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Introduction

This reference guide has been designed because we understand how complex the Nebraska Health Connection/Kids Connection (NHC/KC) program is. In addition, with staff changes and evolving roles, there is an ongoing need for orientation and clarification of program policy. This reference guide is our effort to keep current information readily available to those of you who need it, when you need it. Our goal is to have this guide be a usable tool for you and your staff, so we'll be adding topics to it and refining the current content on an ongoing basis to make it the most effective tool possible.

We understand that you have a choice when it comes to participating in the Nebraska Health Connection/Kids Connection program. We appreciate your participation and are committed to making the processes as easy to navigate as possible. If you have comments or suggestions for changes or additions to the guide, please contact your Provider Resource Specialist.

NOTE: This reference guide is meant to assist you and your staff. This guide is intended to convey information in accordance with federal and state Medicaid laws and does not replace Nebraska Administrative Code (NAC) Title 471, Nebraska Medical Assistance Program, and Title 482, Nebraska Managed Care Program. Please refer to appropriate Medicaid regulations in your Medicaid provider handbook or at the website, http://www.hhs.state.ne.us/reg/t471.htm

Definitions

Health and Human Services – the State of Nebraska agency responsible for administration of Medicaid and Medicaid Managed Care Programs.

Access Medicaid – a cooperative enterprise of two local Health Departments (Lincoln-Lancaster County Health Department and Douglas County Health Department) and two Medical Societies (Lancaster County Medical Society and Metro Omaha Medical Society) in a public/private partnership representing client and physician needs in Medicaid Managed Care. Access Medicaid is responsible to provide client education and enrollment services. This includes information about how to access health care in a managed care environment, Primary Care Physician (PCP) and health plan selection, health assessment, and case management services.

Nebraska Health Connection – the name of the Nebraska Medicaid Managed Care Program. Medical/Surgical managed care components are mandatory for certain clients in the Douglas, Sarpy and Lancaster County area. The Mental Health/Substance Abuse managed care component is mandatory for most clients throughout Nebraska.

Kids Connection – the name used for Nebraska's program that provides health care coverage for qualified children age 18 and younger. It includes both the Children's Health Insurance Program (CHIP) and the Nebraska Medical Assistance Program (also known as Medicaid).

Nebraska Health Connection/Kids Connection – in the Douglas, Sarpy and Lancaster County areas, all clients eligible for Kids Connection have their benefits administered in accordance with the regulations of Nebraska Health Connection. As a result, the two names have been combined to represent one program. Nebraska Health Connection refers to the entire program with specific focus on adults age 19 and over. Kids Connection refers to all eligible children. Although NHC/KC includes Access Medicaid, the two medical plans, and the mental health plan, most clients refer to Access Medicaid as Nebraska Health Connection/Kids Connection.

Share Advantage/Americhoice – one of two managed care health plans available for client selection in the Nebraska Health Connection/Kids Connection program. It is a managed care organization (MCO) health plan responsible for plan administration and claim payment. It is administered by United HealthCare. Clients access services and referrals for certain services from their PCP. Providers of services covered by the MCO plan must be enrolled in the MCO plan network and providers submit claims to the MCO plan for payment.

Primary Care+ - one of two managed care health plans available for client selection in the Nebraska Health Connection/Kids Connection program. It is administered by Blue Cross/Blue Shield of Nebraska. Clients access services and referral or authorization for certain services from their primary care physician. Providers submit claims to Nebraska Medicaid, Department of Health and Human Services Finance and Support. Case Managers can assist with chronic illnesses, difficult members, lock-in clients, diabetic education, coordinate care, and enroll members in the asthma and high risk prenatal programs. A community representative is on staff to offer health activities to benefit the overall community.

Magellan – is responsible for management of mental health and substance (MH/SA) services. Authorization is required for all MH/SA services. Providers submit claims to Nebraska Medicaid, Department of Health and Human Services Finance and Support.

