MARY LEE FOUNDATION
SOUTHPOINTE
1336 LAMAR SQUARE DRIVE
AUSTIN, TEXAS 78704

APPLICATION FOR ADMISSION

Date of Application ____________________

Date of Admission ____________________

I. PERSONAL INFORMATION

Full Legal Name ____________________

Preferred Name to be used ____________________

Address ____________________ City __________ State ______ Zip ______

Height _____ Weight _____ Sex ______ Color of Eyes ______ Hair Color ______

Social Security No. ____________________ Phone ____________________

Birthplace ____________________ Birthday __________ Age __________

Religion ____________________ Church attends and address (if applicable) __________

____

Marital Status __________ If applicable, date of Marriage/Divorce ____________________

Citizenship Status ____________________

Ethnic Heritage __________ Language Spoken or Understood ____________________

Identifying Marks ____________________

Health Insurance and ID #s (Please provide cards)

Primary: ____________________ ID# ____________________

Secondary: ____________________ ID# ____________________

Children (list names, ages and location) ____________________

____

____

Living situation prior to admission (in family's home/own apartment, etc) __________

____

____

Problems encountered with prior living situation ____
____
____

Describe present behavioral concerns, known triggers and prevention methods ____________
____
____
____
____

Past Behavioral Concerns ____
____
____

II Health Record

Diagnoses and Medical or Mental Health Conditions:_____________________________
____
____
____
____

Allergies____
____
____

Surgeries____
____
____

Dietary Concerns____
____
____

Psychiatric Care and Hospitalization (including any institutionalization)

Dates	Name of Hospital	Reason for Admission

Does client wear glasses? ________________ Date last glasses obtained:________________________

Eye Doctor's Name & Address:____
____

List other adaptive aids used by the client____
____
____
____

Date of last Dental Exam: ___________ Dentist's Name, Address & Telephone:________________
____

Describe oral hygiene of client____
____

Does the client require any sedation for dental work? If yes, document details_______________
____
____

Has client been or is client currently under treatment with an Orthodontist? ______________If so, is work completed? __________ Orthodontist's Name, Address and Telephone______________________
____

If there is a history of seizures or epileptic disorder, please answer the following questions:
At what age did client experience onset of this disorder?______________________________

Does client experience Grand Mal Seizures?_________ Petite Mal Seizure?_______ or Both __________

How often does the client experience these seizures?_________________________

Do seizures occur under any particular circumstances? ________________________________
____
____

What was the date (approximate) of last seizure?_____________________________________

Please list all doctors and other professionals who currently see and/or treat the client. (Counselor, Psychiatrist, PCP, Support Groups etc.)

Name____________________ Nature of Service and Frequency of visits
Address__________________ ____
City_____ State_______Zip___ ____

Name____________________ Nature of Service and Frequency of visits
Address__________________ ____

City_____ State_______Zip___ ____

Name______________________ Nature of Service and Frequency of visits
Address____________________ ____
City_____ State_______Zip___ ____

Name______________________ Nature of Service and Frequency of visits
Address____________________ ____
City_____ State_______Zip___ ____

Name______________________ Nature of Service and Frequency of visits
Address____________________ ____
City_____ State_______Zip___ ____

Name______________________ Nature of Service and Frequency of visits
Address____________________ ____
City_____ State_______Zip___ ____

Name______________________ Nature of Service and Frequency of visits
Address____________________ ____
City_____ State_______Zip___ ____

III Family

Father________________________Birth Date_________Birth Place__________________
Address______________________________City______________State________Zip__________
Area Code_________Phone__________________Occupation______________________________

Mother________________________Birth Date_________Birth Place__________________
Address______________________________City______________State________Zip__________
Area Code_________Phone__________________Occupation______________________________

Marital Status of Both Parents____

Siblings:

Name______________________________Sex___Age________ Marital Status___________
Address______________________________City______________State________Zip________
Name______________________________Sex___Age________ Marital Status___________
Address______________________________City______________State________Zip________
Name______________________________Sex___Age________ Marital Status___________
Address______________________________City______________State________Zip________
Name______________________________Sex___Age________ Marital Status___________
Address______________________________City______________State________Zip________

