SEC. 242.501. RESIDENT'S RIGHTS.

(a) The department by rule shall adopt a statement of the rights of a resident. The statement must be consistent with Chapter 102, Human Resources Code, but shall reflect the unique circumstances of a resident at an institution. At a minimum, the statement of the rights of a resident must address the resident’s constitutional, civil, and legal rights and the resident's right:

... (11) to a written statement or admission agreement describing the services provided by the institution and the related charges;

... (20) to discharge himself or herself from the institution unless the resident is an adjudicated mental incompetent;

(21) to not be discharged from the institution except as provided in the standards adopted by the department under Section 242.403;

(b) A right of a resident may be restricted only to the extent necessary to protect:

(1) a right of another resident, particularly a right of the other resident relating to privacy and confidentiality; or

(2) the resident or another person from danger or harm.


RULE §19.204 APPLICATION REQUIREMENTS

(B). The disclosure statement must contain the following information:

...(ii) the preadmission, admission, and discharge process.

SUBCHAPTER E RESIDENT RIGHTS

RULE §19.402 EXERCISE OF RIGHTS

...(d) The facility must comply with all applicable provisions of the Human Resources Code, Title 6, Chapter 102. An individual may not be denied appropriate care on the basis of his race, religion, color, national origin, sex, age, handicap, marital status, or source of payment.
RULE §19.403 NOTICE OF RIGHTS AND SERVICES

(a) The facility must inform the resident, the resident’s next of kin or guardian, both orally and in writing, in a language that the resident understands, of the resident’s rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. This notification must be made prior to or upon admission and during the resident's stay if changed.

...(i) The facility must inform a resident before, or at the time of admission, and periodically during the resident's stay (if there are any changes), of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate. Notice must be in writing, at least 30 days before the effective date of any changes in rates for services not covered by the current charge, or in Medicaid-certified facilities, by Medicaid.

...(l) Notification of changes.

(1) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is:

... (D) a decision to transfer or discharge the resident from the facility.

(m) Additional requirements for Medicaid-certified facilities. Medicaid-certified facilities must:

(1) provide the resident with the state-developed notice of rights under §1919(e)(6) of the Social Security Act (see also §19.402 of this subchapter (relating to Exercise of Rights));

(2) inform a resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of:

(A) the items and services that are included in nursing facility services provided under the State Plan and for which the resident may not be charged;

(B) those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services;

(3) inform each resident when changes are made to the items and services specified in paragraphs (2)(A) and (2)(B) of this subsection;

(4) provide a written description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under §1924(c) of the Social Security Act, which:
(A) is used to determine the extent of a couple's nonexempt resources at the time of institutionalization; and

(B) attributes to the community spouse an equitable share of resources that cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in the process of spending down to Medicaid eligibility levels; and

(5) prominently display in the facility written information, and provide to residents and potential residents oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive funds for previous payments covered by such benefits.

Source Note: The provisions of this §19.403 adopted to be effective May 1, 1995, 20 TexReg 2393; amended to be effective March 1, 1998, 23 TexReg 1314; amended to be effective August 1, 2000, 25 TexReg 6779; amended to be effective July 1, 2001, 26 TexReg 3824; amended to be effective May 1, 2002, 27 TexReg 3207; amended to be effective August 1, 2002, 27 TexReg 6052; amended to be effective June 1, 2006, 31 TexReg 4449; amended to be effective September 1, 2008, 33

RULE §19.404 PROTECTION OF RESIDENT FUNDS

...(c) Statement of resident rights and responsibilities. The facility must provide each resident and responsible party with a written statement at the time of admission that meets the following requirements:

...(2) the statement notes, when applicable, that any charge for the facility handling a Medicaid recipient's personal funds is included in the facility's basic rate.

Source Note: The provisions of this §19.404 adopted to be effective May 1, 1995, 20 TexReg 2393.

RULE §19.405 Additional Requirements for Trust Funds in Medicaid-certified Facilities

...(j) Request for items or services that may be charged to a resident's personal funds. The facility must:

(1) not charge a resident, nor his representative, for any item or service not requested by the resident;

(2) not require a resident, nor his representative, to request any item or service as a condition of admission or continued stay; and
(3) inform the resident or his representative, when he requests an item or service for which a charge will be made, that there will be a charge for the item or service and the amount of the charge.