Medicaid Provider Enrollment Process

This process applies to the following circumstances:

-Adding a new physician
-Opening a new practice
-Changing Federal Tax ID number
-Adding a new practice location
-Change in location/specialty/practice group

Written Procedure

1. Request the Medical Assistance Provider Agreement (MC-19 form) by calling the Medicaid Provider Enrollment Unit at 471-9717 or the Medicaid Inquiry Line at 471-9128.
2. Only an original signature is accepted (no stamps)
3. Always keep a copy for yourself
4. Submit MC-19 form ***simultaneously*** to :

Nebraska Medicaid
Original must be mailed to
Nebraska Medicaid
Medicaid Provider Enrollment Unit
P.O. Box 95026
Lincoln, NE 68509-5026

Managed Care Plans
A copy may be ***faxed*** to:
Primary Care+ Attn: Provider Relations Analyst (402) 548-4633
Share Advantage Attn: Ntwk. Acct. Mgr. (402) 445-5730
Magellan: (402) 437-4266

Fax Procedure

A faxed letter to Medicaid Provider Enrollment (471-8703) is sufficient for the following circumstances:

-*ENTIRE* practice relocates
-Phone/fax changes, suite number changes, age restrictions on patients changes
-Marriage/change of name
-Terminations-retirement, death, leaves service area

Fax this letter including the old information (Prior location address) and the new information (new address, phone number, etc.) to:

Nebraska Medicaid	(402) 471-8703
Share Advantage	(402) 465-6701
Primary Care+	(402) 343-3454
Magellan	(402) 437-4266

Changes to Provider Status

1. Change from accepting new patients to existing only patients
   -Notify PC+ Provider Relations at (402) 392-4275
   -Notify Share Advantage at (402) 465-6717
   -Notify your Provider Resource Specialist at 483-4800
2. Change from accepting existing only patients to accepting new patients
   -same as above
3. Please indicate if your established only status has an exclusion clause for relatives of existing patients or newborns.

How does the client enrollment process work?

- A client applies for Medicaid at a local Health and Human Services office or mails in an application.
- Health and Human Services staff review the application, verify income and resources, and determine eligibility for Medicaid.
- The client is sent a letter from Health and Human Services informing them about their eligibility for Medicaid and, if applicable, they must enroll in Nebraska Health Connection/Kids Connection, the Medicaid Managed Care program. This begins a 45 day, six step outreach process.

Outreach Process

The outreach process incorporates a series of letters, postcards and home visits with information about the program and the health plans. The purpose is to generate client ***self-selection*** of a "medical home" (PCP) and health plan.

If the client fails to respond to this intensive outreach effort, they will be auto assigned. In this situation, the computer assigns a PCP (Primary Care Physician) and health plan based on the client/family age and zip code.

The client can respond to outreach by telephone or by coming in to the NHC/KC office. A Public Health Nurse (PHN) will provide education about managed care, complete a health and social risk assessment, and assist in the selection of a PCP and health plan. The PHN will inquire about an existing relationship with a physician and, where appropriate, will attempt to maintain that relationship. The PHN will also provide case management services to coordinate care and services. If a client/physician relationship is not successful for any number of reasons, the PHN will work with the client and/or the PCP to complete a transfer.

Once enrolled, the client will receive an NHC Identification Document in the mail from HHS on or before the first of each month. The ID Document is ***valid for one month only***. They will receive a new ID Document on or before the first of each month they are eligible. The ID Document lists the client's Medicaid number and the PCP and health plan they have chosen. (see appendix).

The following Medicaid – eligible clients in Douglas, Sarpy and Lancaster counties are required to participate in Medicaid Managed Care:

- Aid to Dependent Children, including clients participating in the Medical Assistance Programs for Children (i.e., Ribicoff), Medical Assistance for Children (MAC), School Age Medical (SAM) and Kids Connection.
- Aid to Aged, Blind and Disabled
- Child Welfare Payments and Medical Services Program, i.e. Former Wards, Subsidized Guardianship cases

What do I do if a client doesn't bring their NHC ID Document?

Your office policy for refusing to see patients who don't bring in their insurance card needs to be the same for Medicaid and non-Medicaid clients alike. You can only refuse if this is the same policy you have for non-Medicaid clients and the policy is posted near your front desk where clients can easily see it.

To avoid this situation, obtain insurance/payer information at the time the appointment is made.

If the card isn't available, you will have the Medicaid ID number to verify eligibility by calling any one of these sources:

- The NMES line, 471-9581 *or*
- Nebraska Health Connection/Kids Connection, 471-7910 *or*
- Your Provider Resource Specialist, 483-4800

What does Nebraska Medicaid Managed Care Cover?

