SEPARATION OF FAMILY PLANNING AND ABORTION SERVICES

A DSHS contractor will not be disqualified from receipt of family planning funds because of its affiliation with an entity that performs elective abortions, provided that such affiliation satisfies the following requirements:

Legal Separation

DSHS contractors and their abortion-services affiliates must be legally separate corporations. Each entity must have separate articles of incorporation with distinct filing certifications from the Texas Secretary of State's Office, separate bylaws, and separate State of Texas Tax Identification numbers. State or local governmental entities that contract with DSHS to provide family planning services and their abortion-services affiliates must be legally separate organizations and must have separate governing structures.

Easily Distinguishable Names

DSHS contractors and their abortion-services affiliates must have easily distinguishable names so that a reasonable person can easily distinguish between the DSHS contractor and the affiliated abortion-services provider. This requirement applies to both the legal names of the entities and their "doing business as" names.

Separate Boards of Directors and Governing Bodies

DSHS contractors and their abortion-services affiliates must maintain separate boards of directors or governing bodies. Each entity's board of directors or governing body must meet separately and maintain separate records. The minutes, recordings, or other documents that record the activities of the board of directors or governing body of a DSHS contractor must clearly indicate that any business discussed by the board of directors or governing body is intended to be primarily business of the DSHS contractor, rather than a discussion of the business of an affiliate.

No Direct or Indirect Subsidy

DSHS contracting agencies may not transfer any family planning funds to their abortion-services affiliate. If there are shared expenses among the entities, a formal "cost sharing" agreement between the entities must be maintained that clearly indicates each of the shared expenses (e.g. overhead, rent, phones, equipment and utilities) and how the expenses have been apportioned between the entities. The methodology used to apportion a fair value for any shared expenses must be in accordance with generally acceptable accounting principles. Each entity must maintain separate cost allocation plans that only include that entity's portion of any shared costs as outlined by the formal "cost sharing" agreement. All financial transactions between entities must be clearly delineated and maintained separately in each entity's financial records. All recorded transaction between entities must include the date, time, amount, and purpose of the transaction.

Detailed Employee Timekeeping

Detailed timekeeping records must be maintained for any person employed by both a DSHS contractor and its abortion-services affiliate. Each entity must keep separate timekeeping records for such employees that clearly reflect the work performed for each entity. Payroll costs for these employees must accurately reflect the timekeeping records of each entity and must show that only time employed for an entity is reflected in that entity's payroll records. Such employees must never be paid by one entity while performing work related duties for the other. For a description of acceptable timekeeping systems that may be used for these purposes please see Section 6.05.01 of the [DSHS Contractor's Financial Procedures Manual](#).

Clear Signage

If a DSHS contractor and its abortion-services affiliate are located at the same physical location, the existence and separate nature of the affiliate relationship and the services provided by each entity must be clearly reflected by all signage located in areas accessible to the public. Signage in this instance is a physical or electronic representation that reflects the name, location, and/or services provided by each entity. Signage may include, but is not limited to:

- signs posted or painted on the interior or exterior doors or windows of a physical location;
- phonebook listings;
- websites;
- social networking sites; and
- email footers.

Family planning funds may never be used to pay for any portion of an abortion-services affiliate's signage. This includes either a physical sign or an electronic representation such as a webpage.

Separate Books

DSHS contractors and their abortion-services affiliates must each maintain separate records adequate to show compliance with the requirements listed above. All transactions between the DSHS contracting agency and its abortion-services affiliate, as outlined in their formal "cost sharing" agreement, must be clearly delineated in each entity's financial records. All recorded transactions between entities must include the date, time, amount, and purpose of the transaction.

Reporting Additional Shared Sites to DSHS

Contractors must notify, in writing, their contract manager if an abortion-services affiliate is located at a new or existing location where DSHS services are provided.

Section II

Eligibility, Client Services, and Community Activities

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

CLIENT ELIGIBILITY SCREENING PROCESS

DSHS Family Planning contracted agencies must screen all potential family planning clients for eligibility in the following programs that provide family planning services: Medicaid, the Texas Women's Health Program (TWHP), and then the DSHS Family Planning Program. Eligibility screening criteria and processes are described below.

SCREENING FOR MEDICAID AND TWHP

If the client has a Medicaid card, it can be used to document Medicaid eligibility. All women 18-44 years of age who are not eligible for full Medicaid services must be screened for TWHP.

How to know if a person is covered by the TWHP:

- She will be issued a 'Your Texas Benefits' card with "TWHP" printed in the upper right corner.
- She should show her 'Your Texas Benefits' card at the point of service delivery.

Even with this card, providers must verify the person's eligibility. Providers can log on to www.YourTexasBenefitsCard.com or call TMHP at 1-800-925-9126. Providers can also log on to TexMedConnect to check the member's Medicaid ID number (PCN).

If a woman is screened as potentially eligible for TWHP, the contractor must assist the client to complete the TWHP Application Form #H1867. (See below for additional information to assist clients with the TWHP application process).

TEXAS WOMEN'S HEALTH PROGRAM (TWHP)

All women 18-44 years of age must be screened for TWHP. TWHP is a state-funded program administered by the Texas Health and Human Services Commission (HHSC) to provide uninsured women with family planning exams, related health screenings, and birth control. Family planning contractors must be a provider of TWHP services.

TWHP is for women who meet the following qualifications:

- ages 18-44 - women can apply the month of their 18th birthday through the month of their 45th birthday;
- U.S. citizens and qualified immigrants;
- reside in Texas;

- do not currently receive full Medicaid benefits, Children’s Health Insurance Program (CHIP), or Medicare Part A or B;
- are not pregnant;
- have not been sterilized, are infertile, or are unable to get pregnant due to medical reasons;*
- do not have private health insurance that covers family planning services, unless filing a claim on the health insurance would cause physical, emotional or other harm from a spouse, parent, or other person; and
- have a countable household income at or below 185 percent of the federal poverty level.

**If a woman has received a sterilization procedure but has not had the sterilization confirmed, the woman may still qualify for TWHP. TWHP covers the confirmation of the sterilization procedure. However, no other TWHP services are covered for women that have received a sterilization procedure.*

Contractors must assist individuals who screen eligible for TWHP to complete the TWHP Application Form #H1867 and verify the person’s income, identity and citizenship in accordance with TWHP policies. Adjunctive eligibility is available if she or a member of her family is participating in a gateway program that requires income verification and is limited to participants at or below 185% FPL (Special Supplemental Nutrition Program for Women, Infants, and Children [WIC], Food Stamps, Temporary Assistance for Needy Families or children’s Medicaid). For more information on documents that are acceptable as proof of adjunctive eligibility see the [TWHP website](#).

The TWHP Application, HHSC Form # H1867 is used to apply for the TWHP if the screening form indicates that a woman is likely to be determined eligible. Note: a TWHP Screening Tool or [TWHP Application Form #H1867](#) must be maintained in the client record for all potentially eligible TWHP clients.

After ensuring that the application is completed and signed, the contractor must fax the front page of the application to the toll-free number included on the application to HHSC for processing. Verification of income, expenses, or adjunctive eligibility, identity, and citizenship must also be faxed with the application. Contractors must fax the application to the eligibility office even if all required documentation is not provided by the client. The eligibility office will contact the client for any missing information. To minimize paperwork and the chance that verification will be lost, the documents should be photocopied to fit on one sheet, if possible. A woman’s enrollment in the TWHP will be effective from the first day of the month the State receives her application for the program. For example, if a woman applies for the TWHP on January 20 and she is certified, her enrollment will be effective starting January 1.

RE-SCREENING FOR THE TWHP

DSHS contractors are not required to re-screen TWHP clients who return for services within 35 calendar days of their initial visit. Any client whose eligibility for TWHP has not been determined after 35 days of the initial visit, must be re-screened at subsequent visits. Clients who were initially screened ineligible for the TWHP because of their citizenship or immigration status must be re-screened annually or when the client reports a change in their citizenship or immigration status. If the client has been deemed ineligible, a copy of the denial letter must be maintained in the client record. Clients who do not provide a copy of denial letter must be re-screened at subsequent visits.

Contractors are not required to re-screen new clients who are already recipients of the TWHP or Medicaid. For clients who have not previously been screened for the TWHP by the clinic where she is seeking services, a photocopy of their eligibility card must be maintained in the client record to document eligibility. Individuals who refuse to apply for the TWHP must be re-screened at subsequent visits.

SCREENING FOR DSHS FAMILY PLANNING PROGRAM ELIGIBILITY

All DSHS Family Planning contractors must perform an annual eligibility screening assessment on all clients who present for family planning services. DSHS Family Planning contractors must use one of the following eligibility screening tools to assess client eligibility for family planning services:

- DSHS INDIVIDUAL Eligibility Screening Form (EF05-14215) (see Appendix B); DSHS HOUSEHOLD Eligibility Screening Form (EF05-14214) with HOUSEHOLD Eligibility Screening Form Worksheet (Form EF05-13227) (See Appendix C); or
- Any other eligibility screening form substitute (e.g., in-house form, electronic/automated form, phone interview, etc.), that contains the required DSHS information for determining eligibility, and is approved by the DSHS Family Planning Program.

The completed eligibility form must be maintained in the client record, indicating the client's poverty level and the co-pay amount he or she will be charged. Client eligibility must be assessed on an annual basis.

The eligibility assessment may be completed over the phone or in the office, but a completed screening tool must be maintained in the client record.

DETERMINING DSHS FAMILY PLANNING PROGRAM ELIGIBILITY**Eligibility Requirements**

- Eligible clients must be:

- females of childbearing age who have not had sterilization surgery or other condition resulting in sterilization and who are seeking family planning services;
- males of reproductive age who have not had sterilization surgery or other condition resulting in sterilization and who are seeking family planning services;
- Texas residents. Residency is self-declared. Contractors may require residency verification, but such verification should not jeopardize delivery of services;
- at/or under 250% of the federal poverty level (FPL). Contractors must require income verification. If the methods used for income verification jeopardize the client's right to confidentiality or impose a barrier to receipt of services, the contractor must waive this requirement. Reasons for waiving verification of income must be noted in the client record.
- For un-emancipated, unmarried individuals UNDER 18 years of age, if parental consent is required for the receipt of services per Section 32 of the Texas Family Code, the family's income must be considered in determining the charge for the service.
- If parental consent is not required to provide services to an individual UNDER 18 years of age, per Section 32 of the Texas Family Code, only the individual's income is used to assess eligibility, not the income of other family members. In this case, the minor's own income is applied and the size of the family should be recorded as one.

Contractors who have expended their awarded funds must continue to serve their existing eligible clients (clients seen within the current contract year).

For the purpose of determining family planning eligibility, the following definitions will be used:

- **Household** -- The household consists of a person living alone or a group of two or more persons related by birth, marriage including common-law, or adoption, who reside together and are legally responsible for the support of the other person. Household is self-declared.
 - For example: If an unmarried applicant lives with a partner, ONLY count the partner's income and children as part of the household IF the applicant and his/her partner have mutual children together. Unborn children should also

be included. Treat applicants who are 18 years of age as adults. No children aged 18 and older or other adults living in the household should be counted as part of the household group.

- **Income** -- All income received must be included. Income is calculated before taxes (gross). Include sources of income as defined in the DSHS Family Planning Definition of Income (See Appendix D).
 - For individuals who are married or who are 18 years of age or older, the income of all family members must be used.
 - For un-emancipated, unmarried individuals UNDER 18 years of age, if parental consent is required for the receipt of services per Section 32 of the Texas Family Code, the family's income must be considered in determining the charge for the service.
 - If parental consent is not required to provide services to an individual UNDER 18 years of age, per Section 32 of the Texas Family Code, only the individual's income is used to assess eligibility, not the income of other family members. In this case, the minor's own income is applied and the size of the family should be recorded as one.
- **Income Deductions** - Dependent care expenses shall be deducted from total income in determining eligibility. Allowable deductions are actual expenses up to \$200.00 per child per month for children under age 2 and \$175.00 per child per month for each dependent age 2 or older.

Legally obligated child support payments made by a member of the household group shall also be deducted. Payments made weekly, every two weeks or twice a month must be converted to a monthly amount by using one of the conversion factors listed below.

Monthly Income Calculation

- If income is received in lump sums or at longer intervals than monthly, such as seasonal employment, the income is prorated over the period of time the income is expected to cover.
- Weekly income is multiplied by 4.33.
- Income received every two weeks is multiplied by 2.17.
- Income received twice monthly is multiplied by 2.
- Subsidized services must be made available to clients up to 250% of the current FPL.

ADJUNCTIVE ELIGIBILITY

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

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

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

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

**NOTE: Presentation of the ‘Your Texas Benefits’ card does not completely verify current eligibility. To verify eligibility, contractors can go to www.YourTexasBenefitsCard.com, call TMHP at 1-800-925-9126, or access [TexMedConnect](#) to enter or give the applicant’s Medicaid ID number (PCN) as listed on the card.

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

CALCULATION OF APPLICANT’S FEDERAL POVERTY LEVEL PERCENTAGE

Household FPL Calculation

If a contractor collects a client co-pay, the contractor must determine the applicant's exact household Federal Poverty Level (FPL) percentage. The steps to do so include:

1. Determine the applicant's household size.
2. Determine the applicant's total monthly income amount.
3. Divide the applicant's **total monthly income** amount by the **maximum monthly income** amount at 100% FPL, for the appropriate **household size**.
4. Multiply by 100%

The maximum monthly income amounts by household size are based on the Department of Health and Human Services [federal poverty guidelines](#). The guidelines are subject to change around the beginning of each calendar year. For more information see Appendix E.

Example:

Applicant has a total monthly income of \$2,063 and counts three (3) family members in the household.

