ENROLLMENT / DISCHARGE / TRANSFER (EDT)
STATE HOSPITALS AND 590 PROGRAM
State Form 32696 (R3 / 2-16) / OMPP 0747
FAMILY AND SOCIAL SERVICES ADMINISTRATION

Sections I, II, and III are to be completed by the institutional facility.

Please check one: ☐ New enrollment ☐ Update	Is the individual currently on Medicaid? ☐ Yes ☐ No	If Yes, enter RID number

I. NEW ENROLLMENT INFORMATION (*Only for first-time enrollments; updates should be entered in section III below.*)

1. Entrance date *(month, day, year)*	2. Last name	3. First name	4. Middle initial

5. Name of institutional facility

6. Address *(number and street)*

7. City	8. State	9. ZIP code	10. Date of birth *(month, day, year)*

11. Race	12. Sex
☐ White ☐ Black ☐ Asian ☐ American Indian ☐ Multiracial ☐ Other: _____	☐ Male ☐ Female

13. DOC or DMH / DDARS number	14. Social Security number *(required)*	15. Medicare number	16. Medicare effective date *(month, day, year)*

II. OTHER HEALTH INSURANCE

17. Name of policy holder	18. Relationship

19. Name of policy	20. Policy number	21. Type of insurance	22. Start date *(month, day, year)*	23. Stop date *(month, day, year)*

III. ENROLLMENT UPDATE INFORMATION

24. Date of death *(month, day, year)*	25. Date of release *(month, day, year)*	26. Date of parole *(month, day, year)*	27. (*Intentionally left blank for future use.*)

28. Date of transfer *(month, day, year)*	29. Name of institution being transferred from	29. Name of institution being transferred to

TO BE COMPLETED BY INDIANA MEDICAID.

Original enrollment	RID number	Start date *(month, day, year)*	Stop date *(month, day, year)*
Update	RID number	Start date *(month, day, year)*	Stop date *(month, day, year)*