**Health & Independence Services**

**Form H: CEILING REQUEST AND**

**PERFORMANCE MEASURES**

**Legal Business**

Name of Applicant: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

This page should reflect all services projected to be delivered during the contract period for those services categories described in your Service Delivery Plan and for which you intend to bill and expect to be paid (See below Form H: Children’s Autism Program Ceiling Request and Performance Measures Guidelines).

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If you provide services in counties located in different HHSC regions, complete a separate form for each HHSC Region. Do not complete a form for each county.

**Estimated Number of Unduplicated Clients**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Health Service Region:** | 1 | 2/3 | 3 | Children & Adolescents (3-15 years) |
| 4 | 5 | 6 | 7 |
| 8 | 9 | 10 | 11 |

|  |  |  |
| --- | --- | --- |
|  | | **FY 2026 Projected** |
|  | Number of Clients\* |  |
| Total $ Amount for all services provided |  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Children’s Autism Program Services** | Currently a provider and interested in continuing: | | Not currently a provider, but interested in applying: | |
| Yes | No | Yes | No |

**\*Note to contractors: The projected Number of Unduplicated Clients is subject to change depending on funding provided.**

## FORM H: CEILING REQUEST AND PERFORMANCE MEASURES GUIDELINES

FORM H must be used for Children’s Autism Program services only. The form reflects the estimated unduplicated number of the Children’s Autism Program Eligible Clients the Applicant proposes to serve, and the total amount estimated to be billed to the Children’s Autism Program. Complete a separate FORM H for each Service Region in which services will be provided.

**Steps to complete form:**

1. Identify the Health Service Region ("HSR") in the first column, row 1.
2. Enter the projected number of unduplicated Clients to be served and the corresponding dollar amounts (rounded to the nearest dollar). The Grand Total must equal the amount of funding requested for Children’s Autism Services.
3. If the Applicant is a current provider and wants to continue to provide Children’s Autism services by checking “Yes” or “No". If the Applicant is not a current provider, check “Yes” or “No” if interested in applying to be a provider. **Note:** A contractor cannot bill Children’s Autism Program for case management codes 948-48 if not registered as a Children’s Autism provider.