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

DATE ELIGIBILITY BEGINS

An individual is eligible for services beginning the date the contractor determines the individual eligible for the program and signs the completed application.

CLIENT FEES/CO-PAYS

All family planning services provided at a DSHS family planning funded clinic, including non-reimbursable services, must be offered on a fee scale. (See sample fee scale Appendix E.)

Please note the following:

- Medicaid-eligible clients must never be charged a fee for services covered by Medicaid.
- TWHP-eligible clients must never be charged a fee for services covered by TWHP.

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- Clients must never be denied services because of inability to pay current fees or any fees owed. Signs indicating this policy should be visibly posted at contractor clinic sites.

CO-PAY GUIDELINES:

- All clients between 101% and 250% FPL must be assessed a fee or co-pay for family planning services. A client's account must reflect that they have been charged a fee or co-pay even if they were unable to pay at the time of services or if the fee or co-pay was waived.
- Clients that are responsible for paying any fee for their services should be given bills directly at the time of services.
- Contractors must maintain records regarding client fees paid and any balance owed. However, contractors must have a system for aging accounts receivable. This system must be documented in the contractor's policy and procedures and must clearly indicate a timeframe for removing balances from a client's account due to inability to pay.
- Contractors must not charge a fee for family planning services to individuals whose income and family size place them at or below 100% FPL, or to Medicaid or TWHP-eligible clients.
- A fee scale must be developed and implemented with sufficient proportional increments so that inability to pay is never a barrier to service. A fee scale is required for individuals with household incomes between 101% and 250% of FPL. Fees must be waived for individuals with family incomes above this amount who, as determined by the service site project director, are unable, for good cause, to pay for family planning services. For a sample sliding fee scale see Appendix E.
- Appendix E is a sample of a flat co-pay scale. Contractors can adopt the sample or develop their own. The flat fee scale must have proportional FPL increments and co-pay amounts. The maximum co-pay amount must not exceed \$30.00. If a contractor does not use the DSHS Family Planning sample, the scale must be submitted to and approved by the DSHS Family Planning Program staff.
- The fee scale must be updated when the revised Federal Poverty Income Guidelines are released. Contractors must have policies and procedures regarding fee collection, which must be approved by the contractor's Board of Directors.

- Services may be provided to clients with third-party insurance if the confidentiality of the client is a concern or if the client's insurance deductible is 5% or greater of their monthly income.
- Client co-pays collected by the contractor are considered program income and must be used to support the delivery of DSHS family planning services.
- Contractors must continue to bill for services when allocated funds are expended.

GENERAL CONSENT

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

Consent information must be effectively communicated to every patient in a manner that is understandable. This communication must allow the patient to participate, make sound decisions regarding her/his own medical care, and address any disabilities that impair communication (in compliance with Limited English Proficiency regulations). Only the patient may consent. For situations when the patient 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 the informed consent of the client for procedures as required by the Texas Medical Disclosure Panel.

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

PROCEDURE-SPECIFIC INFORMED CONSENTS**Sterilization Procedures:**

There are two consent forms required for sterilization procedures:

- the Sterilization Consent Form, and
- the Texas Medical Disclosure Panel Consent.

The Sterilization Consent Form

The Sterilization Consent Form is a federally mandated consent form and is necessary for both abdominal and trans-cervical sterilization procedures in women and vasectomy in men. It is provided in the Texas Medicaid Provider Procedures Manual (TMPPM), and is the only acceptable consent form for sterilizations funded by regular Medicaid (Title XIX), TWHP, or the DSHS Family Planning and Expanded Primary Health Care Programs. An electronic copy of the Sterilization Consent Forms (in English and Spanish) may be found on the [TMHP website](#). In brief, the individual to be sterilized must:

- be at least **21 years old** at the time the consent is obtained;
- be mentally competent;
- voluntarily give his or her informed consent;
- sign the consent form **at least 30 days but not more than 180 days prior** to the sterilization procedure*; and
- may choose a witness to be present when the consent is obtained.

**An individual may consent to be sterilized at the time of premature delivery or emergency abdominal surgery, if at least 72 hours have passed after the client gave informed consent to sterilization. In the case of premature delivery, the informed consent must have been given at least 30 days before the expected date of delivery.*

The consent form must be signed and dated by the:

- individual to be sterilized;
- interpreter, if one is provided;
- person who obtains the consent; and
- physician who will perform the sterilization procedure.

Informed consent may **not** be obtained while the individual to be sterilized is:

- in labor or in the process of delivering an infant or infants;
- seeking to obtain or obtaining an abortion; or
- under the influence of alcohol or other substances that affect the individual's state of awareness.

Texas Medical Disclosure Panel Consent

The [Texas Medical Disclosure Panel \(TMDP\)](#) was established by the Texas Legislature to 1) determine which risks and hazards related to medical care and surgical procedures must be disclosed by health care providers or physicians to their patients or persons authorized to consent for their patients, and 2) establish the general form and substance of such disclosure. TMDP has developed a List A (informed consent requiring full and specific disclosure) for certain procedures, which can be found in the [Texas Administrative Code \(TAC\)](#).

Contractors that directly perform tubal sterilization and/or vasectomy (both List A procedures), must also complete the [TMDP Disclosure and Consent Form](#). This consent is in addition to the Sterilization Consent Form noted on the previous page.

The required disclosures for tubal sterilization are:

- injury to the bowel and/or bladder;

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- sterility;
 - failure to obtain fertility (if applicable);
 - failure to obtain sterility (if applicable); and
 - loss of ovarian functions or hormone production from ovary(ies).

The required disclosures for vasectomy are:

- loss of testicle; and
- failure to produce permanent sterility.

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

CONSENT FOR SERVICES TO MINORS

Minors age 17 and younger are required to obtain consent from a parent or guardian before receiving certain medical services. DSHS Family Planning contractors must have proof of a parent's or guardian's consent prior to providing family planning services to a minor client. Proof of consent must be included in the minor client's medical record.

Parental consent is **not** required for minors to receive pregnancy testing, HIV/STD testing, or treatment for a STD.

For information on health services and consent requirements for minors see: [Adolescent Health – A Guide for Providers](#) and [The Texas Family Code, Chapter 32](#), part of which is outlined below.

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

- (1) is on active duty with the armed services of the United States of America;
- (2) is:
 - (A) 16 years of age or older and resides separate and apart from the child's parents, managing conservator, or guardian, with or without the consent of the parents, managing conservator, or guardian and regardless of the duration of the residence; and

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- (B) managing the child's own financial affairs, regardless of the source of the income;
- (3) consents to the diagnosis and treatment of an infectious, contagious, or communicable disease that is required by law or a rule to be reported by the licensed physician or dentist to a local health officer or the Texas Department of Health, including all diseases within the scope of Section 81.041, Health and Safety Code;
- (4) is unmarried and pregnant and consents to hospital, medical, or surgical treatment, other than abortion, related to the pregnancy;
- (5) consents to examination and treatment for drug or chemical addiction, drug or chemical dependency, or any other condition directly related to drug or chemical use;
- (6) is unmarried, is the parent of a child, and has actual custody of his or her child and consents to medical, dental, psychological, or surgical treatment for the child; or
- (7) is serving a term of confinement in a facility operated by or under contract with the Texas Department of Criminal Justice, unless the treatment would constitute a prohibited practice under Section 164.052(a)(19), Occupations Code.

CONSENT FOR HIV TESTS

[Texas Health and Safety Code](#) §81.105 and §81.106 are as follows:

§ 81.105. INFORMED CONSENT

- (a) Except as otherwise provided by law, a person may not perform a test designed to identify HIV or its antigen or antibody without first obtaining the informed consent of the person to be tested.
- (b) Consent need not be written if there is documentation in the medical record that the test has been explained and the consent has been obtained.

§ 81.106. GENERAL CONSENT

- (a) A person who has signed a general consent form for the performance of medical tests or procedures is not required to also sign or be presented with a specific consent form relating to medical tests or procedures to

determine HIV infection, antibodies to HIV, or infection with any other probable causative agent of AIDS that will be performed on the person during the time in which the general consent form is in effect.

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

CLINICAL GUIDELINES

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

PATIENT HEALTH RECORD (MEDICAL RECORD)

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

All patient health records must be:

- Complete, legible, and accurate documentation of all clinical encounters, including those by telephone;
- Written in ink without erasures or deletions; or documented in Electronic Health Records (EHR) or Electronic Medical Record (EMR);
- Signed by the provider making the entry, including name of provider, provider title, and date for each entry;
 - Electronic signatures are allowable to document provider review of care. However, stamped signatures are not allowable.
- Readily accessible to assure continuity of care and availability to patients; and
- Systematically organized to allow easy documentation and prompt retrieval of information.

The patient health record must include:

- Client identification and personal data including financial eligibility;
- Preferred language and method of communication;
- Patient contact information - include the best way to reach patient to facilitate continuity of care, assure confidentiality, and adhere to HIPAA regulations (also see HIPAA and Minors, Section I Chapter 3);
- Medical history;
- Physical examination;
- Laboratory and other diagnostic tests orders, results, and follow-up;
- Assessment or clinical impression;
- Plan of care, including education, counseling, treatment, special instructions, scheduled visits, and referrals;
- Informed consent documentation;

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- Refusal of services documentation, when applicable;
 - Medication and other allergic reactions recorded prominently in specific location; and
 - Problem list.

MEDICAL HISTORY AND RISK ASSESSMENT

At the initial clinical visit, a **comprehensive** medical history must be obtained on all patients. Any pertinent history must be updated at each subsequent clinical visit. Each clinic visit should include a risk assessment that meets the needs and concerns of the patient. See the [USPSTF recommendations](#).

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

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

- Reason for visit;
- Current health status, including acute and chronic medical conditions;
- Significant past illnesses, including hospitalizations;
- Previous surgery and biopsies with dates, and when possible and pertinent, the results/final diagnosis/pathology;
- Blood transfusions and other exposure to blood products;
- Current medications, including prescription, over the counter (OTC) as well as complementary and alternative medicines (CAM);
- Allergies, sensitivities, or reactions to medicines and other substances;
- Use of tobacco/alcohol/illicit drugs (including type, duration, frequency, route);
- Immunization status/assessment ([see child, adolescent, adult immunization schedules](#));
 - Rubella - based on a history of rubella vaccination or documented rubella serology – non-pregnant female patients of childbearing age with unknown or inadequate rubella immunity must be provided vaccination on-site or referred appropriately.*
- Review of systems with pertinent positives and negatives documented in chart;
- Assessment for sexual and intimate partner violence (IPV) (mandated by [Texas Family Code](#), Chapter 261 and Rider 14;
- Assessment for environmental safety (e.g. bike helmets, seat belts, car seats, etc.);
- Occupational hazards or environmental toxin exposure;
- Pertinent mental health history (e.g., depression, anxiety);
- Pertinent family history; and
- Pertinent partner history, including injectable drug use, number of partners, STI/STDs and HIV history and risk factors, gender of sexual partners.

**Family planning contractors can voluntarily participate in the [Adult Safety Net \(ASN\) Program](#) or the [Texas Vaccines for Children \(TVFC\)](#). Both programs provide vaccines at no cost.*

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

- Menstrual history;
- Pertinent sexual behavior history, including family planning practices (i.e., contraceptive use – past and current), number of partners, gender of sexual partners, last sexual encounter, sexual abuse;
- Obstetrical history;
- Gynecological and urologic conditions;
- STI/STDs, and HIV history, risks, and exposure;
- Cervical cancer screening history (date and results of last Pap test or other cervical cancer screening test, note any abnormal results and treatment).

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

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

PHYSICAL ASSESSMENT

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

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

The following are the required components of client physical assessment.

Initial Family Planning Visit

- Height measurement;
- Body Mass index (BMI), waist measurement and/or other measurement to assess for underweight, overweight, and obesity;
- Blood pressure evaluation;
- Other systems as indicated by history. (e.g., pelvic exam, evaluation of thyroid, heart, lungs, abdomen).

Annual Family Planning Visit (subsequent to initial visit)

- Height measurement annually until 5 years post menarche for females and until age 20 years for males;
- Weight measurement annually (to assess for diagnosis of underweight, overweight, and obesity);
- Blood pressure evaluation;
- Other systems as indicated by history (e.g., pelvic exam, evaluation of thyroid, heart, lungs, abdomen).

Clinic visits for a purpose other than an Initial Family Planning Visit or an Annual Family Planning Visit should include the services that meet the individualized family planning needs and concerns of the patient.

Resources:

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

LABORATORY TESTS

Family planning patients must be provided appropriate laboratory and diagnostic tests **as indicated** by history, physical examination, and clinical assessment, including specific laboratory or diagnostic tests required for the provision of specific contraceptive methods. The following tests or procedures must be provided:

- Cervical cancer screening for females age 21 years and older;
- Sexually transmitted infection screening as per [CDC guidelines](#);
- Pregnancy test must be provided on-site;
- Rubella serology (for females), if status not previously established by patient history and documented in chart, either on-site or by referral;
- Colorectal cancer screening in individuals 50 years of age and older;
- **Human Papillomavirus (HPV) Testing** is only reimbursable for family planning female patients who are 21 years or older after an initial ASC-US Pap result. (See current information about [HPV and HPV testing](#). For the management of abnormal Pap tests, see the [ASCCP Cervical Cytology Consensus Guideline Algorithms](#).)
- HIV Testing; and

- Other labs (such as blood glucose, lipid panel, thyroid stimulating hormone, etc.) as indicated by risk assessment, history and physical, either on-site or by referral.*

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

Agencies must have written plans to address laboratory and other diagnostic tests orders, results and follow-up to include:

- Tracking and documentation of tests ordered and performed for each client;
- Tracking test results and documentation in patients' records;
- Mechanism to notify patients of results in a manner to ensure confidentiality; privacy and prompt, appropriate follow-up; and
- Provider must comply with state and local STI/STD reporting requirements.

