TEXAS
Health and Human Services

[redacted]

Medicaid for the Elderly and People with Disabilities (MEPD)
Referral Cover Sheet

Form H1746-A
Rev. 06/2020
Page 1
ENG

DO NOT photocopy, staple or permanently attach anything to this cover sheet!

*REQUIRED fields

APPLICANT / CONSUMER INFORMATION

TIERS Case Number | Zip Code* | County*

Individual Social Security Number | Individual Number

Individual Last Name*

◯ Select if referral is for applicant and spouse

Individual First Name* | Spouse Individual Number

Date of Birth (MMDDYY) | Spouse Name _____

ACTION

*Select **only one** and **completely fill** in the circle like this ●

◯ Application (Include application form) ◯ Supporting Documents (financial verifications, other documents, etc.) ◯ Redetermination
◯ Significant Change ◯ Program Transfer ◯ Add a Program

PROGRAM

*Select **only one** and **completely fill** in the circle like this ●

◯ CAS ◯ State Supported Living Center ◯ MDCP/STAR Kids ◯ DBMD ◯ NF
◯ ICF-IDD ◯ TxHmL ◯ CLASS ◯ PACE ◯ DFPS Medicaid
◯ HCS ◯ YES ◯ STAR+PLUS ◯ Other

Information for MEPD Worker ◯ MERP shared ◯ LTSS Information shared

Has applicant moved or is moving into an assisted living or adult foster care facility, provide expected move date.

SENDER

***Agency:** ◯HHSC-CCSE ◯LIDDA ◯SSLC ◯CLASS ◯DFPS ◯DSHS
◯DBMD ◯PACE ◯NF ◯HHSC-PSU ◯OTHER

Date: | From: | *Telephone: (Format XXXXXXXXXX)

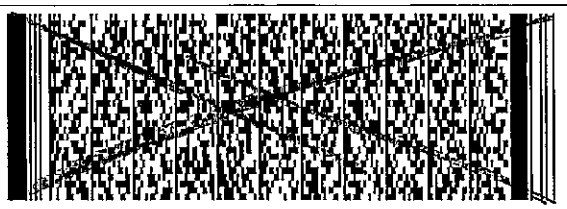
City: | County /Service Area: | Fax:

Additional Comments:

Medical Necessity (MN): ◯ Approved ◯Denied ◯ Pending Individual Service Plan (ISP): ◯ Approved ◯Denied ◯ Pending

Start of Care Date: Functional Assessment for CAS: ◯ YES ◯ NO

Was applicant made aware of choosing between services and QI-1: ◯ YES ◯ NO



INSTRUCTIONS:

NOTE: Either fax **or** mail; **DO NOT** fax and mail the same documents.
Mail to: Document Processing Center **or** Fax to: 1-877-236-4123
P.O. Box 149024
Austin, TX 78714-9024