- Inpatient Hospital Services
- Outpatient Hospital Services
- Clinical and anatomical laboratory services
- Radiology services
- Healthcheck services
- Physician services, including nurse practitioners, certified nurse midwives, and physician assistants, and anesthesia services
- Home Health agency services
- Private duty nursing services
- Therapy services, including physical therapy, occupational therapy, and speech pathology and audiology
- Durable medical equipment and medical supplies, including hearing aids, orthotics, prosthetics and nutritional supplements
- Podiatry services
- Chiropractic services
- Ambulance services
- Medical transportation services
- Visual services
- Family Planning services
- Emergency services
- Transitional mental health and substance abuse services (Magellan)
- Certified nurse midwife services
- Skilled/Rehabilitative and Transitional Nursing Facility
- Specialist Services

When in doubt about what Medicaid covers, contact the appropriate Medicaid program policy staff person (see Attachment 2)

Dental and pharmacy services are covered under fee for service Medicaid (straight Medicaid), while the other listed services are covered by the Medicaid Managed Care Program.

Copays

Medicaid clients who are in managed care (PC+ or Share Advantage) should never be charged a copay for physician services. The only copay they have is for prescription medication (except for birth control.) Children, under the age of 18, are *never* charged a copay, even for prescription drugs. There is no copay for prescriptions in Medicaid Managed Care for pregnant clients.

Fee for Service Medicaid (straight Medicaid) clients over the age of 18 are charged between $1 and $3, depending on the service they are receiving.

NF stands for Nursing Facility and ICF/MR stands for long term care facility for the mentally retarded.

	Medicaid Managed Care				Fee for Service Medicaid			
	18 & Younger	19 & Older	Pregnant	NF or ICF/MR	18 & Younger	19 & Older	Pregnant	NF or ICF/MR
Chiropractic Office Visits	No	No	No	No	No	$1 per visit	No	No
Dental Visits	No	No	No	No	No	$3 per specified Service	No	No
Eyeglasses	No	No	No	No	No	$2 per dispensing fee	No	No
Hearing Aids	No	No	No	No	No	$3 per dispensing fee	No	No
Mental Health and Chemical Dependency Services	No	No	No	No	No	$2 per specified service	No	No
Occupational Therapy	No	No	No	No	No	$1 per non-hospital based service	No	No
Optometric Office Visits	No	No	No	No	No	$2 per visit	No	No
Outpatient Hospital Visits	No	No	No	No	No	$3 per visit	No	No
Physical Therapy	No	No	No	No	No	$1 per non-hospital based service	No	No
Physician Office Visit (excluding PCPs)	No	No	No	No	No	$2 per visit	No	No
Podiatrist Office Visits	No	No	No	No	No	$1 per visit	No	No
Speech Therapy	No	No	No	No	No	$2 per non-hospital based service	No	No
Prescription Drugs	No	$2 per prescription	No	No	No	$2 per prescription	No	No

What is the difference between Fee for Service Medicaid (straight Medicaid) and Medicaid Managed Care?

Differences between Medicaid Managed Care and Fee For Service Medicaid

Category	Medicaid Managed Care	Fee for Service Medicaid
Benefits	Same *	Same
Health Plans	Two health plans: Share Advantage (UHC of the Midlands) Primary Care+ (Blue Cross/Blue Shield of Nebraska)	No health plans are involved. The State of Nebraska administers the program
Coverage Area	Douglas, Sarpy and Lancaster counties	The entire State of NE
Participation	Any Medicaid client who lives within the three-county area and has no other insurance is mandated to enroll in MMC, with a few exceptions.	Anyone who meets the criteria for Medicaid and does not qualify for MMC. (**)
Referrals	Clients must receive referrals for specialists through their PCP	Clients do not need a referral to see a specialist
ER Use	Clients must call their PCP before using the ER for non-emergent needs PC+ does not require prior authorization for *any* ER visits.	Clients do not need authorization to use the ER.
Transportation	Share Advantage: transportation is arranged through plan customer service except for dental and mental health services. Call 1-800-641-1902. PC+: transportation arranged through Lincoln-Lancaster Co. Health Dept. (except for mental health services) in Lincoln. Call 441-8065.	Transportation is arranged through the Lincoln-Lancaster Co. Health Dept. in Lincoln only. In Omaha, coordinate through the local office caseworker. For mental health services, contact Magellan.