Cervical Cancer Screening

ACOG/NBCCEDP/ACS/ASCCP/ASCP Cervical Cancer Screening Guidelines:

- Cervical cancer screening begins at age 21 years;
- Cervical cytology (Pap smear) alone screening every three (3) years for women between the ages of 21 and 29 years;
- Cervical cytology (Pap smear) alone every three (3) years **or** cervical cytology and HPV co-testing every five (5) years for women between the ages of 30 and 65 years;
- Continue screening women who had a hysterectomy for CIN disease for 20 years, even if this extends screening past age 65 years;
- Continue screening women who have had cervical cancer indefinitely as long as they are in reasonable health;
- Both liquid-based and conventional methods of cervical cytology are acceptable for screening.

Women with special circumstances, who are considered high-risk (e.g. HIV+, immunosuppressed or were exposed to Diethylstilbestrol (DES) in utero) may be screened annually or more frequently as determined by the clinician.

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

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

- **Gonorrhea screening** is recommended for all sexually active females age 25 and younger and for older females at increased risk for gonorrheal infection. Increased risk is defined as a history of prior gonorrheal or other sexually transmitted infections; new or multiple sexual partners; inconsistent condom use; sex work; and drug use. The U.S. Preventive Services Task Force (USPSTF) does not recommend routine screening for gonorrhea in men and women who are at low risk for infection.
- **HPV Testing** is only reimbursable for Family Planning female patients who are 21 years or older after an initial ASC-US pap result.
- **Herpes Simplex Virus (HSV) Testing** is frequently diagnosed through clinical evaluation of lesions, and viral culture and serological testing methods are available for use.
 - The Centers for Disease Control and Prevention (CDC) recommends cell culture and polymerase chain reaction (PCR) for patients who present with genital ulcers or other mucocutaneous lesions. There are limitations to the ability to obtain adequate samples for culture depending on staging of the lesion:
 - Screening for HSV-1 or HSV-2 in the general population is not indicated;
 - Type specific serologic testing might be useful in the following cases:

- A presenting patient with recurrent genital symptoms or atypical symptoms with negative HSV PCR or culture.
 - A presenting patient with clinical diagnosis of genital herpes without laboratory confirmation.
 - A presenting patient with a partner with genital herpes.
- **HIV Screening:**
Contractors are required to perform on-site HIV testing. Providers should follow [CDC recommendations](#) that all clients age 13-64 years be screened routinely for HIV infection and that all persons likely to be at high risk for HIV be rescreened at least annually. CDC further recommends that screening be provided after the patient is notified that testing will be performed as part of general medical consent unless the patient declines ([opt-out screening](#)).

EXPEDITED PARTNER THERAPY

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

Texas Administrative Code 22 TAC §190.8 was amended to allow EPT for STI treatment.

- DSHS endorses the [CDC recommendations](#) for the use of EPT. Clinic sites implementing EPT should develop necessary policies, procedures and Standing Delegation Orders (SDOs) to reflect the [CDC guidelines](#). For more information on implementing EPT see the [DSHS HIV/STD website](#). At this time, no reimbursement is available for clinical services to individuals not seen as patients at the clinic.

RADIOLOGY PROCEDURES

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

EDUCATION AND COUNSELING SERVICES

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

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

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

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

Patient education must be:

- Documented in the patient record;
- Appropriate to patient's age, level of knowledge and socio-cultural background; and
- Presented in an unbiased manner.

Initial education must provide patients with information needed to:

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

Persons providing counseling should:

- Be knowledgeable, objective, non-judgmental, and sensitive to the rights and differences of individual patients;
- Provide accurate, consistent, current information about the available contraceptive methods, including benefits, risks, safety, effectiveness, potential side effects, complications, danger signs and return to fertility or other issues related to discontinuation; and
- Document session in the patient record.

Method Counseling

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

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- Results of physical exam and evaluation;
 - Correct use of the contraceptive method(s) selected for personal use by the client, as well as possible side effects and complications;
 - Back up methods, including information about emergency contraception and discontinuation issues;
 - Scheduled revisits;
 - Access for urgent and emergency care, including 24-hour emergency telephone number; and
 - Appropriate referral for additional services as needed.

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

Problem Counseling

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

All patients must receive accurate and thorough patient-centered counseling about STIs and HIV to include:

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

HIV Counseling

Contractors may provide negative HIV test results to patients in person, by telephone, or by the same method or manner as the results of other diagnostic or screening tests. The provision of negative test results by telephone must follow procedures that address patient confidentiality, identification of the client, and prevention counseling. Contractors must always provide positive HIV test results to patients in a face-to-face encounter with an immediate opportunity for counseling and referral to community support services. Test results must be provided by staff knowledgeable about HIV prevention and HIV testing. Clients whose risk assessment reveals high-risk behaviors should be provided directly, or referred for, more extensive risk reduction counseling by a DSHS HIV/STD Program trained risk reduction specialist. To find a DSHS HIV/STD Program contractor, visit the [DSHS HIV/STD website](#).

Preconception Counseling

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

For more information on Preconception Counseling see:

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

Pregnancy Counseling

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

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

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

Counseling Adolescents

Adolescents age 17 and younger must be provided individualized family planning counseling and medical services that meet their specific needs. Appointments

should be available to them for counseling and medical services as soon as possible. It is important not to assume that adolescents are sexually active simply because they have come for family planning services.

Contractors must address these issues in counseling adolescents:

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

Minors and Confidentiality

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

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

For more information see:

[Adolescent Health – A Guide for Providers.](#)

REFERRAL AND FOLLOW-UP

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

Contractors must have written policies and procedures for follow-up on referrals that are made as a result of abnormal physical examination or laboratory test findings. These policies must be sensitive to patients’ concerns for confidentiality

and privacy and must be in compliance with state or federal requirements for transfer of health information. Before a delegate can consider a patient as ‘lost to follow-up,’ the contractor must have at least three documented separate attempts to contact the patient.

For services determined to be necessary, but are not provided by the contractor, patients must be referred to other resources for care. Contractors are expected to have established communications with [Federally Qualified Health Centers \(FQHCs\)](#) or DSHS-funded organizations that provide [primary care](#) or [breast cancer and cervical cancer services](#) for referral purposes, if there are any such providers within their service area. Whenever possible, patients should be given a choice of referral resources from which to select. When a patient is referred to another resource because of an abnormal finding or for emergency clinical care, the contractor must:

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

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

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

METHODS OF FERTILITY REGULATION

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

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

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

Most Effective

1. Contraceptive Implant (e.g., Nexplanon)
2. Intrauterine Devices (IUD) (e.g., Mirena, ParaGard, Skyla, Liletta)
3. Sterilization (male and female)

Moderately Effective

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

Least Effective

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

Note: Provision of emergency contraceptive (EC/ECP) is not a covered service.

A visual depiction of contraceptive methods arranged in order of typical effectiveness can be found on the [CDC website](#).

LARC (IUDs and implants) have definite benefits related to contraceptive efficacy, patient convenience, and long term costs. Contractors should discuss and offer these methods for consideration to all women and adolescents, as medically appropriate. As with all methods, the patient's preference after

receiving unbiased, factual, nondirective education should be respected. For more information on LARC methods, see:

- [ACOG Long Acting Reversible Contraception Program](#);
- [LARC First](#); and
- [Bedsider](#).

Contractors that have a Class D Pharmacy should offer the full range of available contraceptive methods on-site.

The table below outlines which contraceptive methods must be provided on-site based on access to a Class D Pharmacy.

Methods Provided On-Site	Class D Pharmacy	Class D Pharmacy Exemption
Anti-infectives for the treatment of STI	✓	
Barrier methods and spermicides	✓	✓
Injectable hormonal contraceptives	✓	✓
Oral contraceptives	✓	
Sexual abstinence education and counseling	✓	✓
Transdermal hormonal contraceptive (patch) and/or vaginal hormonal contraceptive (ring)	✓	

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

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

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

duration method, such as the contraceptive implant or an IUD, would be an acceptable alternative to sterilization.

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

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

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 and consistent with national evidence-based clinical guidelines. When DSHS revises a policy, contractors need to incorporate the revised policy into their written protocols, SDOs, and procedures.

Protocols

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

Standing Delegation Orders

Contractors that employ unlicensed and licensed personnel, other than advanced practice nurses or physician assistants, whose duties include actions or procedures for a patient population with specific diseases, disorders, health problems or sets of symptoms, must have written SDOs in place. SDOs are distinct from specific orders written for a particular patient. SDOs are instructions, orders, rules, regulations or procedures that specify under what set of conditions and circumstances actions should be instituted. The SDOs delineate under what set of conditions and circumstances an RN, LVN, or non-licensed healthcare provider (NLHP) actions or tasks may be initiated in the clinical setting, and

provide authority for use with patients when a physician or advance practice provider is not on the premises, and or prior to being examined or evaluated by a physician or advanced practice provider. Example: SDO for assessment of Blood Pressure/Blood Sugar which includes an RN, LVN or NLHP that will perform the task, the steps to complete the task, the normal/abnormal range, and the process of reporting abnormal values. Other applicable SDOs when a physician is not present on-site may include, but are not limited to:

- obtaining a personal and medical history;
- performing an appropriate physical exam and the recording of physical findings;
- initiating/performing laboratory procedures;
- administering or providing drugs ordered by voice communication with the authorizing physician;
- providing pre-signed prescriptions for :
 - oral contraceptives;
 - diaphragms;
 - contraceptive creams and jellies;
 - topical anti-infective for vaginal use;
 - oral anti-parasitic drugs for treatment of pinworms;
 - topical anti-parasitic drugs; or
 - antibiotic drugs for treatment of STI/STDs.
- handling medical emergencies – to include on-site management as well as possible transfer of client;
- giving immunizations; or
- performing pregnancy testing.

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

Patient Education

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

Resources

Requirements addressing scope of practice and delegation of medical and nursing acts can be accessed at the following websites: [Texas Medical Board](#); and [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;

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- [Texas Administrative Code](#), Title 22, Part 11, Chapters 221 and 224; and
 - [Texas Administrative Code](#), Title 22, Part 9, Chapter 185 (Physician Assistant Scope of Practice).

EMERGENCY RESPONSIVENESS

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

- There must be a written plan for the management of on-site medical emergencies, emergencies requiring ambulance services and hospital admission, and emergencies requiring evacuation of the premises.
- Each site where sterilization procedures are performed must have an arrangement with a licensed facility for emergency treatment of any surgical complication. If sterilization procedures are performed in a freestanding surgical care center or on an inpatient basis in a hospital, Medicare standards applicable to the facility and staff must be met.
- Each site must have staff trained in basic cardiopulmonary resuscitation (CPR) and emergency medical action. At least one staff trained in basic CPR must be present during all hours of clinic operation.
- There must be written protocols to address vaso-vagal reactions, anaphylaxis, syncope, cardiac arrest, shock, hemorrhage, and respiratory difficulties.
- Each site must maintain emergency resuscitative drugs, supplies, and equipment appropriate to the services provided at that site and appropriately trained staff when patients are present.
- Documentation must be maintained in personnel files that staff has been trained regarding these written plans or protocols.

PROGRAM PROMOTION and OUTREACH

Contractors must promote their primary health care program and provide outreach within the community in order to:

- inform the public of the purpose of the program and available services;
- disseminate basic family planning and primary health care knowledge;
- enlist community support; and
- attract potential clients.

To help facilitate community awareness of and access to family planning and primary health care services, contractors should establish and implement planned community activities to promote their programs.

Contractors should consider a variety of program promotion and client outreach strategies in accordance with organizational capacity, availability of existing resources and materials, and the needs and culture of the local community. In order to gauge the efficacy of program promotion and client outreach activities, contractors must:

- develop an annual primary health care program promotion and client outreach plan that includes a minimum of 6 outreach/promotion activities for the year;
- regularly monitor plan implementation;
- evaluate the plan on an annual basis; and
- modify program promotion and outreach activities, as needed.

Contractors must submit a one-page Program Promotion Plan for the fiscal year within forty-five (45) days of the contract start date. The plan should describe the agency's outreach and marketing strategy, and include a description of planned activities to reach potential family planning clients. Contractors must submit a quarterly Family Planning Program Promotion/Outreach Progress Report to: famplan@dshs.state.tx.us.

Due dates:

- 10/15/2015 – Initial one-page Program Promotion Plan
- 12/31/2015 – 1st quarter Program Promotion Progress Report
- 03/31/2016 – 2nd quarter Program Promotion Progress Report
- 06/30/2016 – 3rd quarter Program Promotion Progress Report
- 08/31/2016 – 4th quarter Program Promotion Progress Report

Section III

Reimbursement, Data Collection and Reporting

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

MEDICAID PROVIDER ENROLLMENT

DSHS Family Planning contractors are required to enroll as Medicaid (Title XIX) providers with TMHP. The Family Planning contractor must complete the required Medicaid provider enrollment application forms and enter into a written provider agreement with the HHSC, the single state Medicaid agency. TMHP Provider Enrollment supplies these forms.

Family Planning agencies are not required to enroll as a Physician Group, which includes an application for Performing Provider number. To enroll as a family planning agency, all that is required is a supervisory practitioner. The supervisory practitioner may be a physician or nurse practitioner, and it may be the same person for all clinic sites. Changes in supervisory practitioner must be reported in writing to TMHP. An application must be submitted for the new supervisory practitioner.

When enrolling as a Title XIX provider, Clinical Laboratory Improvement Amendments (CLIA) information must be provided. For public health agencies that provide limited numbers of tests, one CLIA certificate is all that is required for all clinics.

