CSS ENROLLMENT/ADMISSION FORM

☐ **New** ☐ **Existing**

Consumer Name (Last, First):		
Referral Source: ☐ **Hospital** ☐ **State** - Choose One - ☐ **County** ☐ **Community** ☐ **Inter-Agency**		
Enrollment Date: (*Date consumer was determined eligible for CSS per medical necessity criteria)*:		
Admission Date (*Date consumer is in the community)*:		
Date of Birth (M/D/YYYY):	**Gender:** ☐ **M** ☐ **F**	
Diagnosis (ICD 10):	☐ **Medicaid** **Consumer Medicaid #:**	
☐ **Medicare No.:**	☐ **State Funding**	
☐ **Commercial Ins. Name of Co.**	**Policy No.:**	
CSS Initiative: ☐ **Generic** SPC 19 ☐ **RIST** SPC 20 ☐ **DDMI** SPC 21 ☐ **MESH** SPC 23 ☐ **Forensic** SPC 24 ☐ **ESH** SPC 25 ☐ **RIST/MESH** SPC 26 ☐ **At Risk** SPC 39		
Consumer's County of Residence:		
CSS Service Provider Name:		
CSS Provider Address:		
Phone Number:	**Fax Number:**	
Email Address:	**CSS Medicaid Provider #:**	

Agency Staff /Credential **Signature** **Date**