CMS/TOMA/PHR Quarterly Status Report to TXPHP

All records and information maintained by the TXPHP are confidential under Sec. 167.010 of the Medical Practice Act, and other state and federal statutes protecting patient and TXPHP participant privacy and are not subject to disclosure.

Program Name: ________________________________
Address: ______________________________________
City, State, Zip ___________________________________
Phone: ___________________________________
Email: __________________________________

Re: ____ ____________________
Name of TXPHP Participant TXPHP #

Date: _____________________

What follows accurately reflects the joint opinion of the CMS/TOMA/PHR and the above named TXPHP participant (circle appropriate answer – *please attach a narrative response for any "NO" answer*):

1. YES NO Attendance at CMS/TOMA/PHR Committee meetings is appropriate in frequency and participation.

   If the answer is no, please explain the circumstances for the response: [text box]

2. YES NO Behavior indicates a continuing change consistent with adequate recovery efforts.

   If the answer is no, please explain the circumstances for the response: [text box]

3. YES NO To our knowledge, the participant's family is supportive of recovery efforts.

   If the answer is no, please explain the circumstances for the response: [text box]

4. YES NO To our knowledge, new legal issues have surfaced since the date of the last report or since beginning participation with CMS/TOMA/PHR.

   If Yes, please explain [text box]

5. YES NO To our knowledge, the participant is adhering to their TXPHP Monitoring and Assistance Agreement and any additional agreements with our Committee.

   If the answer is no, please explain the circumstances for the response: [text box]

6. YES NO To our knowledge, the participant's level of involvement in the recovery process demonstrates an appropriate commitment to the process.

   If the answer is no, please explain the circumstances for the response: [text box]

7. YES NO N/A The participant is being tested as part of their agreement with our committee. If tested, all results have been negative.

If the answer is no, please explain the circumstances for the response: [text box]

Please indicate if you would like for the TXPHP Medical Director to call and speak with you about this participant: Yes ☐ No ☐

CMS/TOMA/PHR Chair or Designee: ____

Phone: ______________________ Day of week and time: _____________________

Email: ____________________________

Check one of the following:

[ ] I swear and affirm that my and other entity members' or entity associates' relationship with the TXPHP participant is solely for the purposes of recovery and is limited to interactions through CMS/TOMA/PHR activities only. I and other entity members or entity employees are not in any way related to the participant, nor do we have a close personal relationship of any kind, a professional or healthcare-related relationship of any kind, a business or financial relationship of any kind, or any other relationship that may present an ethical or professionalism issue.

[ ] Either I or another entity member or associate has a relationship with the TXPHP participant beyond the recovery CMS/TOMA/PHR relationship.

Please describe all other relationships with the TXPHP participant and their role in the entity as it related to the participant. [text box for description]

Electronic Signature: ____