Provider Identifiers

When a contractor's Medicaid application is approved, TMHP assigns the contractor a nine-digit Texas Provider Identifier (TPI). **Contractors must have a unique TPI for each clinical service site.**

Contractors must submit claims to TMHP using the billing TPI where clinical services are rendered. Contractors must not provide family planning clinical services at one clinic site and bill those services to TMHP using the TPI of a different clinic site. If an additional TPI clinic site is required, providers must contact TMHP and complete the enrollment process.

The TPI is used in conjunction with a National Provider Identifier (NPI) to identify the provider for claims processing. An NPI is a 10-digit number assigned randomly by the National Plan and Provider Numeration System (NPPES). Contractors may apply for an NPI at the [NPPES](#) website.

When a provider obtains their NPI they are required to attest to NPI data for each of their current TPI. For more information on NPI and the attestation process please visit the [TMHP](#) website.

Texas Medicaid & Healthcare Partnership and Compass 21

DSHS Family Planning Program claims are submitted to TMHP. TMHP processes claims using Compass 21, an automated claims processing and reporting system. Claims are subject to the following procedures:

- Claims are verified through a series of program edits and audits.
- Contractors receive an explanation of each payment or denial. The explanation is called the Remittance and Status (R&S) report, which contractors may access electronically through the TMHP website. The report identifies paid, denied, or pending claims. If no claim activity or outstanding account receivable exists during the time period, the contractor will not receive an R&S for the week.

Texas Medicaid Provider & Procedures Manual

The *Texas Medicaid Provider & Procedure Manual* (TMPPM) includes information related to DSHS Family Planning Program claims submission such as:

- Funding sources;
- Claim billing instructions for family planning and third-party insurance;
- Sterilization consent form instructions;
- Use of the 2017 Claim Form;
- Filing deadlines;
- Claim appeals;
- Family Planning Program information;
- Diagnosis and procedure codes;
- Contraceptive devices and related procedures;
- Drugs and supplies;
- Medical counseling and education;
- Sterilization and sterilization-related procedures; and
- Additional filing resources.

In addition, Medicaid bulletins and R&S banner messages provide up-to-date claims filing and payment information. The R&S banner messages, and the TMPPM are all available on the [TMHP website](#).

REIMBURSEMENT FOR FAMILY PLANNING SERVICES

Family planning contractors may seek reimbursement for project costs using one or two methods.

- a) Contractors may submit monthly vouchers for expenses outlined in a categorical budget approved by DSHS, as required for the categorical cost reimbursement method, and/or
- b) Contractors may be reimbursed using the fee-for-service reimbursement method, by submitting monthly claims to TMHP for services rendered.

Contractors may designate up to 50% of their total award on a categorical cost reimbursement basis. The remaining portion of their award will be paid on a fee-for-service basis. Contractors may designate up to 100% of their total award on a fee-for-services basis.

Categorical Reimbursement

The categorical portion of the DSHS Family Planning Program funding is used to develop and maintain contractor infrastructure for the provision of family planning services. The funding can be used to support clinic facilities, staff salaries, utilities, medical and office supplies, equipment, and travel, as well as direct medical services. Costs may be assessed against any of the following categories the contractor identifies during their budget development process:

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

Up to 50% of the DSHS Family Planning Program funds may be disbursed to contractors through a voucher system as expenses are incurred during the contract period. Program income must be expended before categorical funds are requested through the voucher process. Contractors must still submit vouchers monthly even if program income equals or exceeds program expenses, or if the contract reimbursement limit has been met. When program expenses exceed program income, the monthly voucher will result in a payment. Program income includes all fees paid by the clients, third party reimbursements from Medicaid, TWHP, Medicare, commercial insurance payments, and DSHS family planning fee-for-service.

To request reimbursement for the categorical contract, the following forms must be submitted monthly within **30 days following the end of the month in which the costs were incurred**:

- State of Texas Purchase Voucher (DSHS Form B-13);
- Supporting Schedule for DSHS Family Planning Reimbursement Vouchers (Form B-13X)

The following forms must be submitted within **60 days following the end of the contract term**:

- Final State of Texas Purchase Voucher (DSHS Form B-13)

- Supporting Schedule for DSHS Family Planning Reimbursement Vouchers (Form B-13X).

The [Client Services Contracting Unit \(CSCU\) website](#) provides necessary financial forms. For questions concerning budget and financial reporting contact the Contract Oversight and Support Branch (COS) at 512-776-7484.

Fee-for-Service Reimbursement

The fee-for-service portion of the DSHS Family Planning Program funding pays for direct medical services on a fee-for-services basis. Up to 100% of the DSHS family planning funds may be reimbursed on a fee-for-service basis. Each provider is responsible for determining an individual's eligibility for clinical services. The DSHS Family Planning Program reimburses contractors on a fee-for-service basis for services and supplies that have been provided to eligible clients. DSHS Family Planning Program contractors must continue to provide services to established clients and to submit and appeal claims for client services even after the contract funding limit has been met.

All contractors are required to use the 2017 Claim Form for submission of all DSHS Family Planning Program services to TMHP. A copy of the [2017 Claim Form](#) is available from the TMHP website. The TMPPM provides detailed instructions of how to complete the form, including required fields.

DSHS Family Planning Program claims or appeals must be filed within certain timeframes:

- Initial claims submission: Submitted within 95 days of the date of service on the claim or date of any third party insurance explanation of benefit (EOB). If the 95th day falls on a weekend or holiday, the filing deadline is extended until the next business day.
- Appeals: Submitted within 120 days of the date on the R&S Report on which the claim reaches a finalized status. If the 120th day falls on a weekend or holiday, the filing deadline is extended until the next business day. If the claim is denied for late filing due to the initial submission deadline, documentation of timely filing must be submitted along with the claim appeal. Refer to the TMPPM for further information.
- All claims and appeals must be submitted and processed within 60 days after the end of the contract period.
- All claims must continue to be billed and denied claims appealed even after the contract funding limit has been met.

DSHS Family Planning Program contractors may contact the TMHP Contact Center from 7:00 a.m. to 7:00 p.m. (CST), Monday through Friday at 800-925-9126 for questions about claims and payment status.

Rate Reduction of 7%

The DSHS Budget Reduction was directed to implement a 7% reduction in reimbursement rates effective September 1, 2011. The CPT code reimbursement rates will remain the same and the 7% reduction will be taken from the total amount to be reimbursed. This reduction will not change the contract amount.

DSHS Family Planning Program Procedure Codes

DSHS Family Planning Program reimbursement is limited to a prescribed set of procedure codes approved by DSHS. For a complete list of valid DSHS Family Planning Program procedures see Appendix A.

DSHS Family Planning Program contractors may submit claims for clients' office visits that reflect four different levels of service for **new** clients, and four different levels of service for **established** clients. A new client is defined as one who has not received clinical services at the contractor's clinic(s) during the previous three years. The level of services, which determines the procedure code to be billed for that client visit, is indicated by a combination of factors such as the complexity of the problem addressed and the time spent with the client by clinic providers. The [American Medical Association \(AMA\)](#) publishes materials related to Current Procedural Terminology (CPT) ® coding that include guidance on office visit codes (Evaluation and Management Services – E/M).

Medroxyprogesterone Acetate Injection Fee

Providers may not bill a lower complexity office visit code (99211/99212) when the primary purpose is for the client to receive an injection of Medroxyprogesterone acetate (Depo-Provera/DMPA/depo) injection; rather, they should bill the injection fee (96372) with the Depo-Provera contraceptive method (J1050).

The Texas Women's Health Program (TWHP) may reimburse for treatment of some sexually transmitted infections and diseases (STDs).

TWHP reimbursement for treatment of STDs is available only if the condition was discovered during a visit where the primary purpose was the client's family planning needs, i.e., contraception or contraceptive counseling.

- TWHP covers treatment for the following conditions:
 - Gardnerella
 - Trichomoniasis
 - Candida
 - Chlamydia
 - Gonorrhea

- Herpes
- Procedure codes for STD treatment have not been added as valid TWHP procedure codes, with the exception of gonorrhea. The gonorrhea treatment procedure code is J0696. Clients can access all other prescribed drugs for STD treatment through pharmacies that are enrolled in the [Texas Vendor Drug Program \(VDP\)](#).
- For more information, call the TMHP Contact Center at 800-925-9126.

Electronic Claims Submission

All DSHS Family Planning Program contractors are strongly encouraged to submit claims electronically. TMHP offers specifications for electronic claims formats. These specifications are available from the TMHP Provider Portal and relate the paper claim instruction to the electronic format. Contractors may use their own claims filing system, vendor software, or TexMedConnect (a free Web-based claims submission tool available through the TMHP website) for submission of electronic claims. For more information concerning electronic claims submission, contractors may contact the TMHP Electronic Data Interchange (EDI) Help Desk at 512-514-4150 or 888-863-3638. Additional information may be found on the TMHP website.

TWHP Claims Pending Eligibility Determination

To verify an applicant's TWHP eligibility:

- Clients will be issued a Your Texas Benefits card with "TWHP" printed in the upper right corner.
- Clients should show their Your Texas Benefits card at the point of service delivery.
- Even with this, though, providers will need to verify the client's eligibility. Providers can do this by going to www.YourTexasBenefitsCard.com. Or, providers can continue to call TMHP at 1-800-925-9126 or go to TexMedConnect on the TMHP website and check the member's Medicaid ID number (PCN).

Contractors must hold claims up to 35 calendar days for clients who have applied to the TWHP. If a client's TWHP eligibility has not been determined after 35 calendar days, the contractor may bill the service to the DSHS Family Planning Program if the client has a current eligibility form on file. If the contractor files a DSHS Family Planning Program claim for a potentially TWHP-eligible client before the end of the 35 day waiting period, the contractor should include a copy of the TWHP denial letter in the client record before filing the claim or encounter. After 35 days, the contractor does not have to document in the client record that they checked for the TWHP eligibility or include a copy of the TWHP denial letter in the client record before filing a DSHS Family Planning Program claim.

STERILIZATION BILLING/REPORTING

DSHS Family Planning Program contractors receive reimbursement for vasectomy or tubal ligation sterilization procedures as part of their family planning services. Reimbursement is paid under a global fee and covers all costs associated with the procedure - office visits, lab tests, surgery costs, anesthesia, and follow-up procedures/tests. The client may not be billed for any cost above the reimbursement rate. Client co-pays for sterilizations must follow the contractor's established co-pay policy and may not exceed the allowable amount.

Contractors shall expend no more than 15% of their combined DSHS Fee-for-Service and DSHS Categorical contract amounts on female sterilizations as a part of this contract.

Allowable sterilization codes, descriptions, and reimbursement amounts are as follows:

55250	Male sterilization, Vasectomy, global fee
58565	Female sterilization, hysteroscopy with bilateral fallopian tube cannulation and placement of permanent implants to occlude the fallopian tubes
58600	Female sterilization, Fallopian tube transection, blocking, or other procedure, global fee

Conditions for Sterilization Procedures

Clients receiving a vasectomy or tubal ligation sterilization procedure must:

- be twenty-one years of age or older;
- be mentally competent; clients are presumed to be mentally competent unless adjudicated incompetent for the purpose of sterilization;
- not be institutionalized in a correctional facility, mental hospital, or other rehabilitative facility;
- not give consent in labor or childbirth; and
- not give consent if under the influence of alcohol or drugs.

Waiting Period

- Family Planning contractors may provide sterilization services to their clients after a waiting period of 30 days.
- Sterilization may be performed in less than 30 days but more than 72 hours after the date of the individual's signature on this consent form in the following two instances:

- Premature delivery. Individual's expected delivery date must be completed on sterilization consent form; or
- Emergency abdominal surgery. Individual's circumstances must be described on sterilization consent form.

The consent for sterilization is valid for 180 days from the date of the client's signature.

Sterilization Consent Form

The TMPPM provides both an English and Spanish version of the Sterilization Consent Form to be used by DSHS Family Planning Program contractors. The form may be copied for use and contractors are encouraged to frequently re-copy the original form to ensure legible copies and to expedite consent validation. The TMPPM also includes detailed instructions for the completion of the Sterilization Consent Form. For more information regarding the Sterilization Consent Form and Instructions please see Section II, Chapter 2 in this manual.

Sterilization Complications

Contractors may request reimbursement for costs associated with patient complications related to sterilization procedures. Contractors may be reimbursed for approved charges up to \$1,000 per occurrence. To request reimbursement contractors should provide the DSHS Family Planning Program with the following information:

- A copy of the R&S report showing that a sterilization procedure was performed on the client in question;
- A narrative summary detailing the procedure performed and any related complications;
- All surgical and progress notes for the client related to the complications of the sterilization procedure;
- The initial operative report for the sterilization surgery; and
- A completed paper 2017 Claim Form detailing the procedures for which the contractor is seeking reimbursement (list all procedures related to the complication even if they are not typically reimbursable under the DSHS Family Planning Program).

IUD AND CONTRACEPTIVE IMPLANT COMPLICATIONS

Contractors may request reimbursement for costs associated with patient complications related to IUD or Contraceptive Implant insertions or removals.

Contractors may be reimbursed for approved charges up to \$1,000 per occurrence. To request reimbursement contractors should provide the DSHS Family Planning Program with the following information:

- A copy of the R&S report showing that an IUD or Contraceptive Implant insertion or removal procedure was performed on the client in question;
- A narrative summary detailing the procedure performed and any related complications;
- All surgical and progress notes for the client related to the complication of the IUD or Contraceptive Implant insertion or removal procedure; and
- A completed paper 2017 Claim Form detailing the procedures for which the contractor is seeking reimbursement (list all procedures related to the complication even if they are not typically reimbursable under the DSHS Family Planning Program).