* will cover physical exams for adults if active with Share Advantage. Not covered on PC+ or FFS.

* * An eligible client with private insurance or Medicare will have fee-for-service Medicaid as secondary insurance.

MAC Mom (ineligible pregnant woman)

Who is a MAC Mom?

1. The MAC Mom is a woman who is *NOT* eligible for Medicaid in her own right, but because she is pregnant, she is eligible for healthcare benefits on behalf of the unborn child.

What is the eligibility period?

2. The period of eligibility for the MAC Mom is through the end of the month in which the 60-day post-partum period ends. Day one is the day the baby is born. ***For example, if the child was born on October 7th, eligibility would end on December 31st.***

What services are available to MAC Moms?

3. MAC Moms are eligible to receive ***all*** medically necessary Medicaid covered services including medical, dental, vision and mental health services on behalf of her unborn baby. The health plan is responsible for coordinating referrals for the MAC Mom's health care.

How does the ID Document differ for MAC Moms?

4. Until the baby is born, the mother will present an ID document listing the baby's name as "unborn," the baby's Medicaid number and the baby's PCP. Even though the mother's doctor may not be listed on the ID document, it is okay to see the mother. Remember to coordinate referrals through the baby's health plan (either Share Advantage or PC+)

Submit claims using the Medicaid number of the unborn. However, if the mother is eligible in her own right, submit claims for her services under her number.

If you have questions about coordination of the MAC Mom's care, call:

PC+ - Case Management, 1-800-424-7096 or Member Services, 1-800-424-7097
Share Advantage – Heather Johnson, 1-402-445-5711 or the Executive Director, 1-402-445-5334

PCP Initiated Transfers

Acceptable Reasons: There are several reasons why a PCP may request that a client be transferred to another PCP. These reasons include:

1. Sufficient documentation to establish the client's condition or illness would be better treated by another PCP

2. Sufficient documentation to show the client is uncooperative, disruptive, does not follow medical treatment, does not keep appointments, etc.

3. Travel distance substantially limits the clients' ability to follow through on the PCP services/referrals

4. Sufficient documentation to establish fraud or forgery, or evidence of unauthorized use/abuse of Nebraska Health Connection/Kids Connection.

The PCP shall maintain responsibility for providing care for the patient until a transfer is complete, which may be 30-45 days.

Procedure for initiating a PCP transfer:

The PCP shall submit in writing a request for a transfer to the client's health plan. The client's health plan will work with the client to make an effort to resolve the issue. The written request must include the following:

- Detailed accounting of the reason for the transfer
- Detailed accounting of the attempt (s) made to resolve the issue (s).
- Documentation of the clients' response to all measures taken
- Documentation that the clients behavior has been evaluated to determine if the behaviors of concern are due to mental illness and whether the behaviors can be treated/controlled through appropriate intervention
- Documentation the PCP has explored appropriate alternatives with the client

Fax the request to:
Share Advantage – (402) 465-6701
PC+ - (402) 548-4681

When the NHC/KC PHN receives the information from the Plan, the PHN will investigate the client perspective of the situation and compile the PCP information, Plan information, and client information into a summary to be reviewed by Health and Human Services.

The PCP will be notified of the transfer decision by HHSS. If the client doesn't select another PCP by 10 days after the decision, the client will be reassigned by the health plan. The effective date of the transfer is the first month possible, given system cut-off.

Special Situations:

- Access to Care

Clients are enrolled into Nebraska Health Connection/Kids Connection upon determination of their Medicaid eligibility. Many times, a client will become enrolled but may not be seen for 6-12 months. This client is still your client, even though they've never come in to be seen. You may request a monthly list of your clients from either health plan. Call:

  - Share Advantage – Heather Johnson, 402-445-5711
  - PC+ - Virginia Smith, 402-392-4275

- Client Eligibility can be verified by calling:

  - The NMES line at 471-9581. You will need to have your provider number, the client's Medicaid number or Social Security number, and the month for the date of service in question, *or*
  - Your Provider Resource Specialist at 483-4800, *or*
  - The Medicaid Managed Care Health Plan, *or*
  - The NHC/KC office at 471-7910.

- What do I do if Nebraska Medicaid denies a claim?

  If it's a PC+ claim, call the Medicaid Inquiry Line at 471-9128.
  If it's a Share Advantage claim, call 1-866-331-2243.