Names of Approved Visitors____

____

____

____

Names of people who should not visit_____________________________________

____

____

IV. IN CASE OF EMERGENCY CONTACT:

Name________________Address____________________________City________State__Zip___

Home Phone________________Bus. Phone______________Relationship________________

V. LEGAL COMPETENCY STATUS

Legal Guardian____

Power of Attorney____

Representative Payee for Social Security___________________________________

VI. Financial Arrangements:

A. Income of resident and source (SS, SSI, etc)_____________________________

____

B. Total Tuition to be paid $_ per month (shared) or $ ___ per month (single) __

By Whom________________________________

C. Spending Money and purchase of supplies and other needed items to be paid by whom________

____

D. Medical Bills not covered by insurance to be paid by whom___________________________

VII. OTHER PROBLEMS OR COMMENTS

____

____

VIII. Educational/ Vocational

1. Is client attending school now? ____________ Grade/Level ______________

Name and location of school:__________________

2. High School Graduate? Yes________No__________ If no, grade reached:__________

Name and location of school:__________________

If yes, date of graduation: ________________

GED? Yes________No__________

If yes, date obtained:__________________

3. College Graduate? Yes________No__________ If no, level reached (if any):__________

Name and location of school:__________________

If yes, date of graduation: ________________

Training

1. Has client participated in a vocational training program or participated in a job program (DARS, etc)? (If yes, explain, state location and send a copy of evaluation if possible)

____

____

2. Was training program successfully completed?__________________________
(Please be specific as to areas of success or difficulty)__________________

____

____

3. Competitive Employment

Is client presently employed? __________(If so, where?) ______________

4. Previous Work History

Employer____________________Address___________________City_________State________

Dates of Employment__________Type of work____________________Reason for Leaving________________
____Name of Supervisor____________________________

Employer____________________Address___________________City_________State________

Dates of Employment__________Type of work____________________Reason for Leaving________________
____Name of Supervisor____________________________

5. Is client interested in seeking employment (if not currently working)? If so, what type of work? What does he/she need to be successful?

6. Transportation & Community Safety- Does this person ride the city bus safely? Are there any community safety concerns? Does he/she need training or any restrictions?

IX. Goals

When was this client's difficulties/diagnoses first noticed, and by whom?
(i.e., teacher, doctor, family)

State the nature of the client's present problems and previous difficulties: (Reason for referral and what assistance he/she will regularly need from staff)

____
____
____
____
____
____

Describe briefly your goals and expectations for the client and what you hope Mary Lee Foundation-Southpointe can accomplish:

____
____
____
____
____
____

Authorization for Emergency Medical Care

To Whom It May Concern:

This is to certify that I, the undersigned, consent to the administration of anesthetics, and the performance of whatever surgical procedure is necessary for ______________________________________

(Name of Client)

This Consent is given only to cover those instances, which are considered medical emergencies on the advice of a physician when there is not sufficient time to notify me.

It is also agreed that Mary Lee Foundation may authorize routine medical and dental work, and recommended diagnostic procedures – including electroencephalogram and immunizations.

____ Date

____ Client Signature

____ Guardian Signature or Witness

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFOMATION

Name: ______________________ DOB: ____________ SS#: ______________
(Please print)

I give permission for Austin Travis County Integral Care to release and or share my protected health information (PHI) with:

Name of Agency/Person: Mary Lee Foundation
Address: 1338 Lamar Square Drive
Austin, TX 78704
Contact Number: DBCR
E-Mail Address: tgilmore@maryleefoundation.org

The Agency / Person listed above has my permission to pick up medications at ATCIC Pharmacy.
The Agency / Person listed above has my permission to participate in and attend my appointments.
ATCIC has permission to leave a voice mail message at the specified contact number for purposes of follow-up.

INFORMATION TO BE RELEASED: Check all that apply

Demographic	MCOT Assessment	Nurse's Progress Notes
Psychiatric Evaluation	Narrative Assessments	Caseworker's Progress Notes
Crisis Assessment	Admission /Discharge Dates	UA Results/Lab Results
Diagnosis Review	Medication Listing	Billing Records
Determination of Intellectual Disability (DID)	Psychotherapy Notes	Other:
	Prescriber's Progress Notes	____________

I understand that this authorization extends to all information contained in my records about mental illness, developmental disabilities, chemical or alcohol dependency, communicable diseases such as HIV and AIDS, genetic information, and any other types of protected health information.