RETROACTIVE ELIGIBILITY

Title XIX Retroactive Eligibility

Retroactive eligibility occurs when an individual has applied for Medicaid coverage but has not yet been assigned a Medicaid client number at the time of service. Individuals who are eligible for Title XIX (Medicaid) medical assistance receive three months prior eligibility to cover any medical expenses incurred during that period.

DSHS Family Planning Program Retroactive Eligibility

Any co-pay collected from a client found to be eligible retroactively for Medicaid must be refunded to the client. If a claim has been paid and later the client receives retroactive Title XIX (Medicaid) eligibility, TMHP recoups/adjusts the funds paid from the DSHS Family Planning Program and processes the claim as Title XIX. A DSHS Family Planning Program accounts receivable (A/R) is then established for the adjusted claim.

Note: Contractors are responsible for paying DSHS back the amount of any DSHS Family Planning Program A/R balance that may remain at the end of a state fiscal year.

The contractors' DSHS Family Planning Program R&S Report(s) will reflect the retroactive Title XIX adjustment with EOB message "Recoupment is due to Title XIX retro eligibility."

Assistance on reconciling R&S reports may be provided through the TMHP Contact Center from 7:00 a.m. to 7:00 p.m. CST, Monday through Friday at 800-925-9126. A TMHP Provider Relations representative is also available for these

specific questions, as a representative can be located by region on the TMHP website.

Performing Provider Number and Retroactive Eligibility

DSHS Family Planning claims do not require a performing provider number for reimbursement. However, if a Title XIX retroactive eligibility claim does not have a performing provider number in a TPI format, TMHP will deny the services. A common EOB message for this specific denial is *EOB 00118: Service(s) require performing provider name/number for payment*. A request for reconsideration of claim reimbursement may be sent to TMHP through the appeal methods.

Note: The performing provider number requirement applies to all Title XIX submissions.

Claims Submitted with Laboratory Services

If a Title XIX retroactive eligibility claim includes laboratory services and the DSHS Family Planning Program contractor is not CLIA certified for the date of service on the claim, TMHP will deny the laboratory services. The Title XIX R&S report will reflect *EOB 00488 message: "Our records indicate that there is not a CLIA number on file for this provider number or the CLIA is not valid for the dates of services on the claim"*.

When this occurs, the laboratory that performed the procedure(s) is responsible for re-filing laboratory charges with TMHP to receive Title XIX reimbursement. For claims past the 95-day filing deadline, the laboratory will be required to follow their Medicaid appeals process. DSHS contractors must make arrangements with their contracted laboratory to recoup any funds paid to the laboratory for lab services for DSHS Family Planning Program clients prior to Title XIX retro eligibility determination.

Patient Co-Pays

Title XIX does not allow providers to collect co-pays. DSHS family planning contractors must refund any co-pay collected if the client services were billed to Title XIX.

Also see Section II, Chapter 1 for DSHS Family Planning Program for co-pay guidelines.

Note:

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

BILLING FOR ADDITIONAL WRAP-AROUND SERVICES**TWHP Clients**

To receive DSHS Family Planning Program reimbursement for wrap-around services provided to a TWHP client, a separate DSHS Family Planning claim for the client must be filed, listing only the codes for the wrap-around services.

The following procedure codes are the only codes billable to the DSHS Family Planning Program as wrap-around services:

A9150 Non Prescription Drug
J3490 Unclassified Drug

No other procedure codes, including visit codes, should be included in the DSHS Family Planning Program wrap-around services claim submission.

The following services are also billable for TWHP clients when the primary diagnosis is not contraceptive related:

- Follow-up Pap Test
 - Contractors must file a separate DSHS Family Planning Program claim with a diagnosis code of 622.9. Contractors may be reimbursed for the Pap test, the appropriate counseling code, and the appropriate visit code.
- STD/STI Testing
 - Contractors must file a separate DSHS Family Planning Program claim with a diagnosis code of V01.6. Contractors may be reimbursed for STD/STI tests and STD/STI related services.
- Pregnancy Testing
 - Contractors must file a separate DSHS Family Planning Program claim with a diagnosis code of V72.40.

Medicaid and Emergency Medicaid Clients

The wrap-around process also includes reimbursement for post-partum female sterilizations and long acting reversible contraception (LARC) for Medicaid and Emergency Medicaid clients, as long as the client will also be eligible for the DSHS Family Planning Program at the time of delivery and has signed the Sterilization Consent Forms (as applicable) within the appropriate timeframe. The contractor is responsible for developing a process to determine DSHS Family Planning Program eligibility.

The procedure codes for post-partum LARC and female sterilizations are as follows:

-
- J7300 Copper intrauterine contraceptive
 - J7301 Levonorgestrel-Releasing intrauterine contraceptive system (SKYLA, 13.5 mg)
 - J7302 Levonorgestrel intrauterine contraceptive (Mirena, 52 mg)
 - J7307 Implantable contraceptive capsule
 - 11981 Non biodegradable drug delivery implant insertion
 - 58300 Insertion of intrauterine device
 - 58565 Female sterilization, hysteroscopy with bilateral fallopian tube cannulation and placement of permanent implants to occlude the fallopian tubes
 - 58600 Female sterilization, Fallopian tube transection, blocking, or other procedure, global fee

To receive DSHS Family Planning Program reimbursement for sterilizations and LARCs for Medicaid and Emergency Medicaid clients, contractors must file a separate DSHS Family Planning Program claim with one of above-listed procedure codes.

DONATIONS

Voluntary donations from clients are permissible. However, clients must not be pressured to make donations, and donations must not be a prerequisite to the provision of services or supplies. Donations are considered program income per specification of contract general provisions. All donations must be documented by source, amount, and date they were received by the contractor. Contractors must have a written policy on the collection of donations. Client donations collected by the contractor must be utilized to support the delivery of family planning services.

ADDITIONAL RESOURCES

[The Financial Administrative Procedures Manual for DSHS Contractors](#) provides DSHS contractors with a comprehensive guide on basic accounting and financial management system requirements.

REQUIRED REPORTS

Financial Reporting

VOUCHER AND REPORT SUBMISSION – Categorical**PROGRAM INFORMATION:****Program Name:** Family Planning**Contract Type:** Categorical**Contract Term:** September 1st thru August 31st**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 voucher due within 45 days after end of the contract term.**Submit Copy to:**

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

Instructions: Attach B-13X to voucher form B-13 for CDSB and 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:** Supporting Schedule for Family Planning Reimbursement Vouchers Form B-13X in Excel format**Submission Date:** By the last business day of the following month. Final B-13X due within 45 days after end of the contract term.**Submit Copy to:**

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

Instructions: Attach B-13X to B-13 for CDSB and CPU.

REPORT: Report 1

Report Name: Financial Status Report Form 269A

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

Submit Copy to:

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

Instructions: Form 269A must have an original signature (scanned email or fax accepted).

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

Last Updated/Reviewed: 6/11/2015

PROGRAM INFORMATION:

Program Name: Family Planning

Contract Type: Fee-for-Service (File Furnished Voucher thru TMHP TexMed Connect/Compass 21)

Contract Term: September 1st thru August 31st

CLAIMS SUBMISSION INFORMATION:

Claims Submission Form: 2017 Claim Form--File Furnished Voucher thru TMHP TexMed Connect/Compass 21

Claims Filing Deadline: Within 95 days from date of service or date of 3rd party insurance EOB form. Within 45 days after the end of the contract term.

Claims Submission Entity: Texas Medicaid Healthcare Partnership/Compass 21

NOTE: Claims must continue to be submitted to TMHP TexMed Connect/Compass 21 even if the contract limit has been reached.

NOTE: Appeals must be submitted within 120 days of rejection during the contract term.

All appeals must be submitted and finalized within 45 days after the end of the contract term.

REPORT: Report 1

Report Name: Financial Reconciliation Report (FRR)

Submission Date: No later than 60 days after the end of the contract term

Submit Copy to:

Name of Unit/Branch	Original Signature Required		Accepted Method of Submission	# Copies
	Yes	No		
Contract Development & Support Branch (CDSB)	X		Email (preferred), or Fax	1

Instructions: FRR form does require a signature (scanned or fax accepted), and needs to only be sent to CDSB.

Email Addresses:	CDSB	cdsb@dshs.state.tx.us
Fax Numbers:	CDSB	(512) 776-7521
Mail Codes:	CDSB	Please use mail codes on all mail coming into DSHS to ensure accurate delivery. Mail code 1914
Mailing Address for CDSB:		Contract Development & Support Branch, Mail Code 1914 Department of State Health Services P.O. Box 149347 Austin, TX 78714-9347

Last Updated/Reviewed: 6/11/2015

Financial Status Reports (FSRs) for Categorical Family Planning Contracts

The DSHS Family Planning Program operates using a “Total Budget Concept.” This means that all funding programs that are included in the contractor’s approved budget (Medicaid, patient fees/co-pays, in-kind donations, and other funds) become part of the family planning project. All revenue directly generated by or earned as a result of the project is considered program income, including family planning fee-for-service. Categorical family planning contractors are required to identify and report receipt and expenditure of program income both quarterly and annually on the FSR Form 269A. See Quarters for Categorical FSR submission below. Program income generated under the categorical contract must be expended prior to receiving reimbursement for program costs. The quarterly reports are due 30 days following the end of each quarter of the contract term. The final FSR, 269A, is due within 45 days after the end of the contract term, unless stipulated differently in the contract attachment following the end of the contract term. DSHS reserves the right to base funding levels, in part, upon the contractor’s proficiency in identifying, billing, collecting, and reporting income, and in utilizing it for the delivery of family planning services. For more information on financial reporting, see the [DSHS Client Services Procurement](#) website.

Quarters for Categorical FSR submission:

Quarter 1: September – November 2015

Quarter 2: December 2015 – February 2016

Quarter 3: March – May 2016

Quarter 4: June – August 2016

Family Planning Categorical Budget Revisions – Contractors may shift up to 25% of their total family planning categorical direct budget between categories, except equipment, without prior approval. However, if the amount being shifted is greater than 25% of the contractor’s total budget, the contractor must receive prior approval from DSHS. In such a case, contractors are required to submit a revised budget for review.

Programmatic Reporting

Progress Reports – All family planning contractors must complete annual progress reports on project performance measures and/or objectives established in the contractor’s application. Progress report due dates will be established during contract negotiations.

Section IV

Appendices

APPENDIX A

DSHS FAMILY PLANNING PROGRAM REIMBURSABLE CODES

FY2016

OFFICE VISIT	
99201	Office Visit. New Client. Problem focus. Straightforward decision-making.
99202	Office Visit. New Client. Expanded problem focus. Straightforward medical decision-making.
99203	Office Visit. New Client. Detailed history/exam. Low complexity decision-making.
99204	Office Visit. New Client. Comprehensive history/exam. Moderate complexity decision-making.
99211	Office Visit. Established Client. Minor problem focus. Straightforward decision-making.
99212	Office Visit. Established Client. Problem focus. Straightforward decision-making.
99213	Office Visit. Established Client. Expanded problem focus. Low complexity decision-making.
99214	Office Visit. Established Client. Detailed history/exam. Moderate complexity decision-making.
RADIOLOGY	
73060	Radiologic Examination; Humerus, Minimum of Two Views
74000	X-ray, abdomen, single a/p view
74010	X-ray, abdomen, a/p and additional views
76830	Ultrasound, transvaginal
76856	Ultrasound, pelvic, non-obstetric
76857	Ultrasound, pelvic, non-obstetric, limited or follow-up
76881	Ultrasound, extremity, nonvascular, real-time with image documentation, complete
76882	Ultrasound, extremity, nonvascular, real-time with image documentation, limited, anatomic specific

APPENDIX A

DSHS FAMILY PLANNING PROGRAM REIMBURSABLE CODES

FY2016

MEDICATION AND IMMUNIZATION	
A9150	Non-Rx drugs – Use FP modifier w/ code
J3490	Injection Medication for STD or G/U infection
S5000	Oral prescription medication, generic
90460	IM admin 1st/only component
90471	Immunization admin
90649	HPV vaccine 4 valent, IM
90650	HPV vaccine 2 valent, IM
CONTRACEPTIVE METHOD	
H1010	Instruction, NFP
A4261	Cervical cap
A4266	Diaphragm
57170	Diaphragm or cervical cap fitting w/ instructions
A4267	Condom, male, each
A4268	Condom, female, each
A4269	Spermicide (e.g., foam, gel) each, 6 suppositories or film are quantity of 1
S4993	Oral contraceptive pills, one cycle/ECP
J7300	Copper intrauterine contraceptive
J7301	Skylla IUD (13.5 mg Levonorgestrol intrauterine contraceptive)
J7302	Levonorgestrel-releasing intrauterine contraceptive system
58300	Insertion of intrauterine device
58301	Removal of intrauterine device
J1050	Medroxyprogesterone acetate for contraceptive use, injection
96372	Injection fee, Medroxyprogesterone acetate
J7303	Vaginal ring, each
J7304	Contraceptive patch, each
J7307	Implantable contraceptive capsule
11976	Removal, implantable contraceptive
11981	Non-biodegradable drug delivery implant insertion

APPENDIX A

DSHS FAMILY PLANNING PROGRAM REIMBURSABLE CODES

FY2016

LABORATORY	
80061	Lipid profile w/ cholesterol
81000	Urinalysis, by dipstick or tablet, non-automated, with microscopy
81001	Urinalysis, by dipstick or tablet, automated, with microscopy
81002	Urinalysis, dipstick or tablet, nonautomated
81003	Urinalysis, by dipstick or tablet, automated, without microscopy
81015	Urinalysis, microscopic only
81025	Urine pregnancy test, visual comparison methods
82947	Glucose, blood, except reagent strip
82948	Glucose, blood, reagent strip
84443	Thyroid Stimulating Hormone
84702	Chorionic gonadotropin, quantitative (pregnancy test)
84703	Chorionic gonadotropin, qualitative (pregnancy test)
85013	Microhematocrit, spun
85014	Hematocrit
85018	Hemoglobin
85025	CBC with differential, automated
85027	CBC, automated
86580	Tb skin test, intradermal
86592	Syphilis
86689	HTLV/HIV confirmatory test
86695	Herpes simplex, type 1
86696	Herpes simplex, type 2
86701	HIV-1 antibody
86702	HIV-2 antibody
86703	HIV-1 and HIV-2, single assay
86762	Rubella antibody
86803	Hepatitis C antibody
86900	Blood typing, ABO