RULE §19.406 FREE CHOICE

... (2) The facility must furnish Medicaid recipients with complete information about available Medicaid services, how to obtain these services, their rights to freely choose service providers as specified in this subsection and the right to request a hearing before the Texas Department of Human Services (DHS) if the right to freely choose providers has been abridged without due process.

Source Note: The provisions of this §19.406 adopted to be effective May 1, 1995, 20 TexReg 2393.

RULE §19.408 GRIEVANCES

...(c) A facility may not discharge or otherwise retaliate against:

(1) an employee, resident, or other person because the employee, resident, or other person files a complaint, presents a grievance, or otherwise provides in good faith information relating to the misuse of a restraint or involuntary seclusion at the facility; or

(2) a resident because someone on behalf of the resident files a complaint, presents a grievance, or otherwise provides in good faith information relating to the misuse of a restraint or involuntary seclusion at the facility.

Source Note: The provisions of this §19.408 adopted to be effective May 1, 1995, 20 TexReg 2393; amended to be effective March 1, 1998, 23 TexReg 1314; amended to be effective August 1, 2000, 25 TexReg 6779; amended to be effective May 1, 2002, 27 TexReg 2832; amended to be effective June 1, 2006, 31 TexReg 4449

RULE §19.422 AUTHORIZED ELECTRONIC MONITORING (AEM)

...(b) A facility may not refuse to admit an individual and may not discharge a resident because of a request to conduct authorized video monitoring.

(i) A facility may not discharge a resident because covert electronic monitoring is being conducted by or on behalf of a resident. If a facility discovers a covert electronic monitoring device and it is no longer covert as defined in §242.843, Health and Safety Code, the resident must meet all the requirements for AEM before monitoring is allowed to continue.
j) DHS may assess an administrative penalty of $500 against a facility for each instance in which the facility:

...(2) refuses to admit an individual or discharges a resident because of a request to conduct AEM;

(3) discharges a resident because covert electronic monitoring is being conducted by or on behalf of the resident.

Source Note: The provisions of this §19.422 adopted to be effective July 1, 2002, 27 TexReg 4362

SUBPART F ADMISSION, TRANSFER, AND DISCHARGE RIGHTS IN MEDICAID-CERTIFIED FACILITIES

RULE §19.501 ADMISSIONS POLICY FOR MEDICAID-CERTIFIED FACILITIES

(a) The facility must not require:

(1) residents or potential residents to waive their rights to Medicare or Medicaid; and

(2) oral or written assurance that residents or potential residents are not eligible for, or will not apply for, Medicare or Medicaid benefits.

(b) The facility must not require a third-party guarantee of payment to the facility as a condition of admission or expedited admission, or continued stay in the facility. However, the facility may require an individual who has legal access to a resident's income or resources available to pay for facility care to sign a contract, without incurring personal financial liability, to provide facility payment from the resident's income or resources.

(c) In the case of a person eligible for Medicaid, a nursing facility must not charge, solicit, accept, or receive, in addition to any amount otherwise required to be paid under the State Plan, any gift, money, donation, or other consideration as a precondition of admission, expedited admission, or continued stay in the facility. However, a nursing facility may:

(1) charge a resident who is eligible for Medicaid for items and services the resident has requested and received, and that are not specified in the State Plan as included in the term "nursing facility services" so long as the facility gives proper notice of the availability and cost of these services to residents and does not condition the resident's admission or continued stay on the request for and receipt of these additional services; and

(2) solicit, accept, or receive a charitable, religious, or philanthropic contribution from an organization or from a person unrelated to a Medicaid-eligible resident or potential resident, but only to the extent that the contribution is not a condition of admission, expedited admission, or continued stay in the facility for a Medicaid-eligible resident.
RULE §19.502 TRANSFER AND DISCHARGE IN MEDICAID-CERTIFIED FACILITIES

(a) Definition. Transfer and discharge includes movement of a resident to a bed outside the certified facility, whether that bed is in the same physical plant or not. Transfer and discharge does not refer to movement within the same certified facility.