INFORMATION TO BE RELEASED SHOULD COVER THE TIME PERIOD FROM__ __TO__ __ If no time period is given, the information released will cover six (6) months back from signature date.

THE PURPOSE OF THE RELEASE IS FOR THE FOLLOWING:

_____ Continuity of Care _____ Disability Benefits _____ At my request

_____ Legal _____ School _____ Insurance Other: ____________________

I understand that this authorization is voluntary and I may refuse to sign this authorization. I further understand that my health care and the payment of my health care will not be affected if I do not sign this form. I understand that I can see the protected health information that will be disclosed. If this information is for myself, I can request that it be given to me electronically. This authorization extends to information released in electronic, paper, and verbal format.

This authorization can be cancelled at any time, in writing, to ATCIC, but the cancellation will not affect any disclosures already made prior to receipt of cancellation notice. ATCIC cannot control how the protected health information will be used by the agency/person who receives it under this authorization.

Unless cancelled or otherwise specified, this authorization will expire one year from date of signature.
Other specified expiration date: ____________

Client Signature: ______________________ Date: ____________

Parent/Legal Guardian Signature: ______________________ Date: ____________

Printed Name: ______________________ Relationship: ____________

DISCLOSURE STATEMENT: This information may be disclosed to you from records protected by Federal confidentiality rule 42 CFR part 2. The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

Please submit request for medical records to:
ATCIC-Medical Records Department
P.O. Box 3548
Austin, Texas 78764-3548
(512) 440-4075
(512) 445-7726 (FAX)
FORM #400D (Revised 08/19/15)

For office use only
Process
File

Name of Applicant or Individual	Medicaid ID or Social Security No.

To Persons Applying for Long-Term Care Services Paid by Medicaid

This is an informational notice only. The case manager or eligibility specialist will ask you to sign this form to show the state has met its obligation to inform you about Medicaid estate recovery. You do not have to sign this form. If you choose not to sign it, your application for Medicaid services will not be denied for that reason. However, the state may still file a claim against your estate after you die, unless certain exemptions or hardships exist at that time.

Medicaid Estate Recovery Program

Medicaid is a government program that pays for health care services. Some of these services are for people as they grow older. Medicaid pays for services that help people stay in their own home. It also pays for people to move to a facility, such as a nursing home, if that is what they need.

To help pay for these long-term care services, every state must have a Medicaid Estate Recovery Program (MERP). If you receive long-term care services paid for by Medicaid, the state of Texas has the right to ask for some money back from your estate after you die. In some cases, the state may not ask for anything back. The state will never ask for more money back than it paid for your services.

How does this program work?

You are receiving this notice because you are applying for long-term care services covered by MERP. When you die, the state will send a notice to your estate representative or heirs to remind them that the state may file a MERP claim. The notice will ask them for information so that the state can decide whether it should file a claim, or whether your estate meets one of the exceptions described below.

If the state files a claim, Texas law sets out which claims will be paid first. The state's MERP claim will be paid after the following expenses are paid first, if there are any:

- unpaid expenses for your funeral and any expenses of your final illness, up to $15,000;
- unpaid expenses from your estate administrator for managing your estate, or for keeping your estate intact, and any expenses of a guardian who is appointed for you while you are alive;
- unpaid secured claims and tax liens filed against your home;
- unpaid child support debts you owe;
- unpaid state and local taxes you owe; and
- unpaid expenses from any correctional institution.

What is an estate?

An estate is property, such as money, a house or other things of value that a person leaves to family members or others (heirs) when he or she dies. MERP does not apply to all property that a person may own. Here are some examples of property that the state will not collect on:

- Life insurance policies that name a person to receive the payment.
- Bank accounts that are paid on death to another person.

Does MERP affect you?

This program will affect only long-term care services you receive after the age of 55 and only if you first apply for these services after March 1, 2005. If you applied for these services before March 1, 2005, MERP does not affect you. If you were on an interest list for services before that date but did not complete an application for services until after March 1, 2005, MERP does affect you.