APPENDIX A

DSHS FAMILY PLANNING PROGRAM REIMBURSABLE CODES

FY2016

86901	Blood typing, Rh
87070	Culture, bacterial; any source other than blood or stool; with presumptive identification of isolates
87086	Urine culture, bacterial, quantitative
87088	Urine culture, bacterial, with presumptive identification of isolates
87102	Culture, fungi, with presumptive identification of isolates, source other than blood, skin, hair, or nail
87110	Chlamydia culture
87205	Smear with interpretation, routine stain for bacteria, fungi or cell types
87210	Wet mount for infectious agents (e.g. saline, India ink, KOH preps)
87220	Tissue examination by KOH slide of samples from skin, hair or nails for fungi, ectoparasite ova, mites
87252	Virus isolation, tissue culture inoculation and presumptive identification (herpes)
87340	Hepatitis B surface antigen, by enzyme immunoassay technique
87389	HIV-1 AG w/ HIV-1 & HIV 2 AB
87480	Candida species, direct probe technique
87490	Chlamydia, direct probe technique
87491	Chlamydia, amplified probe technique
87510	Gardnerella vaginalis, direct probe technique
87535	HIV-1 probe & reverse transcription
87590	Gonorrhea, direct probe technique
87591	Gonorrhea, amplified probe technique
87624	HPV, high-risk types
87625	HPV, types 16 and 18 only
87660	Trichomonas vaginalis, direct probe technique
87800	Infectious agent, multiple organisms, direct probe
87810	Chlamydia, immunoassay w/ direct optical observation.
87850	Gonorrhea, immunoassay with direct optical observation
88142	Cytopathology, cervical/vaginal, liquid based, automated
88150	Cytopathology, cervical/vaginal, slides, manual

APPENDIX A**DSHS FAMILY PLANNING PROGRAM REIMBURSABLE CODES****FY2016**

88164	Cytopathology, cervical/vaginal, slides, manual, the Bethesda System
88175	Cytopathology, cervical/vaginal, any reporting system, fluid based, automated screening with manual rescreening or review.
99000	Specimen handling or conveyance
STERILIZATION	
55250	Male sterilization, Vasectomy, global fee
58565	Female sterilization, hysteroscopy with bilateral fallopian tube cannulation and placement of permanent implants to occlude the fallopian tubes
58600	Female sterilization, Fallopian tube transection, blocking, or other procedure, global fee

The Family Planning Program through the DSHS budget reduction, were directed to implement a **7%** reduction in reimbursement rates effective **September 1, 2011**. The CPT code reimbursement rates will remain the same and the 7% reduction will be taken from the total amount to be reimbursed.



PART I - APPLICANT INFORMATION

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

- a) Please contact me by: (check all that apply) Mail Phone Email
- b) Do you have comprehensive health care coverage (Medicaid, Medicare, CHIP, health insurance, VA, TRICARE, etc.)? Yes No
**If yes, DSHS' authorized representative will submit a claim for reimbursement from your insurer for any benefit, service or assistance that you have received.*
- c) Which benefits or health care coverage do you receive? (check all that apply)
- CHIP Perinatal SNAP WIC
 Medicaid for Pregnant Women TWHP None

PART II – HOUSEHOLD INFORMATION

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

How many people are in your household?

PART III - INCOME INFORMATION

List all of your household's income below. Include the following: government checks; money from work; money you collect from charging room and board; cash gifts, loans, or contributions from parents, relatives, friends, and others; sponsor's income; school grants or loans; child support; and unemployment benefits.

Name of person receiving money	Name of agency, person, or employer who provides the money	Amount received per month

PART IV - APPLICANT AGREEMENT

I have read the **Rights and Responsibilities** statements in the *instructions* section of this form. Yes No

The information that I have provided, including my answers to all questions, is true and correct to the best of my knowledge and belief. I agree to give eligibility staff any information necessary to prove statements about my eligibility. I understand that giving false information could result in disqualification and repayment.

I authorize release of all information, including income and medical information, by and to the Texas Department of State Health Services (DSHS) and Provider in order to determine eligibility, to bill, or to render services to me.

Signature – Applicant _____ Date _____

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

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

Eligibility effective date / /

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

	7. Is the client eligible for the following program(s)?			Co-payment amount (if applicable)
	Yes	No	n/a	
BCCS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	\$ _____
DSHS FP	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	\$ _____
EPHC	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	\$ _____
PHC	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	\$ _____
Title V/MCH	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	\$ _____

Notes:

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

PART I - APPLICANT INFORMATION

Fill in the boxes with your information.

- a) Check all the boxes that apply.
- b) Check *yes* or *no*.
- c) Check all the boxes that apply:
- CHIP (Children's Health Insurance Program) Perinatal
 - Medicaid for Pregnant Women
 - SNAP (Supplemental Nutrition Assistance Program)
 - TWHP (Texas Women's Health Program)
 - WIC (Special Supplemental Nutrition Program for Women Infants and Children)
 - None

If you selected one of these benefits or health care coverage programs and you are able to provide proof of current enrollment, you may be adjunctively (automatically) eligible for a DSHS Family & Community Health Services Division program and able to skip Part II and III on this application, if your agency does not collect a co-pay. (Exception -- Adjunctive eligibility does not apply to applicants seeking Title V services.)

PART II – HOUSEHOLD INFORMATION

Fill in the box with the number of people in your household. This number will include you and anyone who lives with you for whom you are legally responsible.

How to determine your household:

- If you are married (including common-law marriage), include yourself, your spouse, and any mutual or non-mutual children (including unborn children).
- If you are not married, include yourself and your children, if any (including unborn children).
- If you are not married and you live with a partner with whom you have mutual children, count yourself, your partner, your children, and any mutual children (including unborn children).

Applicants 18 years and older are adults. Do not include any children age 18 and older, or other adults living in the house, as part of the household. Minors should include parent(s)/legal guardian(s) living in the house.

PART III - INCOME INFORMATION

List all of your household's income in the table. Include the following: government checks; money from work; money you collect from charging room and board; cash gifts, loans, or contributions from parents, relatives, friends, and others; sponsor's income; school grants or loans; child support; and unemployment benefits.

Fill in the table with the following information:

- 1st column: The name of the person receiving the money.
- 2nd column: The name of the agency, person, or employer who provides the money.
- 3rd column: The amount of money received per month.

PART IV - APPLICANT AGREEMENT**Rights and Responsibilities:**

If the applicant omits information, fails or refuses to give information, or gives false or misleading information about these matters, he/she may be required to reimburse the State for the services rendered if the applicant is found to be ineligible for services. The applicant will report changes in his/her household/family situation that affect eligibility during the certification period (changes in income, household/family members, and residency). (*MBCC clients are not required to report changes in income, household, and residency*)

The applicant understands that, to maintain program eligibility, he/she will be required to reapply for assistance at least every twelve months (*not applicable to MBCC*).

The applicant understands he/she has the right to file a complaint regarding the handling of his/her application or any action taken by the program with the HHSC Civil Rights Office at 1-888-388-6332.

The applicant understands that criteria for participation in the program are the same for everyone regardless of sex, age, disability, race, or national origin.

With few exceptions, the applicant has the right to request and be informed about information that the State of Texas collects about him/her. The applicant is entitled to receive and review the information upon request. The applicant also has the right to ask the state agency to correct any information that is determined to be incorrect. See <http://www.dshs.state.tx.us> for more information on Privacy Notification. (Reference: Government Code, Section 552.021, 522.023 and 559.004)

Read the **Rights and Responsibilities** above. Check *yes* or *no*.

Sign and date on the lines. If a person helped you complete the application, he/she should sign, state the relationship to you, and date on the lines.

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

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

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

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

Use the space provided in *Notes* to document other appropriate information concerning eligibility and screening.

Fill in the *Eligibility effective date* box in the top right corner of Part V. Fill in the *Name of Agency*, sign, and date.

APPENDIX B División de Servicios de Salud Familiar y Comunitaria del Departamento Estatal de Servicios de Salud (DSHS) Formulario para la participación INDIVIDUAL



PARTE I - INFORMACIÓN DEL SOLICITANTE

Nombre (apellido, primer nombre, segundo nombre)		Número telefónico		Correo electrónico	
Domicilio en Texas (nombre de la calle o número de apartado postal)		Ciudad	Condado	Estado	Código postal
Número de Seguro Social (SSN) (opcional)		Fecha de nacimiento	Edad	Raza	Origen étnico
					Sexo

- a) Por favor contáctenme por: (marque todo lo que corresponda) Correo postal Teléfono Correo electrónico
- b) ¿Tiene usted cobertura médica integral (Medicaid, Medicare, CHIP, seguro médico, VA, TRICARE, etc.)? Sí No
- *Si contestó que sí, el representante autorizado del DSHS presentará una reclamación de reembolso ante su compañía de seguro médico por las prestaciones, los servicios o la asistencia que usted haya recibido.*
- c) ¿Qué tipo de prestaciones o de cobertura médica tiene? (marque todo lo que corresponda)
- CHIP Perinatal SNAP WIC
- Medicaid para mujeres embarazadas TWHP Ninguno

PARTE II - INFORMACIÓN DE LA FAMILIA

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

¿Cuántas personas viven en su casa?

PARTE III - INFORMACIÓN SOBRE LOS INGRESOS

Enumere abajo todos los ingresos de la familia. Incluya los siguientes: cheques del gobierno; dinero del trabajo; dinero que obtiene por el cargo de alojamiento y comida; regalos en efectivo, préstamos o contribuciones de los padres, familiares, amigos y otros; ingresos que recibe de un patrocinador; becas o préstamos escolares; manutención de menores e ingresos por desempleo.

Nombre de la persona que recibe el dinero	Nombre de la agencia, la persona o el empleador que provee el dinero	Cantidad recibida al mes

PARTE IV - ACUERDO DEL SOLICITANTE

He leído las declaraciones de Derechos y Responsabilidades en la sección de *Instrucciones* de este formulario. Sí No

La información que aquí proporciono, incluidas mis respuestas a todas las preguntas, es verídica y correcta, según mi leal saber y entender. Acepto darle al personal que determina el derecho a la participación cualquier información que sea necesaria para comprobar mis declaraciones respecto a mi derecho a la participación. Entiendo que dar información falsa podría dar por resultado la descalificación y el reembolso de los apoyos recibidos.

Autorizo al Departamento Estatal de Servicios de Salud de Texas (DSHS) y al Proveedor a que dispongan libremente de toda la información que proporciono, incluida la información sobre los ingresos y la médica, con el fin de que determinen mi derecho a la participación y a que paguen o presten servicios a mi familia o a mí.

Firma del solicitante _____ Fecha _____

Firma de la persona que ayudó a completar esta solicitud _____ Relación con el solicitante _____ Fecha _____

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

Eligibility effective date / /

1. Texas resident <input type="checkbox"/> Yes <input type="checkbox"/> No	7. Is the client eligible for the following program(s)?				Co-payment amount (if applicable)		
2. Total monthly household income \$ <input type="text"/>		Yes	No	n/a			
3. Household FPL <input type="text"/> %		BCCS	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	\$ _____
4. Proof of income <input type="checkbox"/> Yes <input type="checkbox"/> Waived		DSHS FP	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	\$ _____
5. Verification of adjunctive eligibility <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> n/a		EPHC	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	\$ _____
6a. Presumptively eligible <input type="checkbox"/> Yes <input type="checkbox"/> No		PHC	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	\$ _____
6b. Full eligibility met <input type="checkbox"/> Yes		Title V/MCH	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	\$ _____
6c. Full eligibility met date <input type="text"/> / /	Notes:						

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

Instrucciones para llenar el formulario para la participación INDIVIDUAL

PARTE I - INFORMACIÓN DEL SOLICITANTE

Llene las casillas con su información personal.

- a) Marque todas las casillas que correspondan.
- b) Marque "sí" o "no".
- c) Marque todas las casillas que correspondan:
 - CHIP (Programa de Seguro Médico Infantil) Perinatal
 - Medicaid para mujeres embarazadas
 - SNAP (Programa de Asistencia de Nutrición Suplemental)
 - TWHP (Programa de Salud para la Mujer de Texas)
 - WIC (Programa de Nutrición Suplemental Especial para Mujeres, Niños y Bebés)
 - Ninguno

Si usted seleccionó uno de estos programas de prestaciones o de cobertura médica y puede proporcionar un comprobante de inscripción actualizado, usted podría de manera adjunta (automáticamente) tener derecho a la participación de un programa de la División de Servicios de Salud Familiar y Comunitaria del DSHS y saltar a las Partes II y III de esta solicitud, si su agencia no cobra un copago. (Excepción: elegibilidad adjunto no se aplica a los solicitantes de los servicios del Título V.)

PARTE II - INFORMACIÓN DE LA FAMILIA

Llene las casillas con el número de personas que hay en su familia. Este número le incluye a usted y a cada persona que viva con usted y de la que usted sea legalmente responsable.

