

MI-Choice Participant Information

IDENTIFYING INFORMATION

Participant Name (Last, First, Middle Initial)

Last _____

First _____ MI _____

Title _____ (Mr, Mrs, Ms, Miss, Dr, Father, Mother, Brother, Sister)

How do you prefer to be addressed?

Primary Language

English Spanish French Other

Communication Support Needs

Interpreter, devices, sign language, etc.

Date of Birth / /

Gender Male Female

Marital Status

- Never Married
- Married
- Widowed
- Separated
- Divorced
- Other
- Partner/Significant Other

Education -Highest level completed

- None Tech or Trade School
- 8th Grade/Less Some College
- 9-11 Grade Bachelor's degree
- High School Graduate degree

Is Person Hispanic or Latino No Yes

Race

American Indian or Alaska Native No Yes

Asian No Yes

Black or African American No Yes

Native Hawaiian or Pacific Islander No Yes

White No Yes

Religious Affiliation

Religious affiliation _____

Contact _____

Area Code _____

Phone _____

Family Contact Information

Name _____

Relationship to Person _____

Area Code _____

Phone _____

Comments: _____

Phone

Type: Home, Mobile, Work, Nursing Facility

Area Code _____

Phone _____

Nursing Facility Admission Date / /

Alternate Phone

Type: Home, Mobile, Work, Nursing Facility

Area Code _____

Phone _____

Hospital Admission Date / /

Preferred Method of Communication

Phone Email Text Other

Person has Advance Medical Directives in place
(i.e. a do not hospitalize order)

No Yes Pending

If other, please specify:

Name _____

Phone _____

Email _____

Advance Medical Directives

Name _____

Area Code _____

Phone _____

My Advance Medical Directives are located: _____

MI-Choice Participant Information

IDENTIFYING INFORMATION, continued

Medicaid ID <input style="width: 100%;" type="text"/>	Annual SD Budget Due Date <input style="width: 100%;" type="text"/>
Medicaid Application If pending, date application submitted Medicaid Determination Date	PDN Renewal Due Date <input style="width: 100%;" type="text"/>
SSI <input type="radio"/> No <input type="radio"/> Yes	Counseling Renewal Due Date <input style="width: 100%;" type="text"/>
QMB <input type="radio"/> No <input type="radio"/> Yes	Section 8 Housing Voucher Renewal Due Date <input style="width: 100%;" type="text"/>
MA Case Number <input style="width: 100%;" type="text"/>	Patient Pay Amount \$ _____
Medicaid Re/Certification Due Date <input style="width: 100%;" type="text"/>	Medicare ID <input style="width: 100%;" type="text"/>
CHAMPS Redetermination Date <input style="width: 100%;" type="text"/>	Part A Effective <input style="width: 100%;" type="text"/>
DHS Case Worker Name Area Code Phone	Part B Effective <input style="width: 100%;" type="text"/>
Level of Care (LOC) Entry Date to DCH Web Site <input style="width: 100%;" type="text"/>	Part D Effective <input style="width: 100%;" type="text"/>
LOCD Renewal Due Date <input style="width: 100%;" type="text"/>	Medicare Part D Company Name Company Area Code Company Phone Card Number
Application ID <input style="width: 100%;" type="text"/>	MA Spend Down
Annual Enrollment to Field Office Due Date <input style="width: 100%;" type="text"/>	Veterans ID
Annual Release of Information Due Date <input style="width: 100%;" type="text"/>	Veteran <input type="radio"/> Person <input type="radio"/> Spouse <input type="radio"/> Child <input type="radio"/> Other <input type="radio"/> Not A Veteran
Liquid Nutrition Supplement Due Date <input style="width: 100%;" type="text"/>	Benefits Received <input type="radio"/> No <input type="radio"/> Yes
Liquid Nutrition Replacement Due Date <input style="width: 100%;" type="text"/>	Social Security Number <input style="width: 100%;" type="text"/>
Oxygen Renewal Due Date <input style="width: 100%;" type="text"/>	Comments

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ADDRESS

Address for Period

Start Date:

Stop Date:

Line 1:

Line 2:

City:

State:

Zip code:

Zip + 4:

County:

Main Address

Type:

Township:

Evacuation Code:

Directions to home:

Comments:

Mailing Address

Address Name (such as "daughter's house" or "person's PO Box")

Addressee (such as "person's name c/o")

Line 1:

Line 2:

City:

State:

Zip code:

Zip + 4:

Billing Address

Address Name (such as "daughter's house" or "person's PO Box")

Addressee (such as "person's name c/o")

Line 1:

Line 2:

City:

State:

Zip code:

Zip + 4: