Appendix 17 Client Enrollment / Termination Information Form

Site Number	MSSP Number	Social Security Number					
Medicare/RRB Number		Aid Code	County Code				
CIN Number		Date of Issue					
Enrollment Date	Date of Birth	Age at Enrollment					
Client Last Name	First Name	MI	Gender				
Client Address							
Client Mailing Address							
Client Phone Number	Lives Alone?						
Marital Status:	Married	Widowed	Separated	Single	Divorce	Domestic Partner	
Race:	White	Black	American Indian/Alaska Native	Asian/Pacific Islander	Hispanic	Other	
Major Language	No Formal Schooling						
Formal Schooling: _____ (Number of Years)							
Level of Care:							
SNF Avoidance	SNF Deinstitutionalization	ICF Avoidance	ICF Deinstitutionalization				
EDS Remarks							
PCM Information:	Name	PCM #					
Emergency Contact Information	Physician Information						
Name	Name						
Address	Address						
Work Phone Number							
Home Phone Number	Phone Number						
Relationship of Emergency Contact							
Referral Source Information	Phone Number						
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 Dept	24	Other
Site Field 1							
Site Field 2							
Site Field 3							
Client Termination Information							
Termination Date							
Reason for Termination							
Narrative on Termination							
Date of Death	Place of Death						
Revision/ Edit Date:	CE/TIF Revision/Edit Date						