Cómo determinar qué personas componen su familia:

- Si usted es casado (incluso en matrimonio de hecho), inclúyase a usted mismo e incluya a su cónyuge y a todos los hijos, tanto los habidos en común como los no habidos en común (incluidos los no nacidos).
- Si usted no es casado, inclúyase a usted mismo e incluya a sus hijos, de tenerlos (incluidos los no nacidos).
- Si usted no es casado y vive con su pareja con la cual tiene hijos en común, inclúyase a usted mismo e incluya a su pareja, a sus hijos y a los hijos que hayan tenido en común (incluidos los no nacidos).

Los solicitantes de 18 años de edad o más se consideran adultos. No incluya a ningún hijo de 18 años de edad o más ni a ningún otro adulto que viva en su casa como parte de la familia. Los menores de edad deben incluir al padre, a la madre o al tutor legal que vivan en la casa.

PARTE III - INFORMACIÓN SOBRE LOS INGRESOS

Enumere en la tabla todos y cada uno de los ingresos de la familia. Incluya los siguientes: cheques del gobierno; dinero del trabajo; dinero que obtiene por el cargo de alojamiento y comida; regalos en efectivo, préstamos o contribuciones de los padres, familiares, amigos y otros; ingresos que recibe de un patrocinador; becas o préstamos escolares; manutención de menores e ingresos por desempleo.

Llene la tabla con la siguiente información personal:

- 1.ª columna: El nombre de la persona que recibe el dinero.
- 2.ª columna: El nombre de la agencia, la persona o el empleador que provee el dinero.
- 3.ª columna: La cantidad de dinero recibida al mes.

PARTE IV - ACUERDO DEL SOLICITANTE

Derechos y Responsabilidades:

Si el solicitante omite información, no la proporciona o se niega a proporcionarla, o da información falsa o engañosa sobre estas cuestiones, podría pedirle que reembolse al Estado el importe de los servicios recibidos si se encontró que el solicitante no cumple con los requisitos para recibir los servicios. El solicitante deberá informar de cualquier cambio en la situación de su hogar o familia que afecte el derecho a la participación durante el periodo de certificación (cambios en los ingresos, en los miembros del hogar o la familia y el lugar de residencia). (Las clientes de MBCC no tienen que informar de cambios en los ingresos ni en el hogar o el lugar de residencia)

El solicitante entiende que, para mantener el derecho a participar del programa, se le pedirá que vuelva a solicitar la ayuda al menos cada doce meses (no aplicable para clientes de MBCC).

El solicitante entiende que tiene el derecho a presentar una queja con respecto al manejo de su solicitud o a cualquier acción llevada a cabo por el programa, ante la Oficina de Derechos Civiles de la HHSC, al teléfono 1-888-388-6332.

El solicitante entiende que los criterios para la participación en el programa son iguales para todos sin importar el sexo, la edad, la discapacidad, la raza o el lugar de nacimiento.

Con unas cuantas excepciones, el solicitante tiene derecho a pedir y a ser notificado sobre la información que el estado de Texas reúne sobre él. El solicitante tiene derecho a recibir y revisar la información al así pedirlo. El solicitante también tiene derecho a pedirle a la agencia estatal que corrija cualquier información que se determine que es incorrecta. Consulte <http://www.dshs.state.tx.us> para obtener más información sobre la Notificación de privacidad. (Fuente: Código Gubernamental, secciones 552.021, 522.023 y 559.004).

Lea los Derechos y Responsabilidades siguientes. Marque "sí" o "no".

Firme y escriba la fecha en las líneas correspondientes. Si alguna persona le ayudó a usted a llenar la solicitud, también debe firmar, declarar cuál es su relación con usted y escribir la fecha en las líneas correspondientes.

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

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

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

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

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

**DSHS Family & Community Health Services Division
HOUSEHOLD Eligibility Form**



Use with HOUSEHOLD Worksheet (Form EF05-13227)

PART I - APPLICANT INFORMATION

Name (Last, First, Middle)	Telephone Number		Email Address	
Texas Residence Address (Street or P.O. Box)	City	County	State	ZIP

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

b) Do you – or anyone in your household – have comprehensive health care coverage (Medicaid, Medicare, CHIP, health insurance, VA, TRICARE, etc.)? Yes No

**If yes, DSHS' authorized representative will submit a claim for reimbursement from your insurer for any benefit, service or assistance that anyone in your household has received.*

c) Which benefits or health care coverage do you receive? (check all that apply)

- CHIP Perinatal SNAP WIC
 Medicaid for Pregnant Women TWHP None

PART II - HOUSEHOLD INFORMATION

Fill in the first line with your information. Fill in the other lines for everyone who lives with you for whom you are legally responsible.

Name (Last, First, Middle)	SSN (optional)	Date of Birth	Sex	Race	Ethnicity	Relationship
1.						
2.						
3.						
4.						
5.						
6.						

PART III - INCOME INFORMATION

List all of your household's income below. Include the following: government checks; money from work; money you collect from charging room and board; cash gifts, loans, or contributions from parents, relatives, friends, and others; sponsor's income; school grants or loans; child support; and unemployment benefits.

Name of person receiving money	Name of agency, person, or employer who provides the money	Amount received per month

PART IV - APPLICANT AGREEMENT

I have read the **Rights and Responsibilities** statements in the *instructions* section of this form. Yes No

The information that I have provided, including my answers to all questions, is true and correct to the best of my knowledge and belief. I agree to give eligibility staff any information necessary to prove statements about my eligibility. I understand that giving false information could result in disqualification and repayment.

I authorize release of all information, including income and medical information, by and to the Texas Department of State Health Services (DSHS) and Provider in order to determine eligibility, to bill, or to render services to my household or me.

Signature – Applicant Date

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

PART I - APPLICANT INFORMATION

Fill in the boxes with your information.

- a) Check all the boxes that apply.
- b) Check *yes* or *no*.
- c) Check all the boxes that apply:
- CHIP (Children's Health Insurance Program) Perinatal
 - Medicaid for Pregnant Women
 - SNAP (Supplemental Nutrition Assistance Program)
 - TWHP (Texas Women's Health Program)
 - WIC (Special Supplemental Nutrition Program for Women Infants and Children)
 - None

If you selected one of these benefit or health care coverage programs and you are able to provide proof of current enrollment, you may be adjunctively (automatically) eligible for a DSHS Family & Community Health Services Division program and able to skip Part II and III on this application, if your agency does not collect a co-pay. (Exception -- Adjunctive eligibility does not apply to applicants seeking Title V services)

PART II – HOUSEHOLD INFORMATION

Fill in the first line with your information. Fill in the other lines for everyone who lives with you for whom you are legally responsible.

How to determine your household:

- If you are married (including common-law marriage), include yourself, your spouse, and any mutual or non-mutual children (including unborn children).
- If you are not married, include yourself and your children, if any (including unborn children).
- If you are not married and you live with a partner with whom you have mutual children, count yourself, your partner, your children, and any mutual children (including unborn children).

Applicants 18 years and older are adults. Do not include any children age 18 and older, or other adults living in the house, as part of the household. Minors should include parent(s)/legal guardian(s) living in the house.

PART III - INCOME INFORMATION

List all of your household's income in the table. Include the following: government checks; money from work; money you collect from charging room and board; cash gifts, loans, or contributions from parents, relatives, friends, and others; sponsor's income; school grants or loans; child support; and unemployment benefits.

Fill in the table with the following information:

- 1st column: The name of the person receiving the money.
- 2nd column: The name of the agency, person, or employer who provides the money.
- 3rd column: The amount of money received per month.

PART IV - APPLICANT AGREEMENT

Read the **Rights and Responsibilities** above. Check *yes* or *no*.

Sign and date on the lines. If a person helped you complete the application, he/she should sign, state the relationship to you, and date on the lines.

Rights and Responsibilities:

If the applicant omits information, fails or refuses to give information, or gives false or misleading information about these matters, he/she may be required to reimburse the State for the services rendered if the applicant is found to be ineligible for services. The applicant will report changes in his/her household/family situation that affect eligibility during the certification period (changes in income, household/family members, and residency). (*MBCC clients are not required to report changes in income, household, and residency*)

The applicant understands that, to maintain program eligibility, he/she will be required to reapply for assistance at least every twelve months (*not applicable to MBCC*).

The applicant understands he/she has the right to file a complaint regarding the handling of his/her application or any action taken by the program with the HHSC Civil Rights Office at 1-888-388-6332.

The applicant understands that criteria for participation in the program are the same for everyone regardless of sex, age, disability, race, or national origin.

With few exceptions, the applicant has the right to request and be informed about information that the State of Texas collects about him/her. The applicant is entitled to receive and review the information upon request. The applicant also has the right to ask the state agency to correct any information that is determined to be incorrect. See <http://www.dshs.state.tx.us> for more information on Privacy Notification. (Reference: Government Code, Section 552.021, 522.023 and 559.004)

Formulario para la participación FAMILIAR

Use with HOUSEHOLD Worksheet (Form EF05-13227)

PARTE I - INFORMACIÓN DEL SOLICITANTE

Nombre (apellido, primer nombre, segundo nombre)		Número telefónico		Correo electrónico	
Domicilio en Texas (nombre de la calle o número de apartado postal)		Ciudad	Condado	Estado	Código postal

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

b) ¿Tiene usted o alguien de su familia cobertura médica integral (Medicaid, Medicare, CHIP, seguro médico, VA, TRICARE, etc.)? Sí No

*Si contestó que sí, el representante autorizado del DSHS presentará una reclamación de reembolso ante su compañía de seguro médico por las prestaciones, los servicios o la asistencia que cualquier persona en su hogar haya recibido.

c) ¿Qué tipo de prestaciones o de cobertura médica tiene? (marque todo lo que corresponda)

- CHIP Perinatal SNAP WIC
 Medicaid para mujeres embarazadas TWHP Ninguno

PARTE II - INFORMACIÓN DE LA FAMILIA

Llene la primera línea con su información personal. Llene las demás líneas con los datos de cada persona que vive con usted y de quien usted sea legalmente responsable.

Nombre (apellido, primer nombre, segundo nombre)	Número de Seguro Social (SSN) (opcional)	Fecha de nacimiento	Sexo	Raza	Origen étnico	Relación
1.						
2.						
3.						
4.						
5.						
6.						

PARTE III - INFORMACIÓN SOBRE LOS INGRESOS

Enumere abajo todos los ingresos de la familia. Incluya los siguientes: cheques del gobierno; dinero del trabajo; dinero que obtiene por el cargo de alojamiento y comida; regalos en efectivo, préstamos o contribuciones de los padres, familiares, amigos y otros; ingresos que recibe de un patrocinador; becas o préstamos escolares; manutención de menores e ingresos por desempleo.

Nombre de la persona que recibe el dinero	Nombre de la agencia, la persona o el empleador que provee el dinero	Cantidad recibida al mes

PARTE IV - ACUERDO DEL SOLICITANTE

He leído las declaraciones de **Derechos y Responsabilidades** en la sección de *Instrucciones* de este formulario. Sí No

La información que aquí proporciono, incluidas mis respuestas a todas las preguntas, es verídica y correcta, según mi leal saber y entender. Acepto darle al personal que determina el derecho a la participación cualquier información que sea necesaria para comprobar mis declaraciones respecto a mi derecho a la participación. Entiendo que dar información falsa podría dar por resultado la descalificación y el reembolso.

Autorizo al Departamento Estatal de Servicios de Salud de Texas (DSHS) y al Proveedor a que dispongan libremente de toda la información que proporciono, incluida la información sobre los ingresos y la médica, con el fin de que determinen mi derecho a la participación y a que paguen o presten servicios a mi familia o a mí.

Firma del solicitante _____ Fecha _____

Firma de la persona que ayudó a completar esta solicitud _____ Relación con el solicitante _____ Fecha _____

Instrucciones para llenar el formulario para la participación FAMILIAR

Use with HOUSEHOLD Worksheet (Form EF05-13227)

PARTE I - INFORMACIÓN DEL SOLICITANTE

Llene las casillas con su información personal.

a) Marque todas las casillas que correspondan.

b) Marque “sí” o “no”.

c) Marque todas las casillas que correspondan:

- CHIP (Programa de Seguro Médico Infantil) Perinatal
- Medicaid para mujeres embarazadas
- SNAP (Programa de Asistencia de Nutrición Suplemental)
- TWHIP (Programa de Salud para la Mujer de Texas)
- WIC (Programa de Nutrición Suplemental Especial para Mujeres, Niños y Bebés)
- Ninguno

Si usted seleccionó uno de estos programas de prestaciones o de cobertura médica y puede proporcionar un comprobante de inscripción actualizado, usted podría de manera adjunta (automáticamente) tener derecho a la participación de un programa de la División de Servicios de Salud Familiar y Comunitaria del DSHS y saltar a las Partes II y III de esta solicitud, si su agencia no cobra un copago. (Excepción: elegibilidad adjunto no se aplica a los solicitantes de los servicios del Título V.)

PARTE II - INFORMACIÓN DE LA FAMILIA

Llene la primera línea con su información personal. Llene las demás líneas con los datos de cada persona que vive con usted y de quien usted sea legalmente responsable.

Cómo determinar qué personas componen su familia:

- Si usted es casado (incluso en matrimonio de hecho), inclúyase a usted mismo e incluya a su cónyuge y a todos los hijos, tanto los habidos en común como los no habidos en común (incluidos los no nacidos).
- Si usted no es casado, inclúyase a usted mismo e incluya a sus hijos, de tenerlos (incluidos los no nacidos).
- Si usted no es casado y vive con su pareja con la cual tiene hijos en común, inclúyase a usted mismo e incluya a su pareja, a sus hijos y a los hijos que hayan tenido en común (incluidos los no nacidos).

Los solicitantes de 18 años de edad o más se consideran adultos. No incluya a ningún hijo de 18 años de edad o más ni a ningún otro adulto que viva en su casa como parte de la familia. Los menores de edad deben incluir al padre, a la madre o al tutor legal que vivan en la casa.