(b) Transfer and discharge requirements. The facility must permit each resident to remain in the facility and must not transfer or discharge the resident from the facility unless:

(1) the transfer or discharge is necessary for the resident's welfare, and the resident's needs cannot be met in the facility;

(2) the transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility;

(3) the safety of individuals in the facility is endangered;

(4) the health of other individuals in the facility would otherwise be endangered;

(5) the resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid;

(6) the resident, responsible party, or family or legal representative requests a voluntary transfer or discharge; or

(7) the facility ceases to operate or participate in the program which pays for the resident's care. See §19.2310 of this title (relating to Nursing Facility Ceases to Participate). If the facility voluntarily withdraws from participation in Medicaid, but continues to provide nursing facility services:

(A) the facility's voluntary withdrawal from Medicaid is not an acceptable basis for the transfer or discharge of residents who were residing in the facility on the day before the effective date of the withdrawal (including those residents who were not entitled to Medicaid assistance as of such day);

(B) for individuals who begin residence in the facility after the effective date of the withdrawal, the facility must provide notice orally and in a prominent manner in writing on a separate page of the admission agreement at the time the resident begins residence and document receipt in writing, signed by the individual, and separate from other documents signed by the individual of the following information:
(i) The facility is not participating in the Medicaid program with respect to these residents.

(ii) The facility may transfer or discharge these residents if they are unable to pay the charges of the facility, even though the resident may have become eligible for Medicaid nursing facility services.

(c) Documentation. When the facility transfers or discharges a resident under any of the circumstances specified in subsection (b)(1)-(5) of this section, the resident’s clinical record must be documented. The documentation must be made by:

1. the resident's physician when transfer or discharge is necessary under subsection (b)(1) or (2) of this section; and
2. a physician when transfer or discharge is necessary under subsection (b)(4) of this section.

(d) Notice before transfer. Before a facility transfers or discharges a resident, the facility must:

1. notify the resident and, if known, a responsible party or family or legal representative of the resident about the transfer or discharge and the reasons for the move in writing and in a language and manner they will understand;
2. record the reasons in the resident’s clinical record; and
3. include in the notice the items described in subsection (f) of this section.

(e) Timing of the notice.

1. Except when specified in paragraph (3) of this subsection, the notice of transfer or discharge required under subsection (d) of this section must be made by the facility at least 30 days before the resident is transferred or discharged.

2. The requirements described in paragraph (1) of this subsection and subsection (g) of this section do not have to be met if the resident, responsible party, or family or legal representative requests the transfer or discharge.

3. Notice may be made as soon as practicable before transfer or discharge when:

   A. the safety of individuals in the facility would be endangered, as specified in subsection (b)(3) of this section;
   B. the health of individuals in the facility would be endangered, as specified in subsection (b)(4) of this section;
   C. the resident's health improves sufficiently to allow a more immediate transfer or discharge, as specified in subsection (b)(2) of this section;
(D) the transfer and discharge is necessary for the resident’s welfare because the resident’s needs cannot be met in the facility, as specified in subsection (b)(1) of this section, and the resident’s urgent medical needs require an immediate transfer or discharge; or

(E) a resident has not resided in the facility for 30 days.

(4) When an immediate involuntary transfer or discharge as specified in subsection (b)(3) or (4) of this section, is contemplated, unless the discharge is to a hospital, the facility must:

(A) immediately call the staff of the state office LTC-R Customer Service Section of the Texas Department of Human Services (DHS) to report their intention to discharge; and

(B) submit the required physician documentation regarding the discharge.

(f) Contents of the notice. For nursing facilities, the written notice specified in subsection (d) of this section must include the following:

(1) the reason for transfer or discharge;

(2) the effective date of transfer or discharge;

(3) the location to which the resident is transferred or discharged;

(4) a statement that the resident has the right to appeal the action as outlined in DHS’s Fair Hearings, Fraud, and Civil Rights Handbook by requesting a hearing through the Medicaid eligibility worker at the local DHS office within 10 days;

(5) the name, address, and telephone number of the regional representative of the Office of the State Long Term Care Ombudsman, Texas Department on Aging, and of the toll-free number of the Texas Long Term Care Ombudsman, 1-800-252-2412;

(6) in the case of a resident with mental illness or mental retardation, the address and phone number of the state mental health/mental retardation authority, which is: Texas Department of Mental Health and Mental Retardation, P.O. Box 12668, Austin, Texas 78711-2668, 1-800-252-8154; and the phone number of the agency responsible for the protection and advocacy of persons with mental illness or mental retardation and/or related conditions, which is: Advocacy Incorporated, 7800 Shoal Creek Boulevard, Suite 175-E, Austin, Texas 78757, 1-800-252-9108.

