Appendix 22 ▪ Participant Enrollment/Termination Information Form (PETIF) Data Input Fields

Site Number:_____ MSSP Number:_____ SSN:_____
Medicare/RRB Number:_____ Aid Code:_____ County Code:_____
CIN Number:_____ Date of Issue:_____
Enrollment Date:_____ Date of Birth:_____ Age at Enrollment:____

Participant Last Name:_____ First Name:_____ MI:____

Gender: _____

Participant Address:

_____

Participant Mailing Address:

_____

Participant Phone Number: _____

Lives Alone? _____

Marital Status:

☐ Married ☐ Widowed ☐ Separated ☐ Single ☐ Divorced ☐ Domestic Partner

Race/Ethnicity:

☐ White ☐ Black or African American ☐ American Indian or Alaska Native ☐ Asian
☐ Middle Eastern or North African ☐ Native Hawaiian or Pacific Islander
☐ Hispanic or Latino ☐ Other:_____

Preferred Language:_____

Years of Formal Schooling:_____

PCM Information: Name _____ PCM #_____

Emergency Contact Information

Name: _____

Relationship:_____

Primary Phone: _____

Secondary Phone:_____

Address:_____

_____

Physician Information

Name: _____

Phone:_____

Address:_____

_____

Referral Source Information

Referral Type:_____

1. Home Health
2. Managed Care
3. Self
4. DPSS (County
5. Family
6. Service Provider
7. Friend
8. Other Care
9. Unknown
10. Acute Care
11. Physician
12. Spouse
13. Health Department
14. Senior Center
15. Adult Day Care
16. SNF
17. Board and Care
18. Medi-Cal
19. Nutrition Center
20. Clergy
21. ICF
22. Social Security
23. Welfare Department
24. Othe

Site Field 1: _____

Site Field 2: _____

Site Field 3: _____

Participant Termination Information

Termination Date: _____

Reason/Code for Termination: _____

Narrative on Termination (brief description of the reason for termination):

_____

Date of Death:_____ Place of Death: _____

PE/TIF Revision/Edit Date:_____