Reset Form

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

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 ☐ White ☐ Black ☐ Asian ☐ American Indian ☐ Multiracial ☐ Other: _____			12. Sex ☐ 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)*
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)*