PARTE III - INFORMACIÓN SOBRE LOS INGRESOS

Enumere en la tabla todos y cada uno de los ingresos de la familia. Incluya los siguientes: cheques del gobierno; dinero del trabajo; dinero que obtiene por el cargo de alojamiento y comida; regalos en efectivo, préstamos o contribuciones de los padres, familiares, amigos y otros; ingresos que recibe de un patrocinador; becas o préstamos escolares; manutención de menores e ingresos por desempleo.

Llene la tabla con la siguiente información personal:

- 1.ª columna: El nombre de la persona que recibe el dinero.
- 2.ª columna: El nombre de la agencia, la persona o el empleador que provee el dinero.
- 3.ª columna: La cantidad de dinero recibida al mes.

PARTE IV - ACUERDO DEL SOLICITANTE

Lea los **Derechos y Responsabilidades** siguientes. Marque “sí” o “no”.

Firme y escriba la fecha en las líneas correspondientes. Si alguna persona le ayudó a usted a llenar la solicitud, también debe firmar, declarar cuál es su relación con usted y escribir la fecha en las líneas correspondientes.

Derechos y Responsabilidades:

Si el solicitante omite información, no la proporciona o se niega a proporcionarla, o da información falsa o engañosa sobre estas cuestiones, podría pedírsele que reembolse al Estado el importe de los servicios recibidos si se encontró que el solicitante no cumple con los requisitos para recibir los servicios. El solicitante deberá informar de cualquier cambio en la situación de su hogar o familia que afecte el derecho a la participación durante el periodo de certificación (cambios en los ingresos, en los miembros del hogar o la familia y el lugar de residencia). (*Las clientes de MBCC no tienen que informar de cambios en los ingresos ni en el hogar o el lugar de residencia*)

El solicitante entiende que, para mantener el derecho a participar del programa, se le pedirá que vuelva a solicitar la ayuda al menos cada doce meses (*no aplicable para clientes de MBCC*).

El solicitante entiende que tiene el derecho a presentar una queja con respecto al manejo de su solicitud o a cualquier acción llevada a cabo por el programa, ante la Oficina de Derechos Civiles de la HHSC, al teléfono 1-888-388-6332.

El solicitante entiende que los criterios para la participación en el programa son iguales para todos sin importar el sexo, la edad, la discapacidad, la raza o el lugar de nacimiento.

Con unas cuantas excepciones, el solicitante tiene derecho a pedir y a ser notificado sobre la información que el estado de Texas reúne sobre él. El solicitante tiene derecho a recibir y revisar la información al así pedirlo. El solicitante también tiene derecho a pedirle a la agencia estatal que corrija cualquier información que se determine que es incorrecta. Consulte <http://www.dshs.state.tx.us> para obtener más información sobre la Notificación de privacidad. (Fuente: Código Gubernamental, secciones 552.021, 522.023 y 559.004)

**APPENDIX C DSHS Family & Community Health Services Division
HOUSEHOLD Eligibility Worksheet**



PART I – APPLICANT INFORMATION

Name (Last, First, Middle)	Today's Date (MM-DD-YYYY)	Eligibility Effective Date (MM-DD-YYYY)
Case Record Action <input type="checkbox"/> Adjunctive <input type="checkbox"/> Presumptive <input type="checkbox"/> Supplemental <input type="checkbox"/> Approved <input type="checkbox"/> Denied	Client/Case #	Type of Determination <input type="checkbox"/> New <input type="checkbox"/> Re-certification
Texas resident <input type="checkbox"/> Yes <input type="checkbox"/> No		
Other benefits or health care coverage (Medicaid, Medicare, CHIP, private health insurance, VA, TRICARE, etc.)		
Special circumstances		

PART II – HOUSEHOLD INFORMATION

1.	Notes
2.	
3.	
4.	
5.	
6.	

PART III – INCOME INFORMATION

Income Type	Name(s) of household member(s) with income		Documentation of income (if applicable)
Gross earned income			
Cash gifts/contributions			
Child support income			
Dividends/interest/royalties			
Loans (non-educational)			
Lawsuit/lump-sum payments			
Mineral rights			
Pensions/annuities			
Reimbursements			
Social security payments			
Unemployment payments			
VA payments			
Worker's compensation			
Total countable income			
Deductions	-	-	
Net countable income			
			Household FPL %

PART IV – PROGRAM ELIGIBILITY

1. <input type="checkbox"/> BCCS <input type="checkbox"/> EPHC <input type="checkbox"/> DSHS FP <input type="checkbox"/> PHC <input type="checkbox"/> Title V/MCH	2. <input type="checkbox"/> BCCS <input type="checkbox"/> EPHC <input type="checkbox"/> DSHS FP <input type="checkbox"/> PHC <input type="checkbox"/> Title V/MCH	3. <input type="checkbox"/> BCCS <input type="checkbox"/> EPHC <input type="checkbox"/> DSHS FP <input type="checkbox"/> PHC <input type="checkbox"/> Title V/MCH
4. <input type="checkbox"/> BCCS <input type="checkbox"/> EPHC <input type="checkbox"/> DSHS FP <input type="checkbox"/> PHC <input type="checkbox"/> Title V/MCH	5. <input type="checkbox"/> BCCS <input type="checkbox"/> EPHC <input type="checkbox"/> DSHS FP <input type="checkbox"/> PHC <input type="checkbox"/> Title V/MCH	6. <input type="checkbox"/> BCCS <input type="checkbox"/> EPHC <input type="checkbox"/> DSHS FP <input type="checkbox"/> PHC <input type="checkbox"/> Title V/MCH
Co-Pay/Fees		

Name of Agency	Signature – Agency / Staff Member	Date
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**APPENDIX C DSHS Family & Community Health Services Division
HOUSEHOLD Eligibility Worksheet Instructions**



PART I - APPLICANT INFORMATION

Fill in the boxes with the applicant's information.
Check the appropriate boxes.

Other benefits or health care coverage: Document other benefits received/denied. (An applicant or family member eligible for Medicare Part A/B must be referred to the Medicare Prescription Drug Plan (Part D) for prescription drug benefits.)

Special circumstances: Document any special circumstances.

PART II – HOUSEHOLD INFORMATION

Fill in the boxes with members of the household.

This number will include a person living alone or two or more persons living together where legal responsibility for support exists.

Legal responsibility for support exists between: persons who are legally married (including common-law marriage), a legal parent and a minor child (including unborn children), or a legal guardian and a minor child.

(Title V contractors may add whether household members are US citizens, eligible immigrants, or non-US citizens.)

Program Eligibility by 2016 Federal Poverty Level (FPL)

Effective March 1, 2016

Family Size	Title V - MCH	PHC EPHC BCCS	FP
	185% FPL	200% FPL	250% FPL
1	\$1,832	\$1,980	\$2,475
2	2,470	2,670	3,338
3	3,108	3,360	4,200
4	3,747	4,050	5,063
5	4,385	4,740	5,925
6	5,023	5,430	6,788
7	5,663	6,122	7,653
8	6,304	6,815	8,519
9	6,946	7,509	9,386
10	7,587	8,202	10,253
11	8,228	8,895	11,119
12	8,870	9,589	11,986
13	9,511	10,282	12,853
14	10,152	10,975	13,719
15	10,794	11,669	14,586

PART III - INCOME INFORMATION

Income may be either earned or unearned. If actual or projected income is not received monthly, convert it to a monthly amount using one of the following methods:

- weekly income is multiplied by 4.33;
- income received every two weeks is multiplied by 2.17;
- income received twice a month is multiplied by 2.

Fill in the *Income Type* table with name(s) of household member(s) and income amounts.

Calculate the *Total countable income*.

Calculate the *Deductions*:

- child support payments;
- dependent childcare;
 - up to \$200 per child per month for children under age 2;
 - up to \$175 per child per month for children age 2 and older;
- adults with disabilities;
 - up to \$175 per adult per month.

Total the *Net countable income*.

Calculate the household FPL using the applicable DSHS program policy and fill in the *Household FPL* box.

Use the *Documentation of income* box for notes (if applicable).

PART IV – PROGRAM ELIGIBILITY

Determine program eligibility for each household member using the corresponding numbers from the household information section.

Document applicable copayments and fees by program in the *Co-Pay/Fees* box.

Fill in the *Name of Agency*, sign, and date.

DSHS Family Planning Program Definition of Income

Types of Income	Countable	Exempt
Adoption Payments		✓
Cash Gifts and Contributions*	✓	
Child Support Payments*	✓	
Child's Earned Income		✓
Crime Victim's Compensation *		✓
Disability Insurance Benefits	✓	
Dividends, Interest, and Royalties*	✓	
Educational Assistance		✓
Energy Assistance		✓
Foster Care Payment		✓
In-kind Income		✓
Job Training		✓
Loans (Non-educational)*	✓	
Lump-Sum Payments*	✓	✓
Military Pay*	✓	
Mineral Rights*	✓	
Pensions and Annuities*	✓	
Reimbursements*	✓	
RSDI /Social Security Payments*	✓	
Self-Employment Income*	✓	
SSDI	✓	
SSI Payments		✓
TANF		✓
Unemployment Compensation*	✓	
Veteran's Administration*	✓	✓
Wages and Salaries, Commissions*	✓	
Worker's Compensation*	✓	

****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.

APPENDIX D

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

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

Dividends, Interest and Royalties – Countable. Exception: Exempt dividends from insurance policies as income. Count royalties, minus any amount deducted for production expenses and severance taxes.

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

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

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

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

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

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

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

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

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

SSI Payments – Exempt Supplemental Security Income (SSI) benefits.

Terminated Employment – Count terminated income in the month received. Use actual income and do not use conversion factors if terminated income is less than a full month's income. Income is terminated if it will not be received in the next usual payment cycle.

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

VA Payments – Count the gross Veterans Administration (VA) payment, minus any amount being recouped for a VA overpayment. Exempt VA special needs payments,

APPENDIX D

such as annual clothing allowances or monthly payments for an attendant for disabled veterans.

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

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

SAMPLE
DSHS Family Planning Program Fee Scale
Based On Monthly Federal Poverty Guidelines

FAMILY SIZE	100% FPL	100-133% FPL	133-150% FPL	150-185% FPL	185-225% FPL	225-250% FPL	Above 250% FPL
	\$0 Co-Pay	\$5 Co-Pay	\$15 Co-Pay	\$20 Co-Pay	\$25 Co-Pay	\$30 Co-Pay	100% PAY
1	990.00	990.01 - 1,317.00	1,317.01 - 1,485.00	1,485.01 - 1,832.00	1,832.01 - 2,228.00	2,228.01 - 2,475.00	2,475.01 +
2	1,335.00	1,335.01 - 1,776.00	1,776.01 - 2,003.00	2,003.01 - 2,470.00	2,470.01 - 3,004.00	3,004.01 - 3,338.00	3,338.01 +
3	1,680.00	1,680.01 - 2,235.00	2,235.01 - 2,520.00	2,520.01 - 3,108.00	3,108.01 - 3,780.00	3,780.01 - 4,200.00	4,200.01 +
4	2,025.00	2,025.01 - 2,694.00	2,694.01 - 3,038.00	3,038.01 - 3,747.00	3,747.01 - 4,557.00	4,557.01 - 5,063.00	5,063.01 +
5	2,370.00	2,370.01 - 3,153.00	3,153.01 - 3,555.00	3,555.01 - 4,385.00	4,385.01 - 5,333.00	5,333.01 - 5,925.00	5,925.01 +
6	2,715.00	2,715.01 - 3,611.00	3,611.01 - 4,073.00	4,073.01 - 5,023.00	5,023.01 - 6,109.00	6,109.01 - 6,788.00	6,788.01 +
7	3,061.00	3,061.01 - 4,071.00	4,071.01 - 4,592.00	4,592.01 - 5,663.00	5,663.01 - 6,887.00	6,887.01 - 7,653.00	7,653.01 +
8	3,408.00	3,408.01 - 4,532.00	4,532.01 - 5,112.00	5,112.01 - 6,304.00	6,304.01 - 7,667.00	7,667.01 - 8,519.00	8,519.01 +
9	3,755.00	3,755.01 - 4,994.00	4,994.01 - 5,632.00	5,632.01 - 6,946.00	6,946.01 - 8,447.00	8,447.01 - 9,386.00	9,386.01 +
10	4,101.00	4,101.01 - 5,455.00	5,455.01 - 6,152.00	6,152.01 - 7,587.00	7,587.01 - 9,227.00	9,227.01 - 10,253.00	10,253.01 +

Based on the HHS Federal Poverty Guidelines, Department of Health & Human Services, January 2016

Effective March 1, 2016

Note: Clients must never be denied services because of an inability to pay current or past fees.

APPENDIX F

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

Recommendations and Reports

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

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

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

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

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

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

APPENDIX F

TABLE 2. Check list of family planning and related preventive health services for women

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

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

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

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

§ CDC recommendation.

¶ U.S. Preventive Services Task Force recommendation.

** Professional medical association recommendation.

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

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

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

APPENDIX F

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

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

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

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

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

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

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

†† Professional medical association recommendation.

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

TYPICAL EFFECTIVENESS OF FDA-APPROVED CONTRACEPTIVE METHODS

The figure shows the typical effectiveness of FDA-approved contraceptive methods, ranging from least effective (fertility-awareness based methods and spermicide) to the most effective (implants, intrauterine devices, and sterilization).

MMWR Providing Quality Family Planning Services: Recommendations of CDC and the U.S. Office of Population Affairs, Recommendations and Reports. April 25, 2014 / 63(RR04);1-29. (See http://www.cdc.gov/mmwr/preview/mmwrhtml/rr6304a1.htm?s_cid=rr6304a1_w)

