

Appendix B. LIFE Participant Demographic Form

Name: _____
(First, Middle, Last)

Address: _____
_____, PA _____

Date of Birth: _____ Social Security Number: _____

Gender Designation: Male Female Non-binary/other

Ethnicity: Hispanic Non-Hispanic

Race: American Indian/Alaskan Native Asian Black/African American
 Native Hawaiian/Pacific Islander White Other

Payor Source

1. Is the participant private pay? Yes No
2. Is the VA the payor for the participant? Yes No
3. Does the participant have Medical Assistance? Yes No Pending

If yes, please complete:

Medical Assistance: _____ - _____
County # Record # Line #

Recipient ID #: _____

4. Does the participant have Medicare? Yes No Pending

If yes, please complete:

Medicare ID #: _____ - _____ - _____
Part A Part B

5. Does the participant have other health insurance/payor source? Yes No

If yes, please complete:

Insurance Name: _____

Insurance ID #: _____

Enrollment Information

LIFE Promise Provider ID #: _____

Service Location Code: _____ H-Code: _____

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Effective Date of Enrollment: _____

Service Begin Date: _____

Will an Alternate Care Setting (ACS) be used? Yes No

Referral Data

1. Did the participant receive Long-Term Care Services prior to enrolling in your LIFE program? Yes No If yes, where:

- Community Health Choices
- Nursing Facility*
- Options Program
- Other _____

**If the nursing facility stay was greater than 60 days, the participant may be eligible for Money follows the Person (MFP).*

2. The participant was referred to LIFE from:

- Independent Enrollment Broker
- Self
- Family Member/Caregiver
- Other _____