(g) Orientation for transfer or discharge. A facility must provide sufficient preparation and orientation to residents to ensure safe and orderly transfer or discharge from the facility.

(h) Notice of relocation to another room. Except in an emergency, the facility must notify the resident and either the responsible party or the family or legal representative at least five days before relocation of the resident to another room within the facility. The facility must prepare a written notice which contains:
(1) the reasons for the relocation;
(2) the effective date of the relocation; and
(3) the room to which the facility is relocating the resident.

(i) Fair hearings.

(1) Individuals who receive a discharge notice from a facility have 10 days to appeal. If the recipient appeals, he may remain in the facility, except in the circumstances described in subsections (b)(5) and (e)(3) of this section, until the hearing officer makes a final determination. Vendor payments and eligibility will continue until the hearing officer makes a final determination. If the recipient has left the facility, Medicaid eligibility will remain in effect until the hearing officer makes a final determination.

(2) When the hearing officer determines that the discharge was inappropriate, the facility, upon written notification by the hearing officer, must readmit the resident immediately, or to the next available bed. If the discharge has not yet taken place, and the hearing officer finds that the discharge will be inappropriate, the facility, upon written notification by the hearing officer, must allow the resident to remain in the facility. The hearing officer will also report the findings to Long Term Care-Regulatory for investigation of possible noncompliance.

(3) When the hearing officer determines that the discharge is appropriate, the resident is notified in writing of this decision. Any payments made on behalf of the recipient past the date of discharge or decision, whichever is later, must be recouped.

(j) Discharge of married residents. If two residents in a facility are married and the facility proposes to discharge one spouse to another facility, the facility must give the other spouse notice of his right to be discharged to the same facility. If the spouse notifies a facility, in writing, that he wishes to be discharged to another facility, the facility must discharge both spouses on the same day, pending availability of accommodations.

Source Note: The provisions of this §19.502 adopted to be effective May 1, 1995, 20 TexReg 2393; amended to be effective March 1, 1998, 23 TexReg 1314; amended to be effective January 1, 2000, 24 TexReg 11781; amended to be effective August 1, 2000, 25 TexReg 6779

RULE §19.503 NOTICE OF BED-HOLD POLICY AND READMISSION IN MEDICAID-CERTIFIED FACILITIES

(a) Notice before transfer. Before a nursing facility transfers a resident to a hospital or allows a resident to go on therapeutic leave, the nursing facility must provide written information to the resident and a family member or legal representative that specifies:
(1) the duration of the bed-hold policy under the Medicaid State Plan (see §19.2603 of this title (relating to Therapeutic Home Visits Away from the Facility) if any, during which the resident is permitted to return and resume residence in the facility; and

(2) the facility’s policies regarding bed-hold periods, which must be consistent with subsection (c) of this section, permitting a resident to return.

(b) Bed-hold notice upon transfer. At the time of transfer of a resident to a hospital or for therapeutic leave, a nursing facility must provide to the resident and a family member or legal representative, written notice which specifies the duration of the bed-hold policy described in subsection (a) of this section.

(c) Permitting resident to return to facility. A nursing facility must establish and follow a written policy under which a resident whose hospitalization or therapeutic leave exceeds the bed-hold period under the State Plan, is readmitted to the facility immediately upon the first availability of a bed in a semi-private room if the resident:

(1) requires the services provided by the facility; and

(2) is eligible for Medicaid nursing facility services.

(d) Bed-hold charges. The facility may enter into a written agreement with the recipient or responsible party to reserve a bed.