- Failed Appointments: If you have a patient that has failed an appointment, you may request intervention on your behalf from the Public Health Nurses at Nebraska Health Connection/Kids Connection or from the appropriate Health Plan.

Fax or call in the following information as soon as possible after the failed appointment:

- Name, address, telephone number of patient
- Medicaid number of patient
- Date of missed appointment
- Doctor patient was scheduled with
- Whether this is the first, second or third appointment missed
- Reason for the appointment

Nebraska Health Connection/Kids Connection – Fax – 471-7942
PC+ - Fax – 402-548-4681
Share Advantage – Fax – 402-445-5730

- Interpretation: *The Department of Health and Human Services Office of Civil Rights issued guidelines in August, 2000, to require all physicians who receive federal funding, i.e., Medicaid payments, to provide at their own expense, some form of interpretation for all their patients with limited English skills.*

Forms of language interpretation include:

*CHIRP Line – provides ***free*** telephone interpretation in 15 minute increments. If you need longer than 15 minutes, hang up and call back. The telephone number is 434-6500. The five languages the CHIRP line can interpret for are Bosnian, Arabic, Russian, Spanish and Vietnamese.

*Coordinate with the managed care Health Care Plan (Share Advantage or PC+) to use their language telephone lines at no charge. Share Advantage provides access 1-2 times until you are able to set up your own interpreter access.

*Hire a private interpreter. Costs can range anywhere from $30-$75 an hour. Contact the Provider Resource Specialist for assistance in locating interpreters.

- Lock-In Clients: If you suspect someone is abusing prescription medications, or misusing medical assistance services, please contact the State Pharmacy Unit at 471-9301. If you have questions about how lock-in procedures work, contact the State Pharmacy Unit or your Provider Resource Specialist, 483-4800.

- Medicaid as Secondary Insurance: Medicaid as a secondary payment is considered to be payment in full. The combined payment made between the primary payer and Medicaid will equal at least the Medicaid allowable amount.

The Medicaid client is not liable for any insurance copay amounts and cannot be balance billed.

Example: if two Medicaid patients walk into your office and one also has a primary insurance, and the Medicaid allowable rate for your service is $50, the reimbursement by Medicaid for the patient who does not have primary insurance will be $50, while the reimbursement by Medicaid for the patient who does have a primary insurance will be the balance between the $50 allowable amount and the amount paid by the primary insurance.

If the primary insurer pays $30, then Medicaid will pay $20. If the primary insurer pays $50, then Medicaid will pay $0. The combined payments are considered to be payment in full when the Medicaid allowable amount has been received. The copay is considered to be part of the allowable amount.

If you have a client who needs to change their Third Party Liability (TPL) status, the client needs to call the TPL Unit at 471-9128, option "1."

- Other State Medicaid Programs: In order for Nebraska providers to bill other state Medicaid programs, contact that state's Medicaid agency's provider unit to enroll. Contact your Provider Resource Specialist at 483-4800, for a list of State telephone numbers.

- Past Medical Bills: If a client was previously terminated for unpaid bills and gets reassigned to your office, they can be terminated again for that same reason. However, the NHC staff encourages offices to accept these patients because all subsequent bills will now be covered by Medicaid.

- Presumptive Eligibility: Presumptive Eligibility is temporary Medical Assistance coverage only available to pregnant women.

Pregnant women may apply for presumptive eligibility at a qualified provider's office. A qualified provider is a doctor, clinic, hospital, or community agency approved by Nebraska Medicaid. In Lincoln, the qualified providers are:

- Nebraska Urban Indian Medical Center
- Lincoln-Lancaster County Health Department
- Lincoln Medical Education Partnership

One presumptive eligibility period per pregnancy can be granted. The presumptive eligibility period begins on the date a qualified provider determines the applicant is eligible. The presumptive eligibility period ends on the day the local HHS office makes a final determination on whether or not the client qualifies for Medicaid.

For questions about presumptive eligibility, please contact the Program Specialist at 471-9530.

- Prior Authorization by Nebraska Medicaid for Medicaid Managed Care Clients: The following services must be prior authorized by Nebraska Medicaid for clients including those enrolled in one of the Medicaid Managed Care plans:

    - Abortions
    - HEALTH CHECK (EPSDT) treatment services not covered by the State Plan
    - Sterilization Exceptions (see 471 NAC 18)
    - Transplants

Family planning, services, emergency services, and Native Americans seeking tribal clinic or Indian Health hospital services do not require prior authorization by Nebraska Medicaid or the PCP or health plan.

