

## Appendix 17 ▪ Client Enrollment/Termination Information Form

Site Number	MSSP Number	Social Security Number	County Code
Medicare/RRB Number		Aid 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		Phone Number	
Home 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	1 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	
CE/TIF Revision/Edit Date			