(1) The facility may charge the recipient an amount not to exceed the DHS daily vendor rate according to the recipient’s classification at the time the individual leaves the facility.

(2) The facility must document all bed-hold charges in the recipient’s financial record at the time the bed-hold reservation services were provided.

(3) The facility may not charge a bed-hold fee if the Texas Department of Human Services (DHS) is paying for the same period of time, as in a three-day therapeutic home visit.

Source Note: The provisions of this §19.503 adopted to be effective May 1, 1995, 20 TexReg 2393; amended to be effective March 1, 1998, 23 TexReg 1314.

RULE §19.504 EQUAL ACCESS TO QUALITY CARE IN MEDICAID-CERTIFIED FACILITIES

(a) A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the Medicaid State Plan for all individuals regardless of source of payment.
(b) The facility may charge any amount for services furnished to non-Medicaid residents consistent with the notice requirement in §19.403(h) and (i) of this title (relating to Notice of Rights and Services).

(c) The Texas Department of Human Services is not required to offer additional services on behalf of a recipient other than services provided in the State Plan.

Source Note: The provisions of this §19.504 adopted to be effective May 1, 1995, 20 TexReg 2393.

SUBCHAPTER M PHYSICIAN SERVICES

RULE §19.1202 PHYSICIAN VISITS

The physician must:

...(4) write, sign, and date a physician’s discharge summary within 20 workdays of being notified by the facility of the discharge, except as specified in §19.1912(e) of this title (relating to Additional Clinical Record Service Requirements), if the resident has been temporarily discharged for 30 days or less, and readmitted to the same facility; and

Source Note: The provisions of this §19.1202 adopted to be effective May 1, 1995, 20 TexReg 2393.

SUBCHAPTER X REQUIREMENTS FOR MEDICAID-CERTIFIED FACILITIES RULE

§19.2302 REQUIREMENTS FOR A CONTRACTED MEDICAID FACILITY

...(d) A facility may not participate in the Texas Medical Assistance Program if it has restrictive policies or practices, including:

...(7) restricting the resident from applying for Medicaid for a specified period of time;

(8) denying appropriate care to an individual on the basis of his race, religion, color, national origin, sex, age, disability, marital status, or source of payment; and

RULE §19.2304 CONTRACT REQUIREMENTS

...(c) The contracting nursing facility agrees to:

(1) comply with Title VI of the Civil Rights Act of 1964 (Public Law 88-352), §504 of the Rehabilitation Act of 1973 (Public Law 93-112), the Age Discrimination Act of 1975, the Americans with Disabilities Act of 1990 (Public Law 101-336), the Safe Medical Devices Act of 1990, and all amendments to each, and all requirements imposed by the regulations
issued pursuant to these acts. In addition, the contractor agrees to comply with Chapter 73 of this title (relating to Civil Rights). These provide in part that no persons in the United States shall, on the grounds of race, color, national origin, sex, age, disability, political beliefs or religion be excluded from participation in, or denied, any aid, care, service or other benefits provided by federal and/or state funding, or otherwise be subjected to discrimination;

Source Note: The provisions of this §19.2304 adopted to be effective May 1, 1995, 20 TexReg 2393.

SUBCHAPTER Y MEDICAL REVIEW AND RE-EVALUATION

RULE §19.2407 DENIED MEDICAL NECESSITY

(a) If the state Medicaid claims administrator determines that a Medicaid applicant or a recipient does not meet the criteria for medical necessity described in §19.2401 of this subchapter (relating to General Qualifications for Medical Necessity Determinations), the state Medicaid claims administrator notifies the attending physician and the nursing facility in writing and provides them an opportunity to present additional information about the applicant's or recipient's medical need for nursing facility care.

   (1) If the attending physician or a nursing facility physician does not respond or contest the findings of the state Medicaid claims administrator within 10 working days after receipt of the written notice about the decision, the findings are final.

   (2) If the attending physician or a nursing facility physician contests the findings of the state Medicaid claims administrator, at least one physician with the state Medicaid claims administrator must review the case. If the state Medicaid claims administrator's physician determines that the applicant's or recipient's admission or stay is not medically necessary, the determination becomes final.