Out of state service authorization for NHC/KC health plan clients is the responsibility of the health plan. However, out of state providers must be enrolled in Nebraska Medicaid.

- May I bill a patient if they request a non-Medicaid covered service?

Yes, but only under the following circumstances:

- The specific service needs to be written out, for example, "Adult Check-Up"
- The *cost* of the service/test needs to be written out
- The patient needs to understand whatever they are requesting is not a covered service and they will be billed by the physician's office
- The same set of circumstances must be applied to non-Medicaid patients, if applicable.

- Calling offices regarding existing patients

Beginning July 1st, 2002, the Nebraska Health Connection/Kids Connection public health nurses discontinued the practice of calling provider offices to confirm existing patient status. They do, however, continue to check claim history. In the program evaluation process this was found to be an unnecessary step in most situations. This policy will avoid taking your time to verify patient information by telephone. If you should acquire a patient into your practice that you had previously dismissed, please have that patient immediately call the Assistant Nursing Supervisor, Becky Davis, RN, BSN at 471-7946.

- What do I do if a patient brings in both a Fee For Service Medicaid card and a NHC ID Document?

If a patient presents both of these cards within the same month, fax both documents to your Provider Resource Specialist. She will follow up with the State to see why two documents are being produced. The State will honor the claim for payment with whichever document was initially presented. Please keep copies of both documents in the patient's file until payment is resolved.

Nebraska Health Connection (NHC/KC): Lincoln Area

Medicaid Managed Care Contact Information
(1-27-04)

HHS Medicaid Contacts

NMES line to verify Medicaid Eligibility 471-9581
Local Office (caseworkers).....471-7000
Medicaid Provider Enrollment Form Requests (MC19) 471-9128
Provider Enrollment Fax.....471-8703
Medicaid BILLING Inquiry Line.....471-9128
(*Above number is for previously submitted Medicaid claims*)

John Naujokaitis, NHC Program Analyst 471-6353
FAX.....471-9092
State of NE: Claims Website www.hhs.state.ne.us/med/medindex.htm
HHS Website..... www.hhs.state.ne.us/med

Health Plan Contacts

PC+ (Blue Cross/Blue Shield of Nebraska)

Customer Service ..... (402) 392-4180 or (800) 424-7097
Case Management..... (800) 424-7096
Referral/Authorization
Outpatient Surgery/Specialist Referrals..... (800) 662-3559
Inpatient..... (800) 247-1103
FAXED Referrals..... (800) 255-2838
Website available for Referrals at: www.bcbsneprovider.com/services/precertification/pc
Health Network Services Rep: Virginia Smith .....(402) 392-4275
FAX..... (402) 548-4681

Share Advantage (United Health Care of the Midlands/AmeriChoice)

Customer Service..... (800) 641-1902
Provider Service ..... (866) 331-2243
Case Management Team ..... (800) 641-1905
Website available for eligibility/claims submission: www.AmeriChoice.com
Senior Network Manager: Sharon Votava ..... (402) 465-6717
Network Acct. Manager: LeAnn Ortmier (Omaha)..... (402) 445-5515
Program Assistance: Heather Johnson ..... (402) 445-5711
FAX: ..... (402) 465-6701

Magellan, Mental Health/Substance Abuse

Member/Provider Services.....(800) 424-0333

Access Medicaid/Lincoln

Client Helpline.....471-7715
General Line 471-7910
FAX.....471-7942

Lancaster County Medical Society

Joan Anderson, Executive Director.....483-4800
E-mail: joanianderson@yahoo.com
Provider Resource Specialist – Kate Mueller.....483-4800
E-mail: kate@lcmsne.org
FAX: 483-4802

Referral to Access Medicaid for Follow-up of No Show Appointments

Client Name: _____

Telephone: _____

Address: _____

Birthdate: _____

Client's 11-digit Medicaid #: _____

Client's PCP: _____

Type and Number of No Shows and Dates, if possible:

_____

_____

_____

_____

_____

Has your office ever discussed the consequences of no shows with this family?

Yes _____

No _____