CSS ENROLLMENT/ADMISSION FORM

☐ New ☐ Existing

*Consumer Name (Last, First):	
*SSN:	
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 (DSM-V):	* Consumer Medicaid #:
☐ * Medicaid	☐ * NJ State Funding
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 #:

**Must be completed*

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