   (3) The state Medicaid claims administrator sends written notification of the final determination of denied medical necessity to the attending physician, the nursing facility, and the applicant or recipient (or responsible party).

(b) After an applicant receives written notice of a determination of denied medical necessity, the applicant or responsible party must request a fair hearing within 90 days after the date of denied medical necessity, or the applicant loses the right to a fair hearing.

(c) After a recipient receives written notice of a determination of denied medical necessity, the recipient or responsible party must request a fair hearing within 10 days after the date of the written notice in order to have nursing facility services paid for during the appeal.

   (1) If the recipient requests a fair hearing within 10 days after the date of the written notice and the determination of denied medical necessity is upheld, the effective date of the denial is 10 days after the hearing officer's written decision.
(2) If the recipient does not request a fair hearing within 10 days after the date of the written notice, DADS makes vendor payments to the nursing facility at the previously established RUG rate for 15 days or until the recipient is discharged, whichever occurs first.

(3) If the recipient does not request a fair hearing within 10 days after the date of the written notice, the recipient must request a fair hearing within 90 days after the date of denied medical necessity, or the recipient

(d) Fair hearings are conducted by the Texas Health and Human Services Commission (HHSC) in accordance with HHSC rules at 1 TAC Chapter 357.

Source Note: The provisions of this §19.2407 adopted to be effective September 1, 2008, 33

**SUBCHAPTER AA  VENDOR PAYMENT**

**RULE §19.2602 ADDITIONAL CHARGES (ITEMS AND SERVICES EXCLUDED FROM VENDOR PAYMENT)**

(a) The Texas Department of Human Services (DHS) does not make vendor payments when a Title XIX recipient is absent from the facility because of:

(1) therapeutic home visits that extend beyond three days; or

(2) hospital inpatient services. However, DHS makes vendor payments for periods when a recipient is a hospital outpatient subject to the following limitations.

(A) DHS makes vendor payments when a Title XIX recipient is absent from the nursing facility past midnight for outpatient hospital services, including services resulting from hospital outpatient observation. In these cases the facility must document in the clinical record that the recipient was not admitted as an inpatient in the hospital.

(B) If the recipient is admitted to the hospital for inpatient services anytime during a hospital outpatient observation period, a patient transaction notice showing discharge must be submitted effective the date the recipient left the nursing facility.

(b) The facility may enter into a written agreement with the recipient or responsible party to reserve a bed, according to the specifications of §19.503 of this title (relating to Notice of Bed‐hold Policy and Readmission in Medicaid‐Certified Facilities).

Source Note: The provisions of this §19.2602 adopted to be effective May 1, 1995, 20 TexReg 2393.

**RULE §19.2603 THERAPEUTIC HOME VISITS AWAY FROM THE FACILITY**

(a) The facility must have written policies and procedures governing recipient therapeutic home visits away from the facility for the purpose of visiting with relatives and friends.
(b) The following conditions must be met for the facility to receive vendor payment:

(1) the recipient’s plan of care provides for physician-authorized therapeutic visits;

(2) the facility must provide equipment and supplies necessary to meet the needs of the recipient, including, but not limited to, medication and oxygen and supplies for its administration;

(3) if a visit exceeds three days, the facility submits a discharge form effective the first day. Days are defined as 24-hour periods extending from midnight to midnight. In determining days of absence from a facility, the first day is the first 24-hour period beginning at midnight after the recipient’s departure. Situations that require a discharge form effective the first day include: alternate care living arrangements, including at home; transfer or discharge to other medical care or living arrangements covered under Title XIX; and

(C) therapeutic visits that are over three days (one night must be spent in the facility between therapeutic home visits if vendor payment is to be made);

(4) the facility must maintain a record of each therapeutic visit away from the facility. Verification that therapeutic visits took place and were documented is a part of the audit procedures during the DHS audit of the facility. DHS does not pay for therapeutic visits which were not documented.

(c) Before a resident goes on therapeutic leave, the facility must provide written notification to the recipient, and, if known, a responsible party, or family or legal representative, regarding the three-day time limit for a home visit, as specified in subsection (b)(3) of this section.

Source Note: The provisions of this §19.2603 adopted to be effective May 1, 1995, 20 TexReg 2393.