The following services and programs are affected by MERP:

- Nursing Facility Care (nursing homes)
- Intermediate Care Facility for Individuals with an Intellectual Disability or Related Conditions (ICF/IID)
- The following Medicaid Waiver Programs:
  - Home and Community-based Services (HCS)
  - Community Living Assistance and Support Services (CLASS)
  - Texas Home Living (TxHmL) Waiver
  - Deaf Blind with Multiple Disabilities (DBMD) Waiver
  - Consolidated Waiver Programs (CWP)
  - Community Based Alternatives (CBA)
  - STAR+PLUS Waiver (SPW)
  - Integrated Care Management Waiver (ICMW)
  - Community Attendant Services (CAS)

MERP also affects the costs of certain hospital and prescription drug services you receive. Primary Home Care (PHC) is not affected by MERP.

If you are not sure whether MERP applies to the services you will be receiving, you should ask your Department of Aging and Disability Services (DADS) case manager. If you are a Medicaid managed care enrollee, you should ask your service coordinator with the health plan from which you receive your services.

Are there any times when the state will not ask for money back?

Yes, the state will not ask for money back after you die if:

- Your spouse is still alive.
- You have a child under age 21.
- You have a child of any age who is blind or permanently and totally disabled.
- Your unmarried adult child lives full-time in your home for at least one year before you die.
- The value of your estate is $10,000 or less.
- The amount of your Medicaid costs was $3,000 or less.
- The cost of selling your property is more than the property is worth.

Does the state make any exceptions for hardship?

Yes, the state may not file a MERP claim to ask for money back when this would cause an undue hardship for the heirs. The state may grant a hardship waiver when:

- The estate property is a family business, farm or ranch for at least 12 months before you die and is the main source of income for your heirs.
- Your heirs would need financial assistance from the government if the state files a MERP claim.
- Your heirs will be able to stop getting financial assistance from the government if the state does not file a MERP claim.
- You are receiving services as the result of being a crime victim.

There are other circumstances that may create a hardship.

One type of hardship applies just to your home. If one or more of your heirs has a family income under a certain amount, MERP may grant a hardship waiver for up to $100,000 of your home value.

In 2011, this income limit for one person is $32,670. For a family of four, it is $67,050. These figures are adjusted each year. To get a waiver based on an undue hardship, your heirs must ask for it and provide proof of the hardship.

Will the state ever reduce the amount owed?

Yes, if you or someone else spends money to maintain your home while you are in a nursing facility, these costs can be deducted from the MERP claim. If you or someone else spends money to pay for care that helps you live at home longer before entering a nursing home, those costs can be deducted as well. Your heirs must have receipts to show what was spent on your home or services when they ask the state to deduct these amounts from the MERP claim.

If your estate has debts such as funeral costs, legal costs or a home mortgage, those costs are paid first before MERP is paid.

What happens if I give away or transfer my assets before moving into a nursing home?

Giving away resources for no compensation, or refusing to accept income, or reducing income you could receive before moving into a nursing home may result in:

- a penalty against you for not paying for nursing facility or ICF/IID facility services when you were able to do so, or
- a decision by the state that you are ineligible for waiver program services or state supported living center services.

The state may "look-back" up to 60 months before you applied for nursing home, ICF/IID or waiver services to determine when your income was reduced and resources were transferred. To determine how long you may be penalized (or prevented from receiving nursing home care paid for by Medicaid), the state will divide the value of your transferred assets by the average cost of nursing home care paid for by a private-pay patient. The state will calculate the penalty period in terms of how long ago you transferred assets and how long you refused to accept income or reduced your income.

How can I get more information on Medicaid estate recovery?

For more detailed information on this program, call the agency's toll-free number at 1-800-641-9356. This line is answered from 8:00 a.m. through 5:00 p.m., Monday through Friday. Voicemail is available 24 hours a day.

You may also email your questions to

merp@dads.state.tx.us.

You may also visit the DADS website at:

www.dads.state.tx.us/services/estate_recovery/.

Medicaid ID or Social Security No. ____________________

☐ **I have received and understand the information about MERP.**

Printed Name – Individual		Signature	Date
Printed Name – Responsible Person	Relationship to Individual (if not individual)	Signature	Date
Printed Name – Case Manager		Signature	Date

☐ *Form 8001, MERP Receipt Acknowledgement, was provided to the individual or responsible person and the person chose not to sign the form.*

Form 8648
October 2015-E

Identification of Preferences

Name of Individual to Receive Services	Local Case Number

The Local Intellectual and Developmental Disability Authority (LIDDA) representative provided the primary correspondent with an Explanation of Intellectual and Developmental Disabilities Services and Supports.

