

Form K, Ceiling Request

FORM K must be used for Epilepsy Program services only. The form reflects the estimated unduplicated number of the eligible Epilepsy Program Clients the Respondent proposes to serve and the total amount estimated to be billed to the Epilepsy Program.

Instructions to Complete FORM K:

1. Select the Health Service Region ("HSR") where services will be provided. Please complete a separate **FORM K, Ceiling Request** for each HHSC Health Service Region (HSR) in which services will be provided.
2. In the 'Number of Clients*' row, enter the projected number of unduplicated Clients to be served in the 'FY 2026 Projected' column. The corresponding dates for FY 2026 are September 1, 2025 through August 31, 2026.
3. In the 'Total Dollar Amount for All Services Provided' row, enter the estimated dollar amount, rounded to the nearest dollar, for the cost of services to clients in the 'FY 2026 Projected' column.
4. In the 'Total Dollar Amount per Client' provide the quotient of 'Total Dollar Amount for All Services Provided' divided by the 'Number of Clients'
5. If the 'Total Dollar Amount per Client' is greater than \$350/client, please provide a one-page justification explaining the projected dollar amount per client as an attachment to this form, **FORM K, Ceiling Request**.
6. In the 'Epilepsy Program Services' table, the Respondent will select the correct column to complete based on whether or not they are a current provider.

If the Respondent is a current provider for the Epilepsy Program, the Respondent can choose if they want to continue providing Epilepsy services by checking "Yes." If the Respondent, no longer wishes to provide service by checking "No".

If the Respondent is not a current provider, check "Yes" or "No" if interested in applying to be a provider. **Note:** A contractor cannot bill Epilepsy Program for case management codes if not registered as an Epilepsy provider.



Epilepsy Program
FORM K: CEILING REQUEST

Legal Business

Name of Respondent: _____

This page should reflect all services projected to be delivered during the contract period for those services categories described in **Form D, Work Plan** and for which you intend to bill and expect to be paid.

Please complete a separate FORM K for each HHSC Health Service Region (HSR) in which services will be provided.

Health Service Region:	<input type="checkbox"/> 1	<input type="checkbox"/> 2/3	<input type="checkbox"/> 4/5N
	<input type="checkbox"/> 6/5S	<input type="checkbox"/> 7	<input type="checkbox"/> 8
	<input type="checkbox"/> 9/10	<input type="checkbox"/> 11	

	FY 2026 Projected	<u>*If the total dollar amount for all services provided is greater than \$350 per client, provide a one-page justification as an attachment to this form. See page 3.</u>
Number of Clients*		
Total Dollar Amount for All Services Provided		
Total Dollar Amount per Client		

Epilepsy Program Services	<u>Currently a provider and interested in continuing:</u>	<u>Not currently a provider, but interested in applying:</u>		
	Yes <input type="checkbox"/>	No	Yes	No

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

Dollar Amount for All Services Provided

***If the total dollar amount for all services provided is greater than \$350 per client, provide a one-page justification. Use only the space below.**