



## Long-Term Care Regulation Provider Letter

**Number:** PL 2023-13

**Title:** Changes to Initial Self-Reporting Methods and Provider Investigation Report Form 3613/3613-A

**Provider Types:** Assisted Living Facility (ALF), Day Activity and Health Services (DAHS), Home and Community Support Services Agency (HCSSA), Intermediate Care Facility for Individuals with an Intellectual Disability or Related Conditions (ICF/IID), Nursing Facility (NF), Prescribed Pediatric Extended Care Center (PPECC)

**Date Issued:** June 6, 2023

### 1.0 Subject and Purpose

The purpose of this letter is to remind providers that the option to submit a self-reported incident via scripted voicemail has not been available since January 1, 2023.

### 2.0 Policy Details & Provider Responsibilities

#### 2.1 Incident Reporting Methods

Long-term care providers can submit a self-reported incident using one of the following methods:

- Online via [TULIP](#),
- Via email to [ciicomplaints@hhs.texas.gov](mailto:ciicomplaints@hhs.texas.gov); or
- speak with one of our live agents at 1-800-458-9858 between the hours of 7:00 am and 7:00 pm, Monday through Friday.

If the initial self-reported incident cannot be submitted via TULIP due to character limit size, submitting via email to [ciicomplaints@hhs.texas.gov](mailto:ciicomplaints@hhs.texas.gov) is an alternate option.

Initial self-reported incidents emailed to [ciiprovider@hhs.texas.gov](mailto:ciiprovider@hhs.texas.gov) **will not** be accepted and should only be emailed to [ciicomplaints@hhs.texas.gov](mailto:ciicomplaints@hhs.texas.gov) or Online via TULIP.

## 2.2 Submitting Form 3613/3613-A

Form 3613/3613-A can be submitted with a HHSC intake number:

- Online via TULIP;
- Email to [ciiprovider@hhs.texas.gov](mailto:ciiprovider@hhs.texas.gov);
- Fax to 1-877-438-5827; or
- Mail to Texas Health and Human Services Commission

Regulatory Services Complaint and Incident Intake  
Mail Code E-249  
PO BOX 149030  
Austin, TX 78714-9030

## 3.0 Background/History

The following revisions were made to the Provider Investigation Forms (HHSC 3613 and HHSC 3613-A):

- Reporter fax number was removed and replaced with email address
- Questions for Individualized Skills and Socialization (ISS) providers
- Additional guidance on necessary information for resident assessment, provider response and investigation summary

## 4.0 Resources

Provider Investigation Report Form [3613](#)

Provider Investigation Report Form [3613-A](#)

Long-term care providers are encouraged to use the attached template when submitting via email to [ciicomplaints@hhs.texas.gov](mailto:ciicomplaints@hhs.texas.gov). This will ensure that the necessary information is provided to conduct proper triage and minimize follow-up contact for additional information.

## **5.0 Contact Information**

If you have any questions about this letter, please contact the Policy and Rules Section by email at [LTCRPolicy@hhs.texas.gov](mailto:LTCRPolicy@hhs.texas.gov) or call (512) 438-3161.

**CII Self-Report Email Template**  
**Email to: [ciicomplaints@hhs.texas.gov](mailto:ciicomplaints@hhs.texas.gov)**

**Reporter Information**

- **Reporter's Name and Title:**
- **Facility/Agency Name:**
- **Facility/Agency Address:**
- **Vendor/Facility ID #:**
- **Primary phone number where you can be reached:**
- **Secondary phone number where you can be reached:**

**Resident/Client Information**

- **Resident/Client Name:**
- **DOB:**
- **SSN:**
- **\*Medicaid #**
- **\*Medicare #**
- **\*Physical Address:**
- **\*Provide the client's payment source and the program the client is in (example: CBA, HCS, PHC, Star-Plus, Family Care, etc.).**
- **\*Provide the specific services the client is receiving, including the number of hours per week the services are delivered.**
- **Pertinent Medical Diagnosis:**
- **Is special supervision required, if so please specify:**
- **Level of cognition:**
- **Is there a history of similar or prior incidents, if so please specify:**
- *For ISS providers only: name and address of the person responsible for the care of the individual:*

*\*HCSSA providers only*

**Incident Details**

- **Date/Time you first learned of incident:**
- **Date/Time the incident occurred:**

- **Brief narrative summary of the reportable incident:**
- **Witnesses name and title:**
- *For ISS providers only:* **At the time of the incident was the individual receiving ISS services?**

### **Assessment Details**

- **The date and time of the assessment:**
- **Name and title of person who completed assessment:**
- **Results of the assessment including extent of injuries. Provide details of any physical harm, pain, or mental anguish including serious bodily injury, or other injuries including but not limited to measurements, location, color of bruises, scratches, lacerations, fractures, changes in resident's behavior that is different from the normal baseline:**
- **Were X-Rays required? If so, provide results:**
- **Type of treatment provided, and when and where treatment was provided:**
- **Was the resident/client sent to the hospital? If so, provide the name and address of the hospital:**
- **Describe treatment provided at the hospital:**

### **Alleged Perpetrator**

- **Name and title:**
- **Social security number:**
- **\*Phone number:**
- **\*Physical address:**
- **Was the alleged perpetrator removed, suspended or terminated?**

*\*HCSSA providers only*

### **Actions and Notifications**

- **Who did the facility/agency notify about the incident? Ex. physician, family, ombudsman:**
- **Was the incident reported to the police? If so, provide case number:**

- **If the Texas Department of Family and Protective Services was notified, please include the DFPS call ID reference number:**
- **Provide all steps taken immediately to ensure resident(s) are protected including but not limited to evaluating if resident feels safe, room relocation, increased supervision and other measures to prevent further abuse, neglect, exploitation and misappropriation:**
- **Was an in-service conducted? If so, provide topic of in-service:**
- **Any other relevant information:**