When completed, this form serves as documentation of stated preferences for services and supports as indicated on this form.

Services and supports are provided based upon availability.

If the individual's name is added to the Home and Community-based Services or Texas Home Living interest list, it is the responsibility of the primary correspondent to keep the LIDDA informed of changes to his or her contact information.

Indicate the individual's preference(s) by selecting at least one of the following:

☐ **Home and Community-based Services (HCS) Program**
The individual's name will be added to the HCS interest list.

or

☐ **Remove the individual's name from the HCS interest list.**
The individual's name will be removed from the HCS interest list effective the date the primary correspondent signs this form.

☐ **Texas Home Living (TxHmL) Program**
The individual's name will be added to the TxHmL interest list.

or

☐ **Remove the individual's name from the TxHmL interest list.**
The individual's name will be removed from the TxHmL interest list effective the date the primary correspondent signs this form.

☐ **State Supported Living Center (SSLC)**
(Check only if the individual wants the service within the next 30 days.)
The process to determine admission eligibility will begin immediately.

☒ **Community-Based Intermediate Care Facility for Individuals with Intellectual Disability (ICF/IID)**
(Check only if the individual wants the service within the next 30 days.)
The process to determine admission eligibility will begin immediately.

☐ **LIDDA Community Services and Supports**
(Check only if the individual wants the service within the next 30 days.)
The eligibility determination process will begin as soon as possible as local resources allow.

☐ **Community First Choice (CFC) Services**
(Check only if the individual wants the service within the next 30 days.)
The eligibility determination process will begin as soon as possible as local resources allow.

Date of Discussion (required)

Primary Correspondent for Interest List

Name (required)	Area Code and Telephone No. (required)
Mailing Address (required)	Alternate Telephone No. (required, if available)

Signature – Primary Correspondent — Date
(Required if the individual's name is to be removed from the HCS or TxHmL interest list.)

Signature – LIDDA Representative (required) — Title – LIDDA Representative (required) — Date

Texas Department of Aging and Disability Services

Form 8601
September 2012

Waiver Program/Programa opcional

Verification of Freedom of Choice/Verificación de libre opción

Name of Individual/Nombre de la persona	CARE ID/Núm. de identificación (HCS and TxHmL Only)	Medicaid No./Núm. de Medicaid
Address (Street, City, State, ZIP Code)/Dirección (calle, ciudad, estado y código postal)		

As a recipient or potential recipient of Medicaid funded services, I understand that I have a choice between the waiver program I have selected and the applicable institutional program from which it is waived.

I have been informed of the services available through the waiver program I have selected. The services I would receive through this waiver program will be identified on my service plan.

I have received information about the types of institutional services available to me.

Providing that I meet the eligibility requirements, I have been given the choice of either institutional or home and community-based services and I choose the following:

- ☐ **Community Living Assistance and Support Services (CLASS)**
- ☐ **Consolidated Waiver Program (CWP)**
- ☐ **Deaf Blind with Multiple Disabilities (DBMD)**
- ☐ **Home and Community-based Services (HCS) Program**
- ☒ **Intermediate Care Facility for Individuals with an Intellectual Disability or Related Conditions (ICF/IID) Institutional Program**
- ☐ **Nursing Facility (NF) Institutional Program**
- ☐ **Texas Home Living (TxHmL) Program**
- ☐ **Other:** ________________

for the following reason: ________________

Como beneficiario o posible beneficiario de servicios financiados por medio de Medicaid, entiendo que tengo una opción entre el programa opcional que he seleccionado y el programa institucional que me hubiera correspondido.

Me han informado de los servicios disponibles por medio del programa opcional que he seleccionado. Los servicios que recibiría bajo este programa opcional estarán indicados en mi plan de servicios.

He recibido información sobre los tipos de servicios institucionales que puedo recibir.

