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:

☐ White ☐ Black ☐ American Indian/Alaska Native ☐ Asian/Pacific Islander

☐ Hispanic ☐ Other: _____

Major Language: _____

No Formal Schooling _____ Formal Schooling _____ # of Years

EDS Remarks: _____

_____

PCM Information: Name_____ PCM # _____

Emergency Contact Information **Physician Information**

Name: _____ Name: _____

Address: _____ Address: _____

Work Phone Number: _____ Phone: _____

Home Phone Number: _____

Relationship of Emergency Contact: _____

Phone Number: _____

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 Dept	24	Other

Site Field 1_____

Site Field 2_____

Site Field 3_____

Participant Termination Information
Termination Date _____
Reason for Termination _____
Narrative on Termination
_____
_____
_____
_____

Date of Death _____ Place of Death _____

PE/TIF Revision/Edit Date _____