Siempre y cuando yo llene los requisitos de elegibilidad, me han dado la opción de seleccionar entre servicios institucionales y de apoyo en el hogar y en la comunidad, y escojo el siguiente:

- ☐ Servicios de Apoyo y Asistencia para Vivir en la Comunidad (CLASS)
- ☐ Programa Opcional Combinado (CWP)
- ☐ Programa Opcional de Personas Sordociegas con Discapacidades Múltiples (DBMD)
- ☐ Programa de Servicios en el Hogar y en la Comunidad (HCS)
- ☐ Programa institucional de Centros de atención intermedia para personas con una discapacidad intelectual o un padecimiento relacionado (ICF/IID)
- ☐ Programa institucional de Centros para Convalecientes (NF)
- ☐ Programa de Texas para Vivir en Casa (TxHmL)
- ☐ Otro: ________________

por las siguientes razones: ________________

X ________________ ________________

Signature – Individual/Legally Authorized Representative
Firma de la persona o del representante legalmente autorizado

Date/Fecha

________________ ________________

Signature – Agency Representative
Firma del representante del departamento

Date/Fecha

________________ ________________

Agency Name
Nombre del departamento

Comp Code (HCS and TxHmL Only)

MARY LEE FOUNDATION
SOUTHPOINTE

PHOTO RELEASE FORM FOR PUBLICATION

I, ____ do / do not (please circle) hereby give my consent to the Mary Lee Foundation to take my picture, for use in publications for public educational purposes, and for the Mary Lee Foundation website and Facebook page, with all identifying information deleted.

____
Client or Guardian Signature

Yes ______________ No ______________

____
Date

Notification of ICF/IDD Placement Offer

(for legibility, please print clearly) Revised 10/23/13

Provider Company Name: Mary Lee Foundation Component Code: 08CR
Provider Company Address: 1336 Lamar Square Drive, Austin, TX 78704
Provider Company Phone Number: 512-442-6077 Fax Number: ____________
Name of Contact Person: Tisha Gilmore
E-mail address: tgilmore@maryleefoundation.org

Individual Name: ____________
Date of Birth: ____________ CARE ID: ____________
Move in Date: ____________
Address and name of Group Home where Individual is residing: ____________

Contract Number of House where Individual is residing: ____________

Physician Name and Lic # ____________
Date of last physical examination: ____________

*Please submit copy of DMR and ICAP Booklet & Scoring

Notification of Offer: ____________

ICF/IDD Provider Signature: ____________
Date of Signature: ____________

Notification of Acceptance: ____________

Provider Chosen by:
Individual Printed Name: ____________
Individual/LAR Signature: ____________
Date of Signature: ____________

Contact Person: [illegible]@atcic.org for further assistance

Mary Lee Foundation
ICF Payment Explanation and Agreement

Resident Name:________________________________

Date of Admission:_____________________________

Date of Agreement:_____________________________

An Intermediate Care Facility (ICF) is paid a daily rate for each resident, determined by Texas Health and Human Services Commission (HHSC), depending on his/her Level of Need, which is determined by the Local Authority. This daily rate pays for all the expenses of the facility. Some of these expenses are: room and board, case management, nursing, bookkeeping, direct care staff, meals, medical bills not covered by other insurance (ie. Medicaid, Medicare, etc.), personal hygiene items, items for behavior management plans, basic furnishings and maintenance.

This amount the facility is paid either comes 1) completely from Medicaid, 2) from Social Security and Medicaid or 3) from the resident's Applied Income/Co-pay (earnings from a job, Social Security, other income sources) and Medicaid.

1. If the resident is receiving SSI, when the resident is admitted to the facility, the amount of SSI he/she receives from Social Security will drop down to $30 per month and Department of Aging and Disability Service (DADS) will supplement the resident with a Personal Needs Allowance (PNA) of $30 per month. The resident will not pay for ICF services at all, as Medicaid will completely cover the cost. The $60 he/she receives per month will be strictly for the resident to receive in a weekly budget and Special Requests.

2. If the resident is receiving SSDI or RSDI, when the resident is admitted he/she will likely continue to receive the same amount from Social Security. However the resident keeps only $60 for their PNA, strictly to be used for the resident to receive in a weekly budget and Special Requests. Any amount from Social Security over $60 will go toward paying for his/her living expenses in the ICF. The portion of the daily rate due from the resident is referred to as Applied Income or Co-pay and it is calculated by HHSC.

3. If the resident is working and receiving SSI, the SSI will likely be terminated or reduced to $0. If the earnings from working are high enough then HHSC will calculate an Applied Income due from the resident. The resident will retain $60 PNA from net earned